Massachusetts

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

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 09/01/2015 11.35.54 AM)

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 073130932

Expiration Date

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

Agency Name Executive Office of Health and Human Services

Organizational Unit Department of Mental Health

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. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/1/2015 11:34:43 AM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Beth

Last Name Lucas

Telephone 617-626-8084

Fax 617-626-8330

Email Address Beth.Lucas@massmail.state.ma.us

Footnotes:

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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**
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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 OPMâ€™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 childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™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 childrenâ€™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: Marylou Sudders

Signature of CEO or Designee[1]: _____

Title: Secretary, Executive Office of Health & Human Services Date Signed: _____

mm/dd/yyyy

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

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

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

July 9, 2015

Ms. Virginia Simmons
Supervisory Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the Commonwealth of Massachusetts, for the duration of my tenure, I delegate signatory authority to the Secretary of the Executive Office of Health and Human Services, or other official in this role for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Sincerely,

Charles D. Baker
Governor

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

State Information

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

Fiscal Year 2016

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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: MARYLOU SUDDERS

Signature of CEO or Designee[1]: M Sudders

Title: SECRETARY
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Date Signed: 17 July 2015
mm/dd/yyyy

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

Footnotes:

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

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

July 9, 2015

Ms. Virginia Simmons
Supervisory Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

Dear Ms. Simmons:

As the Governor of the Commonwealth of Massachusetts, for the duration of my tenure, I delegate signatory authority to the Secretary of the Executive Office of Health and Human Services, or other official in this role for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Sincerely,

Charles D. Baker
Governor

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

State Information

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

Fiscal Year 2016

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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: MARYLOU SUDDERS

Signature of CEO or Designee[1]: M Sudders

Title: SECRETARY
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Date Signed: 17 July 2015
mm/dd/yyyy

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

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:

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 7,838 square miles and an average of 839.4 people per square mile. In 2015, it had a population of 6,792,591, a 3.7% increase over 2000, and ranks 3rd in population density and 43rd in total land area among the states. The Boston region is the major employment and population center, with strong population growth predicted over the next two decades. The state is 190 miles, east to west, and 110 miles, north to south, at its widest parts. According to the U.S. Census 2014 population estimates, 83.2% of the population was white, 8.1% African-American, 0.5% Native American, 6.0% Asian, 2.2% some other race alone, 2.1% multiracial and 10.5% Hispanic or Latino The white population has increased approximately 2% since 2010. 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.

In Massachusetts, the population's mental health service needs are addressed via private health plans, public health plans, Medicare, the Commonwealth's Medicaid program (MassHealth), the Massachusetts Department of Public Health (DPH) and the Massachusetts Department of Mental Health (DMH). The following sections describe DMH's role in the behavioral health system and efforts to integrate behavioral health planning and services with these health plans, federal and state agencies to serve the Massachusetts population.

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. The Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department 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. 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 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, enabling them to live, work, attend school and fully participate as valuable, contributing community members. Additionally, services are

delivered flexibly, often in individuals' homes and local communities. 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, and MassHealth Managed Care Entities (MCEs).

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 and Adolescent 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 extended stay inpatient units, and child and adolescent intensive residential treatment programs. Within Central Office, there are offices of Human Rights and Recovery and Empowerment. Quality improvement activities and data analytics are also coordinated through the Central Office Division of Clinical and Professional Services. This Division also has primary responsibility for the Mental Health State Plan.

Each of the five DMH Areas is managed by an Area Director and Area leadership teams, which include medical directors, senior psychiatrists, child/adolescent psychiatrists, directors of community services, directors of child/adolescent services, and quality managers. Further, Child and Adolescent services are managed by six Child/Adolescent Directors aligned with an earlier six area structure. 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. They assess needs and resources and participate in planning and developing programs and services in their geographic domain. A Mental Health Advisory Council (MHAC), appointed by the Secretary of EOHHS and comprised of consumers, family members, professionals, interested citizens and advocates, receives and analyzes 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. 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 two advisory groups to the Office of Multicultural Affairs.

All of the state hospitals, Community Mental Health Centers, adolescent inpatient units, and child and adolescent 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.

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.

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 being continuously evaluated and refined to ensure individuals do not fall through the cracks when transferring from the MassHealth managed behavioral health care vendor (acute care) to DMH (extended stay/continuing care), and to ensure that individuals who need DMH services receive them.

Further, the DMH Child and Adolescent Services Division uses the Child and Adolescent 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 DMH adoption of the CANS promotes standardization of assessment and allows for cross-agency comparative analyses. DMH clients receiving case management now 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.

DMH conducts ongoing review of all its regulations to identify those regulations in need of revision to assure that they are up to date and reflect current practice and philosophy around person-centered, recovery oriented and trauma informed care. In making these revisions DMH assures adequate agency oversight and monitoring of the programs and services it provides, contracts for or licenses, while also seeking to streamline administrative processes and to reduce the regulatory burden for providers.

DMH 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 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.

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 funds two Centers of Excellence; one in Clinical Neuroscience and Neuropharmacology (Commonwealth Research Center at the Beth Israel Deaconess Medical Center, Harvard Medical School) and one in Behavioral and Forensic Sciences (Center for Mental Health Services Research at the University of Massachusetts Medical School). Both Centers are conceptualized as Public/Academic Liaisons, a model of interaction for clinical research championed by the Center for Mental Health Services. The Centers are structured independently with DMH and an accredited academic institution. They are expected to meet mutually agreed upon standards and to leverage DMH funds to procure outside research grants. The Centers provide general research assistance, as well as consultation to DMH-operated or contracted programs and DMH Central Office on request.

The current contracts stipulate several important enhancements intended to ensure a close working relationship between DMH and each Center, and between the two Centers. The enhancements include increased communications among all parties; a focus on multicultural research, especially in the area of eliminating disparities in services; a renewed focus on child, adolescent and family research; an emphasis on incorporating the perspectives of consumers and families in planning and implementing research; and the incorporation of a "Science to Service to Science" perspective in the Centers. The Deputy Commissioner for Clinical and Professional Services holds monthly meetings with representatives of the two Centers in order to ensure that these goals are being met.

The "Science to Service to Science" perspective is a direct response to the challenges identified in The President's New Freedom Commission Report, and the issues identified by the Institutes of Medicine. DMH is working collaboratively with the two Centers to identify promising research results that can be used to assist DMH in

meeting its mission, and to generally increase the visibility of research as a practical tool throughout the service system. Towards that end the two Centers co-sponsor an annual conference which brings together consumers, providers, and researchers to hear about current research and to identify future research priorities. Each Center maintains an active Consumer Advisory Board, including members who receive DMH services, that provides consultation, participates in organizing the annual conference and even initiates research projects.

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. 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.

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/Adolescent Human Rights Officers across the Commonwealth. Regulation and policy require that Human Rights Officers and Human Rights Committees be active in public and private inpatient settings as well as in state-operated and contracted community programs. Additionally, there is a statewide Human Rights Advisory Committee that advises and assists the Commissioner in matters regarding the human and civil rights of people served by DMH.

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. As of August 2015, thirty police-based JDPs were in existence or development.
- **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.
- **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. As part of the effort at improving collaboration with

DOC, enhanced coordination of services has taken place, such as the establishment of a joint DMH/DOC committee to review issues that arise in the care and treatment of female inmates with mental illness at Massachusetts Correctional Institute in Framingham who may be sent to DMH for evaluation and treatment or may be re-entering the community. Similarly, a committee comprised of representatives from DMH and the Bridgewater State Hospital (BSH) has been re-established. BSH is a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial as well as individuals otherwise committed for mental health issues from DOC prisons.

- **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 DFMH 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 and accountability for reducing mental health disparities among diverse racial, ethnic, and linguistic populations in Massachusetts by improving access to quality care. OMCA serves as the catalyst and synthesizes the recommendations of the Department's Cultural Competence Action Team, Multicultural Advisory Committee, and mental health stakeholders to create the DMH Cultural and Linguistic Competence Action Plan. http://www.mass.gov/eohhs/docs/dmh/p-cultural-action-plan.pdf. The Action Plan operationalizes the Department's mission of providing culturally and linguistically competent care to ensure that the state mental health system is attentive to the needs and effective care of culturally and linguistically diverse populations.

The Action Plan establishes goals and objectives on six critical system transformation areas to improve access to quality care.

- Community Partnerships - Partner with multicultural communities, mental health providers, community organizations, and government agencies in the planning, development, and implementation of culturally and linguistically

effective programs to support the Department's Community First Initiative for adults and children with serious mental health challenges.

- Leadership - Promote leadership in cultural competence and linguistic competence, recovery and resiliency in and outside of DMH to reduce mental health disparities.
- Services - Strengthen culturally and linguistically competent services throughout the entire DMH service delivery system and Children's Behavioral Health Initiative.
- Training and Education - Integrate mental health disparities and cultural and linguistic competence into training and staff development for DMH employees and staff at DMH contracted vendors. Provide educational activities to enhance communities' mental health literacy.
- Data and Research - Use of analyses on population census, service applicants, client enrollment and service utilization, client satisfaction, and outcomes to inform policy, research, program development, clinical practice, and workforce development to ensure equitable care and reduce mental health disparities.
- Information - Promote communication and information dissemination on issues of health and mental health disparities, mental illness prevention and total wellness promotion, and cultural and linguistic competent practices.

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

Training for Mental Health Providers

Ongoing professional development opportunities for staff continues to take place at the local level, including mandatory topics, Evidence Based Practices and other clinical and workplace management topics. The DMH Office of Training and Development sought to introduce new curricula into its training programs, beginning with its orientation requirements. A workgroup reviewed DMH's existing curriculum, which was designed primarily to reduce restraint and seclusion use in its inpatient facilities, teaching concepts from SAMHSA's Six Core Strategies. The workgroup extensively researched the existing literature in order to retool that curriculum to expand and integrate concepts of Trauma Informed Care and to include more opportunity for practicing primary prevention skills toward promoting a recovery oriented environment for persons served. Building upon that new training focus, the Personal Safety Workgroup simultaneously began development on a similar curriculum for community-based programs. This curriculum also promotes a collaborative recovery oriented focus while providing site specific information regarding safety for staff and persons served. Both curricula have been completed, Master Trainers have been trained and full roll-out across the agency is underway.

DMH continues to maintain its commitment to increasing diversity in the workplace by ensuring that all staff attends Diversity training. The following conferences were sponsored or co-sponsored by DMH and were open to DMH staff, people receiving services and provider staff and other stakeholders:

- Mental Health and Law Enforcement conference: Spotlight on Special Populations

- Fifth Annual Asian American and Pacific Islanders Conference: Healing through the Arts
- Preventing Violence, Trauma and the use of Seclusion and Restraint two-day forum and follow-up consultation with Maggie Bennington-Davis
- Second Annual Stephanie Moulton symposium on Safety
- Annual Mentally Ill/Problematic Sexual Behavior conference: Recovery in and Uncertain and Changing World: Public Policy and its impact of housing, working and living for people with mental illness and problematic sexual behaviors

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. Last year, each of the DMH Areas offered a wide variety of topics ranging from customer service training ("The Ripple Effect"), current trends in street drugs and gang awareness, resolution-focused crisis intervention, CBT for the treatment of schizophrenia, affordable housing options, understanding the DSM 5, human trafficking, recovery skills enhancement and specialized training for young adults in discerning their talents and gifts in preparation for career planning. Several facilities offer a range of monthly topics as well for both staff and people receiving services.

Emergency Service Provider Training

DMH continues to review and improve emergency plans at the Site, Area and Departmental level. The focus of these plans is for DMH to continue to provide services during a disaster event and to ensure the safety of the individuals DMH serves and DMH staff. DMH also ensures that all contracted providers have plans in place to make certain the providers' operations continue during an emergency event.

DMH partners with other state agencies to make sure that statewide disaster plans are cognizant of the needs of DMH consumers. This effort was entered into the statewide plan in 2014 via DMH participation MEMA committee (VPN) whose purpose is to plan services for disabled persons. DMH collaborates with the Department of Public Health (DPH) in the area of disaster behavioral health; this partnership includes integrating behavioral health into all phases of emergency response: mitigation, preparedness and recovery. DMH also serves as co-chair with DPH-BSAS, this committee meets quarterly to maintain the MassSupport Plan.

In 2012 and 2013, The Center for Multicultural Mental Health (CMMH) at Boston Medical Center (BMC) and the Emergency Preparedness Bureau at the Massachusetts Department of Public Health (DPH), in collaboration with the Massachusetts Department of Mental Health (DMH), began offering disaster behavioral health training for public health, healthcare, public safety, and other disaster response personnel throughout the Commonwealth. This project was developed through a contract with the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program. Unfortunately, the Federal funding to DPH was cut. In 2014, three trainings were provided under the Block Grant for staff who works with Children and LGBTQ in Psychological First Aid.

MassHealth and Medicaid Managed Care

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 and MassHealth ensure 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 also exercises its role as the State Mental Health Authority in overseeing this contract. Currently, additional populations of children and additional functions important to mental health services have been added to MBHP's work. DMH provides funding to manage the Emergency Services Program, some forensic evaluations, and the Massachusetts Child Psychiatry Access Progam (MC-PAP), a pediatric psychiatry consultation service, the children's Community Service Agencies and new children's services funded by MassHealth. Currently leadership from DMH and MBHP meet monthly to discuss areas of mutual interest and opportunities to collaborate.

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).

MassHealth implemented its Duals Initiative, known as One Care, on October 1, 2013. DMH was actively involved in the design of this initiative and remains actively engaged in implementation of the three chosen Plans, which are managed by three way contracts with CMS, MassHealth and the chosen One Care Plans DMH is very supportive of this initiative and has over about 1,300 clients enrolled. This initiative also has a unique feature of including DMH state-operated in-patient and out-patient facilities in the One Care networks, providing an opportunity for improved care coordination and new benefits.

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, 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 recommendations from the Governor's Opioid Addiction Working Group, procurements of MassHealth managed care entities, integrated behavioral and physical health models, and joint collaboration with state agency and academic partners, notably the Department of Corrections, Department of Youth Services. These initiatives are described throughout the Plan documents.

Comprehensive Community-Based Mental Health Services - Adult

Available Services Narrative

DMH directly provides and/or funds a range of services for approximately 25,000 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, emergency and outpatient 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.

The Community Based Flexible Supports (CBFS) service is the cornerstone of the DMH adult community-based system and serves approximately three quarters of all adults receiving a DMH community-based service. CBFS enhanced and transformed service components by combining into one service type the delivery of residential and community rehabilitative services that were previously provided via separate funding and through a more fragmented system.

DMH continued its redesign of the adult community mental health system with the re-procurement of respite services in SFY10. Respite services were realigned to integrate service planning with CBFS and enhanced with a new non-site based mobile capacity to maximize flexibility. New outcome measures were developed to emphasize the short-term nature of the service and the goal of community integration.

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. The new Clubhouse services contracts were implemented beginning July 2013.

During SFY15, DMH has been working 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). Emergency services are further described in the Crisis Services section.

DMH was appropriated funding for community service system expansion associated with the Balancing Incentive Program (BIP) that is targeted to assist with the discharge of at least 160 individuals out of DMH Continuing Inpatient Hospitals and into community placements. To accomplish this, DMH is expanding its PACT capacity by three new teams that will serve two Areas (one in the Central Mass Area and two in the Northeast Area) that are expected to serve at least 19 individuals discharged from DMH Continuing Care. Each team will have a maximum capacity of 50 which will translate into additional capacity in the community services system. DMH is also developing new capacity in CBFS that will enhance or expand resources to allow for at least 138 individuals to be discharged. DMH is planning to use this funding to purchase specialized community placements for 3 individuals.

DMH has been working with the Executive Office of Health and Human Services (EOHHS) to set rates for CBFS, Homeless Support Services, PACT and Respite. DMH anticipates competitive procurements for each service types once the rates are finalized.

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 that delivered some 1,000 units of supported housing in FY14 and the EOHHS Housing Committee that brings together all human service agencies in an effort to coordinate activity and promote good communication. 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 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, warm-lines and Recovery Learning Communities (RLCs).

Employment Services

In consideration of the evidence for supported employment, specifically the Individual Placement and Support/Supported Employment Model (IPS/SE) developed by Becker and Drake of the New Hampshire-Dartmouth Psychiatric Research Center, DMH is embedding and integrating supported employment within its community-based services. IPS is a core component of CBFS services. All CBFS providers are expected to utilize IPS principles and employment outcome data are collected from providers consistent with the IPS model.

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 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. CBFS providers are encouraged to address the needs of people served through collaboration, coordination, consultation and linkage to providers with specialized knowledge of alcohol and drug services. The delivery and coordination of substance abuse services is also a priority within PACT services. In addition, training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

Health and Mental Health Services

Medical and Dental Services

Please refer to Health Care System and Integration section.

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.

The redesign of DMH adult community-based services, including CBFS, is intended to promote community living and reduce hospitalizations by providing flexible and individualized services that are adjusted to meet the need of people served as they change. CBFS providers report person-level data to DMH on admissions to and discharges from acute-care psychiatric and medical admissions, crisis stabilization units, substance abuse facilities and skilled nursing facilities, as well as incarcerations. These data are used to report outcome measures of community tenure, hospitalization rates, and median lengths of stay, which are a core component of how DMH monitors provider performance. CBFS providers are expected to develop linkages with hospital and community providers to support community tenure. DMH's performance review system identifies people with multiple psychiatric and medical admissions for further discussion with CBFS providers to ensure that they are providing quality services and addressing service needs. DMH Respite services were also enhanced through re-procurement in SFY10 to integrate service planning with CBFS and provide new mobile capacity to enhance flexibility.

In addition, DMH collaborated with MassHealth on the rebid of the Emergency Services Program network, which was operational as of July 1, 2009. Several program enhancements including the inclusion of peers as staff and more crisis stabilization beds are expected to enhance community tenure.

DMH procured a new service, Peer-Run Respite in 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.

During SFY15, DMH discharged 135 clients from its continuing care facilities, creating new community placements and fulfilling the goals of the Community Expansion Initiative. To support the discharged clients, DMH designated a staff Liaison for each one, and developed Internal Protocols to provide clients with crisis planning and emergency services via a multi-disciplinary team.

DMH Community-Based Services

Case Management: 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.

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.

Community Based Flexible Support Services (CBFS): CBFS services support persons served as they increase their capacity for independent living and recover from mental illness. Services are individualized and delivered in partnership with each person served. The mix and intensity of CBFS services provided are flexible so as to meet each person's changing needs and goals. The flexible nature of CBFS cultivates resiliency and supports each person's path to recovery. CBFS Services are coordinated with the person's DMH services and, to the extent feasible, non-DMH services. Service goals include rehabilitation, support, supervision, stable housing, participation in the community, self management, self determination, empowerment, wellness, improved physical health, and independent employment. Individual Placement and Support (IPS) principles are incorporated into employment support services.

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.

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

DMH directly provides and/or funds a range of direct services for approximately 3,421 children and adolescents (ages 0 to 19) 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 4,000 parents across the Commonwealth who participate in an array of Family Support activities and groups. This latter initiative is available to all parents in Massachusetts whose children experience mental health

challenges and is not limited to parents of DMH youth clients. Publicly funded acute-care services, including inpatient, emergency and outpatient as well as some family stabilization and case management services are managed by MassHealth, except in one area of the state (Southeast) where DMH operates the emergency services; in this division, DMH serves approximately 1,500 children per year through nearly 4,000 encounters.

Health and Mental Health Services

Medical and Dental Services

Please refer to the Health Care System and Integration section.

Rehabilitation Services

As DMH is the primary provider/contractor of continuing care community-based services, the concepts of rehabilitation and support are at the core of its programs. However, the word 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, after-school day services, supported education and skills training, therapeutic foster care, 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 DMH/DCF Caring Together (CT) services, a unique collaboration between DMH and DCF which, through a single procurement, creates standardization in services, rate structure, administrative processes, quality oversight, and evaluation for all youth in need or at risk of out-of-home services, through a variety of different service models. Full implementation of Caring Together Services occurred on July 1st, 2014. Services under the Caring Together umbrella, which are designed using the principles and values of SAMHSA's Building Bridges Initiative (BBI), include:

- **Continuum:** For youth who meet clinical criteria for out-of-home placement, the Continuum provides intensive community-based wrap-around services with out-of-home services available as needed; includes on-going support and education to families regardless of where the services are provided. Continuum services can be delivered in group residential treatment programs, therapeutic foster homes, supervised apartments and the child's own home.
- **Residential School placements**: Purchase of available slots in Operational Services Division-approved, Department of Early Education and Care (DEEC)-licensed, 766 residential schools.
- **Group Home slots**: Purchase of available slots in a DEEC-licensed group treatment setting from the EHS Caring Together Master Agreement.

In addition to community based services, DMH also contracts for continuing care inpatient services for adolescents, and for secure intensive residential treatment programs. Emergency services, available to the community at large, are provided through the MassHealth contracted behavioral health vendor (MBHP), except in one DMH division in which they are state-operated. 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 continuing care 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, 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.

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.

Employment Services

The focus on transition age youth and young adults, ages 16-25, has increased the attention given to pre-vocational skill development and 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 training for case managers in understanding the requirements of IDEA in regard to transition have focused on helping them learn to use the IEP to promote vocational preparation, and also about services available through the Massachusetts Rehabilitation Commission (MRC). Family Support Specialists have also been trained on these topics.

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. DMH also continues to add Transition Age Youth Peer Mentor positions within the agency.

Through the leadership of DMH's Director of Employment, DMH and MRC have recently signed a "Memorandum of Understanding (MOU)." Through this MOU, an "Implementation/Steering Committee" will be created consisting of staff from both agencies, as well as young adult representatives. While this committee is addressing needs for the adult population, there is an inclusion on serving special populations (e.g. transition age young adults).

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 has also been active in a Transition Age Youth (TAY) education and employment interagency workgroup comprised of representatives from MRC, Commcorp, and Department of Elementary and Secondary Education (DESE). This workgroup is identifying those elements needed to successfully educate and employ transition age youth through the expansion of best practice models such as Wayside's TEMPO program in Framingham and Elliot Human Services Youth Adult Vocational Program (YAVP) in Arlington.

In addition, DMH is entering the third year of operating the SAMHSA System of Care Expansion Grant, known as STAY (Success for Transition Age Youth). The project has expanded from the six original pilot Community Service Agencies (CSAs) to ten sites. A total of 18 part-time peer mentors positions now exist at the CSAs. Peer mentors are fully integrated into the treatment teams and are key to successfully reaching and engaging youth/young adults aged 16-21 in services. All peer mentors participate in the GIFT training and in addition, some have become certified peer specialists. According to Child and Adolescent Needs and Strengths (CANS) data, the six pilot sites are now seeing more young adults that they were prior to STAY and the pilot sites are seeing a greater number of young adults that the CSAs without STAY. The project has developed a sustainability plan for peer mentoring through billing Medicaid under therapeutic mentoring codes. This strategy was developed with collaboration and support from MassHealth, CBHI and the CSAs. CSAs are piloting this strategy now with a plan to phase in fully when grand dollars end. The hope is to sustain the role of the young adult peer mentors and to further build a career ladder for young adults interested in pursuing mental health careers. Additionally, 16 Intensive Care Coordinators (ICCs)

completed Achieve My Plan (AMP) training and certification in SFY15. This enhancement to Wraparound provides ICC with an additional tool for reaching young adults in a developmentally appropriate way that is youth driven.

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 in our society 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 its clients. DMH maintains housing staff which works with DMH providers and state and local housing agencies to promote housing supply development efforts in support of DMH's locally administered discharge planning process and to achieve other DMH agency-wide housing and community-based treatment goals. DMH Central Office housing staff works with Area Housing Coordinators in each of DMH's five Area offices.

A few members of the Youth Development Committee (YDC) have joined the State Mental Health Planning Council's newly established Housing Subcommittee to represent and ensure the housing needs and concerns of young adults are addressed. Staff from the DMH TAY initiative and STAY grant is partnering with the Housing Subcommittee and young adult peers to begin a focused discussion on the housing needs of young adults and reviewing existing models for young adult housing. DMH's Transition Age Youth Initiative has also been 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. The Commission submitted its final report to the Governor and the Legislature in March 2013.

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. In some Areas, DMH-funded staff participates on student support teams within schools.

DMH was also a co-funder and Steering Committee member of an EOHHS pilot project involving state agencies and 13 school districts and educational collaboratives to improve linkages between schools and mental health and social services. DMH was a member of the Task Force on Behavioral Health and the Public Schools. Between 2008 and 2011, the task force has developed a framework to increase the capacity of schools to collaborate with behavioral health providers as well as provide supportive school environments that improve educational outcomes for children with behavioral health needs. The framework reflects the intent of Chapter 321, the Children's Mental Health Law, and the Task Force to enhance school success for all students by creating a statewide infrastructure to improve behavioral health in public schools. The Task Force designed the organizational structure of the framework to encourage schools to tailor local solutions to address the needs of their communities. In addition to the framework, the Task Force created an assessment tool to measure schools' capacities in these areas. In 2009, the Task Force piloted this assessment tool and used the findings to finalize its recommendations. Work conducted by the pilot sites provided the Task Force with useful information regarding efforts undertaken by a diverse group of schools to address students' behavioral health needs. In August 2011, the Task Force released its final report, "Creating Safe, Healthy, and Supportive Learning Environments to Increase the Success of All Students" which details recommendations for statewide use of the framework. These recommendations are based on the assessment process undertaken in the pilot sites, and an exhaustive review of promising practices and innovative strategies from within Massachusetts and across the country.

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 Education, 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.

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 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.

Case Management Services

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.

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.

Although it does not provide acute-care hospitalization, DMH continues to attend to issues related to it. DMH collaborated with MassHealth on the rebid of the Emergency Services Program network, which was operational as of July 1, 2009. Several program enhancements including the inclusion of peers and parent partners as staff and the addition of youth mobile crisis intervention are expected to enhance community tenure.

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. In FFY14, PATH enrolled 2,197 individuals and of these, 330 obtained housing, 306 secured benefits, 83 secured employment and 189 received primary medical care. Of those enrolled 27% were between 18 and 34 years of age, 35% were 35-49 and 32% were 50-64, 2% were 65-74 and 1% were 75+. 11% of people were

Black / African American, 17% were Latino / Hispanic, and 73% were White. The majority of people (65%) were diagnosed with Affective Disorders, 11% were diagnosed with Schizophrenia or other Psychotic illnesses, 6% with Other Serious Mental Illness, and 16% Unknown. 45% were estimated to have co-occurring mental health and substance abuse disorders and 55% had a mental health diagnosis only. With respect to the housing status of the PATH enrollees, 73% were first contacted in shelter and 13% were living outdoors. Within the shelter / outdoors population, 22% were homeless for more than a year, 19% for more than 90 days but, less than a year, 20% more than 30 days but less than 3 months and 27% were homeless 30 days or less.

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. The Aggressive Street Outreach program that was funded through HUD McKinney was not supported by HUD in FFY14 and was discontinued. DMH supports this change as the outreach needs of homeless individuals can be adequately met by PATH and it allows the HUD funding to target the delivery of supportive housing in the community.

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). This program is funded at $668,000 annually through a HUD homeless grant, with an additional $490,000 from DMH and $165,000 from DPH. 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. Beginning in SFY15, DMH 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. The Commission submitted its final report to the Governor and the Legislature in March 2013.

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.

In 2012, members of the Elder Collaborative attended a SAMHSA Policy Academy on the behavioral health needs of older adults. At the request of SAMHSA, senior leaders from Elder Affairs, MassHealth, DMH and DPH Bureau of Substance Abuse Services (BSAS) attended a Northeast regional meeting at SAMHSA headquarters, which also included senior leaders from SAMHSA, CMS and ACL (formerly the Administration on Aging). As part of the action plan, the group committed to doing a summit related to this topic. The Summit on Older Adults: Behavioral Health Issues and the Coming Wave, was held on October 30, 2014. It was a joint effort of three state agencies, Department of Mental Health, Department of Public Health and the Executive Office for Elder Affairs, as well as the Massachusetts Association of Older Americans. This invitation only event was attended by over 100 health policy, health care delivery and aging services leaders. The speakers included Dr. Stephen Bartels, a researcher on aging and behavioral health issues from Dartmouth, Dr, Thomas McGuire, a Harvard health economist, and A. Kathryn Power, the Northeast SAMHSA Regional Administrator. The meeting was well received and most feedback emphasized the timeliness and urgency of the topic. The planning committee is producing a report on the event.

The focus of the group in SFY12-14 was to take a more in-depth look into the opportunities offered by the Affordable Care Act that fit both the Massachusetts state initiative and federal health care reform. These include becoming more involved in a number of initiatives in Massachusetts to integrate primary and behavioral health through the Primary Care Medical Home Initiative, the Dual Eligibles Initiative, Health Homes, Money Follows the Person and the Balancing Incentive Program. Previously, the Collaborative has strengthened relationships with the three dual Special Needs Plan (SNP) providers, known as Senior Care Organizations (SCOs) and engaged the DMH leadership in the Areas and Sites to hear about their work with older adult clients and how the Collaborative may be able to help. These outreach efforts resulted in DMH designating staff to focus on elder issues, the Directors of Community Services and supported EOEA as they received an Options Counseling grant from the Administration on Aging, with a major focus on mental health training. The DMH training department was instrumental in creating a successful and well received curriculum for Options Counselors.

Other relevant MassHealth developments in the last few years include significant work in the Primary Care Clinician Plan, Behvioral Health vendor carve out re-procurement to enhance primary integration and development of a more inclusive Integrated Care Management system in the contract award to the Massachusetts Behavioral Health Partnership (MBHP). In the recent past, improvements were made in the Emergency Services Program (ESP) provider network, operated by the Massachusetts Behavioral Health Partnership, effective July 1, 2009. Improvements focused on a new encounter-based data system which is proving helpful in the management and integration of peers into the ESP workforce. With the support of DMH, which is also a primary funder, there was a significant effort to engage other state agencies and local providers in this procurement through public forums. Stakeholder input had a significant impact on designing services for elders and other special populations. Through a performance incentive vehicle a few years ago the carve-out vendor trained clinicians in the ESP

system and aging network regarding the unique issues of assessing older adults and directing them to appropriate services.

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.

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. To address this need, DMH in collaboration with MassHealth, obtained a SAMHSA/CMHS System of Care Expansion Planning Grant for Transition Age Youth and their Families to determine how CBHI can assist youth and young adults transition to adulthood and actively partner with their families throughout this process. A TAY-led effort, the Planning Grant led to a series of recommendations that DMH and its partners are now implementing with the award of the SAMSHA/CMHS Implementation Grant in 2013. The implementation grant, STAY, supports the piloting of enhanced outreach, service planning, and engagement services for transition-age youth served by six MassHealth Community Service Agencies (CSA), including the creation of six TAY Peer Mentor positions.

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.

Needs: While initial training and ongoing support and consultation require significant resources to achieve fidelity and sustainability, funding is limited. DMH has often relied 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. This led to the redesign and procurement of Community Based Flexible Supports (CBFS) and Respite services in the adult system and planning for the re-procurement of Clubhouse services in SFY13. Within the child system, the re-procurement of Individual and Family Flexible Supports occurred in SFY12 and a joint procurement of residential services with the Department of Children and Families (DCF) occurred in SFY13. These changes were 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. Feedback obtained from youth and families served by DMH have also informed the implementation of the Children's Behavioral Health Initiative (CBHI).

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. In addition, DMH is actively pursuing opportunities under the federal Affordable Care Act. 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 on a number of opportunities available through the ACA as well as Chapter 227, 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 establishment of the Office of Multicultural Affairs is that cultural and linguistic competence becomes not only a structural priority within the State Mental Health Authority but an integrated focal point of increasing access to quality care for diverse populations.

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 have demonstrated leadership and innovation in developing and achieving the goals outlined in the multi-year Cultural Competence Action Plans, and in building analysis of mental health care disparities into DMH's quality improvement activities.

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

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

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

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

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

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

Footnotes:

State Health Plan

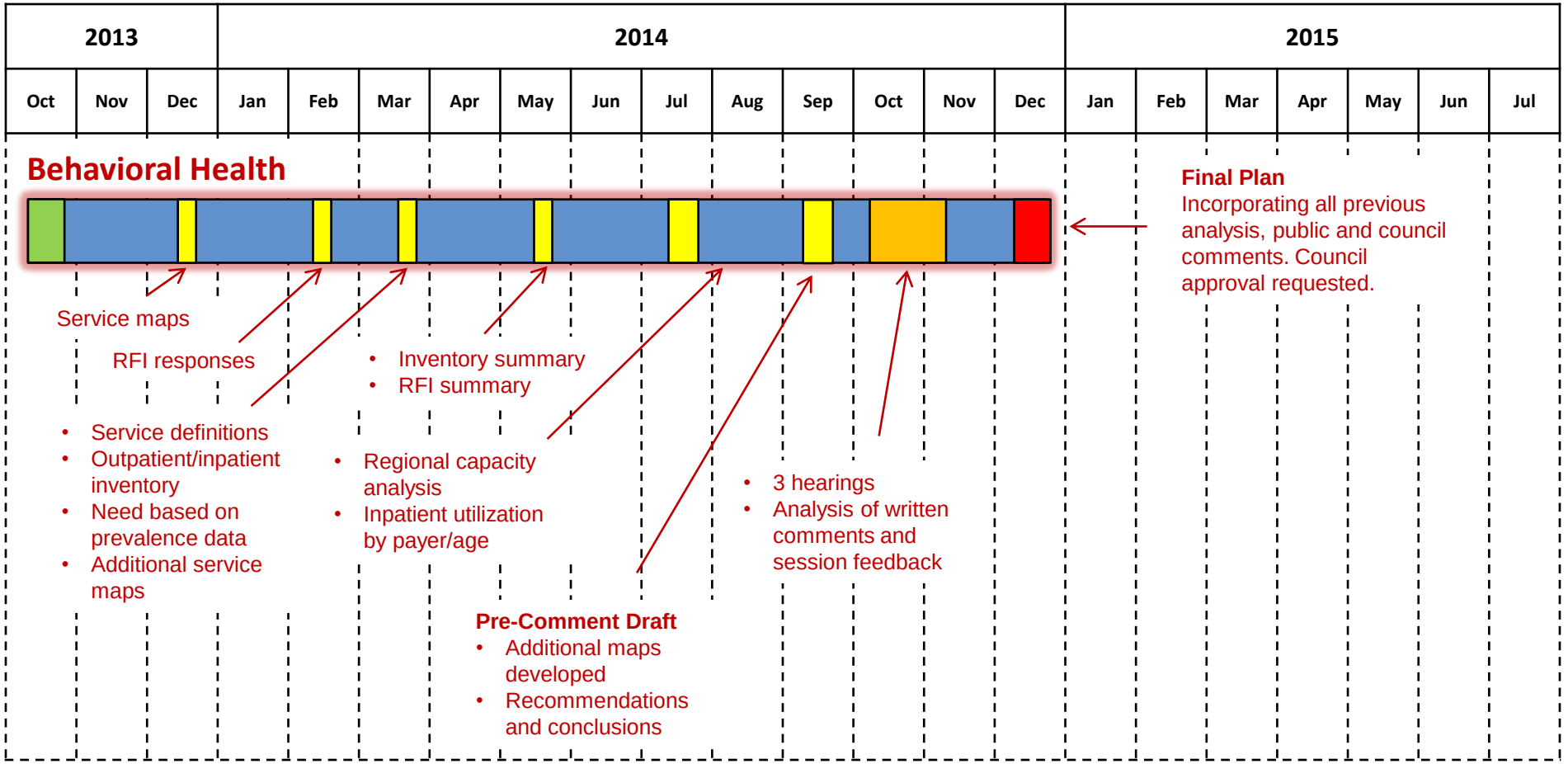
Behavioral Health

Massachusetts
Department of Public Health
December 2014
www.mass.gov/dph/ohpp

Slide 1

Commonwealth of Massachusetts
Department of Public Health

Health Planning Life Cycle



Council approval of service line

Data collection and analysis

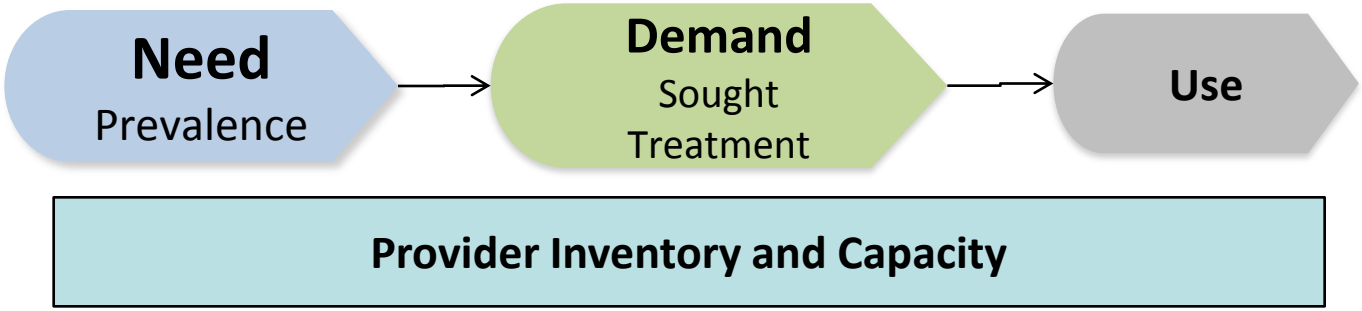
Draft reports presented at Council meetings

Public comments collected (written and hearings)

Final report approved (pending)

Slide 2

Analytic Road Map and Framework – Report



- What is the capacity of Massachusetts' behavioral healthcare system to serve those in need?
- Needs based upon national prevalence and survey data.
- Demand for services in behavioral health is highly elastic and data such as wait lists are not readily available. Many people meeting diagnostic criteria are not "ready" for treatment. Interviews, document review and comparisons of claims levels will help us comment on demand.
- Use data came from five primary sources: DPH-BSAS; DMH; MassHealth; Medicare 5%; APCD commercial data.
- Provider inventory is available primarily for licensed programs and is covered in this presentation.

Slide 3

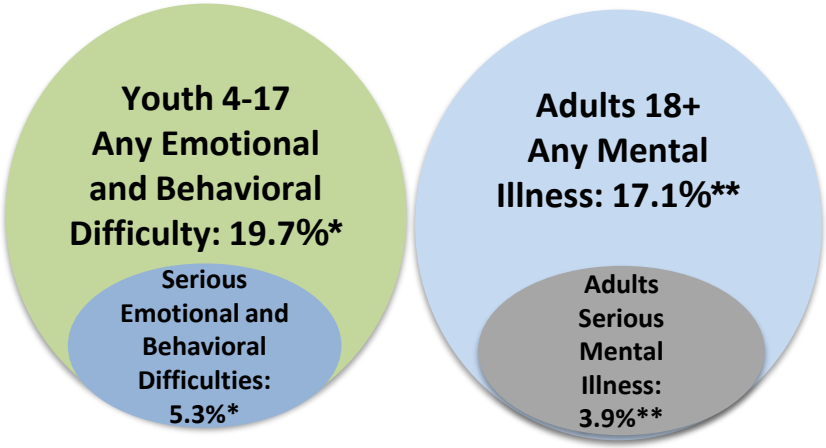
Estimation of Need

Summary: Need

- People with any signs of mental illness comprise 17-19% of the population; more serious conditions are reported for 4-5% of the population.
- People with substance use disorders are roughly 10% of the population, but national data suggest only 11% of these actually receive services.

Mental Health Conditions

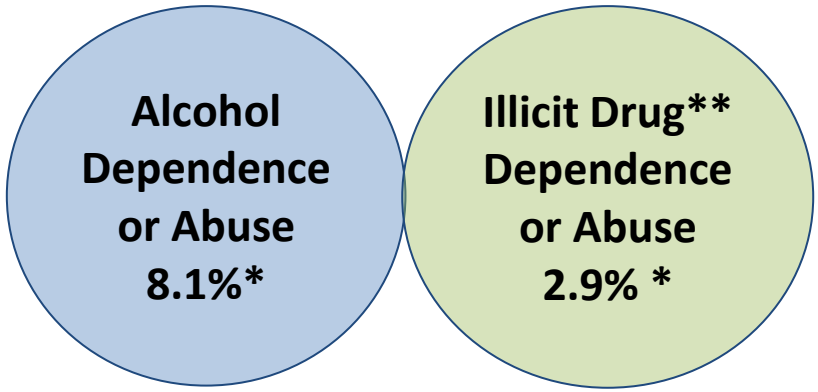
NSDUH and National Health Information Survey



* National Health Information Survey 2011
** National Survey of Drug Use and Health 2008-11 (rev 10/13) and 2012
***2014 population projections from UMass Donahue Institute

Substance Dependence and Abuse (MA)

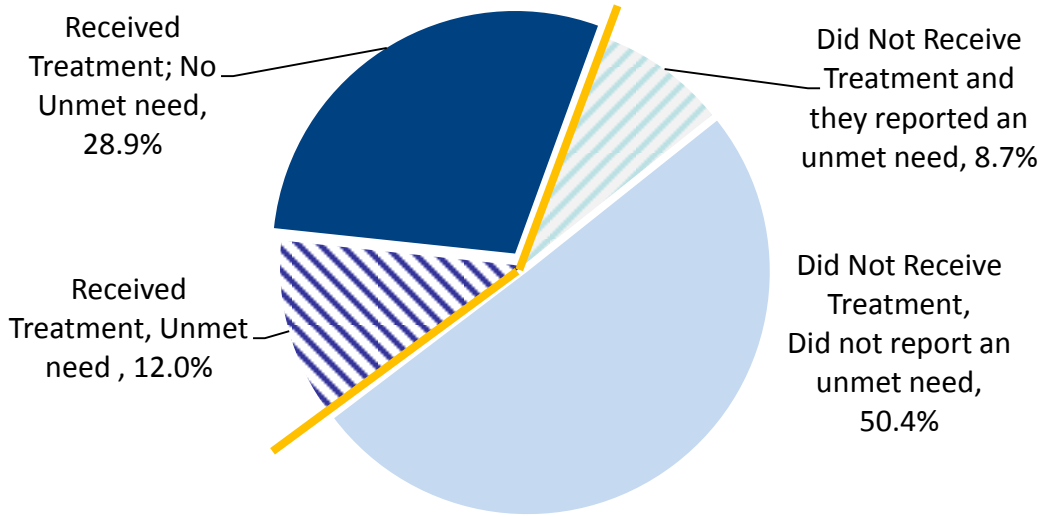
(2008-11 and 2012 NSDUH Combined)



**Dependence or Abuse Past Year Ages 12+* – NSDUH 2008-11 (rev 10/13) and 2012
***Illicit Drugs* include cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics and marijuana used non-medically
***NSDUH 2012
2014 population projections from UMass Donahue Institute

Significant Number of People with Any Mental Illness (AMI) Did Not Get Treatment and Did Not Report an Unmet Need

Unmet Need for Treatment in the Past Year and Receipt of Treatment, Among those with AMI, Ages 18+ in the US, 2012



Received Treatment?	Unmet Need? Yes	No
Yes	12.0%	28.9%
No	8.7%	50.4%

Respondents who were identified as having AMI were asked "was there any time when you needed mental health treatment or counseling for yourself but didn't get it?"

- 9% did not get treatment and yet they reported an unmet need
- Half of people reporting a mental illness did not get treatment, and did not report an unmet need (despite being identified with a mental illness)
- 12% got treatment, and reported an unmet need
- 29% who met the criteria for any mental illness were receiving treatment with no unmet need.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012
http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm - Tables 1.1A , 1.24A , 1.39A
Source on Massachusetts: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2013. HHS Publication No. SMA-13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857, p.9

Commonwealth of Massachusetts
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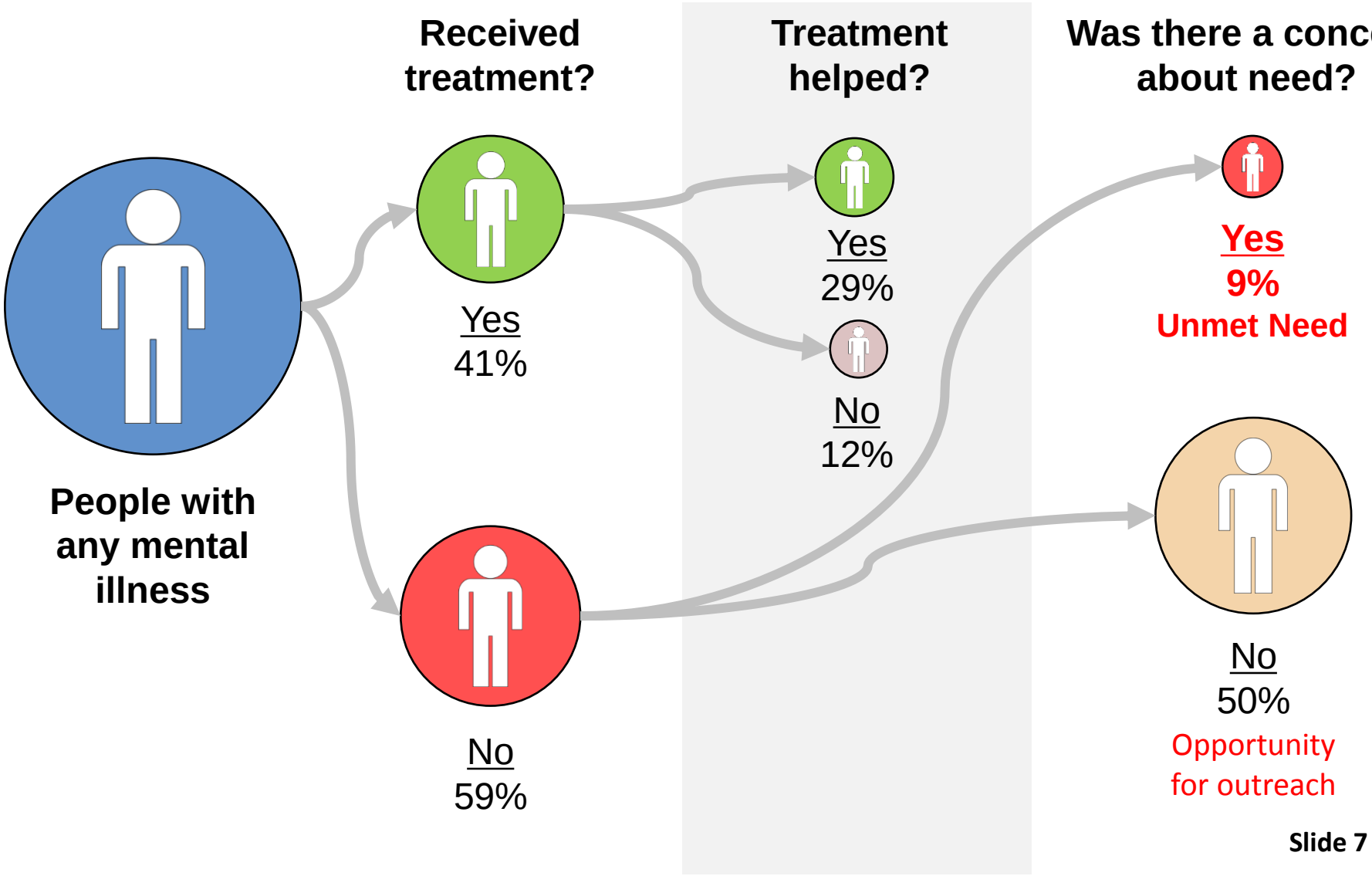
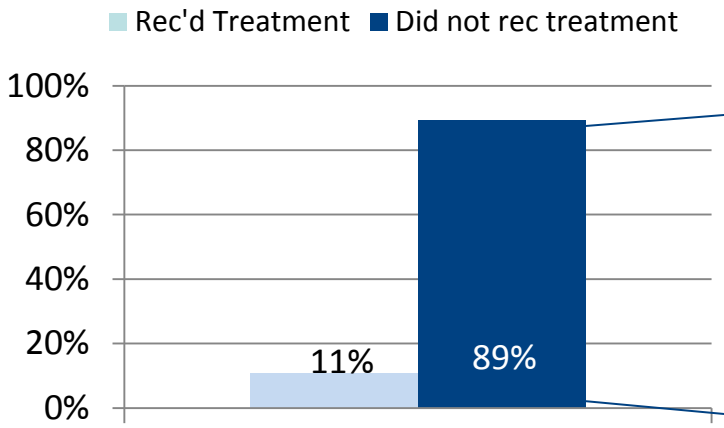
Significant Number of People with Any Mental Illness (AMI) Did Not Get Treatment and Did Not Report an Unmet Need



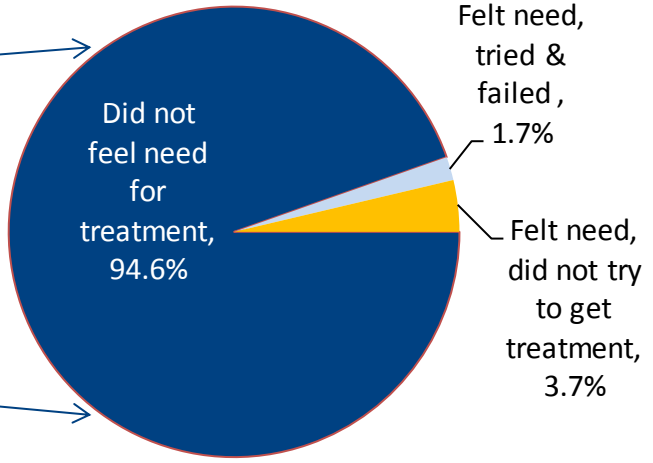
Slide 7

Significant Number of People with SUD Do Not Feel a Need for Treatment

Percentage of People with SUD who Received Treatment

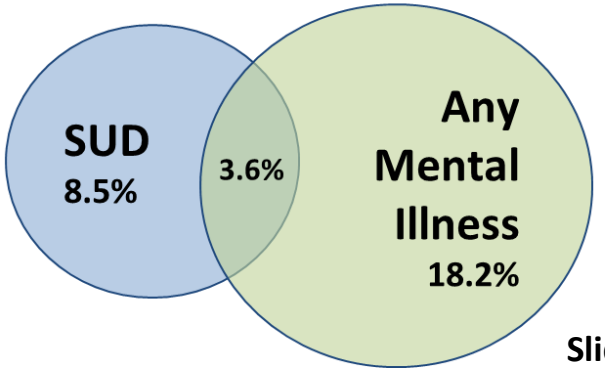


Percentage of People who did Not Receive Treatment by Perceived Need and Attempts to Get Treatment



- **Only 11% of people reporting an SUD received treatment**
- **Of the remaining 89%, most of these (95%) did not "feel the need for treatment" (awareness).**
- **3.6% of the 18.2% with AMI or 8.5% with SUD had co-occurring conditions**

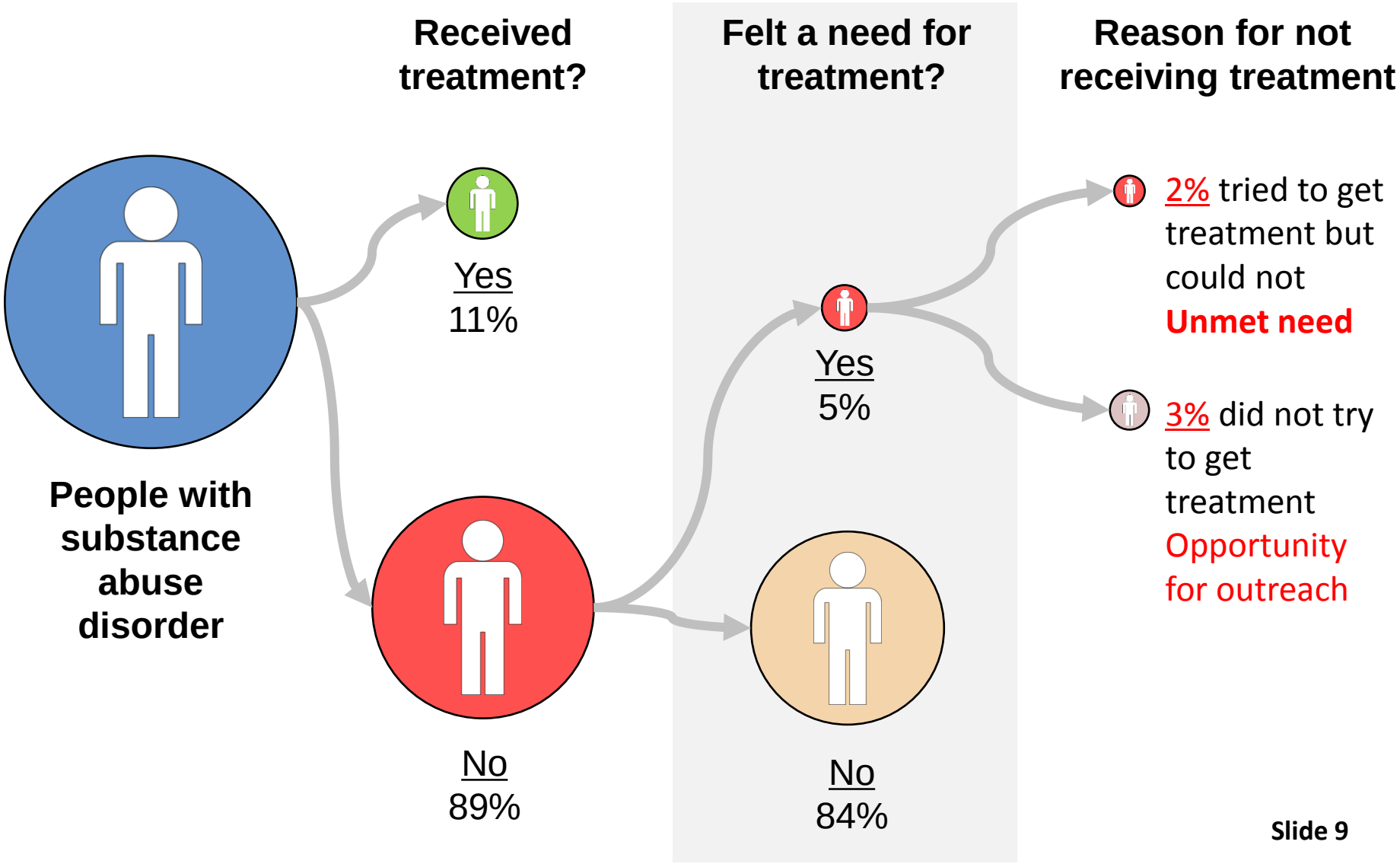
Co-occurring Substance Use Disorder & Mental Illness Conditions (US – 2012)**



Source on Need for and Receipt of Treatment: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012 - Table 5.51A , Table 5.53A - http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect5peTabs1to56-2012.htm

Slide 8

Significant Number of People with SUD Do Not Feel a Need for Treatment



Slide 9

Population Growth

- The Donahue Institute at UMass Boston developed population projections for Massachusetts that projected a modest 1.8% overall increase in the state's population over the next 6 years (in 2020 - see next page).
- Metro Boston showed the highest growth rate at 3.6% over that period, while the Cape and the Islands showed a minor decrease in population.
- Data were not readily available for racial and ethnic groups for the HPC regions and for utilization data.
- **These estimates have a very small impact on the capacity projections and the regional variation is also very small.**
- An increasingly aging population and improvements in health and wellness may in fact increase number of people with SMI and SUDs requiring long-term services and supports

HPC Region	2014 Estimates	2020 Estimates	% Increase
Western MA	821,826	826,758	0.6%
Central MA	763,769	787,434	3.1%
Northeast	1,401,973	1,410,555	0.6%
Metro West	660,610	667,763	1.1%
Metro Boston	1,575,595	1,632,689	3.6%
Metro South	820,790	838,931	2.2%
South Coast	340,404	342,096	0.5%
Cape and Islands	243,352	242,567	-0.3%
Total	6,628,319	6,748,792	1.8%

Source: UMass Donahue Institute – Special Analysis for Health Planning Council November 2013.

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Informational Surveys and Interviews

Informational Survey and Interviews

Selected interviews with state agencies, advocacy organizations, trade associations and others were conducted to supplement the survey results and better describe perceptions of need and service demand.

Informational Survey

- Distributed via email to over 1000 stakeholders on 1/24 with response due by 2/5
- Informational Survey content:

I. Background of the statute & introduction to Health Resource Planning

II. Brief overview of Behavioral Health services in MA & listing of services under consideration for planning

III. Four questions for response

Informational Survey

Four questions for response:

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

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

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

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

Summary Findings: Survey and Interviews

Summary of findings from two sources:

- The Request For Information (RFI) was released by DPH in January 2014. The majority of the 27 RFI responses came from provider organizations, with smaller numbers from statewide organizations and government agencies;
- Key Informant Interviews (March through April 10). Health Planning Council staff and consultants conducted 18 key informant interviews. The interviewees include state leaders, representatives of payors, managed behavioral health organizations, consumers, and other providers.

Summary Findings

Summary of Interview and Responses by Category

	Interviews	RFI Responses	Total	
			Number	Percent
Consumer/Family Association	5	2	7	16%
Government	3	3	6	13%
Payers and plans	3	3	6	13%
Provider	1	17	18	40%
Provider Association	6	2	8	18%
Total	18	27	45	100%

Most RFI respondents and interviewees are providers or stakeholders and offer their perspective from within the system, which may contain biases (though not always in the same direction). In order to minimize the impact of this bias on the findings of the report, feedback from consumers and observations of others, including experts on the Health Planning Council and Advisory Group, will complement findings from the RFI responses and interviews in the final report.

Stakeholder Feedback Process

DPH released a request for information in January 2014. There were 27 responses and 18 additional interviews were held with state leaders, payors, consumers and provider associations.

The following 5 points summarize the stakeholder input:

1. Compared to public payors, commercial insurers currently provide more limited coverage of residential recovery or treatment and other community services for mental health and substance abuse care.
2. Patient access to an optimal continuum of mental health and substance abuse care is seriously reduced by the limited capacity of residential and community care and of some types of inpatient care.
3. Low payment rates and funding are reported to adversely affect system capacity and access.
4. Divided responsibilities and a lack of statewide planning capacity have inhibited comprehensive understanding and improvement of behavioral services.
5. Data sources available to document the extent of the unmet demand for community services are in need of further development

Inventory

Commonwealth of Massachusetts
Department of Public Health

The Framework: Service Definitions

The Health Planning Workgroup organized services into eight major service categories that include all mental health and substance abuse services provided in the state. These service categories, which differ only slightly between mental health and substance abuse, provided a framework for thinking about the state's inventory and the utilization of services.

MENTAL HEALTH SERVICES		SUBSTANCE ABUSE SERVICES	
Service Group	**Definition**	**Service group**	**Definition**
Inpatient and Continuing Care	Acute or extended inpatient psychiatric hospitalization services	**Inpatient and Other Acute Care**	Care in hospitals and non-hospital settings for acute detoxification, stabilization and other substance abuse treatment
Intermediate Care	Services provided as a step-down or alternative to inpatient care	**Intermediate Care**	Care provided as a step-down or alternative acute care
Residential Care	Care provided in a 24-hour residential program	**Residential Care**	Rehabilitation services with a planned care program in a 24-hour residential setting
Community and Outpatient Care	Care in an ambulatory setting such as a mental health center, hospital outpatient clinic or a professional's office	**Outpatient Care**	Care in an ambulatory setting such as a community health center, substance abuse treatment program, hospital outpatient department, a professional's office, or a patient's home
Care Management	Services to manage mental health care or to coordinate with other health or social services	**Case Management**	Discrete services to manage substance abuse care or to coordinate with other health or social services
Bundled Services	A coordinated array of mental health and supportive services for people with mental illness living in the community		
Recovery and Family Support Services	Programs to help people support each other in their recovery from mental illness and to support families of children with mental illness	**Recovery Support Services**	Programs to help people maintain their recovery and support each other in recovery
Emergency Services	Care provided in hospital emergency departments and in specialized programs of emergency mental health services	**Emergency Response**	Care and other services provided for substance abuse-related emergencies

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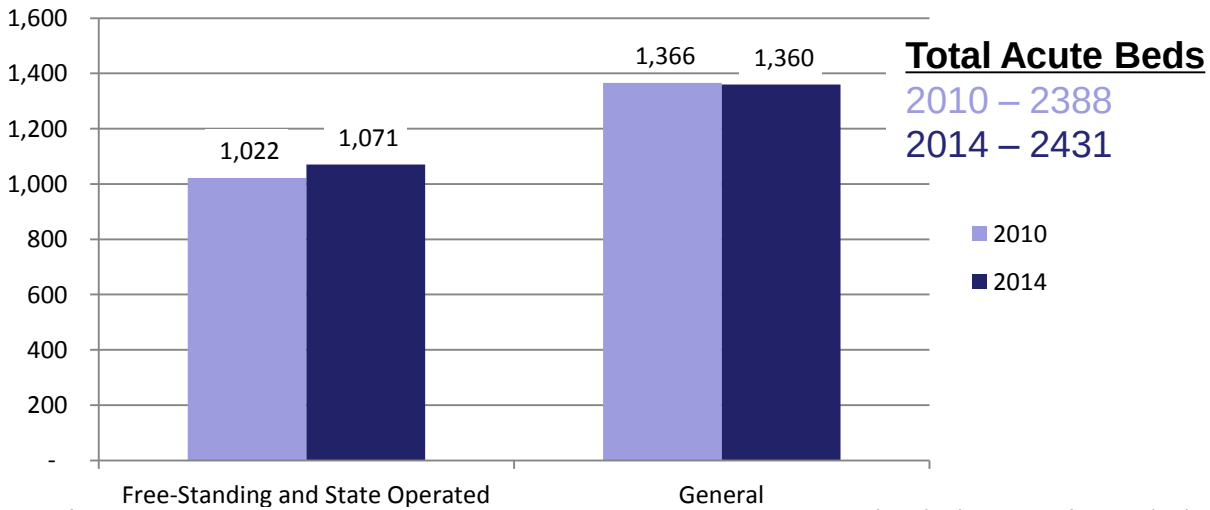
Mental Health Inventory

Inpatient Psychiatric Beds 2010 & 2014

There are a total of 67 acute hospitals or psychiatric units across the state, with 2,431 acute beds across different hospital groups.

- These facilities include 15 free-standing acute psychiatric hospitals, 50 psychiatric units in general hospitals, and two psychiatric units in state mental health facilities. Of the 2,431 beds, 43% are in free-standing hospitals, 56% in general hospitals, and 1% in state facilities.
- These 2,431 beds receive clients from a statewide population of 6.6 million residents, for a ratio of beds to population of 37 beds per 100,000 population.
- For age groups, 10% of beds are for children and adolescents, 73% of beds are for adults, 17% of the beds are in specialized geriatric units.

Inpatient Psychiatric Beds in Free-Standing Psychiatric Hospitals, General Hospitals and State-Operated Units, 2010 and 2014

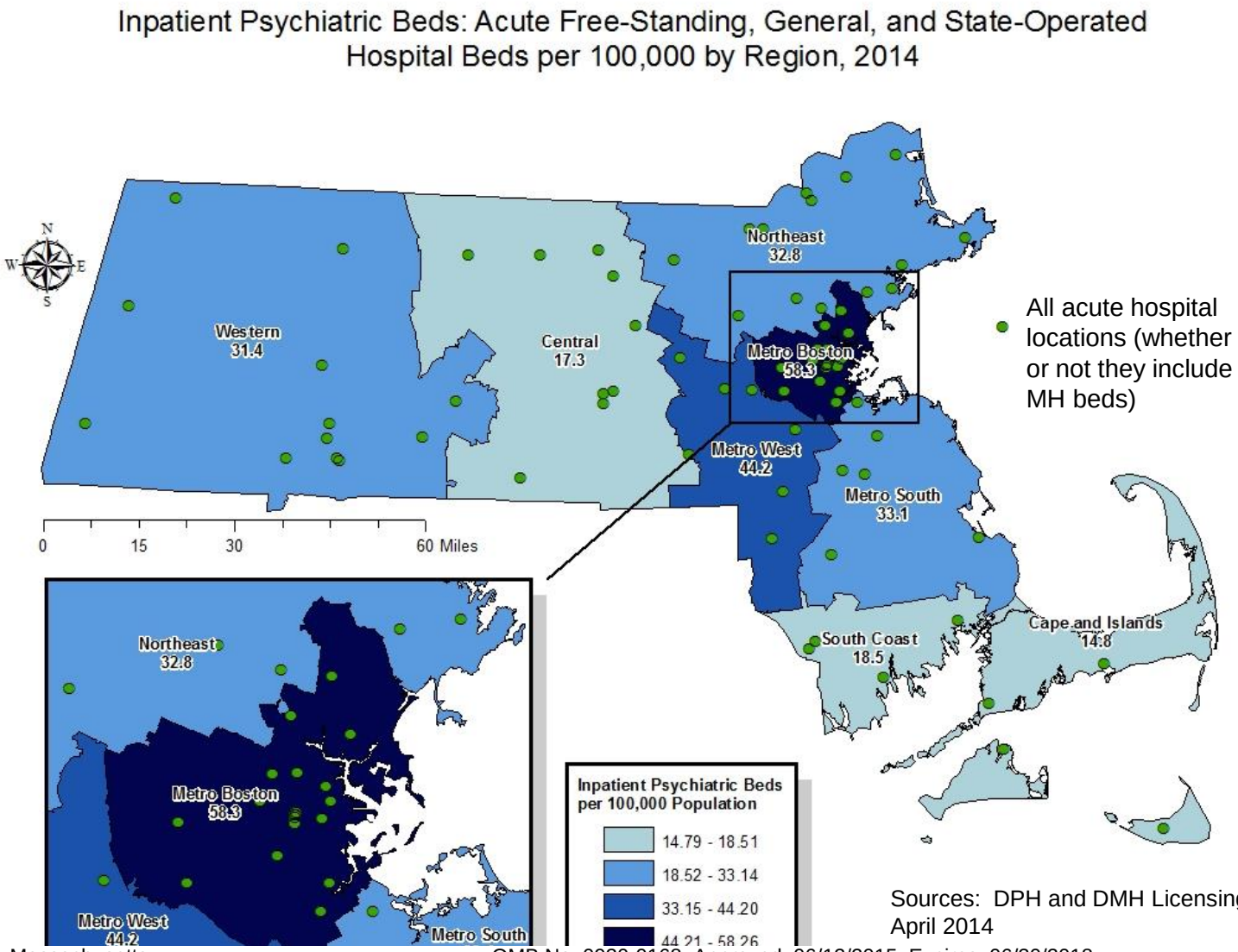


From 2010 to 2014, bed capacity has grown 5% among the free-standing hospitals and 2% among all hospitals.

Free-standing hospital bed growth of 5% over the last four years contrasts with no growth for general acute hospital psychiatric beds that may provide care for more complex, medically involved cases.

Source: DPH and DMH licensing data, March 2014 (prior to the closing of North Adams Hospital)

MH Inpatient Beds: 8 Regions

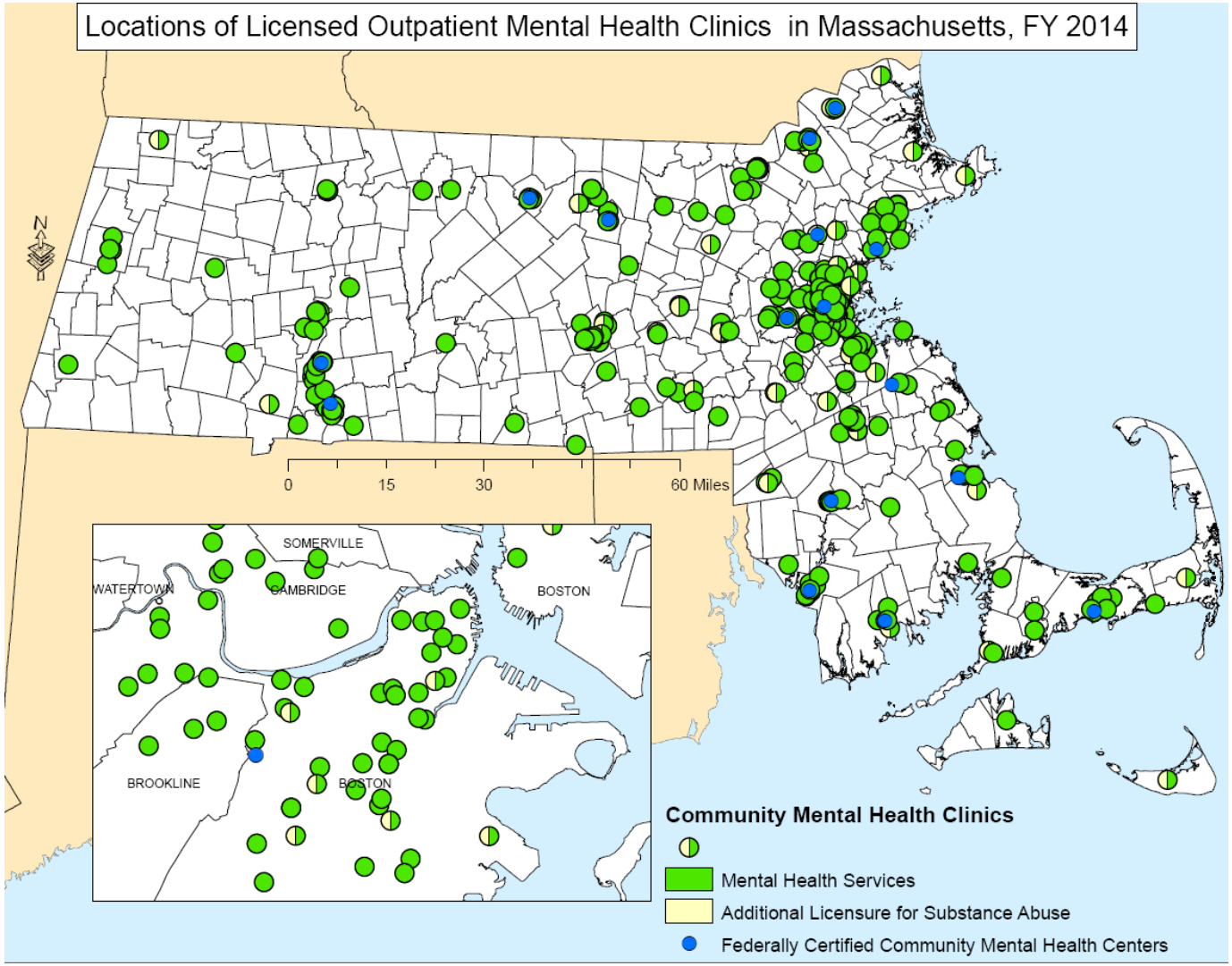


Bed density based on data from entire MA population.

Metro Boston has the highest concentration of beds while Cape and Islands, Central, and South Coast regions are the lowest.

Sources: DPH and DMH Licensing data, April 2014

Service Map:
Outpatient Mental Health Clinics



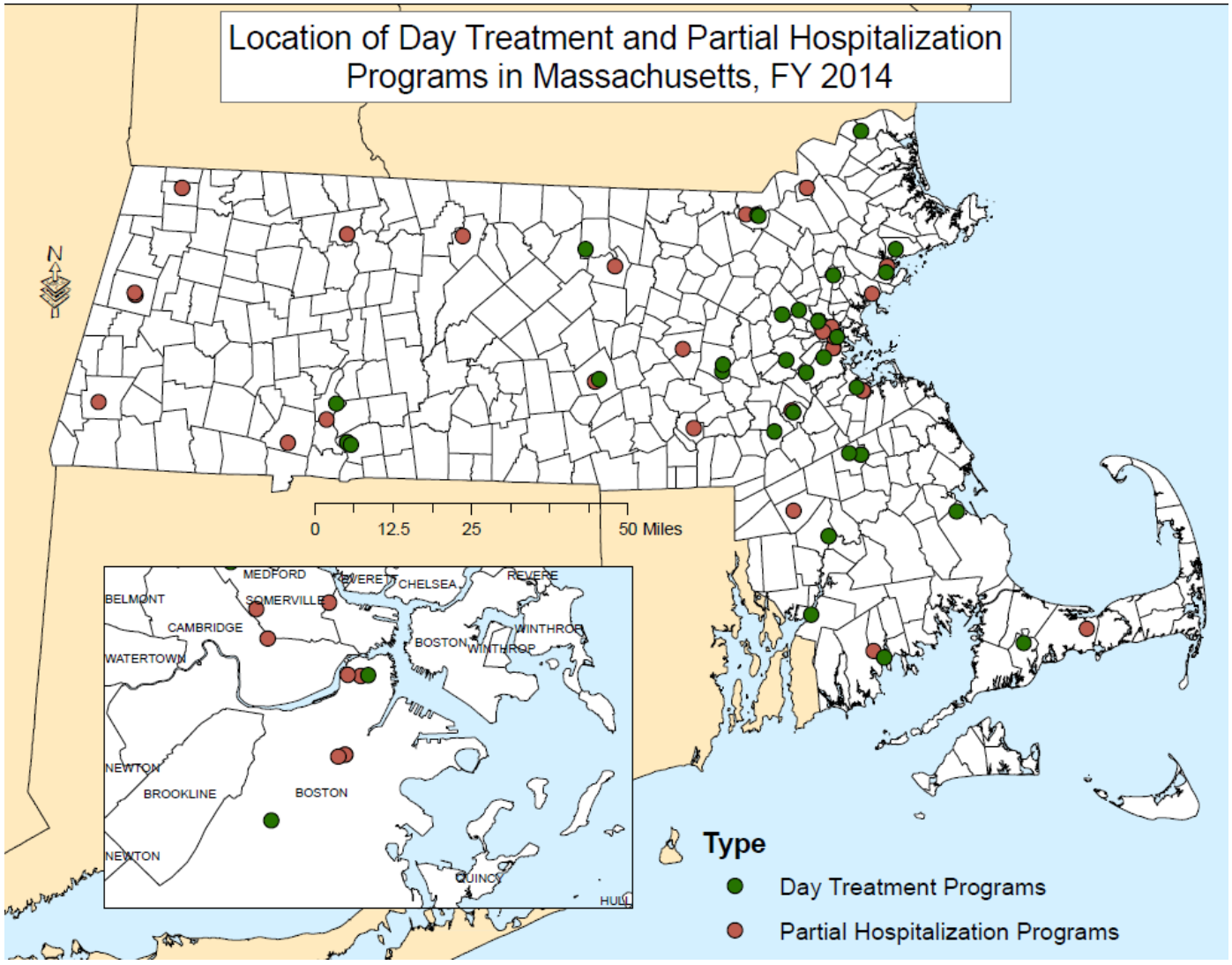
Data reflects a point in time and is updated as of 12/27/13

Outpatient Mental Health Clinics

- Outpatient mental health clinics deliver comprehensive diagnostic and psychotherapeutic treatment services in interdisciplinary team under the medical direction of a psychiatrist. Services include: diagnosis and evaluation; medication management; consultation; and individual, family and group treatment for people with Mental Health or Substance Abuse disorders.
- The green/yellow dots represent clinics licensed by the Department of Public Health (DPH), Bureau of Health Care Safety & Quality. Blue dots represent locations that meet federal requirements for mental health centers. Although any of the locations may treat individuals with a "dual diagnosis" of mental health & substance abuse, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat substance abuse. The dots do not represent any of the "private practitioners" who offer mental health or substance abuse treatment nor the clinics that are separately licensed by the DPH, Bureau of Substance Abuse Services.
- Services are available to people with public insurance or to those with private insurance that contract with these providers.

OMB No. 0930-0168 Approved: 06/12/2015 Expires: 06/30/2018

Service Map: Diversionary Services - Partial Hospitalization & Day Treatment Programs



Partial Hospitalization Programs

- Partial Hospitalization programs provide intensive short-term psychiatric outpatient day-treatment to individuals as a step-down from inpatient services or to prevent an inpatient admission. These programs are typically associated with acute inpatient psychiatric units/facilities .
- Each dot represents a facility that provides partial hospitalization services, licensed by the Department of Mental Health (DMH).
- These services are typically covered by private and public insurance.

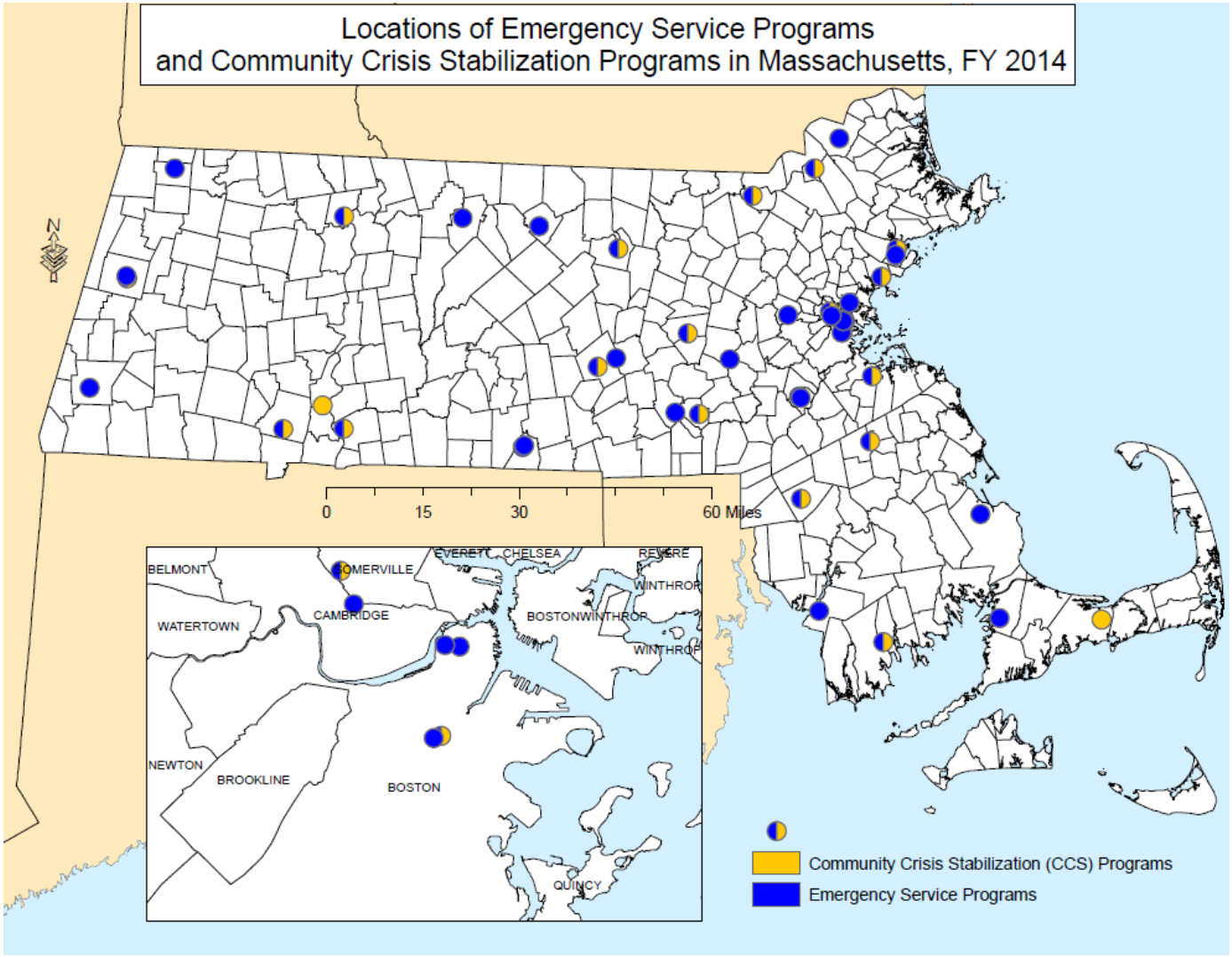
Psychiatric Day Treatment Programs

- Psychiatric Day Treatment programs provide a coordinated set of therapeutic supportive services to individuals who need more active or inclusive treatment than is typically available through traditional outpatient mental health services. The service is less intensive than partial hospitalization programs and typically of longer duration.
- They provide rehabilitative, prevocational, educational, and life-skill services to promote recovery and attain adequate community functioning .
- Each dot represents a provider organization that offers a psychiatric day treatment program, licensed by the Department of Public Health (DPH).
- These services are covered by public insurance and some private insurance

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: Diversionary Services- Emergency Service Programs & Community Crisis Stabilization Programs



Emergency Service Program (ESP)

- ESPs are a statewide network of emergency service providers providing a comprehensive, integrated program of crisis behavioral health services, including behavioral health crisis assessment, intervention and stabilization services.
- ESPs are distributed to community-based locations and emergency departments.

Community Crisis Stabilization (CCS)

- CCS programs are ESP components that provides a staffed, secure treatment beds in the community as an alternative to inpatient psychiatric services. Length of stay is typically shorter than acute care.
- Dots represent organizations funded via the Department of Mental Health (DMH) & MassHealth through a competitive process and found in the Massachusetts Behavioral Health Partnership Directory. And, DMH directly operates two ESPs in the Southeast Region.
- Services are available to people with public insurance, no insurance, or to those with private insurance that contract with these providers.

Data reflects a point in time and is updated as of 12/27/13

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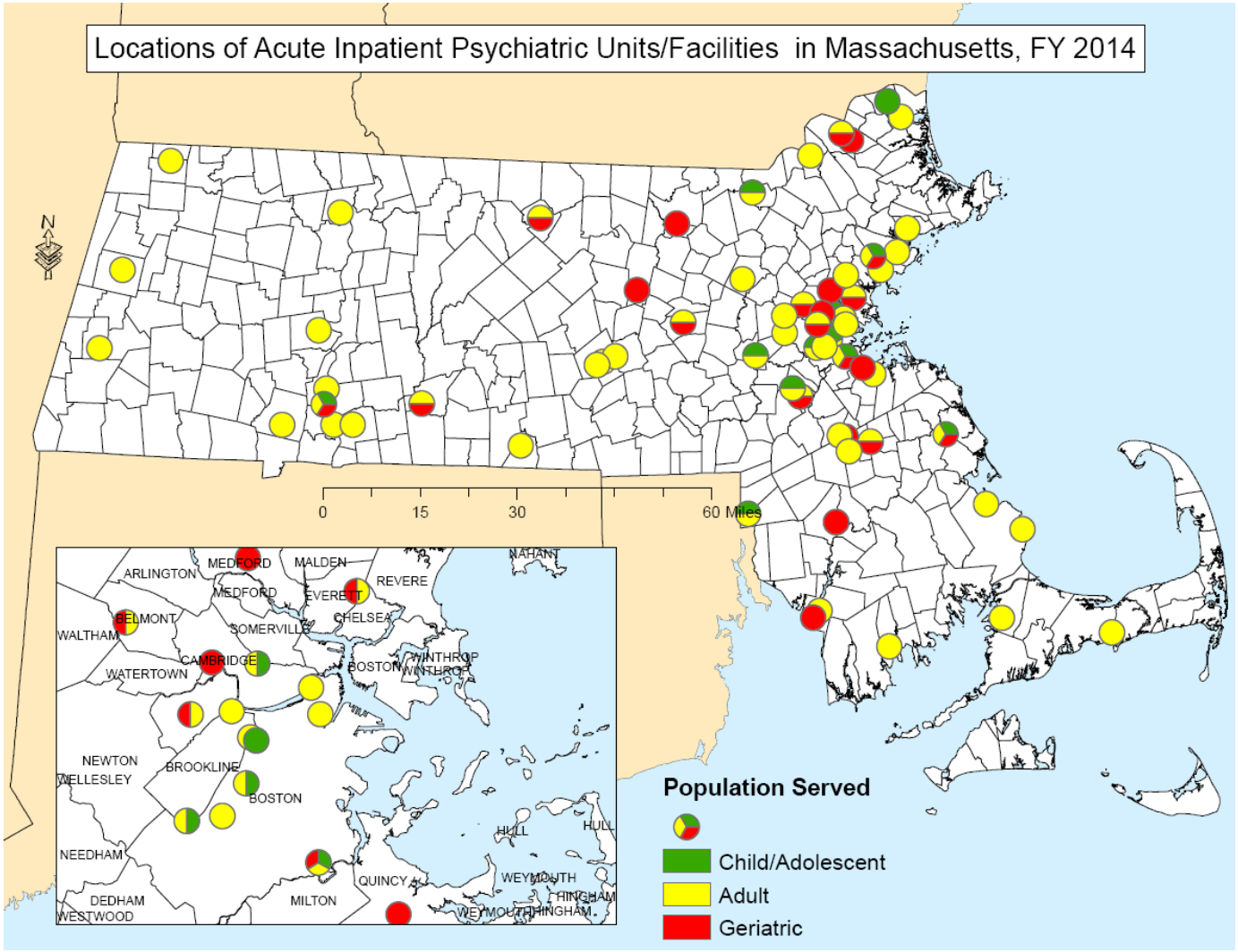
Service Map:
Acute Inpatient Psychiatric Units/Facilities



Acute Inpatient Psychiatric Units/Facilities

- Most individuals who need psychiatric inpatient care receive such services at an acute inpatient psychiatric unit in a general hospital or a private psychiatric facility.
- Psychiatric units in general hospitals and private psychiatric hospitals provide short-term, intensive diagnostic, evaluation, treatment and stabilization services to individuals experiencing an acute psychiatric episode.
- The dots represent the general hospital psychiatric units and private acute psychiatric hospitals licensed by the Department of Mental Health (DMH). In addition, DMH operates two inpatient units at Community Mental Health Centers in the Southeast region.
- Services are available to people with public insurance and to those with private insurance that contract with these providers.

Data reflects a point in time and is updated as of 12/27/13

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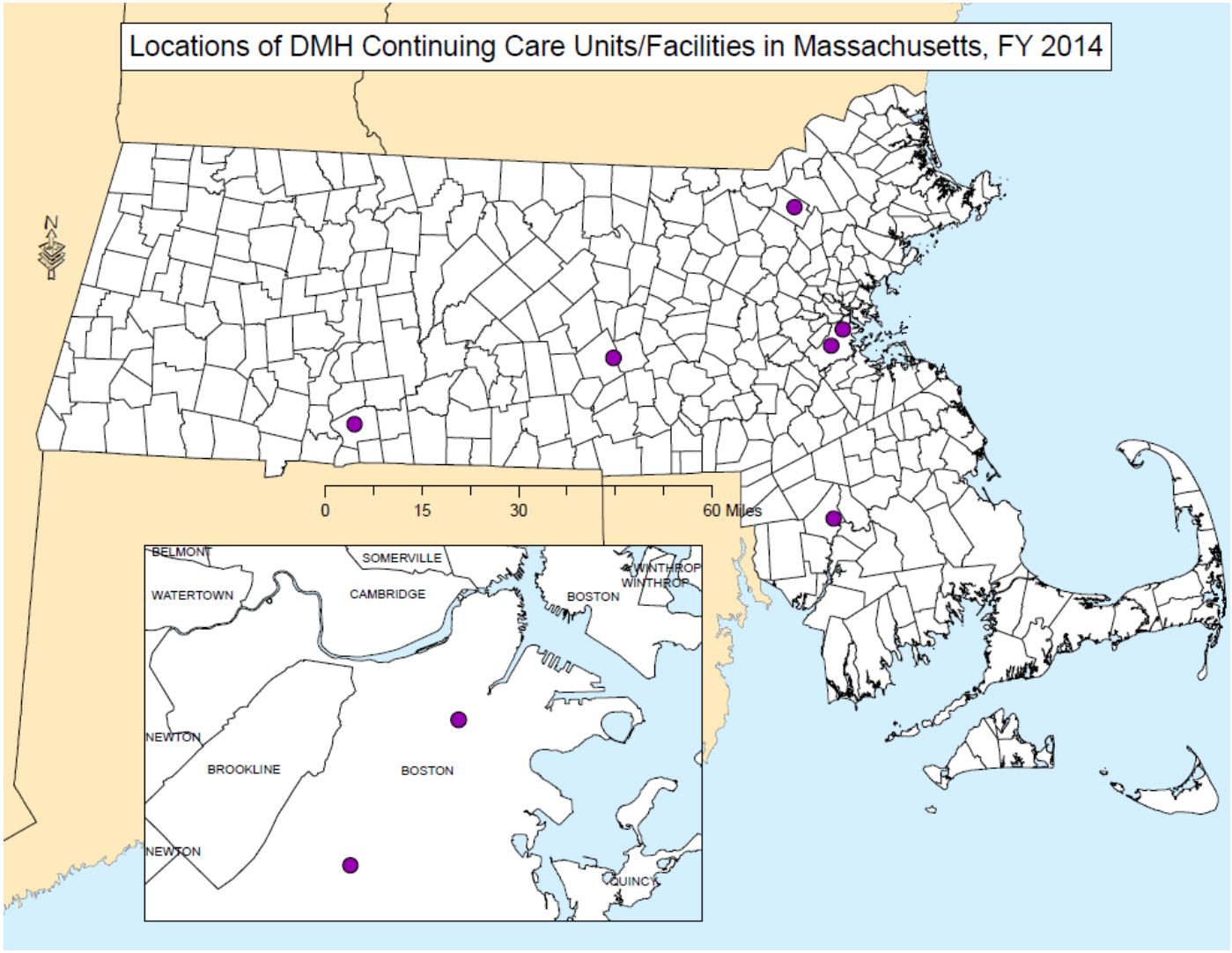
Service Map:
DMH Continuing Care Units/Facilities

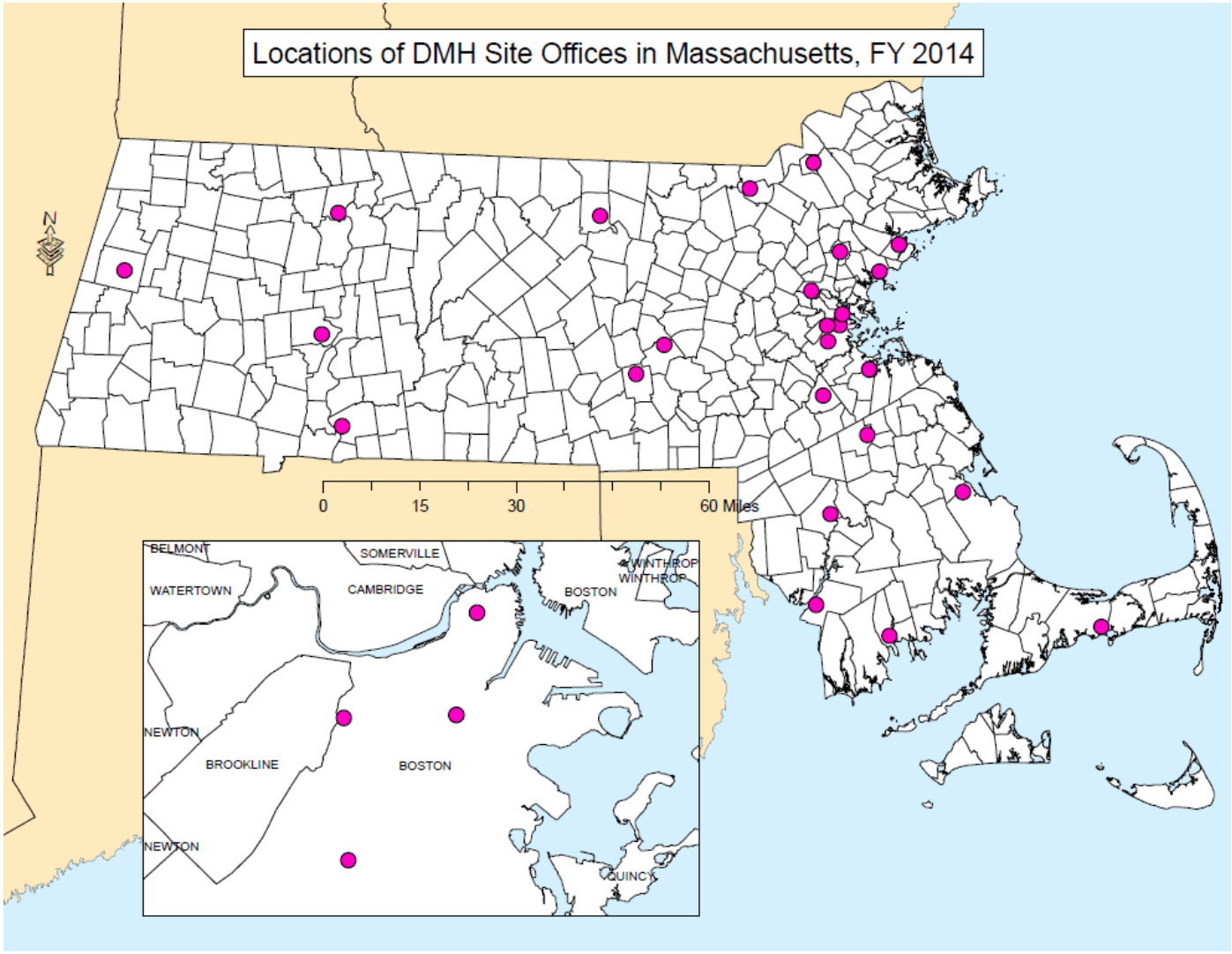


Department of Mental Health (DMH) Inpatient Continuing Care

- DMH funds or operates 6 inpatient units or "state hospitals" that provide ongoing treatment, stabilization and rehabilitation services to a small number of individuals with serious and persistent mental illness who need longer term hospitalization.
- Services are available when a referral is made to the DMH facility by a transferring hospital. Individuals are generally transferred to DMH after the conclusion of a course of treatment in an acute inpatient psychiatric unit or facility and are admitted to the first available bed in a DMH-operated inpatient unit or state hospital.
- Like private hospitals & units, the facilities are accredited by the Joint Commission and certified by the Center for Medicare and Medicaid Services (CMS).
- The dots represent the 6 state-funded Inpatient Units or facilities.

Data reflects a point in time and is updated as of 12/27/13

Service Map: DMH Site Offices



Department of Mental Health (DMH) Site Offices

- DMH provides services through 27 site offices within 25 locations across Massachusetts. The site offices provide case management and oversee an integrated system of community rehabilitative and recovery-based services for adults and youth.
- Individuals must apply to DMH to receive community-based services to determine they have a "qualifying mental disorder" as the primary disorder requiring treatment, and meet functional impairment and other criteria. There are "needs & means" criteria, in addition to clinical criteria, as part of the review for access.
- Services are delivered flexibly, often in individuals' homes and local communities. Services are designed to meet the behavioral health needs of individuals of all ages, enabling them to live, work, attend school and fully participate as valuable, contributing members of our communities.
- DMH also offers a range of supports to parents and people receiving mental health services through peer and parent support organizations. Individuals and families do not need to be authorized for services to access these supports.

Data reflects a point in time and is updated as of 12/27/13

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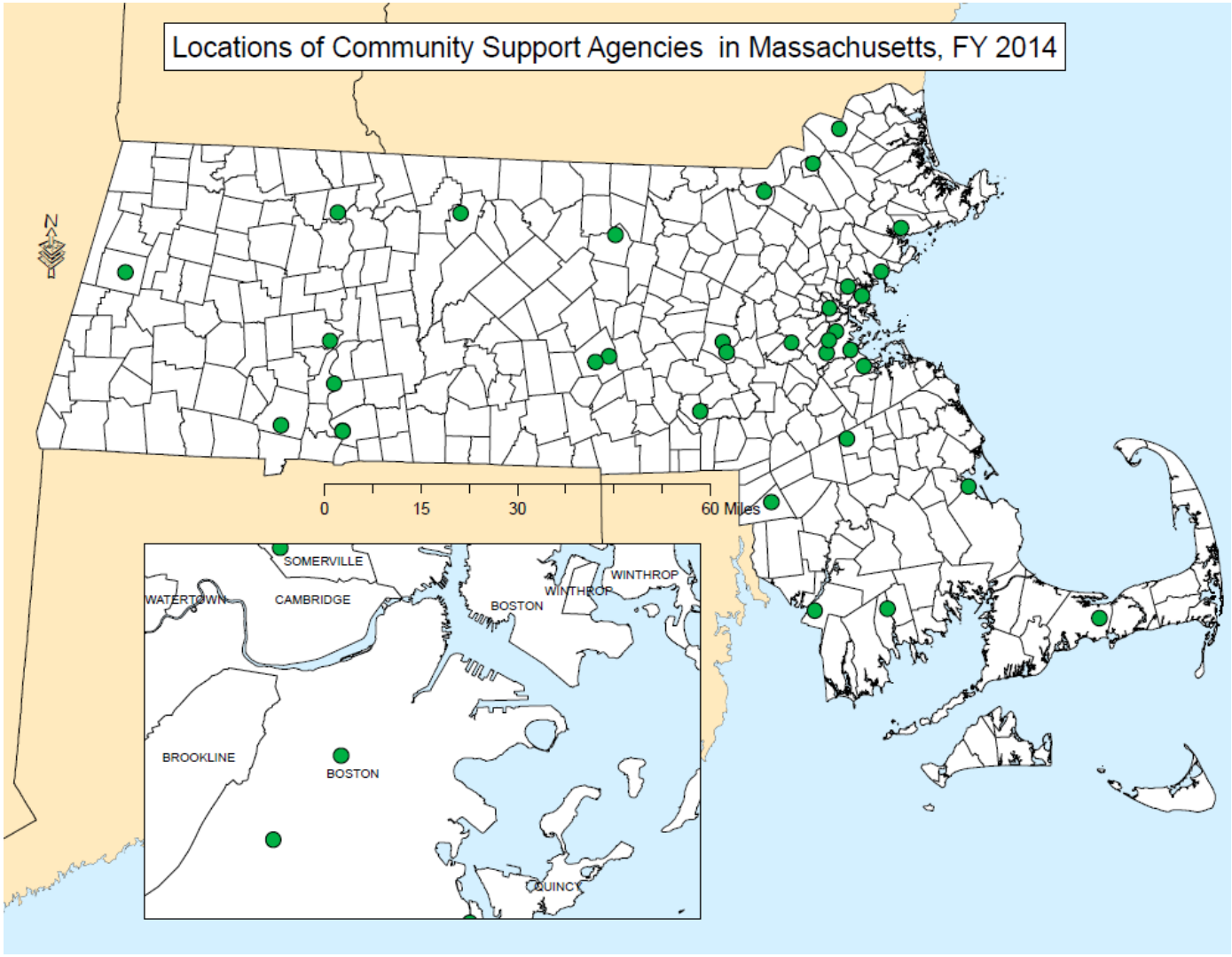
Service Maps:
Community Support Agencies



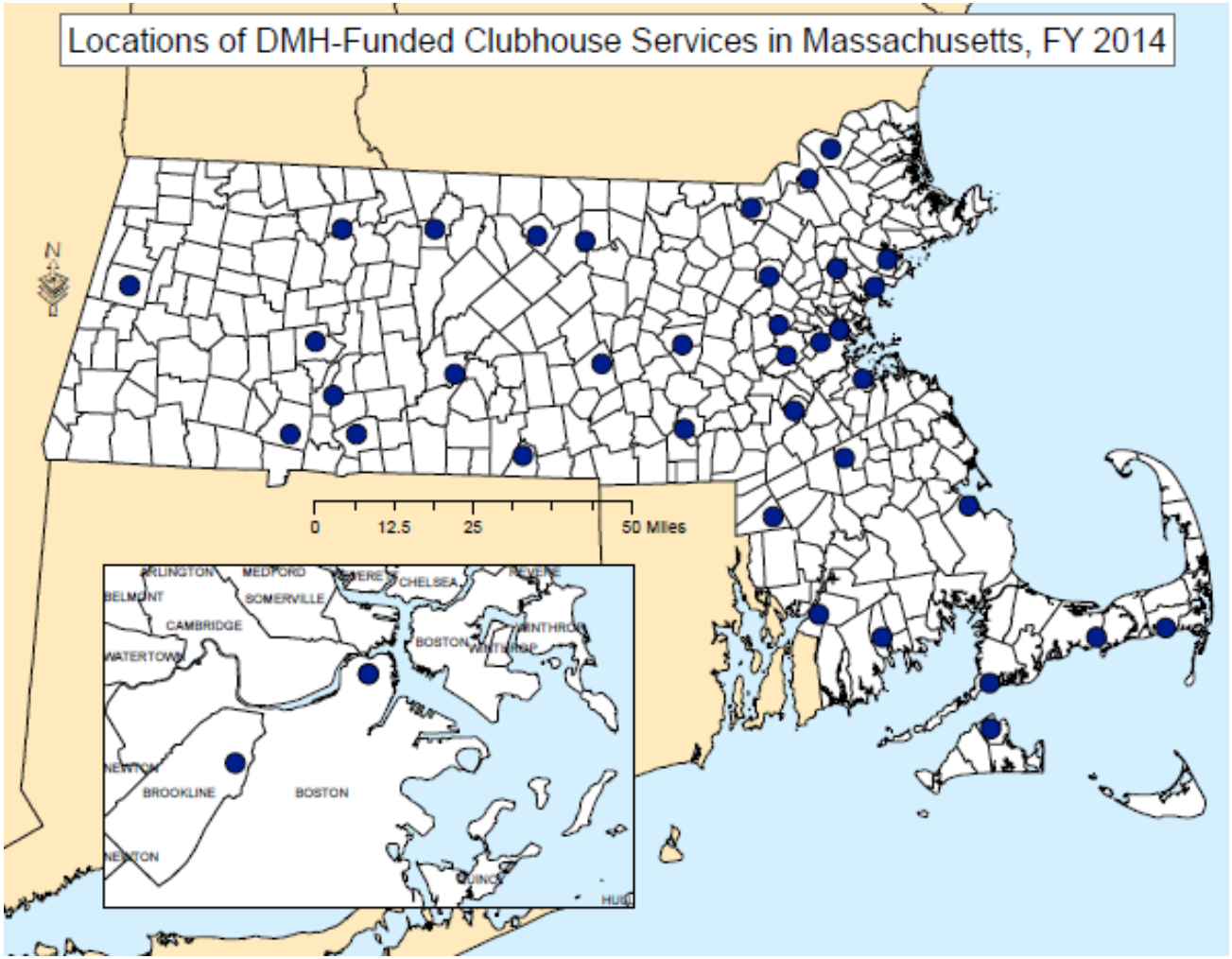
Community Support Agencies (CSA)

- CSAs are a statewide network of community-based organizations that facilitate access to, and ensure coordination of, care for youth with serious emotional disturbance (SED) and their families who require or are already utilizing multiple services or are involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health).
- Dots represent service providers funded by MassHealth through a competitive process. Services are available only to residents with MassHealth. Services are coordinated with the Department of Children & Families (DCF).
- Dots do not represent any independent services available for youth with private insurance.
- Dots represent the 32 CSAs: 29 that are geographically consistent with the current 29 service areas for the Department of Children and Families and three culturally and linguistically specialized CSAs to address the needs of specific cultural or linguistic groups in Massachusetts.

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: DMH-Funded Clubhouse Services

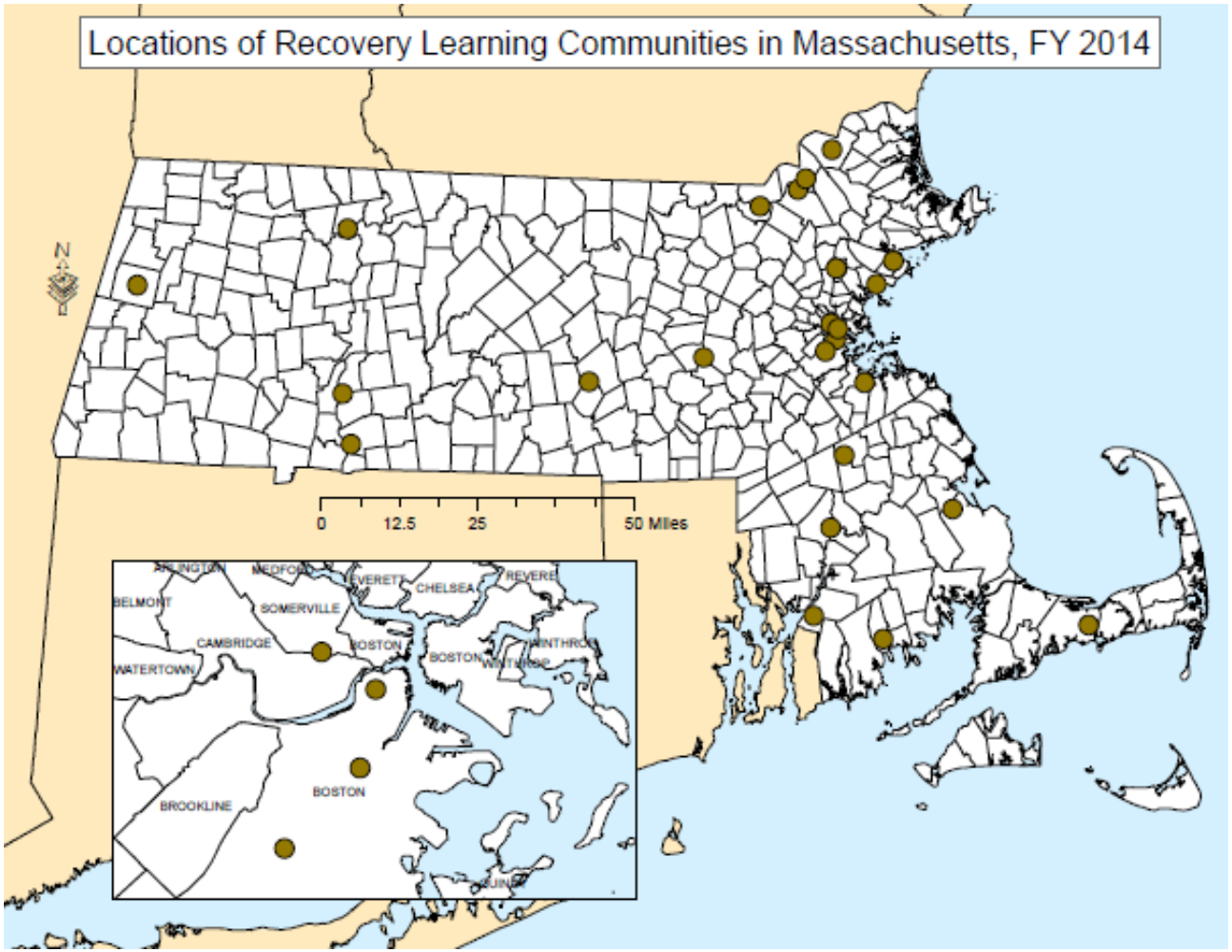


DMH-Funded Clubhouse Services

- Clubhouse Services, a psychosocial rehabilitation service, provide supports through a membership-based community center. Clubhouse Services assist people served to recognize their strengths, develop goals, and enhance the necessary skills for living, working, learning, and fully participating in their communities. The Clubhouse offers a daily schedule of activities, and works with people to connect them with jobs, school, interests and social activities within their own community.
- Each dot represents one of the 37 Clubhouse locations.
- Clubhouse services are available to people with a serious and long-term mental illness.

Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Service Map: Recovery Learning Communities (RLC)



Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Recovery Learning Community (RLC)

- The RLC provides a wide range of peer-to-peer support and resources to individuals with serious mental illness. Further, RLCs support the peer providers though training, continuing education, and consultation. Additionally, RLCs link with other peer-operated services and supports
- Supports may be offered in a variety of settings including, but not limited to the RLC site. Other settings include community mental health centers, inpatient hospitals, generic community settings, town hall, fairs, shopping mall, etc.
- Each dot represents one of 24 RLC network locations.
- RLCs are open to anyone seeking support

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DMH Community Redesign: Policy Context

- DMH began a re-design of its community services in 2009
  - Supports the Administration's Community First initiative
  - Promotes recovery and resiliency, flexible and individualized services
- Redesigned services include:
  - Adults: Community Based Flexible Supports, Respite, Clubhouse
  - Child and Adolescent: Caring Together (DMH-DCF joint residential); Individual and Family Flexible Support Services (IFFSS or "Flex")
- Redesigned services and additional community funding resulted in new community placements and less reliance on inpatient and other intensive services
- Result for 2011-2013: decreased continuing care beds and increased capacity of community-based services

Licensed MH Clinics

- 380 clinics statewide licensed by DPH provide MH services – two-thirds of the total clinics*
- Among the 558 clinics providing medical care, mental health care or both:
  - 51% provide mental health care only
  - 17% provide both mental health and medical care
  - 32% provide medical care only
- MH Clinics can provide both mental health and substance abuse services

* Numbers of clinics include license-holding clinics and their satellite clinics, each counted separately. Among the excluded clinics are those that provide only dental, pharmacy, physical rehab or MRI services. Also not included are physician-owned offices, which are not licensed by DPH.

HPC Regions and DMH Site Offices

- DMH funded services are contracted or operated from 27 local site offices. Most of these services are provided within the person's own community, often in the home or other settings chosen by the client
- DMH capacity data reflect the region with the location of the site office where the contract is held or service is operated
- DMH site offices do not align with the HPC regions. The DMH system of site offices has been built around community boundaries while the HPC regions are based upon hospital service areas and hospital referral regions. Some HPC regions have multiple site offices, some have none.

Continuing and Intermediate Care

- 626 continuing care beds provide ongoing treatment, stabilization and rehabilitation for the relatively few people needing more inpatient care after an acute inpatient hospital stay
- Other important services that complement the use of the hospital include:
  - 39 partial hospitalization programs
  - 30 day treatment programs
  - 22 crisis stabilization programs
  - 42 emergency services programs

Continuing Care
Mental Health Services

Continuing care provides ongoing care in a hospital setting for the relatively few people needing more inpatient care after an acute inpatient hospital stay.

Statewide continuing care beds, 2011-2013

Year	Continuing care beds
2011	671
2012	626
2013	626

Notable changes include:

- Worcester State Hospital closed in 2011-2012, eliminating 136 beds
- 124 beds were reduced at Taunton from 2011-2012
- Worcester State Recovery Center and Hospital opened in August, 2012 (+156 beds) and expanded in 2013.

Other Mental Health Services

- Community Based Flexible Supports, the "cornerstone" of the DMH community mental health system for adults with serious mental illnesses
  - provides services in partnership with clients and their families to promote and facilitate recovery
  - Point-in-time capacity in 2013: 11,814 individuals
  - Includes rehabilitative and support services to manage psychiatric symptoms and medical conditions in the community and that support independent living, wellness and employment
- Other important DMH services include: adult respite, intensive residential treatment programs for children, case management, and recovery learning centers

Inpatient Psychiatric Beds

Inpatient Psychiatric Beds in Free-Standing and General Hospitals by Region, 2014

Region	Number of Hospitals or Psychiatric Units*				Number of Beds				Population	Beds per 100,000	Ratio to Statewide Average
	Free-Standing	General	State-Operated	Total	Free-Standing	General	State-Operated	Total			
Western	1	9	0	10	30	228	0	258	821,826	31	0.8
Central	0	6	0	6	0	132	0	132	763,769	17	0.5
Northeast	3	10	0	13	163	297	0	460	1,401,973	33	0.9
Metro West	2	3	0	5	177	115	0	292	660,610	44	1.2
Metro Boston	5	14	0	19	490	428	0	918	1,575,595	58	1.6
Metro South	4	5	0	9	179	93	0	272	820,790	33	0.9
South Coast	0	2	1	3	0	47	16	63	340,404	19	0.5
Cape and Islands	0	1	1	2	0	20	16	36	243,352	15	0.4
Statewide Total	**15**	**50**	**2**	**67**	**1,039**	**1,360**	**32**	**2,431**	**6,628,319**	**37**	1.0
Percent	22%	75%	3%	100%	43%	56%	1%	100%			

*For free-standing and general hospitals, each hospital with psychiatric beds is counted once. The two state-operated psychiatric units, Corrigan in Fall River and Pocasset on Cape Cod, are located within state mental health centers.

DPH-Licensed Clinics

DPH-Licensed Outpatient Clinics Providing Mental Health and Medical Services by Region, 2014

Region	Numbers of Licensed Clinics Providing Indicated Services				
	Mental Health	Mental Health Only	Mental Health *and* Medical	Medical Only	Total Three Types of Clinics (MH only, MH and Med., Med. only)
Western	56	51	5	27	83
Central	45	34	11	39	84
Northeast	71	50	21	36	107
Metro West	21	20	1	21	42
Metro Boston	105	61	44	21	126
Metro South	46	41	5	22	68
South Coast	20	18	2	7	27
Cape and Islands	16	12	4	5	21
Total Statewide	**380**	**287**	**93**	**178**	**558**
Share of All Clinics	**68%**	**51%**	**17%**	**32%**	**100%**

Notes: The clinics described in this table are ambulatory care providers licensed by the DPH Division of Health Care Quality for specific services such as medical care or mental health care. The numbers of clinics include both license-holding clinics and their satellite clinics, each counted separately. Data from April 25, 2014.

The counts of clinics in this table represent only a subset of the clinics licensed by DPH: Clinics that do not provide either mental health or medical services were excluded.

In addition, because DPH regulation excludes from its licensing requirements those medical offices and group practices wholly owned and controlled by their physicians, such offices and practices are also not included in the table.

DMH Community Based Flexible Support Services

Community Based Flexible Services, Capacity by Region, 2011-2013

Region	2011	2012	2013	Population 2013	2013 Capacity/ 100,000	Ratio to state average
Western	1,810	1,995	2,000	821,002	244	1.4
Central	1,629	1,664	1,667	759,774	219	1.2
Northeast	2,448	2,421	2,421	1,400,532	173	1.0
Metro West	350	356	360	659,412	55	0.3
Metro Boston	3,405	3,368	3,368	1,565,936	215	1.2
Metro South	1,242	1,248	1,264	817,737	155	0.9
South Coast	433	433	436	340,118	128	0.7
Cape and Islands	294	298	298	243,483	122	0.7
Statewide	**11,611**	**11,783**	**11,814**	**6,607,993**	**179**	**1.0**

Note: The capacity is the fixed number of people who can be served at any point in time.

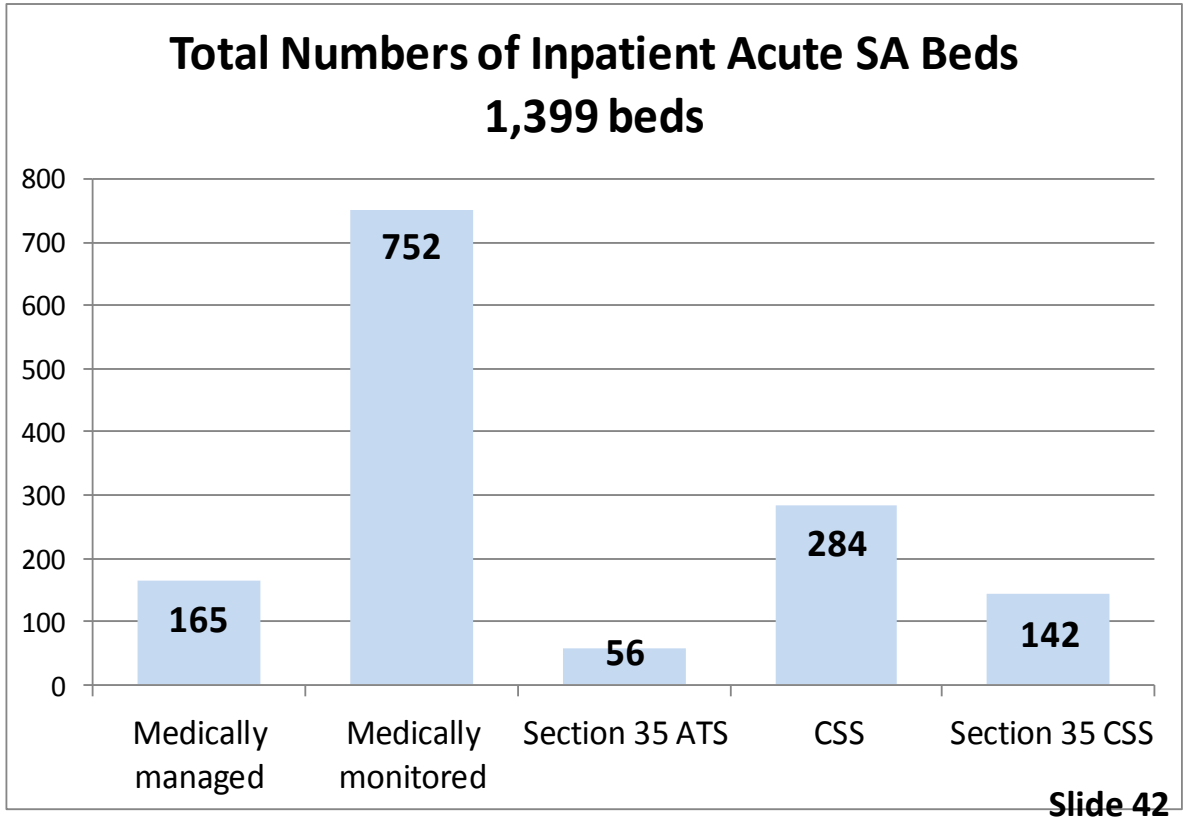
Substance Abuse Inventory

Commonwealth of Massachusetts
Department of Public Health

Substance Abuse Inpatient and other Acute Services

Inpatient and other acute substance abuse services inventory includes a total of 1,399 beds. These 1,399 beds receive clients from a statewide population of 5.6 million residents 13 years and older, for a ratio of beds to population of 25 beds per 100,000 population. A variety of acute substance abuse care beds serves people with different levels of need.

The medically managed and medically monitored beds involve the highest level of medical oversight. ATS means acute treatment services. Section 35 is the state statute for court-ordered treatment of substance abuse conditions. CSS means clinical stabilization services. Note that Sec. 35 CSS programs preferentially admit Section 35 ATS discharges for longer term stabilization services.



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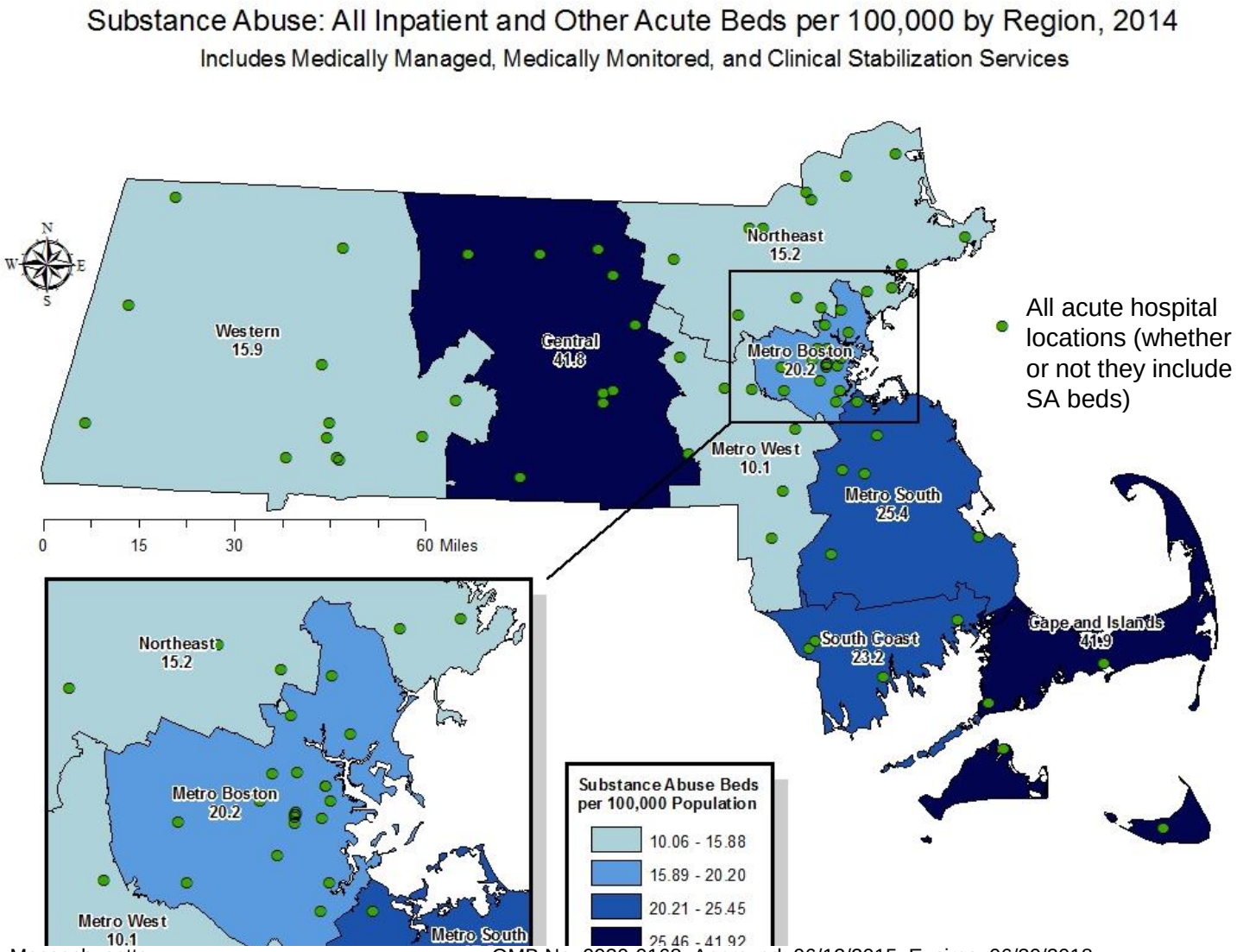
SA Inpatient and Other Acute Service Beds

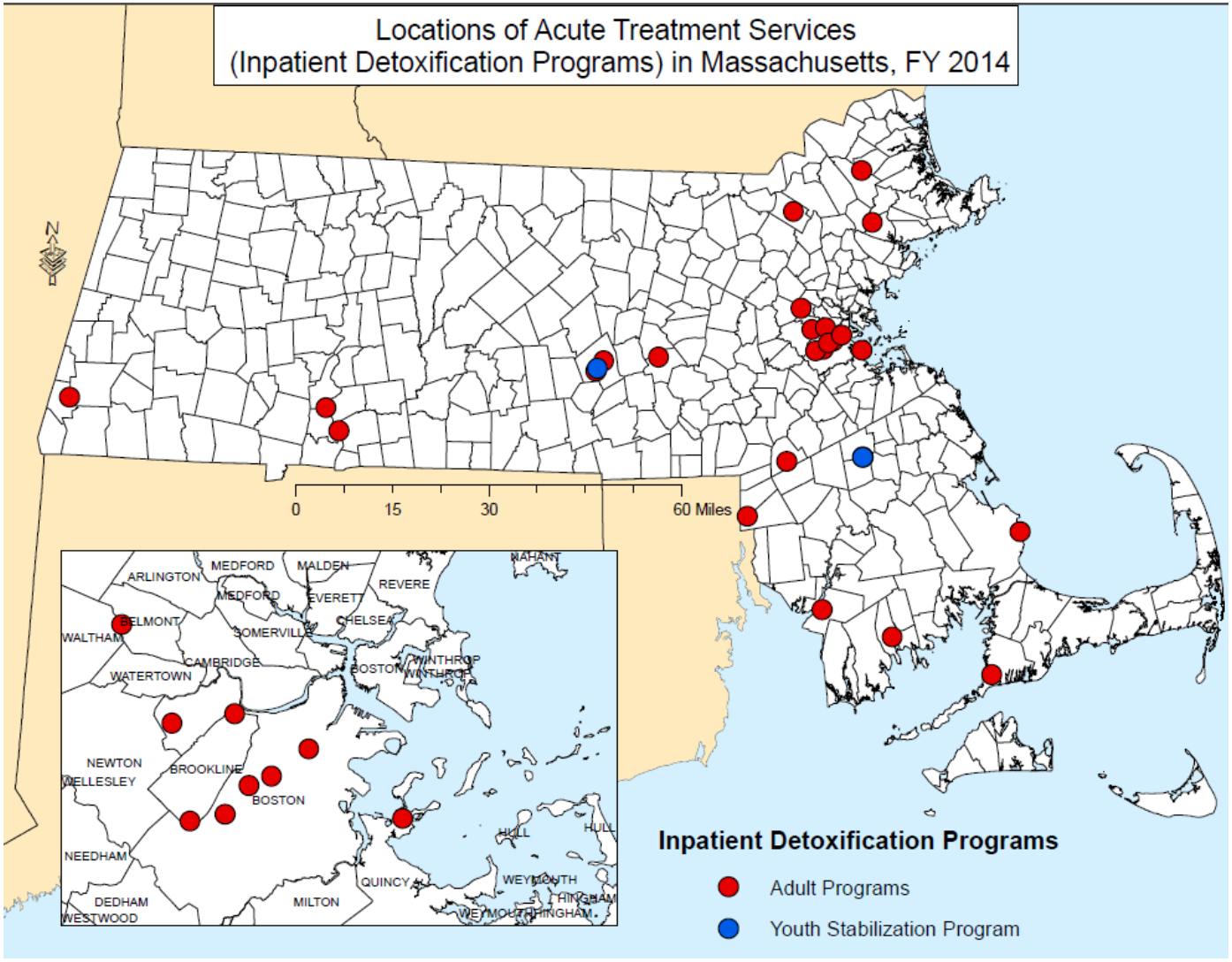


Bed density based upon MA population data for ages 13+.

Central Mass and Cape Cod have the highest concentration of beds while Metro-West region is the lowest.

Commonwealth of Massachusetts
Department of Public Health

Service Map : Acute Treatment Services (Inpatient Detoxification Programs)



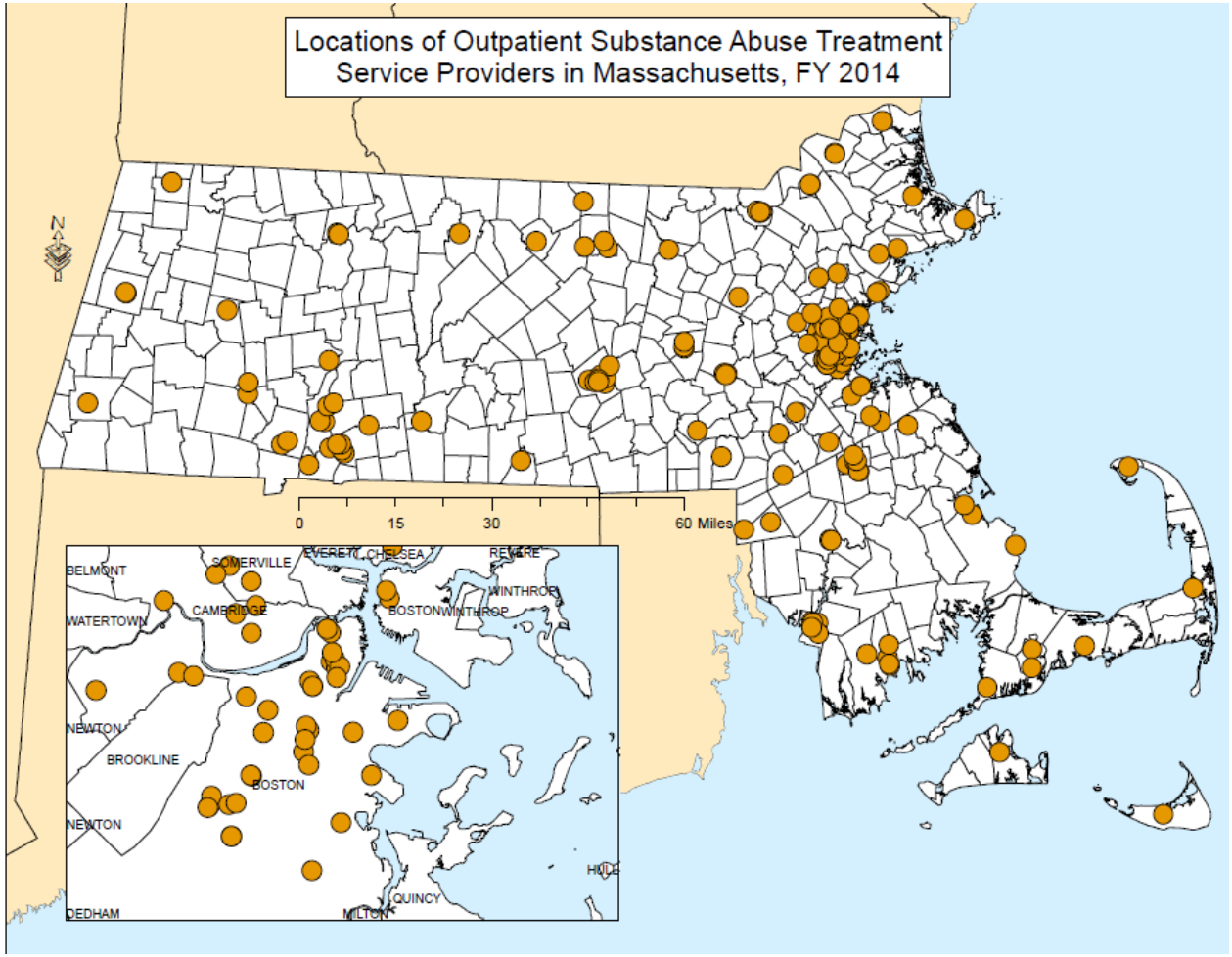
Acute Treatment Services (ATS)

- ATS programs are commonly referred to as inpatient detoxification programs. These programs operate in free standing and hospital based settings. The primary purpose of ATS programs is to medically treat withdrawal symptoms in persons who are dependent upon alcohol and/or other drugs.
- Specialized inpatient services are available to adolescents under 18 years of age who require ATS services. These services are referred to as Youth Stabilization Programs.
- All adolescent and adult programs encourage individuals who complete detoxification to continue receiving addiction treatment in other settings such as residential rehabilitation or outpatient settings.
- Services are available to people with public insurance, and to those with private insurance that contract with these providers.
- Dots represent the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) licensed Substance Abuse Acute Treatment Services (including adult & adolescent) either as units in a hospital or a freestanding facility.

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map:
Outpatient Substance Abuse Treatment



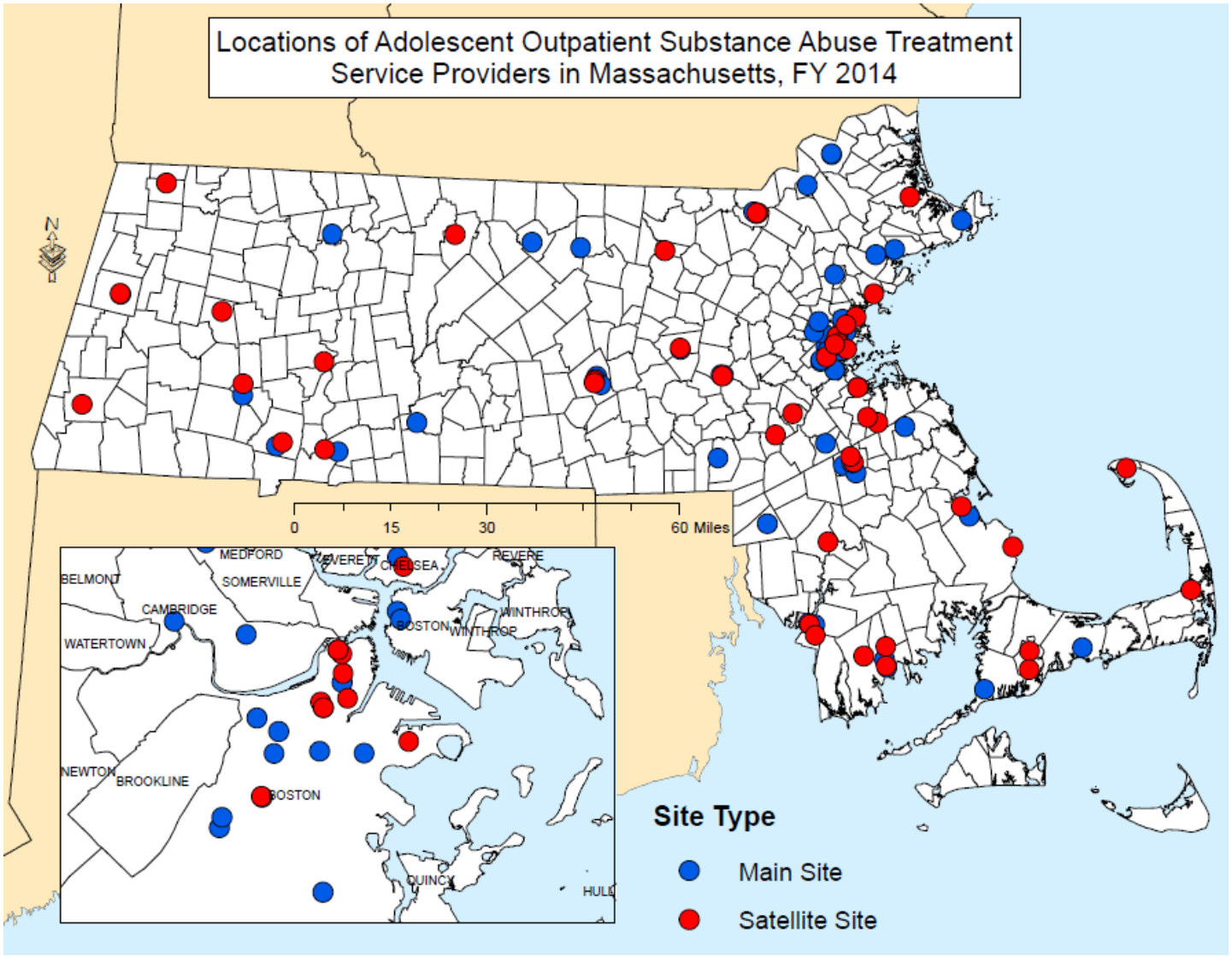
Outpatient Substance Abuse Treatment

- Outpatient Substance Abuse Treatment is provision of in-person addiction counseling services to individuals, aged 13 and older, who are not at risk of suffering withdrawal symptoms and who can participate in organized services in an ambulatory setting such as a substance abuse treatment program, mental health clinic, hospital outpatient department or community health center.
- Services may include individual, group and family counseling, intensive day treatment and educational services for persons convicted of a first offense of driving under the influence of drugs or alcohol. Some outpatient substance abuse treatment programs meet additional regulatory requirements to provide these services to specialty populations including adolescents, age 13-17, pregnant women, persons with co-occurring mental health disorders, persons age 60 or older and persons with disabilities
- Services are available to people with public insurance, and to those with private insurance that contract with these providers.
- Dots represent programs that are either licensed or approved by the Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS).
- Although any of the locations may treat individuals with a “dual diagnosis” of substance abuse and mental health, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat persons with primary mental health problems.
- Of note, licensed mental health clinics may provide addiction counseling services to persons with primary addictive disorders under their outpatient mental health clinic licensure. Those clinics are not represented on this map. The map does not represent any of the “private practitioners ” who provide treatment & counseling.

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: Adolescent Outpatient Substance Abuse Treatment (Subset)



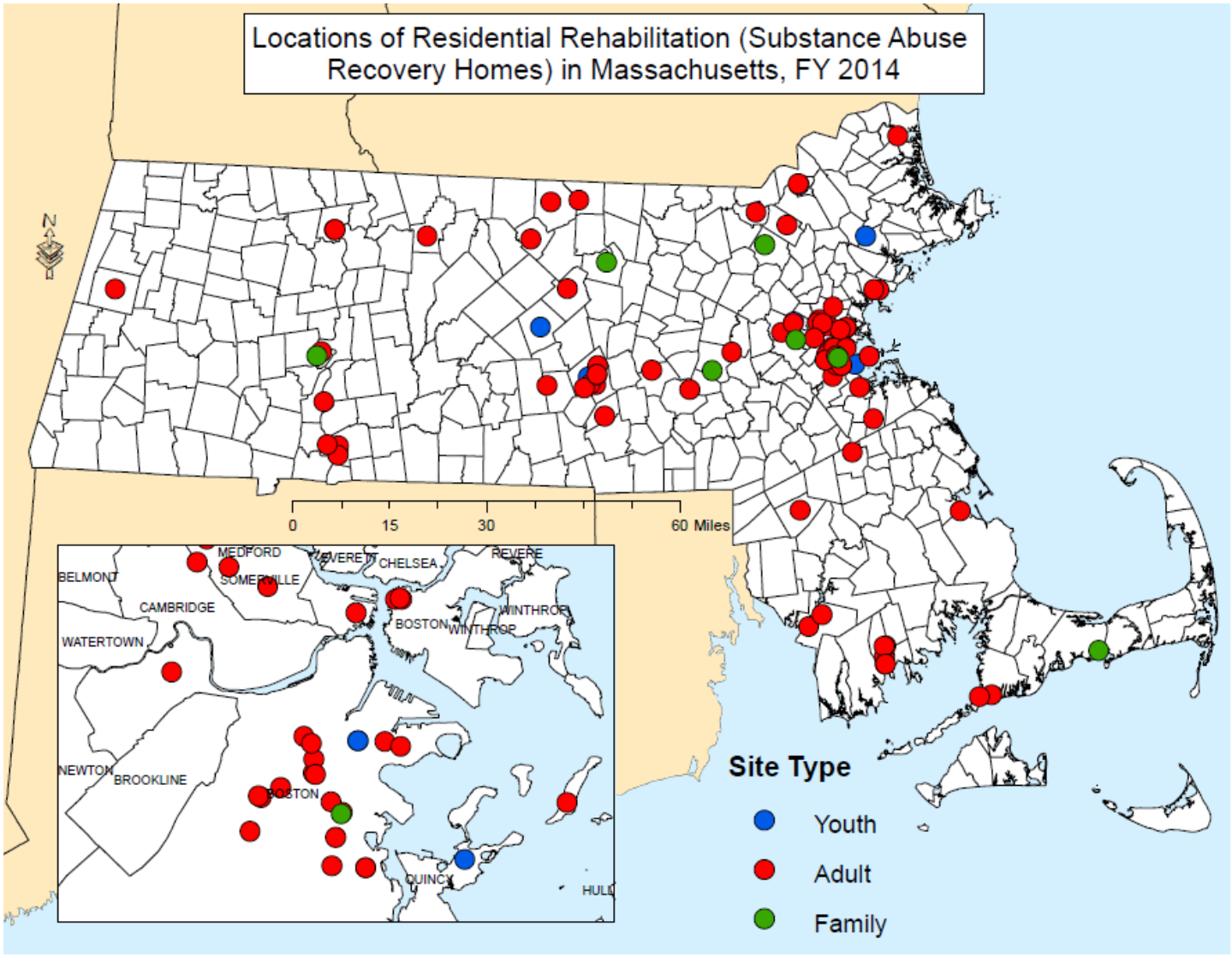
Adolescent Outpatient Substance Abuse Treatment (Subset)

- These licensed outpatient substance abuse treatment providers have met additional, regulatory requirements to provide services to adolescents, 13-17 years old.
- Of note, licensed mental health clinics may provide addiction counseling services if they maintain compliance with the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) regulations. However, they are not required to seek BSAS licensure or approval. Therefore this map does not represent the outpatient mental health clinics that may be providing addiction treatment services under their mental health clinic licensure.
- Dots do not represent any of the "private practitioners" who offer substance abuse treatment & counseling services.

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: Residential Rehabilitation (Substance Abuse Recovery Homes)



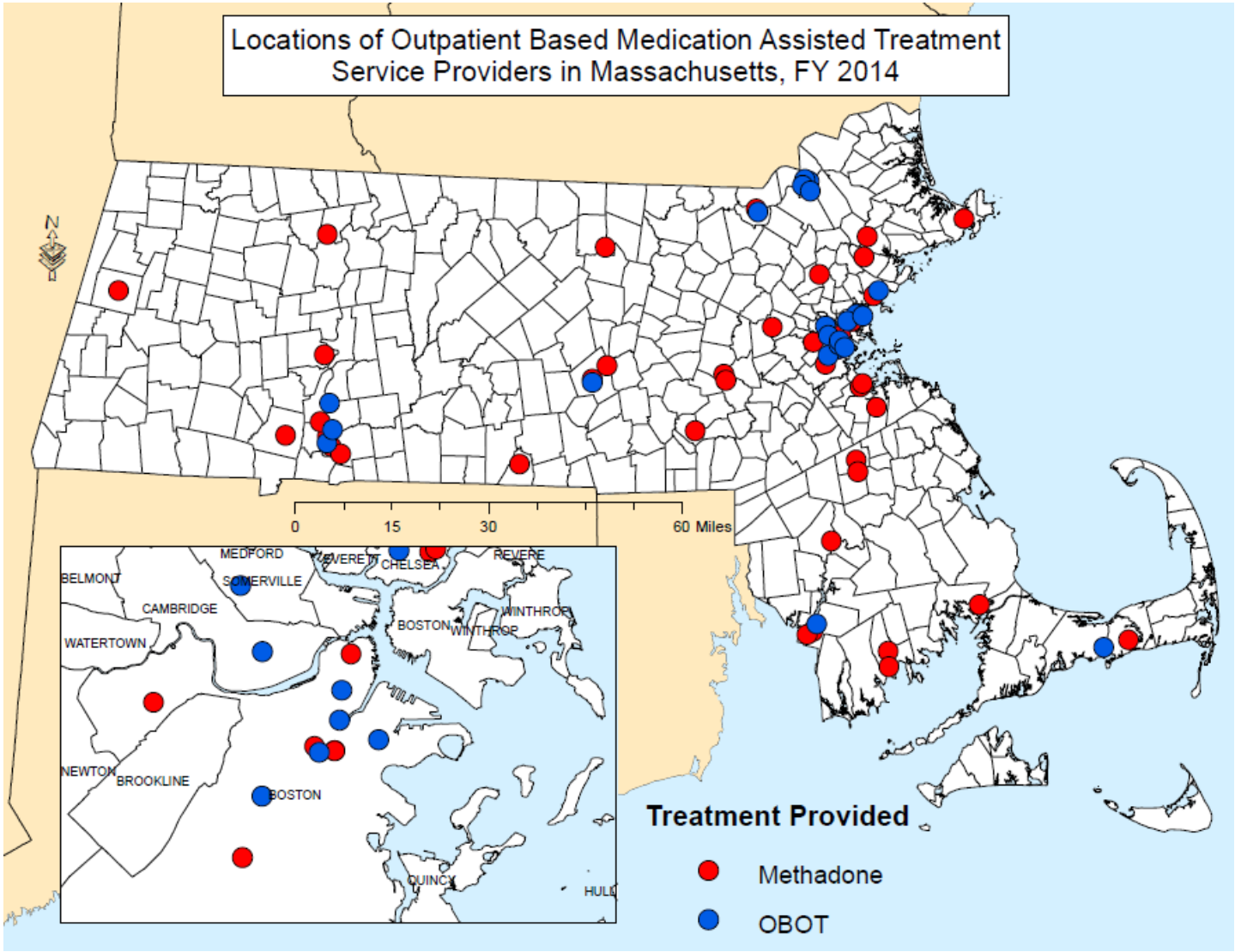
Residential Rehabilitation Substance Abuse Treatment

- Residential rehabilitation programs are organized substance abuse treatment and education services featuring a planned program of care in a 24-hour residential setting in the community. They are staffed 24 hours a day.
- Services are provided in permanent facilities where clients in the early stages of addiction recovery, who require safe and stable living environments in order to develop their recovery skills, reside on a temporary basis.
- Types of residential rehabilitation services include programs for adults age 18 and older, adults with their families, adolescents age 13-17 and Transitional Age Youth who are 16-24 years old. Adolescents typically receive treatment for 3 months, while adults typically receive treatment in this setting for 6-12 months.
- Dots represent facilities that are licensed by and primarily funded by the Department of Public Health (DPH), Bureau of Substance Abuse Services.

Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: Outpatient Based Medication Assisted Treatment Providers



Opioid Treatment Programs

- The Department of Public Health, Bureau of Substance Abuse Services (BSAS) licensed opiate treatment programs provide medication, such as methadone, along with a comprehensive range of medical and rehabilitative services in an ambulatory setting to individuals to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. Opioid treatment includes both maintenance and detoxification.

Office Based Opiate Treatment (OBOT) Programs

- BSAS funds 14 OBOT programs in community health centers across the state. These programs provide medication (buprenorphine) for the treatment of opiate addiction in a primary care setting. Buprenorphine treatment includes both maintenance and detoxification. This treatment does not require BSAS licensure.
- Dots represent only the 14 BSAS-funded OBOT programs and does not reflect the hundreds of physicians who are able to provide this treatment in their medical practices.

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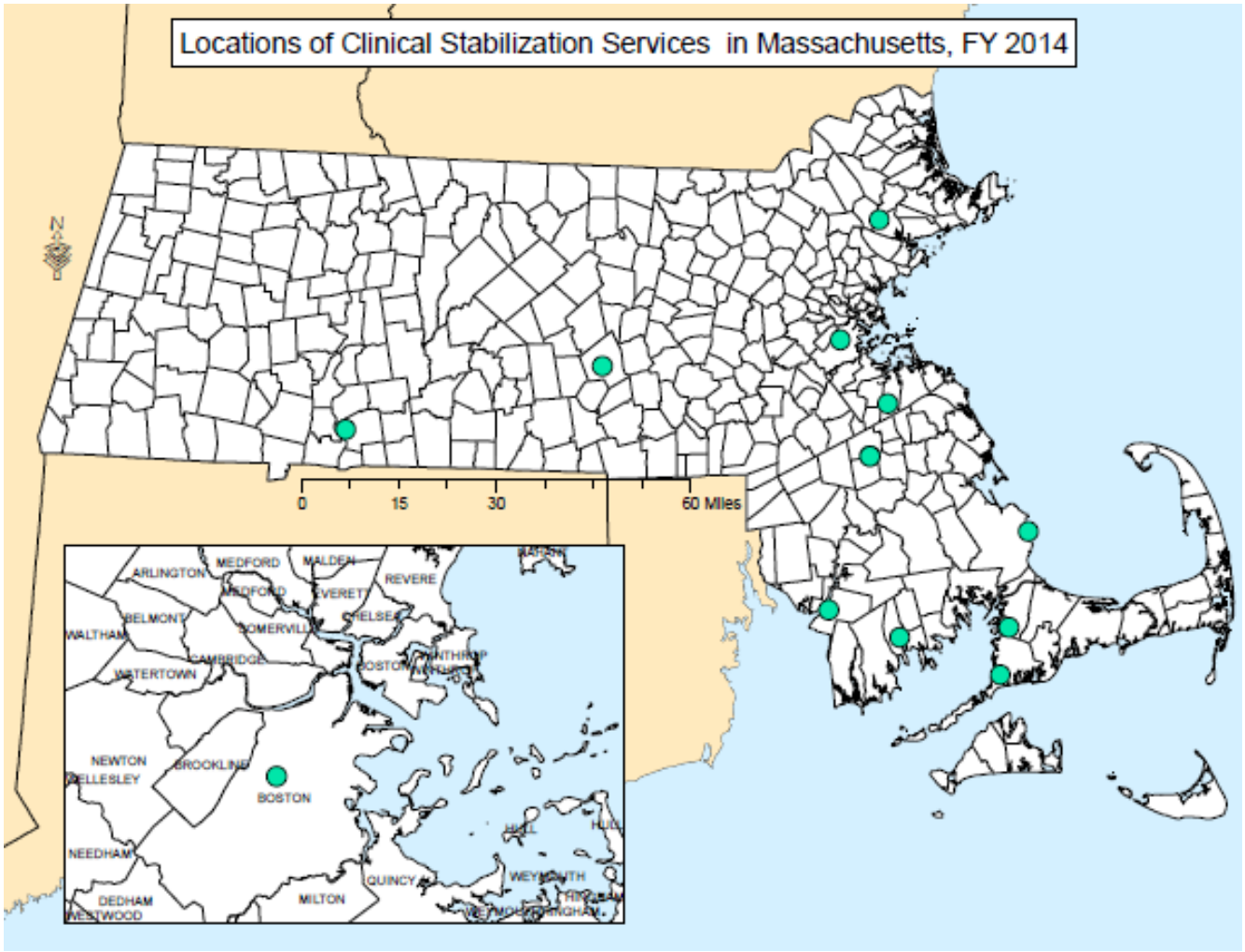
Data reflects a point in time and is updated as of 12/27/13

Commonwealth of Massachusetts
Department of Public Health

Service Map: Clinical Stabilization Services (CSS)



Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Clinical Stabilization Services (CSS)

- CSS offer 24-hour treatment, usually following Acute Treatment Services (ATS) for substance abuse. Typically clients stay in the program for 10-14 days, during which they receive a range of services including nursing, intensive education and counseling regarding the nature of the addiction and its consequences, relapse prevention and aftercare planning for individuals beginning to engage in recovery from addiction
- These programs provide multidisciplinary treatment interventions and emphasize individual, group and family. Linkage to aftercare, relapse prevention services, and self-help groups, such as AA and NA, are integrated into treatment and discharge planning.
- This service is not intended as a step-down service from a psychiatric hospitalization level of care or psychiatric stabilization service. It is intended for individuals with a primary substance use disorder
- This service is covered by some insurance plans including MassHealth. As payer of last resort BSAS pays for uninsured clients.
- Clients are generally accepted from many settings including Acute Treatment Services (detoxification) programs, residential rehabilitation programs, outpatient including opioid treatment services, as well as self-referral. All CSS clients must meet an ASAM Level 3.5 criteria.

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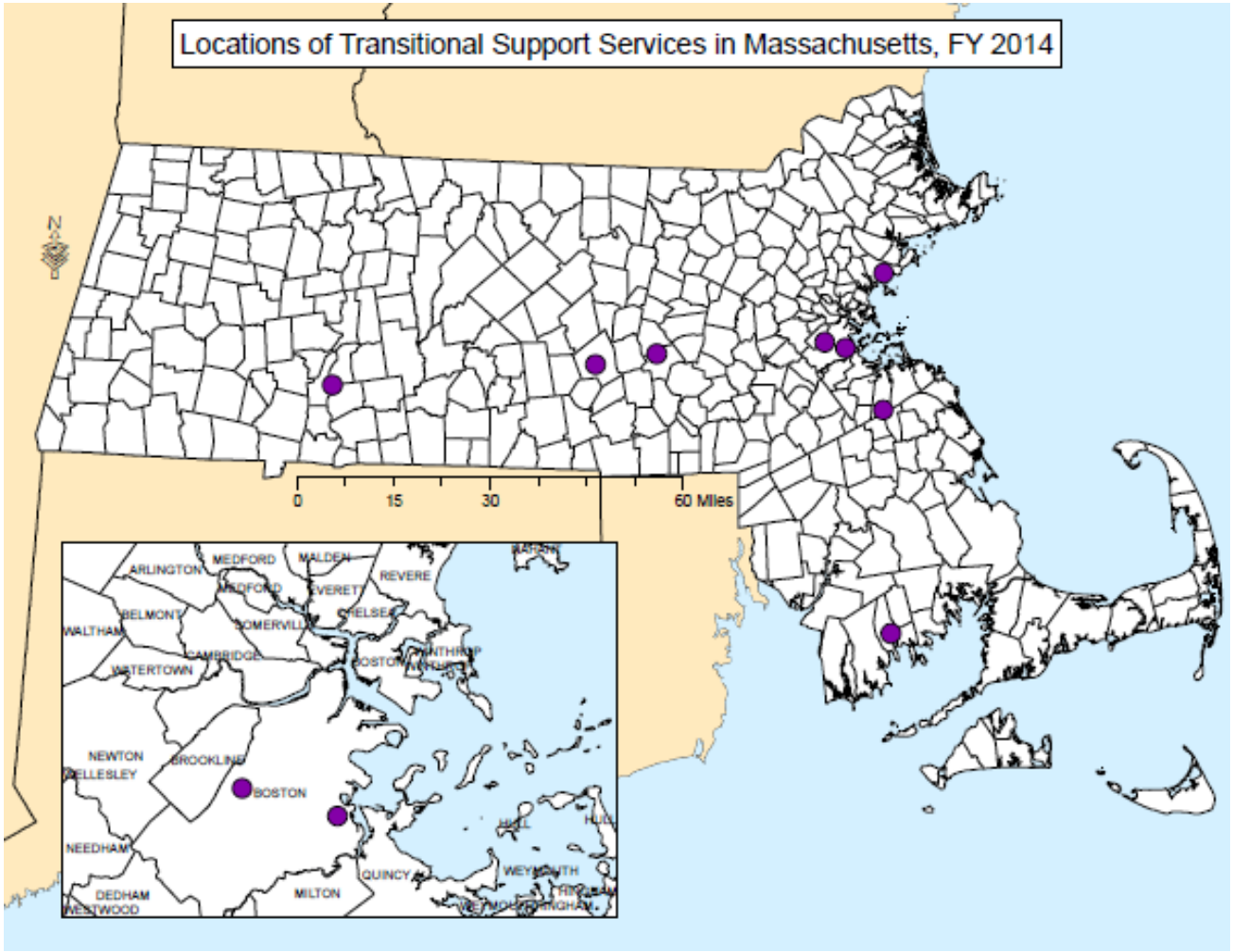
Commonwealth of Massachusetts
Department of Public Health

Service Map: Transitional Support Services (TSS)



Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Transitional Support Services (TSS)

- TSS are defined as 24-hour short-term residential treatment up to 30 days, providing nursing, case management, psycho-educational programming, and aftercare planning.
- Services are provided to primarily bridge the gap between Acute Treatment Services and residential rehabilitation. Programs provide intensive case management in order to prepare clients for long-term residential care
- TSS clients are accepted from BSAS funded Level 3.7 Acute Treatment Services program or Level 3.5 Clinical Stabilization Services program. Upon medical clearance, clients can also be accepted from a public homeless shelter.
- BSAS is the primary payer for TSS services.

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Commonwealth of Massachusetts
Department of Public Health

DPH: The Role of Bureau of Substance Abuse Services

- Single State Authority
- The Bureau of Substance Abuse Services (BSAS):
  - Oversees substance abuse prevention, intervention, treatment and recovery support services for adults and adolescents (available to youth and adults 13 years of age and older)
  - Licenses treatment facilities and alcohol and drug counselors
  - Funds a continuum of programs and services including detoxification, step-down services, residential rehabilitation, outpatient counseling, medication assisted treatment and community-based recovery support.
  - Tracks substance abuse trends in the state

DPH Licensing Responsibilities

- BSAS licenses substance abuse treatment programs, e.g., day treatment, methadone programs.

- The Division of Health Care Quality (DHCQ) licenses general hospitals and outpatient clinics, some of which provide substance abuse treatment services.

Substance Abuse Service Inventory

Service Group	Tables by Service
All	Overview of All Beds
All Inpatient and Other Acute Care	Number of All Acute and Other Beds and CSS Beds by Region, 2014
Inpatient and Other Acute Care	Number of Acute Level IV Inpatient Beds by Region, 2014
	Number of Acute Level III.7 Treatment Service Beds by Region, 2014
	Number of Clinical Stabilization Service Beds by Region, 2014
Intermediate Care	Number of Transitional Support Services Beds by Region, 2014
Residential Care	Number of Residential Beds by Region, 2014
Outpatient Care	Opioid Treatment Programs by Region, 2014

Note: Additional tables provided in a comprehensive set of tables on all services.

Additional detail on the inventory of services above is being developed by the team. This will include other important SA services: Day Treatment, Outpatient Substance Abuse Counseling, Recovery Support Services, Recovery High School, Naloxone distribution.

Overview of Licensed Beds

Summary of All Beds to Treat Substance Abuse Licensed by DPH

Major Service Group	Service	Beds	Beds per 100,000
Inpatient and Other Acute	Medically-managed	165	3
Inpatient and Other Acute	Medically-monitored	752	14
Inpatient and Other Acute	Clinical Stabilization Services	284	5
Inpatient and Other Acute	Section 35 (May 2014)		
	Medically monitored	56	1
	Clinical Stabilization Services	142	3
A) Inpatient & Other Acute Care	Total of services listed above	1399	25
B) Intermediate Care	Transitional Support Services	291	5
C) Residential Care	Residential Services	2341	42
	TOTAL BEDS (A + B + C)	**4031**	**73**
	Eligible population, all persons 13 years of age and older, 2010	*5,554,121*	

Note: All data except otherwise noted is based on March 2014 reports.
Note: 117 families are also served by DPH, these numbers are not noted on this overview table.

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Intermediate Substance Abuse Services

- Transitional Support Services (may follow inpatient detox):
  - 7 programs
  - 291 beds
  - 5 beds per 100,000
- 49 day treatment programs
  - These 49 programs fall under the 120 licensed outpatient programs.
  - Programs must be licensed as an outpatient program to provide day treatment.

BSAS licensing data as of March 27, 2014

Residential Rehabilitation Services

- 2,341 residential beds
  - 42 beds per 100,000
  - 94% single adult beds
  - Gender breakdown an important planning issue
  - Proportion of beds by gender (May 2014):
    - 56% men only
    - 28% women only
    - 16% co-ed
- Additional capacity to serve 117 families in residences

RSAS licensing data as of March 27, 2014

Outpatient Care

- 120 counseling programs
- 50 medication-assisted treatment programs
  - 36 DPH-licensed opioid treatment programs (methadone)*
  - According to SAMHSA, there are 72 office based opioid treatment (OBOT) programs providing Buprenorphine in Massachusetts.
  - BSAS funds 14 OBOT programs
  - See the SAMHSA Treatment Locator for more information
    http://dpt2.samhsa.gov/treatment/directory.aspx
  - Limited capacity information

* BSAS licensing data as of March 27, 2014

Opioid Overdose Intervention

- Intervention Programs funded by DPH
  - Naloxone distribution programs for bystanders and first responders (14 programs with 19 sites)
  - Learn to Cope (one program with 12 sites)

Provides training on overdose prevention, recognition and response; distribute naloxone kits to people in the community who are likely to witness an overdose. Likely bystanders include opioid-users, their friends and family members, and human services providers who serve opioid-users.

Other Substance Abuse Services

- Recovery and support programs
  - 4 recovery high schools
  - 7 recovery support centers

- Case management to assist people in maintaining their recovery through supportive housing, community engagement and peer support

Overview of All Beds Substance Abuse Services

All Inpatient and Other Acute Beds, 2014

Includes Medically Managed (Level IV), Medically Monitored (Level III.7), and Clinical Stabilization Services

Region	Beds	Population	Beds per 100,000
Western	111	698,807	16
Central	258	617,789	42
Northeast	172	1,132,698	15
Metro West	58	576,314	10
Metro Boston	270	1,336,899	20
Metro South	175	687,721	25
South Coast	67	289,198	23
Cape and Islands	90	214,695	42
Total Statewide	**1201**	**5,554,121**	**22**

Total Section 35-Medically Monitored and CSS	**198**	**5,554,121**	**4**

All Inpatient and Other Acute	**1399**	**5,554,121**	**25**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding.

Note: This includes all medically managed and medically monitored beds including Section 35 beds, as of May 5, 2014.

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Acute Inpatient Medically Managed Substance Abuse Services

Acute Inpatient Beds (Level IV), Medically Managed in a Hospital, by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	0	698,807	0
Central	114	617,789	18
Northeast	31	1,132,698	3
Metro West	0	576,314	0
Metro Boston	20	1,336,899	1
Metro South	0	687,721	0
South Coast	0	289,198	0
Cape and Islands	0	214,695	0
Total Statewide	**165**	**5,554,121**	**3**

Note: Data as of March 27, 2014.

Commonwealth of Massachusetts
Department of Public Health

Acute Medically Monitored Substance Abuse Services

Acute (Level III.7) Treatment Medically Monitored Service Beds in Community Facilities by Region, 2014

Region	Beds			All Ages	
	Adults	Adolescents (13-17)	Total	Population	Beds per 100,000
Western	81	0	81	698,807	12
Central	90	24	114	617,789	18
Northeast	118	0	118	1,132,698	10
Metro West	58	0	58	576,314	10
Metro Boston	196	0	196	1,336,899	15
Metro South	89	24	113	687,721	16
South Coast	37	0	37	289,198	13
Cape and Islands	35	0	35	214,695	16
Total Statewide	**704**	**48**	**752**	**5,554,121**	**14**

Section 35 ATS-only beds:

Metro South	32		32	5,554,121	0.6
South Coast	24		24	5,554,121	0.4
Total	**56**		**56**	**5,554,121**	**1**

Note: Data as of March 27, 2014.

Note: The Section 35 beds listed on this table are ATS-only beds and represent only a portion of the beds funded by DPH.

Clinical Stabilization Services
Substance Abuse Services

Clinical Stabilization Services, Beds by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	30	698,807	4
Central	30	617,789	5
Northeast	23	1,132,698	2
Metro West	0	576,314	0
Metro Boston	54	1,336,899	4
Metro South	62	687,721	9
South Coast	30	289,198	10
Cape and Islands	55	214,695	26
Total Statewide	**284**	**5,554,121**	**5**

Section 35 CSS beds:

Metro South	76	5,554,121	1
South Coast	66	5,554,121	1
Total	**142**	**5,554,121**	**3**

Note: Data as of March 27, 2014.

Note: The Section 35 beds listed on this table are CSS beds and represent only a portion of the beds funded by DPH. This data is as of May 5. 2014.

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Transitional Support Substance Abuse Services

Transitional Support Services Beds by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	27	698,807	4
Central	72	617,789	12
Northeast	25	1,132,698	2
Metro West	0	576,314	0
Metro Boston	71	1,336,899	5
Metro South	60	687,721	9
South Coast	36	289,198	12
Cape and Islands	0	214,695	0
Total Statewide	**291**	**5,554,121**	**5**

Note: Data as of March 27, 2014.

Commonwealth of Massachusetts
Department of Public Health

Residential Rehabilitation Substance Abuse Services

Region	Adults			Beds			Calculation		Capacity to Serve Families
	Male	*Female*	*Co-Ed*	Adults	Transitional Age and Adolescents	Both	Population	Total Beds per 100,000	
Western	113	65	71	249	16	265	698,807	38	21
Central	163	97	164	424	33	457	617,789	74	12
Northeast	35	83	58	176	41	217	1,132,698	19	15
Metro West	179	35	0	214	0	214	576,314	37	22
Metro Boston	586	181	60	827	45	872	1,336,899	65	34
Metro South	72	23	0	95	0	95	687,721	14	0
South Coast	70	85	0	155	0	155	289,198	54	0
Cape and Islands	28	38	0	66	0	66	214,695	31	13
Total Statewide	**1246**	**607**	**353**	**2206**	**135**	**2341**	**5,554,121**	**42**	**117**
	56%	**28%**	**16%**	**100%**					

Note: Data as of March 27, 2014.

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Opioid Treatment Services
Substance Abuse Services

Opioid DPH-Licensed Treatment Programs and Office-Based DPH-Funded Treatment Programs, 2014

This list does not include satellites.

Region	Opioid Treatment Programs, Licensed by DPH, (methadone programs)	Office-Based Opioid Treatment Programs, Funded by DPH (suboxone programs)	Both program types
			Number
Western	7	2	9
Central	4	1	5
Northeast	6	3	9
Metro West	2	0	2
Metro Boston	8	6	14
Metro South	3	0	3
South Coast	5	1	6
Cape and Islands	1	1	2
Total Statewide	**36**	**14**	**50**

Note: Data as of March 27, 2014.

Note: This is a partial list of the opioid treatment programs in Massachusetts, based on programs either licensed or funded by DPH.

DPH licenses opioid treatment programs providing methadone treatment, but does not license OBOT programs.

DPH funds 14 OBOT programs, but there are more than 14 such programs in Massachusetts. A complete list is not publicly available.

Doctors in each state must have waivers to prescribe buprenorphine/suboxone, which is used in OBOT.

According to the DEA, there are 72 programs representing 606 physicians certified for buprenorphine treatment.

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BSAS Services

- Note that residents from regions that appear to have no substance abuse treatment capacity do receive substance abuse treatment services.
  - Substance abuse treatment is a statewide system.
  - Providers accept and provide services to individuals from across the state and across health planning regions.

Utilization and Access

Commonwealth of Massachusetts
Department of Public Health

Payor Groups: Data sources and limitations

Medicare: From Medicare 5% sample

- Medicare: Small cell size in the Medicare under-65 population may be statistically unstable. Data were limited to FFS only (Medicare Parts A & B eligible ; Medicare HMO participation). Enrollment was defined by member months and available from an eligibility feed.

Medicaid: From MassHealth

- MassHealth: Data included claims where Medicaid was the primary insurer; in addition, third party liability claims were included to capture all service use associated with Medicaid patients. Crossover claims were attributed to Medicare (the primary insurer) and therefore excluded from Medicaid. Enrollment (i.e., member months by gender and age group) was provided by MassHealth. MassHealth data includes data for members for whom MassHealth may be a partial or third party payer, which could skew utilization results.

Commercial: All Payer Claims Database from Center for Health Information & Analysis (CHIA)

- Top 17 commercial carriers were identified based on number of behavioral health service utilizers in 2012. Enrollees aged 65 and over were excluded because they are covered by Medicare. Enrollment (i.e., member months) was obtained from CHIA's eligibility file.

Claims identified on the basis of having a behavioral-health related primary diagnosis. Differences across payers in the data fields on claims and changes in coding could result in inaccuracies in the reported utilization. There are also significant differences in coverage and benefits, and case mix severity, across plan types. Because only medical service claims were considered, and not self pay or pharmacy claims, these data likely underestimate the number of behavioral health utilizers.

The 2012 data from the three sources above cover an estimated population of 5,852,795 MA residents, or 89% of the 2014 population.

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Data Sources and Methods

- Utilization data was collected from five main sources: MassHealth; Medicare; Commercial All Payer Claims Data; DMH and BSAS.
- The sample was limited to claims with primary diagnosis codes shown in the list. This range of codes includes the dementias, even though these disorders are generally thought of as neurological conditions rather than mental illness.
- Data from 2010-2012 was analyzed.
- Data was de-identified as specified in the data use agreements

ICD9-CM Diagnosis Codes	
Mental Health	
290	Dementia (senile, presenile, vascular, and other senile psychotic conditions)
293	Delirium due to conditions classified elsewhere
294	Amnestic disorder in conditions classified elsewhere
295	Schizophrenic disorders
296	Bipolar disorders
297	Paranoid states, delusional disorders
298	Psychosis
299	Autistic disorder, childhood disintegrative disorder, other pervasive developmental disorders
300	Anxiety disorders
301	Personality disorders
302	Psychosexual disorders
306	Psychophysiological malfunction
307	Eating disorders, disorders of sleep, chronic motor or vocal tic disorders, psychogenic pain, other and unspecified special symptoms or syndromes not elsewhere classified
308	Predominant disturbance of emotions, consciousness, or psychomotor function; other acute reactions to stress
309	Adjustment disorders
310	Nonpsychotic mental disorders following organic brain damage
311	Depressive disorder not elsewhere classified
312	Conduct disorders
313	Emotional disturbances of childhood or adolescence
314	Attention deficit disorder, hyperkinetic syndromes
315	Reading, learning, speech, and language disorders; other developmental disorders
316	Psychic factors associated with diseases classified elsewhere
Substance Abuse	
291	Alcohol withdrawal, alcohol-induced mental disorders, idiosyncratic alcohol intoxication
292	Drug withdrawal, drug-induced mental disorders, pathological drug intoxication
303	Acute alcoholic intoxication in alcoholism, other and unspecified alcohol dependence
304	Drug dependence
305	Nondependent alcohol or drug abuse

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Data Methods: Inclusion Criteria & Population Definitions

The inclusion criteria used for the MA Behavioral Health Analysis were as follows:

- Claims:
  - ICD9-CM primary diagnosis codes in the range of 290 – 316;
  - Year of service equal to 2010, 2011, or 2012
- Eligibility:
  - Residence of MA, as defined by MA zip code

Note that there are significant differences in coverage and benefits, and case mix severity across the plan types.

Commonwealth of Massachusetts
Department of Public Health

Enrollment Totals – Payer Groups

MEDICARE ENROLLMENT

FFS only

	2010	2011	2012
0 - 17	20	20	20
Male	20	20	20
Female	NA	NA	NA
18 - 25	5,305	5,862	5,968
Male	2,630	3,052	3,373
Female	2,675	2,810	2,595
26 - 64	166,493	174,950	184,982
Male	85,220	89,807	94,873
Female	81,273	85,143	90,108
65 & over	584,295	603,368	615,855
Male	236,568	246,705	254,667
Female	347,727	356,663	361,188
All ages	756,113	784,200	806,825
Male	324,438	339,583	352,933
Female	431,675	444,617	453,892
TOTAL	756,113	784,200	806,825

MassHealth ENROLLMENT

	2010	2011	2012
0 - 17	489,666	504,146	518,381
Male	251,391	258,768	265,866
Female	238,275	245,378	252,515
18 - 25	139,548	142,285	143,364
Male	57,443	59,825	61,618
Female	82,106	82,460	81,746
26 - 64	501,936	530,567	554,477
Male	210,905	226,548	239,165
Female	291,031	304,019	315,312
65 & over	134,173	136,701	139,440
Male	42,498	43,998	45,806
Female	91,676	92,703	93,634
All ages	1,265,352	1,313,713	1,355,672
Male	562,251	589,146	612,460
Female	703,101	724,567	743,212
TOTAL	1,265,352	1,313,713	1,355,672

APCD ENROLLMENT

Top 17 Plans

	2010	2011	2012
0 - 17	827,130	799,699	808,048
Male	421,990	407,635	411,718
Female	405,139	392,064	396,330
18 - 25	466,863	488,995	496,966
Male	230,523	243,866	249,979
Female	236,340	245,129	246,988
26 - 64	2,360,549	2,335,618	2,385,285
Male	1,127,445	1,115,339	1,140,470
Female	1,233,104	1,220,279	1,244,814
65 & over	NA	NA	NA
Male	NA	NA	NA
Female	NA	NA	NA
All ages	3,654,542	3,624,311	3,690,298
Male	1,779,958	1,766,839	1,802,166
Female	1,874,583	1,857,472	1,888,132
TOTAL	3,654,542	3,624,311	3,690,298

The 2012 data from the three sources above cover an estimated population of 5,852,795 MA residents, or 89% of the 2014 population. All enrollment is expressed as member months divided by 12 to standardize the rates and minimize duplication between plans.

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Commercial – APCD Top 17

Top 17 APCD Plans *						
Rank	Plan ID	Plan Name	2012 Enrollment***	As % of total enrollment	2012 Members who Used BH Services**	As % of total members who used BH services
1	291	Blue Cross Blue Shield of Massachusetts	1,284,768	32%	235,197	37%
2	300	Harvard Pilgrim Health Care	597,208	15%	111,976	17%
3	8647	Tufts Health Plan	426,515	11%	66,539	10%
4	10932	United Healthcare Insurance Company - United Behavioral Health	111,611	3%	34,275	5%
5	10632	WellPoint, Inc.	247,781	6%	28,097	4%
6	3735	Neighborhood Health Plan	89,896	2%	19,814	3%
7	10441	Aetna Life Insurance Company	82,483	2%	17,549	3%
8	301	Health New England, Inc.	103,079	3%	17,298	3%
9	296	Fallon Community Health Plan	101,157	3%	16,343	3%
10	10444	United Healthcare Insurance Company - Harvard Pilgrim	142,603	4%	16,302	3%
11	312	United Healthcare Insurance Company	195,566	5%	14,679	2%
12	295	Connecticut General Life Insurance Company - Medic	192,653	5%	14,326	2%
13	3505	Boston Medical Center HealthNet Plan	47,050	1%	14,245	2%
14	302	Health Plans, Inc.	24,445	1%	7,571	1%
15	8026	Fallon Health and Life Assurance Company	18,272	0%	2,924	0%
16	7789	United Healthcare Student Resources	11,692	0%	2,749	0%
17	10353	Aetna Life Insurance Company - Aetna Student Health	13,519	0%	2,596	0%
		Top 17 sub-total	3,690,299	92%	622,480	97%
		Total APCD	4,016,529	100%	643,648	100%

*Top plans by number of behavioral health client counts in 2012

**Members who used BH Services refers to number of unique clients with an ICD9 diagnosis in the 290 - 316 range

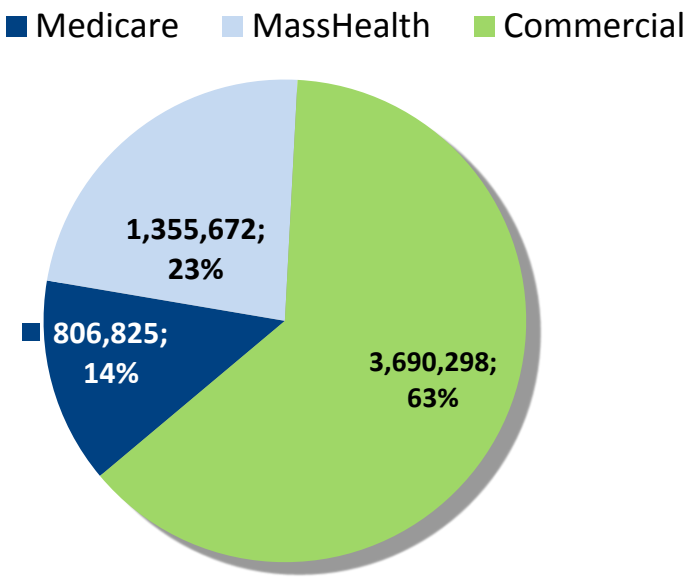
***Enrollment = member months/12 (may under count members as some Commercial enrollees are not enrolled for full 12 months)

Note: Sample shown in slide are filtered by following criteria: MA residents only (based on members zip codes); age = 64 years old and under; Commercial plans only (not Medicare, Medicaid, Medigap)

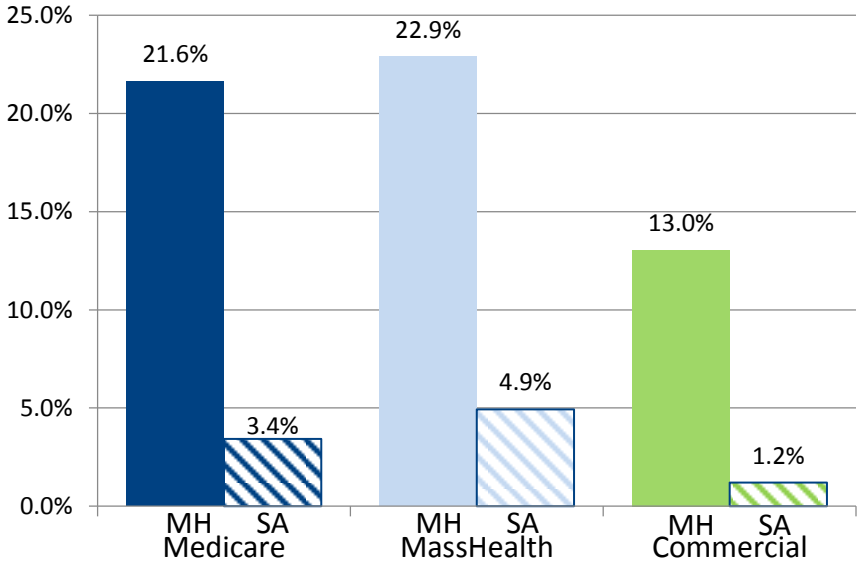
Slide 73

Summary: Access to care by Payor Group

2012 Study Population: Enrollment by Payor



2012 BH Penetration Rates

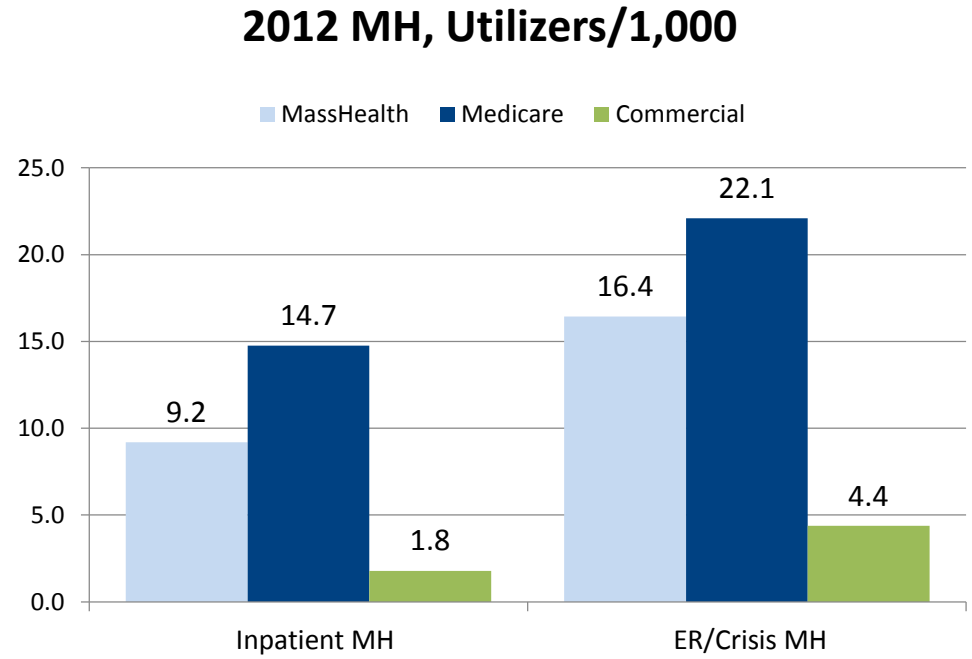


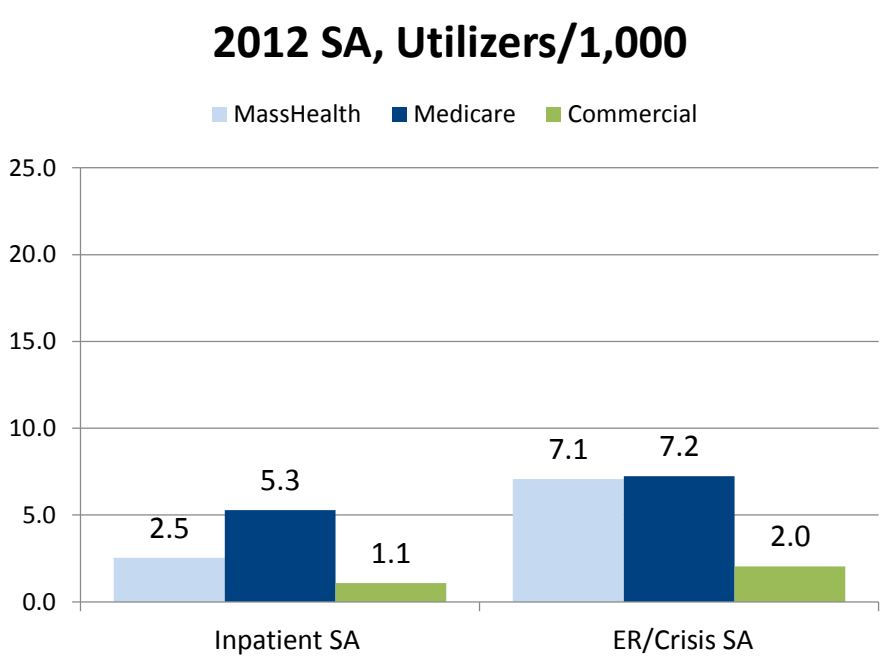
Overall mental health penetration rates were 13% to 23% for different payors, in the range expected from the NSDUH needs data. Substance abuse penetration rates were 1% to 5%, a rate lower than the prevalence rate. Medicare (1.7x) and MassHealth (1.8x) had higher mental health utilization rates than Commercial plans. Medicare substance abuse penetration rates were 2.8x commercial rates; MassHealth was 4x. These differences likely reflect differences in populations and severity of conditions.

Source: Medicare 5% sample, MassHealth, APCD

* Penetration rates are shown as the number of clients accessing BH services who have a diagnosis, divided by the number of enrollees (member months divided by 12). Enrollment = member months divided by 12 (because some members are not enrolled in an individual plan for all 12 months, these data likely underestimate enrollment)

MH and SA Inpatient and ER
Service Utilizers per 1,000 Enrollees





- Medicare FFS had the highest rates of utilizers/1000 for inpatient and emergency room visits for both mental health and substance abuse. MassHealth utilization rates for mental health inpatient services were 5 times the Commercial rates.
- MH and SA inpatient days decreased over the three-year period, though the magnitude varied across payor groups.
- Utilization of ER visits appeared to increase among Medicare enrollees; this trend was not seen among MassHealth and Commercial enrollees.
- Age cohorts for each payer showed important differences
- The handling of claims for dual eligibles skews the results on this and subsequent slides.

Slide 75

Source: Medicare 5% sample, MassHealth, ABCD

Inpatient and Acute Treatment Services: 2010-2012

Utilization of MH and SA inpatient days decreased over the three-year period, though the magnitude varied across payor groups.

INPATIENT ACUTE & PYSCH HOSPITAL								
MENTAL HEALTH								
RATES								
	Days/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	219.4	204.7	194.2	-5.7%	9.6	8.9	9.2	-2.2%
Medicare	412.0	393.0	358.7	-6.5%	16.4	17.0	14.7	-5.0%
Commercial	23.7	23.9	22.9	-1.7%	1.9	1.9	1.8	-3.3%
SUBSTANCE ABUSE								
RATES								
	Days/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	21.4	21.4	20.0	-3.3%	2.4	2.5	2.5	1.9%
Medicare	70.3	69.1	70.2	-0.1%	5.4	5.4	5.3	-1.1%
Commercial	9.3	10.4	10.0	3.9%	1.0	1.1	1.1	4.8%

Emergency and Crisis Services: 2010-2012

Utilization of ER visits appeared to increase among Medicare enrollees; this trend was not seen among MassHealth and Commercial enrollees.

EMERGENCY ROOM/CRISIS								
MENTAL HEALTH								
RATES								
	Encounters/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	39.3	36.6	39.5	0.2%	17.2	16.0	16.4	-2.3%
Medicare	46.8	47.5	56.2	10.0%	21.1	22.5	22.1	2.3%
Commercial	6.9	6.8	6.8	-1.2%	4.4	4.3	4.4	-0.5%
SUBSTANCE ABUSE								
RATES								
	Encounters/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	18.4	17.1	18.9	1.4%	7.4	6.9	7.1	-2.3%
Medicare	21.6	21.9	24.1	5.7%	7.5	7.5	7.2	-1.7%
Commercial	4.0	4.1	4.1	0.6%	2.0	2.0	2.0	1.0%

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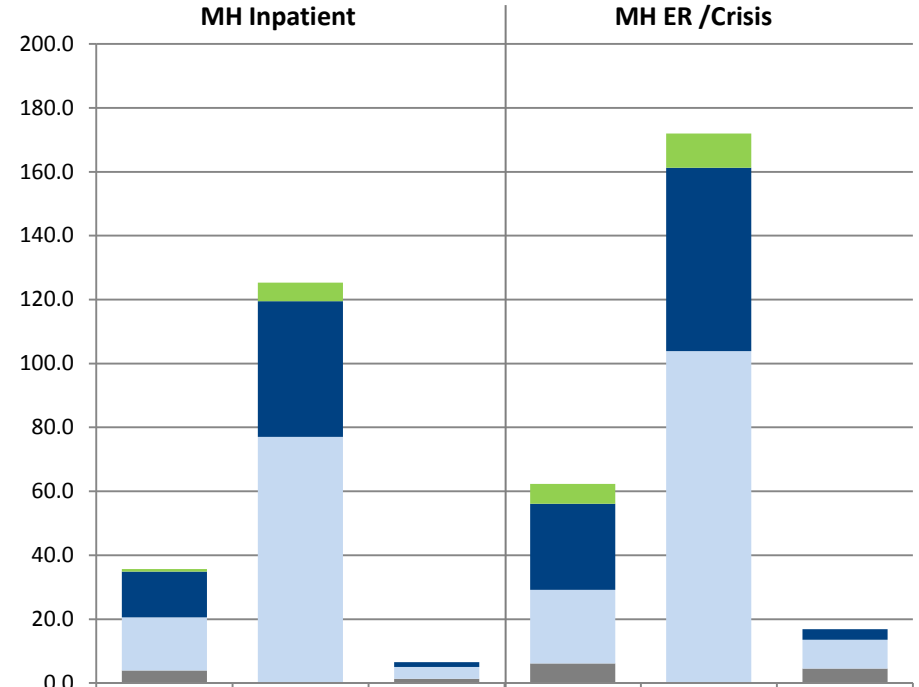
Commonwealth of Massachusetts
Department of Public Health

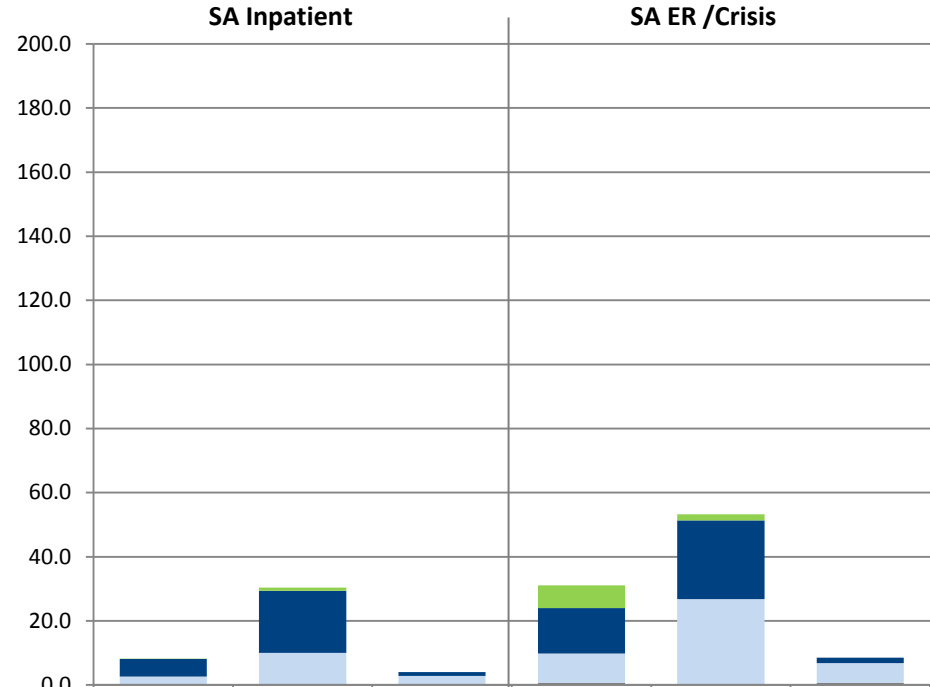
Inpatient & ER Utilizers/1,000 by Age Group, 2012

Service Users/1,000 by Age Group, 2012



	MassHealth Inpt	Medicare Inpt	Commercial Inpt	MassHealth ER/Crisis	Medicare ER/Crisis	Commercial ER/Crisis
65+	0.8	5.8	0.0	6.2	10.7	0.0
26-64	14.3	42.4	1.5	26.9	57.4	3.3
18-25	16.6	77.1	3.7	23.1	103.9	9.0
0-17	4.0	0.0	1.4	6.1	0.0	4.6

Service Users/1,000 by Age Group, 2012



	MassHealth Inpt	Medicare Inpt	Commercial Inpt	MassHealth ER/Crisis	Medicare ER/Crisis	Commercial ER/Crisis
65+	0.1	1.0	0.0	7.1	1.9	0.0
26-64	5.4	19.4	1.2	14.2	24.5	1.7
18-25	2.6	10.1	2.7	9.2	26.8	6.2
0-17	0.1	0.0	0.1	0.6	0.0	0.6

Inpatient & ER Utilizers/1,000 by Age Group, 2012

Mental Health Inpatient and ER Utilizers Per 1,000 Covered Lives by Payer, 2012			
	MassHealth	Medicare	Commercial
Age 0-17			
Inpatient	4.0	0.0	1.4
ER	6.1	0.0	4.6
Age 18-25			
Inpatient	16.6	**77.1**	1.4
ER	23.1	**103.9**	4.6
Age 26-64			
Inpatient	14.3	**42.4**	1.5
ER	26.9	**57.4**	3.3
Age 65+			
Inpatient	0.8	**5.8**	0.0
ER	6.2	**10.7**	0.0

Substance Abuse Inpatient and ER Utilizers Per 1,000 Covered Lives by Payer, 2012			
	MassHealth	Medicare	Commercial
Age 0-17			
Inpatient	0.1	0.0	0.1
ER	0.6	0.0	0.6
Age 18-25			
Inpatient	2.6	**10.1**	2.7
ER	9.2	**26.8**	6.2
Age 26-64			
Inpatient	5.4	**19.4**	1.2
ER	14.2	**24.5**	1.7
Age 65+			
Inpatient	0.1	**1.0**	0.0
ER	7.1	**1.9**	0.0

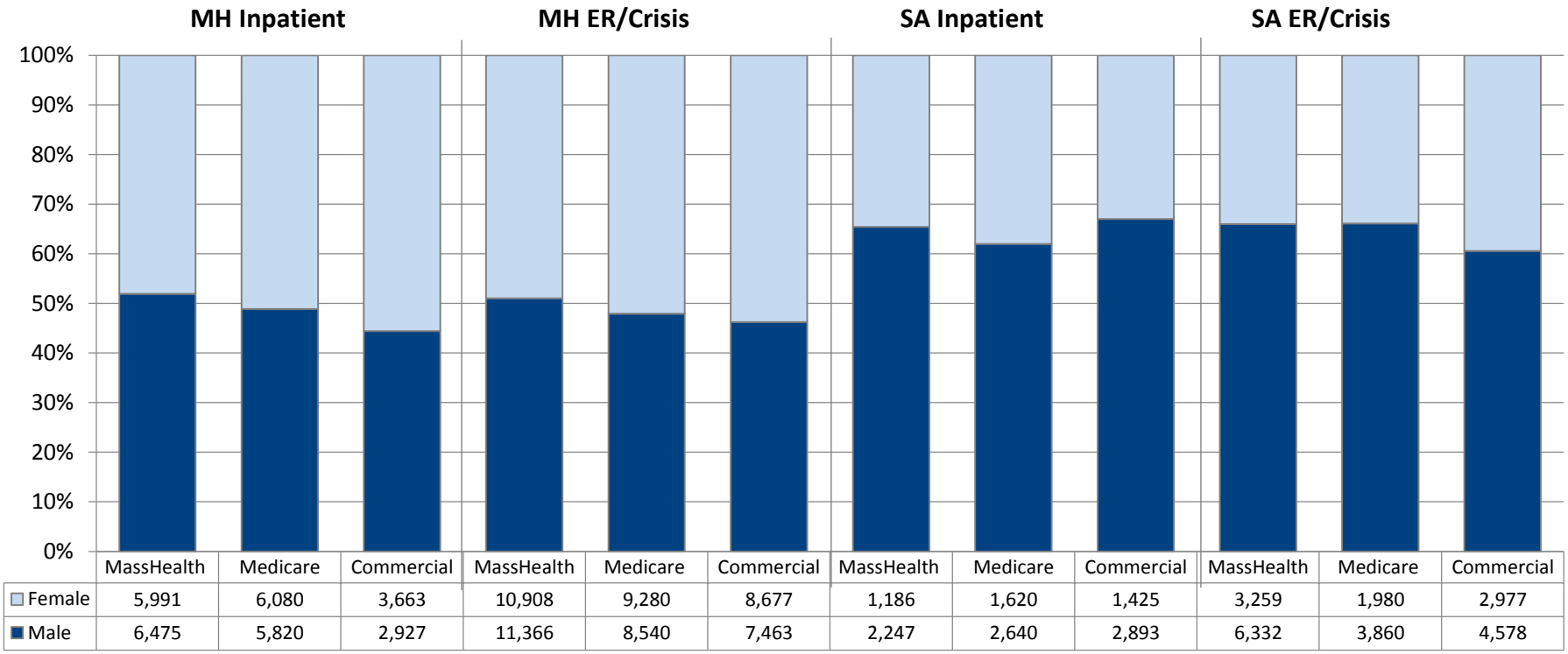
Medicare FFS has high utilization rates largely as a result of the under 65 disabled population. Medicare MH utilization for individuals 26-65 was 5.5x (ER) and 7.5x (Inpt) more likely than for those 65 and older. For SA services, the differences were even higher at 12.9x (ER) and 19.1x (Inpt). Small sample sizes may contribute to these findings.

Not shown, females had slightly higher MH service use rates than males, however males were significantly higher than females for substance abuse treatment services.

Source: Medicare 5% sample, MassHealth, APCD

Inpatient/ER Service Users by Gender, 2012

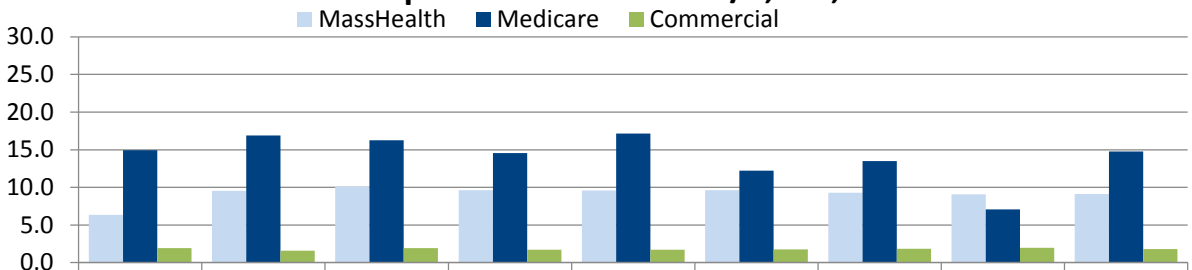
Inpatient/ER Utilizers by Gender, 2012



	MH Inpatient			MH ER/Crisis			SA Inpatient			SA ER/Crisis		
	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial
Female	5,991	6,080	3,663	10,908	9,280	8,677	1,186	1,620	1,425	3,259	1,980	2,977
Male	6,475	5,820	2,927	11,366	8,540	7,463	2,247	2,640	2,893	6,332	3,860	4,578

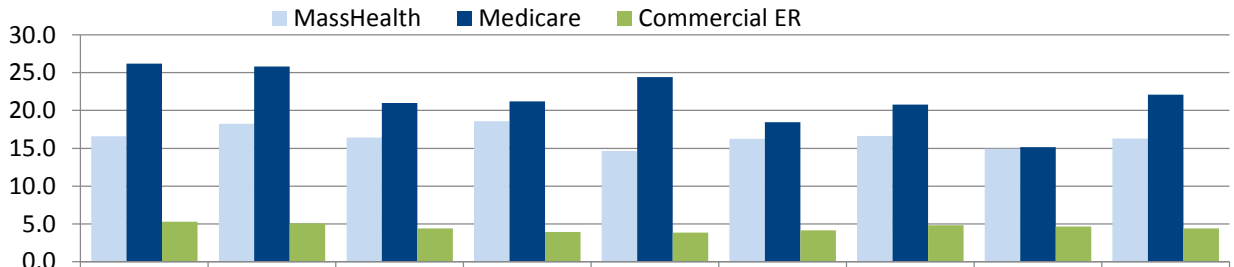
MH Service Users/1,000
2012 Regional Variation

Mental Health - Inpatient Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	Total
MassHealth	6.4	9.5	10.1	9.6	9.6	9.6	9.3	9.1	9.1
Medicare	14.9	16.9	16.3	14.6	17.1	12.2	13.5	7.1	14.7
Commercial	1.9	1.6	1.9	1.7	1.7	1.7	1.8	2.0	1.8

Mental Health - ER/Crisis Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	Total
MassHealth	16.6	18.3	16.4	18.6	14.6	16.2	16.6	14.9	16.3
Medicare	26.2	25.8	21.0	21.2	24.4	18.5	20.8	15.2	22.1
Commercial ER	5.3	5.1	4.4	3.9	3.8	4.1	4.8	4.7	4.4

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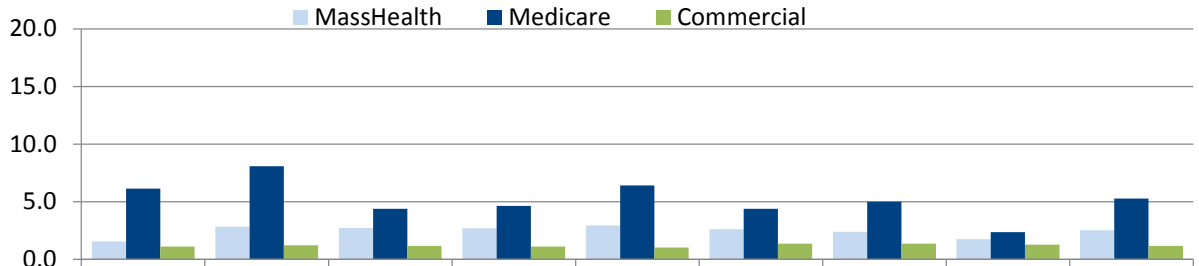
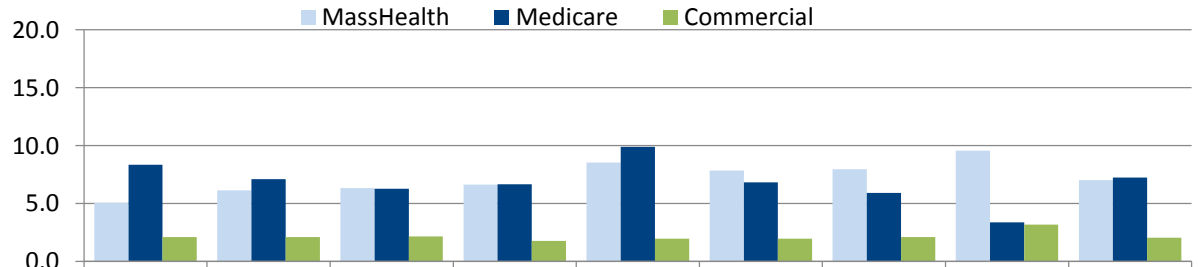
Substance Abuse Service Users/ 1,000 2012 Regional Variation

Substance Abuse - Inpatient Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	TOTAL
MassHealth	1.5	2.8	2.7	2.7	2.9	2.6	2.4	1.7	2.5
Medicare	6.1	8.1	4.4	4.6	6.4	4.4	5.0	2.4	5.3
Commercial	1.1	1.2	1.2	1.1	1.0	1.4	1.4	1.3	1.2

Substance Abuse - ER/Crisis Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	TOTAL
MassHealth	5.1	6.1	6.3	6.6	8.5	7.9	8.0	9.6	7.0
Medicare	8.3	7.1	6.3	6.7	9.9	6.8	5.9	3.4	7.2
Commercial	2.1	2.1	2.2	1.8	2.0	2.0	2.1	3.2	2.1

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Commonwealth of Massachusetts
Department of Public Health

Inpatient Occupancy Rates

Massachusetts Psychiatric Hospital Data

- Free standing occupancy rates average slightly less than 84%.[6]
- Acute general hospital rates are around 90%.[7]
- Snapshot on a single day in August 2014 from MABHAccess website shows occupancy rates are higher, with variation by population and region.[8]
- Qualitative research shows that hospitals aim for 90-95% occupancy, and are nearly fully utilizing all licensed beds.

Occupancy Benchmarks

- One commonly cited study states that above 85% occupancy, bed shortages occur in hospital emergency departments.[1] [2]
- Several state health plans use figures from 70% to 85% occupancy rates as thresholds to demonstrate need for increased psychiatric capacity.[3] [4] [5]

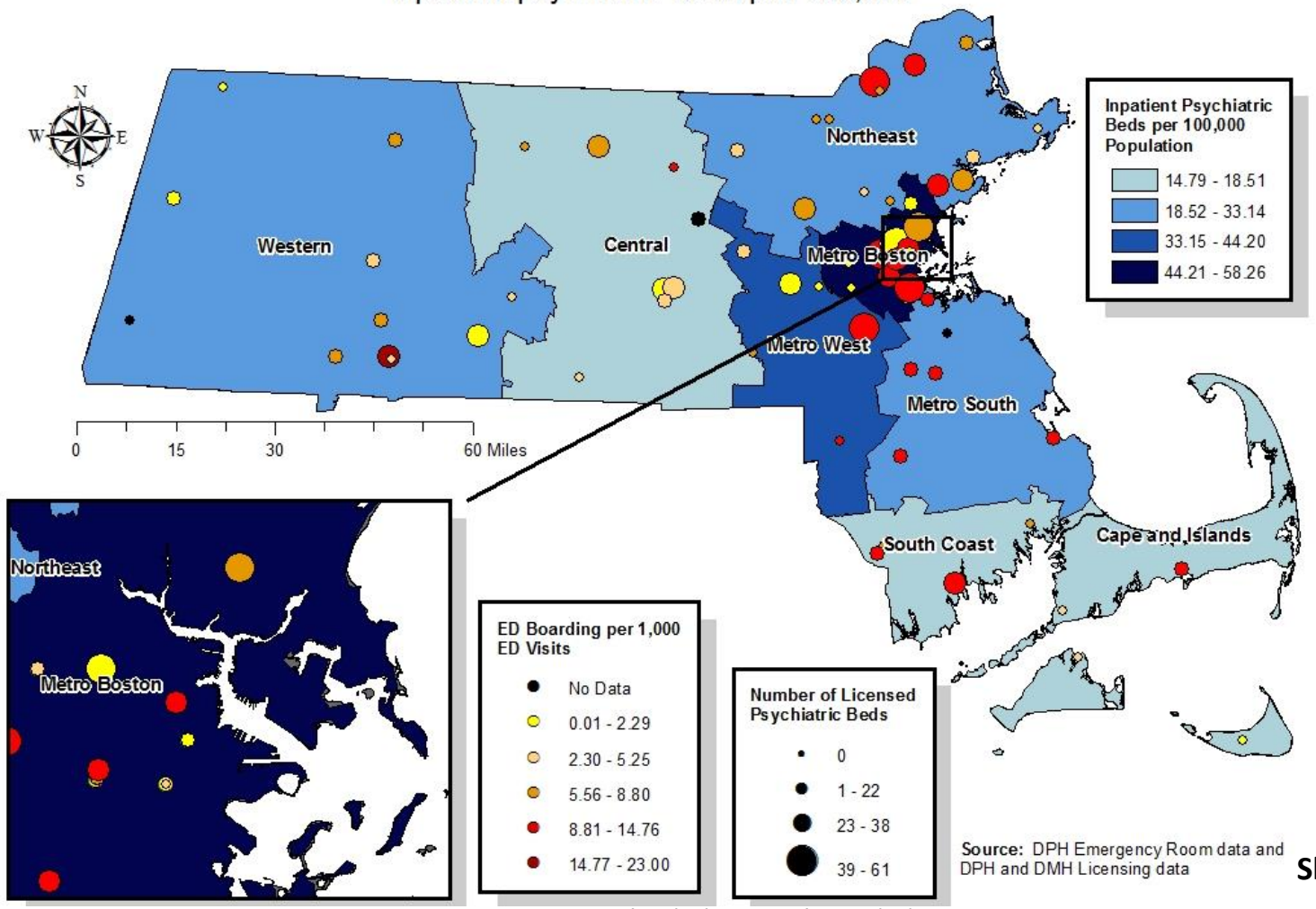
Conclusion: Multiple sources of data suggest that both free-standing and psychiatric units at general hospitals are operating at or above full capacity.

1. Adrian Bagust, Michael Place and John W Posnett, "Dynamics of bed use in accommodating emergency admissions: stochastic simulation model," *BMJ* 319 (1999): 155–8.
2. Royal College of Psychiatrists, "Do the right thing: How to judge a good ward," June 2011.
3. *South Carolina State Health Plan 2012-2013*, "Chapter IV: Psychiatric Services," http://www.scdhec.gov/Health/docs/2012-2013%20SC%20Health%20Plan.pdf.
4. *Mississippi State Health Plan 2014*, "Chapter 3 – Mental Health," http://www.msdh.state.ms.us/msdhsite/index.cfm/19,5619,184,pdf/Chapter_3_Mental_Health.pdf.
5. Florida Administrative Code, 59C-1.040. Hospital Inpatient General Psychiatric Services, http://florida.eregulations.us/rule/59c-1.040; Florida Administrative Code, 59C-1.041, Hospital Inpatient Substance Abuse Service, http://florida.eregulations.us/rule/59c-1.041.
6. Center for Health Information and Analysis, Massachusetts Hospital Profiles: Data Through Fiscal Year 2012 - Non-Acute Hospital Data Appendix (March 2014).
7. Massachusetts Hospital Association, Inc., *PatientCareLink,* http://patientcarelink.org/.

Slide 83

Emergency Department Utilization

Number of patients (per 1,000 ED visits) with a behavioral health diagnosis with an ED stay >=12 hours after a disposition decision has been made in 2013 overlaid with inpatient psychiatric beds per 100,000



Source: DPH Emergency Room data and DPH and DMH Licensing data

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DMH and BSAS Utilization

- DMH and BSAS both reported on the number of clients served for most services (see next slide) but each agency uses two or more data systems with significant limitations on some of these systems. DMH payment methods and their data systems do not permit the agency to easily track clients' utilization of multiple services and some data is limited to authorization data not actual use. Most of the clients reported by DMH and BSAS are included in other client counts from MassHealth, Medicare or Commercial coverage.
- DMH and BSAS fund an extensive array of recovery and rehabilitation services in community settings for anyone meeting the need. They are not available from most other payers. CBFS services are an example of the kind of payment reforms needed for the system but cross agency data are needed to understand the levels of inpatient and ER use for these clients when paid from MassHealth or Medicare.
- The majority of services reported by each agency are active rehabilitative treatment options, long-term residential support services or step-down levels of care (e.g., CSS and TSS services) that are not fully funded by most other payers. BSAS also pays for services for the uninsured.

Commonwealth of Massachusetts
Department of Public Health

DMH / BSAS Utilization: Client Use of Services by Year

DMH

BSAS

DMH - Clients Served by Service and by Calendar Year, 2011-2013				
	CY2011	CY2012	CY2013	Avg Annual Change
Continuing Care	1,595	1,607	1,639	1%
CBFS	14,153	13,608	13,487	-2%
Clubhouse*	N/A	N/A	3,710	N/A
Adult Case Management	5,760	5,763	5,581	-2%
C/A Case Management	1,097	1,010	945	-7%
PACT	997	1,095	1,128	6%
IRTP	145	151	141	-1%
Flex	1,364	1,706	2,387	32%
Adult Respite	1,236	1,335	1,438	8%

*Contracts began 7/1/13, utilization reflects 6 months.

BSAS Clients Served by Service and by Calendar Year, 2011-2013					
Service Group	Service	CY2011	CY2012	CY2013	Avg Annual Change
Inpatient and Other Acute Care	Acute Treatment Services (ATS)	20,992	21,891	23,276	5%
	Section 35	2,906	2,918	3,026	2%
	Clinical Stabilization Services	5,504	5,305	5,485	0%
Intermediate Care	Transitional Support Services	3,823	3,596	3,848	1%
	Day Treatment	5,054	4,612	3,742	-14%
Residential Care	Residential	7,645	7,997	8,174	3%
Outpatient Care	Counseling	25,422	24,706	24,331	-2%
	Methadone	18,631	19,342	20,100	4%
	Office-Based Opioid Treatment (OBOT)	2,617	2,782	2,621	0%

Notes for Table 3

ATS includes Detox level iii.7 licensed programs including Youth Stabilization Programs. OBOT service only contains data from the 14 BSAS-funded programs.

Definition of measures Clients received treatment service in the calendar year funded by MassHealth, BSAS and other payors.

Source: BSAS treatment data prepared on June 18, 2014 by the Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health. Data as of May 13, 2014.

Commonwealth of Massachusetts
Department of Public Health

DMH and BSAS: Clients by Gender, Race and Age, CY2013

DMH

	DMH												
	Gender			Race/Ethnicity					Age (years)				
	Male	Female	Transgender	White, Non-Hispanic	White, Hispanic	Non-White, Non-Hispanic	Non-White, Hispanic	Unknown	0 to 17	18 to 25	26 to 64	65+	Unknown
Continuing Care	1,058	581	N/A	933	462	136	66	42	49	295	1,213	86	
CBFS	7,533	5,954	N/A	9,108	797	2,401	121	1,060	0	1,419	11,090	978	N/A
Clubhouse	2,282	1,428	N/A	2,520	173	516	33	468	0	295	3,208	207	N/A
Adult Case Management	3,076	2,505	N/A	3,714	435	944	64	424	0	934	4,323	324	N/A
FLEX - Children and Youth	1,338	1,049	N/A	917	276	323	57	814	2,089	298	0	0	N/A

BSAS

	BSAS												
	Gender			Race/Ethnicity					Age (years)				
	Male	Female	Transgender	White, Non-Hispanic	White, Hispanic	Non-White, Non-Hispanic	Non-White, Hispanic	Unknown	13 to 17	18 to 25	26 to 64	65+	Unknown
Acute Treatment Services (ATS)	16,094	7,170	12	18,314	606	1,956	259	2,141	540	5,035	17,658	92	119
Section 35	1,764	1,262	-	2,658	32	165	22	149		1,001	1,990	33	8
Clinical Stabilization Services (CSS)	3,841	1,643	*	4,435	96	505	76	373		1,213	4,265	*	22
Transitional Support Services (TSS)	2,503	1,340	*	3,203	54	375	36	180		997	2,857	*	*
Residential	5,352	2,815	7	6,404	201	825	101	643	321	1,976	5,862	18	28
Methadone	11,453	8,645	*	16,195	727	1,037	218	1,923	N/A				
Office-based Opioid Treatment (OBOT)	1,606	1,015	0	1,771	101	180	40	529	*	324	2,282	15	*
Day Treatment	2,384	1,356	*	2,800	99	448	49	346	44	819	2,845	21	15

Notes for BSAS

General Notes

Utilization Demographic tables, Table 2: A-H are available for the following service lines from the Bureau of Substance Abuse Services Treatment System: ATS, CSS, TSS, Section 35, Residential. Clients Served measures are available for Methadone, OBOT and Day Treatment

* = counts less than or equal to 5 are suppressed for confidentiality reasons

N/A = not applicable

Age

Age represents the age of the client at admission.

The age group 65+ represents ages 65 to 90. Unknown Age represents clients with invalid ages.

A client could be multiple ages in one year if he was admitted multiple times before and after his birthday; this person would be counted in multiple age-bands.

Race/Ethnicity

For Unknown Race/Ethnicity, either the race was unknown (Invalid, Missing, Not Applicable, Not Collected, Other, Unknown, Refused) or the Hispanic indicator was missing

Services

Service line categories are based on previous Service Definition work from Health Planning Workgroup.

The service line, ATS, contains Detoxification level iii.7 licensed programs including Youth Stabilization Programs.

The service line, Residential includes Adult and Youth Residential programs.

Section 35, CSS, and TSS service definitions consist of adult treatment programs.

OBOT service only contains data from the 14 BSAS-funded programs.

Definition of measures Clients Served: Patients that received care in the calendar year.

Source: BSAS treatment data prepared on June 18, 2014 by the Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health. Data as of May 13, 2014.

Outpatient Services: Factors adding to variation

Outpatient claims were analyzed and marked inconsistency in encounter rates was found between payers. ***As a result, further analysis of outpatient service has been deferred to develop consensus on data reporting conventions and to more accurately interpret the findings.***

The key factors affecting variations in the observed levels of use are:

- Underlying population characteristics including factors such as employment status, poverty, age and disability. The data were not case-mix adjusted for these factors
- Significant differences in coding and benefit plans between payer groups, including:
  - A variety of unique codes in MassHealth providing a broad range of community based support services in 15 minute billing intervals.
  - A range of special services in MassHealth for youth such as Therapeutic Behavioral Services, targeted case management and self-help/peer support.
  - Broad use and coverage of methadone dosing and counseling in MassHealth but not in other health plans.
- Future work will be done to identify outpatient services and service providers.

Summary

Summary

- The Health Planning Council's work has produced a first-of-its-kind review of inventory, need and utilization across all payers. This report should serve as a baseline for future analyses and establishes a framework for the state to utilize in evaluating capacity.
- Data has been provided on need for services, the inventory of providers and types of service and the utilization of services. These data cover 89% of the MA population and include all licensed facilities/programs/clinics.
- A low proportion of licensed clinics integrate mental health and medical services (17%). DPH operates the Behavioral Health Integration Initiative Committee (IIC) designed to improve the current limitations on integration.
- Obtaining reliable data on the inventory, capacity, and utilization of outpatient services remains challenging and further work is needed.
- The data on the behavioral health system are particularly weak for the community outpatient system of clinics, independent professionals, group practices and other specialty organizations not under contract with the state.
- This is one of the first instances of using the Health Policy Commission (HPC) regions* for health planning across all payer groups. Historically neither DMH or BSAS have used these regions, but future work should benefit from this foundation.

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* http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf

Summary: Inventory

- There are 2431 psychiatric inpatient beds in Massachusetts.
- Relative to other states there is a generally high level of inpatient MH beds and a slight increase from 2010-2012. Hospital occupancy rates are also high in both freestanding and acute general hospital beds.
- There does not appear to be a regional association of ED boarding with bed inventory, suggesting that other factors are involved.
- There are 917 Level 4 and Level 3.7 beds or 16.5 beds/100,000. This does not include 482 CSS and Section 35 beds. Relevant comparison points for substance abuse bed capacity are not available because of differences in reporting.

Summary: Utilization

- Overall inpatient utilization declined slightly from 2010 to 2012, but Medicare MH emergency room and crisis utilization increased.
- 18-25 year olds have disproportionately high utilization levels for inpatient and crisis services (both MH and SA) compared to other age groups for Medicare and Commercial plans.
- Access or penetration rates for substance abuse services are much lower than mental health services as a percent of estimated need.
- Males are 60% or more of the substance abuse treatment utilization population.
- Regional variation did not show a consistent pattern.

Note: Supporting analysis can be found here: http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/ohpp/hpc/2014-hpc-meetings.html

Recommendations

Recommendations: Data Collection and Analysis

- Expand data collection and reporting on hospital and community capacity. For example:
  - Improve data collection about occupancy rates
  - Where possible, leverage the Registration of Provider Organization (RPO) process to streamline data collection efforts
  - Explore making information about service availability more publicly accessible
  - Examine opportunities to collect data through professional licensing renewal processes
- Continue to analyze outpatient and APCD data.
- Implement a Behavioral Health Data Planning group with staff from key agencies, including DPH, DMH, MassHealth, CHIA, and HPC.

Recommendations: Ensuring Access

- Continue the work of the Massachusetts Department of Public Health's Behavioral Health Integration Initiative Committee* (IIC) to address the current Agency regulatory barriers that may restrain development of the integration of mental services, substance abuse, and primary care.
- Support the behavioral health integration initiatives of health reform through expanded data collection and continued iterative heath planning.
- Support a robust community system with the resources and capabilities to: 1) keep people healthier, preventing the need for more acute levels of care, 2) divert patients from emergency departments and inpatient services, when clinically appropriate 3) provide patients with strong post-discharge supports, thus enabling timely discharges, and 4) provide timely post-discharge follow-up care.

Public Feedback

Public Comment Questions

Access and Availability

- What challenges are patients/family members/providers encountering as they are trying to help people access behavioral health care (including in inpatient, outpatient and community settings)?
- The data presented show that many people have a mental health or substance use disorder but don't seek treatment. What are some of the things that might prevent people from seeking and obtaining treatment? What can we do to address those barriers?

Quality and Best Practices

- What are the best practices to ensure high quality, timely behavioral health care?
- How can the Plan's analysis and recommendations best be used to promote these best practices in behavioral health services?
- Is screening for mental health and substance abuse problems happening? If so, where? If not, why not?

Public Comment Questions

Information and Data

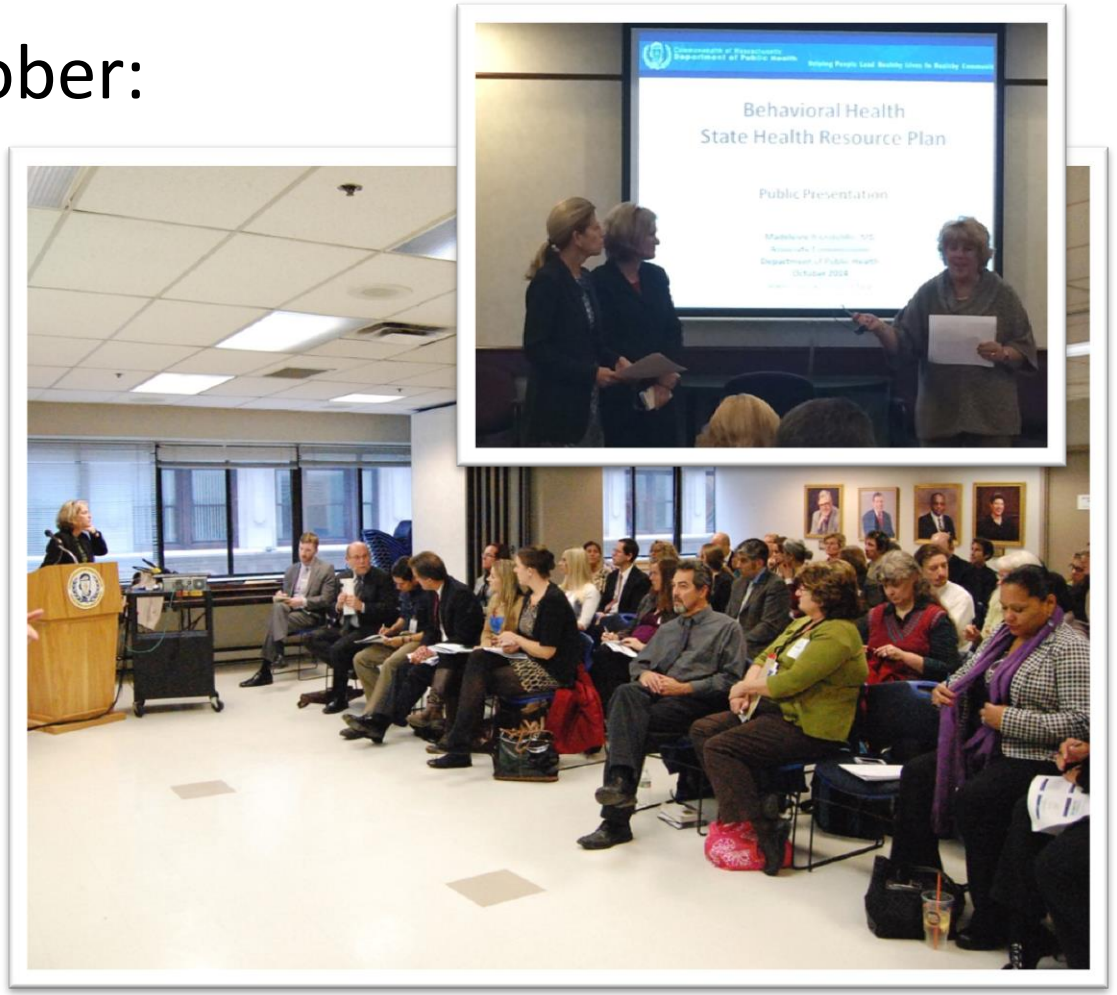
- As a patient moves through the behavioral health care system, what happens during transitions of care? Are there smooth hand-offs?
- What additional information do consumers, providers, and policymakers need to make the best decisions around behavioral health care delivery and planning?

Public Feedback

Three hearings in October:

- Springfield: 24
- Fall River: 25
- Boston: 54
- **Attendees: 103**

Written comments: 23



Asked for feedback about:

- Access and Availability
- Quality and Best Practices
- Information and Data

Public Feedback

Access and Availability

- **Access**
  - Long wait times (especially for intermediate and community-based care – such as clinics and addiction treatment centers)
  - Lack of outpatient resources create access problems and force patients into higher levels of care
  - Lack of access and adequate staff in rural areas
  - Substance use patients sometimes occupy mental health beds
- **Community Care**
  - Need for more community-based care, especially to allow patients to step down from inpatient care
  - Lack of peer support resources

Public Feedback

Access and Availability (cont'd)

- **ED Boarding**
  - Homeless population a significant proportion of ED boarders
  - High medical acuity patients more challenging to place because can only be admitted to acute care hospitals
  - Ability to access open beds challenging during evenings and weekends
- **Stigma**
  - Stigma around mental health causes many people to avoid seeking help
  - Many people will not go to behavioral health clinician if referred

Access and Availability (cont'd)

- **Insurance/Reimbursement**
  - Prior and on-going authorizations still a barrier
  - Medical necessity clauses and utilization policies can become a barrier to care, especially if vague
  - Patients had difficulty identifying in-network providers (especially if insurers do not update online directories)
  - High deductibles and copays of some plans limit access to care
  - Medicare cap of one service per billing day creates barriers
  - Patients reliant on insurance often cannot access private practice clinicians
  - Clinicians have difficulty getting on insurance panels, or low reimbursements discourage clinicians from joining panels
  - Fee-for-service model encourages seeing high number of patients
  - Although MassHealth plans differ in coverage, generally cover more services than commercial plans

Public Feedback

Access and Availability (cont'd)

- "Behavioral health care must be better integrated into primary care settings, school based settings, settings that are easy access points and also eliminate or reduce the fear of stigma and address the stigma (normalization)." *- Dawn Casavant, Heywood Healthcare*
- "Association for Behavioral Healthcare supports the overarching principle that medical cost savings can be achieved through more accessible and effective behavioral health services, but outpatient services must be the first option for this vision to succeed." *- Vicker DiGravio, Association for Behavioral Healthcare*
  - *Note:* Analysis from the Health Policy Commission indicates that average spending for patients with behavioral health comorbidities is 1.6x to 2.2x than that of the average patient. *(Health Policy Commission 2013 Cost Trends Report)*

Public Feedback

Access and Availability (cont'd)

- Factor contributing to ED boarding: "The lack of less intensive services within the behavioral health continuum to receive discharged inpatients (slows the [ability to transition patients out] of inpatient beds and impacts ED stays)."
  – Tim Osner, Sisters of Providence Health System
- "The ongoing and extraordinary difficulty of finding outpatient services for patients with health insurance coverage, and the extremely limited availability of outpatient providers participating in public and private health plans for behavioral health services."
  - *William Greenberg, Beth Israel Deaconess Medical Center*

Quality and Best Practices

- **Behavioral Health Integration**
  - Primary care should be thought of as the most effective setting for behavioral health care delivery, given that primary care is often the only setting where behavioral health care occurs
  - Primary care doctors need training in order to assess and treat behavioral health issues
  - Barriers to integration should be reduced, and incentives needed to encourage integration
- **Pilots and Evaluation**
  - Grant-funded pilots reveal best practices, and providers need further state and federal resources to evaluate and disseminate these best practices

Quality and Best Practices (cont'd)

- **Screening**
  - Need adequate time, proper incentives, and sufficient training to ensure screening happens in various settings
  - Behavioral health screening should happen in prisons
- **Transitions and Coordination**
  - Because a patient's clinician changes as level of care changes, time is needed to allow for coordination and communication by clinicians (warm hand-offs)
  - Lack of funding/reimbursement for coordination activities
  - Regulatory and financial barriers impede providers from doing follow up and outreach activities
  - Because care happens at different sites sometimes far from home, lack of transportation is a barrier to care

Quality and Best Practices (cont'd)

- "The need for planning and supporting behavioral health services in primary care is highlighted when we realize that it is the only venue in which the vast majority of behavioral health needs of minority, immigrant and other stressed and vulnerable populations can be identified and treated." *- Alexander Blount, UMass Medical School*
- "It seems that many providers seek private or federal or other state funding to create pilots. These often have great outcomes, then the funding ends and the programs go away. It seems it's a great opportunity to leverage grant money as start up for ongoing state-funded programs." *- Katherine Wilson, Behavioral Health Network, Inc.*

Quality and Best Practices (cont'd)

- "We need to show that we as a society value the people who provide mental health services by investing in financial incentives, training, and supports to ensure that the most experienced and skilled clinicians can continue to provide high quality, timely, behavioral health care to those in need." *- Dianne Corbin, Merrimack Valley Trauma Services*
- "Incentives for treatment of complex patients with mental health, substance use and medical comorbidities; Screening is incentivized in medical care settings by using measures such as the PHQ9; Incentives to provide a full array of mental health services in an integrated medical care system; Facilitation of easy communication across systems/providers if not integrated." *- Massachusetts Psychiatric Society*

Public Feedback

Quality and Best Practices (cont'd)

- "Increase reimbursement for care coordination and systems navigation services for the region. This will assure agencies have the appropriate supports in place to assist individuals in navigating the complex system and receiving warm hand-offs between organizations if needed, ultimately maximizing the use of resources." *– Kerrie D'Entremont, Greater Lowell Health Alliance*

Information and Data

- **Data Needs**
  - Outpatient data is a critical missing piece of health plan
  - Pharmacy data should be included in future analysis
  - More data about disparities in behavioral health care needed
  - Data in health plan should be broken down by age to highlight needs and services for children/adolescents
  - Data on primary care behavioral health care is crucial, to assess the amount of care that happens in primary care settings
  - More information about ED boarding needed
  - National level need data might not reflect Massachusetts experience
  - Problem gambling not addressed in plan

Public Feedback

Information and Data (cont'd)

- **Quality Metrics**
  - Need better outcome measures for behavioral health
  - Reimbursement rates sometimes tied to performance measurements which do not accurately measure quality
  - Disconnect between quality metrics and best practices, including concerns over reporting metrics that increase provider liability
- **Reporting**
  - Insurance companies should report more data about utilization and coverage
  - Existing reporting requirements should be reviewed and streamlined
  - Often difficult for smaller providers to collect data
- **Benchmarks**
  - Data on other states should be included in plan for comparison

Information and Data (cont'd)

- "Inpatient Care is only one component of the Behavioral Health system and the Step Down, Outpatient, and Community resources should also be analyzed in order to get an accurate assessment of the availability and access to behavioral health services." *- David Matteodo, Massachusetts Association of Behavioral Health Systems; Anuj Goel, Massachusetts Hospital Association*
- "We strongly encourage the Health Planning Council to take a closer look at the outpatient system before drawing conclusions about the state of the Commonwealth's behavioral health system."
  - Vicker DiGravio, Association for Behavioral Healthcare
- "The health resource planning process has not addressed the significant and specific needs of children, adolescents, and their families distinct from the needs of adults, nor have we seen inclusion of transitional services." *- Nancy Allen Scannell, Children's Mental Health Campaign*

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 and adolescent services, service planning is intertwined with planning and implementation of the Children's Behavioral Health Initiative (CBHI), the Commonwealth's long-term, interagency effort to establish a comprehensive community-based service system for families of children with serious emotional disturbance. 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 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 began a redesign of its community service system in SFY09 with the procurement of a new service model, Community Based Flexible Supports and continued its redesign efforts with the re-procurement of Respite Services in SFY10, procurement of a new model, Peer-Run Respite in SFY12 and the re-procurement of Clubhouses in SFY13.

DMH has maintained this commitment to engage stakeholders in the redesign process. During the Clubhouse procurement process, DMH held nine regional bidder's conferences and received extensive stakeholder input. In addition, DMH released an RFI seeking input into the development of a new statewide Deaf and Hard of Hearing Respite service.

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, including employment and health/wellness. Through the procurement of CBFS services, DMH made a significant shift in focusing the system on promoting positive outcomes and holding DMH and its providers accountable. 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.

Employment

Numerous studies on supported employment have documented that the majority of people with mental health conditions want to work. In light of this, recent DMH data demonstrates that there is a significant opportunity to improve employment outcomes. For example, in SFY14, 12% of adults receiving DMH case management services were employed; 11% of adults receiving CBFS services; and 20% of adults receiving PACT services. These rates include competitive employment as well as people who are employed in a program owned or managed positions (such as transitional employment) and those who are sporadically employed (odd jobs). In addition, preliminary data indicates that 15% of adults receiving Clubhouse services are competitively employment.

As Recovery Learning Communities (RLCs) are the most recent addition to DMH's network of community services, DMH is also currently evaluating the RLCs' effectiveness in terms of employment. In addition to offering job clubs, computer courses, and part-time work experiences for members, a preliminary assessment of how RLCs impact employment has found:

- 76% of RLC members have started to think about looking for a job since being connected to the RLC;
- 59% have started looking for work;
- 56% have improved their computer skills;
- 37% have started a new job;
- 23% have enrolled in school or a GED program; and
- And over 74% of respondents acknowledge that the RLCs have contributed to these outcomes.

When DMH re-procured its clubhouse services in SFY13, it changed the way employment outcomes are tracked and collected. This change aligns clubhouse employment measures with the seven federal employment categories used by DMH's other primary community services – CBFS since SFY10 and, as of SFY14, PACT. It also stipulates that changes in employment status be tracked as "events", to be reported as closely to "real time" as possible. Tracking employment outcomes as "events" will provide a much more vivid picture of who is working, for how long, and at what wages. Currently DMH is validating baseline data (as presented above) received through this process for all persons receiving clubhouse supports, and plans to produce reports of employment rates for clubhouse services using these revised metrics in SFY16. In light of this, employment will act as DMH's primary performance measure for Clubhouse services with a target of increasing the percentage of Clubhouse members who are competitively employed from 12% to 17%.

The Employment Subcommittee of the State Mental Health Planning Council (ESSMHP) has been a strong advocate for increasing access to employment services and improving employment outcomes. Largely through the ESSMHP's advocacy, DMH created the position of Director of Employment in SFY14, to monitor, evaluate, and coordinate the Department's various employment services and staff. For SFY15, the ESSMHP has prioritized a variety of

goals, including: reviewing and recommending employment benchmarks for CBFS; analyzing the role of peer specialists vis a vis employment specialists; and supporting Medicaid reimbursement for the peer workforce. The ESSMHP plans to continue in its role as a supporter of collaboration, networking, and communication among DMH, its provider community, persons-served, and the larger Mental Health Planning Council.

The Employment Subcommittee has also identified a need for greater collaboration between agencies and providers of employment services and with mainstream employment and career centers. Employment subcommittee members cite examples within their own experience of limited knowledge and working relationships between these entities. These experiences were supported by surveys conducted by DMH and the Massachusetts Rehabilitation Commission (MRC) in 2010 of Area and Site office staff employed in their respective agencies. The survey of DMH staff found that 22% of respondents did not know the MRC staff in their area; 31% felt that they did not have an understanding about the role of MRC vocational rehabilitation (VR) staff, including rules regarding eligibility for VR services; and 48% did not have contact with MRC VR staff. Half of the respondents also reported they believed that DMH CBFS staff was not aware of MRC VR resources. This survey led to a collaborative effort with MRC and Work Without Limits (WWL), an initiative originally funded by the CMS-funded, Medicaid Infrastructure and Comprehensive Employment Opportunities (MI-CEO) grant, to provide regional conferences for DMH and MRC staff. These efforts continued with a statewide DMH/MRC employment summit in April 2013 specifically for managers of each agency.

As a result of this summit, DMH and MRC signed a Data-Sharing Agreement in April 2014 and formal Memorandum of Understanding (MOU) in May 2014. Through the data-sharing agreement, DMH and MRC identified over 2,800 clients who were shared between the agencies at some point in SFY14. For over 2,300 active clients, aggregate information detailing their local office affiliation, employment outcome, and demographics was shared. Implementation of the MOU will begin in SFY15, starting with the designation of liaisons at each agency to assist with interagency referrals and coordination of services. In support of this initiative, MRC has designated the theme for its annual Mental Health Liaison Forum as "Collaboration," which will be opened widely to DMH- and DMH-provider staff for the first time. Featured training will be provided by David Lynde, formerly of the Dartmouth Supported Employment Center, on VR/MH/IPS models of collaboration nationally, challenges such models faced, and strategies proven successful in overcoming them.

Through its Director of Employment in SFY14, DMH began convening a quarterly, statewide meeting of DMH and provider-affiliated employment staff as a forum to share best-practices, disseminate information, standardize practices, review data, and address statewide/systemic barriers to employment. Topics include those which have statewide, cross-service applicability, and have included, for example: DMH/MRC Collaboration; Hospital/Community coordination; CBFS/Clubhouse coordination; transportation resources; engaging individuals in employment; staff training; the Family Self Sufficiency (FSS) program; and how unemployment can exacerbate physical health conditions. Related to this, the Director of Employment has made a variety of interagency contacts at the Massachusetts Rehabilitation Commission (MRC); Department of Housing and Community Development (DHCD); Executive Office of Elder Affairs (EOEA); and Department of Developmental Services (DDS), which have contributed to cross-training opportunities and service coordination. Ongoing initiatives include work to better coordinate the vocational rehabilitation services provided while individuals are inpatient with those individuals receive in the community; coordination with DMH's Housing Division regarding the promotion of a work incentive for beneficiaries of the DMH Rental Subsidy program; and monthly coordination of DMH's regional employment coordinators.

Linkages are also being made between the adult and young-adult employment-service systems. Young Adults are being actively recruited for both the ESSMHP as well as the DMH/MRC MOU Implementation Committee. The Director of Employment is additionally a member of the steering committee for the Department's STAY (Success for Transition Age Youth) Initiative. CBFS data from SFY12 shows that while young adults (aged 27 years or less) comprised 27% of those receiving CBFS services, they made up 37% of those working in CBFS, 34% of those unemployed but engaged in employment services, and only 24% of those unemployed in CBFS and not engaged in employment services. In light of this information and given 1) the level of interest young adults display in employment; 2) the critical importance of engaging individuals as early as possible in work to best position them to work as adults; and 3) the likelihood that stably employed young adults will not need to be lifelong "consumers" of public mental health services, DMH and Work Without Limits created **www.ReachHIREma.org**, a website targeted expressly-to- and developed-largely-by- young adults, focused on work, education, and financial management. ReachHIRE includes a wealth of information provided in a variety of formats, including seven customized videos of, by, and for young adults speaking directly to their peers about what's helped them recover through work, school, and self-care.

In SFY14, DMH as well issued a request for response (RFR) and contracted for two Regional Employment Collaboratives (RECs) in Central and Western MA. Building off of the successful model originally funded by WWL's MI-CEO grant, DMH coordinated its RFR process with DDS (the Massachusetts Department of Developmental Services), which is co-funding the successful bidder in each region. RECs are designed to provide two core functions: 1) Job Developer Networks (JDNs) – forums for job developers across multiple agencies to exchange job leads and provide technical assistance and peer support, and 2) Business Account Managers (BAMs) – high-level, "macro" job developers, whose sole function is to outreach to regional and state-level employers to build relationships at the corporate level, yielding quantities of jobs at multiple locations which would not otherwise be possible for employment generalists. In SFY15, DMH worked to monitor and integrate the RECs into Massachusetts' existing employment-services landscape, specifically to ensure that DMH providers are affiliated and active participant and that the RECs themselves are linked to other collaborative and inter-agency groups statewide.

DMH also continues to promote the use of the Individual Placement and Support Supported Employment (IPS/SE) model throughout its system. The IPS/SE Model, developed by Becker and Drake of the New Hampshire-Dartmouth Psychiatric Research Center, is considered to be the "gold standard" in evidence-based supported employment services. Provider agencies offering CBFS are required to provide employment services consistent with the principles underlying this model. Beginning in August 2009, DMH and Work Without Limits utilized MI-CEO grant funds to support a Train-the-Trainer effort, with nine identified individuals attending a 3-day intensive training in the IPS/SE Model at the New Hampshire-Dartmouth Psychiatric Research Center to become the Massachusetts IPS Master Trainers. In three years, the IPS Master Trainers have grown to a cadre of 12 trainers who are experts in the IPS/SE Model and who provide trainings, consultations, and mentoring on the IPS/SE Model to CBFS Employment Specialists in Massachusetts.

A survey conducted in March 2010 of CBFS Employment Specialists showed that more than 60% of these staff have less than 1 year of experience in providing employment services, but more than 66% have at least five years of experience working with people living with mental illness. These data along with information gathered during discussions with employment specialists and supervisors have informed the IPS Master Trainers in how to tailor the training

and consultation experience to address the issues identified. In addition, with the ongoing support of Work Without Limits, the Master Trainers have developed a 10-hour core curriculum – IPS4CBFS – targeted to CBFS and other providers.

Since 2010, the IPS Master Trainers have provided 45 trainings to over 350 individuals. Audiences have included CBFS employment staff, non-employment CBFS staff, PACT teams, Peer Specialists, Clubhouse staff, DMH Case Managers, and staff from the Massachusetts Rehabilitation Commission (MRC). The topics covered to date have included: overviews of the IPS Model and its eight principles; ways to identify and use community resources (MRC, Career Centers, etc.); in-depth discussions of providing on-going supports; job development; and fostering a team-based approach to employment. IPS Trainers also sponsored a specialized training focusing on how an individual's criminal history affects his/her employment prospects and how to address this. In SFY15, additional training for Supervisors and Managers of Employment Specialists was offered. In addition, DMH offered a 2-day "Train-the-trainer" workshop with Debbie Becker and Sarah Swanson of Dartmouth College, more than doubling the number of IPS Trainers in Massachusetts. Following this training, DMH is reconvening the statewide Trainers group as a Community of Practice (COP) to update the training curriculum and to coordinate a series of statewide trainings, share best practices, provide peer-support, and generally improve the fidelity and outcomes of CBFS employment programs. The COP will systematically review Dartmouth's updated 2008 fidelity scale, discussing its applicability to CBFS and Massachusetts, as well as topics germane to IPS and Supported Employment (e.g. transportation, assessments, etc).

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 SFY15, the data include:

- 25% of people identify diet and nutrition as a current need; 65% of these people "desire change now"; and over 55% 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; 64% of people identify their level of physical activity as light; and 19% identify physical activity as a current need.
- 19% of people identified smoking cessation as a current need; 22% of these people "desire change now"; and 80% 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.

In 2014, Massachusetts was invited to participate in SAMHSA's State Policy Academy on Tobacco Control in Behavioral Health, and followed up with the Massachusetts State Leadership Academy on Tobacco-free Recovery. This event was held on June 16, 2015 and was jointly sponsored by the Massachusetts Departments of Mental Health and Public Health. Participants included representatives from insurers, providers, legislators, professional and advocacy associations, and champions of the peer recovery movement, besides staff from DMH and DPH. Providers of both substance abuse and mental health services were included. The initial action plan consists of committees formed to address Organizational Change through Education and Training, Payer Issues, Peer Workforce, Policy and Legislation, and Data pertaining to tobacco cessation. These committees will continue to be guided by the Leadership Academy planners from DMH and DPH.

2. Addressing the needs of specific populations

The redesign of adult community-based services has strengthened DMH's ability to carry out its commitment to addressing the needs of specific populations. DMH is promoting a service system that is founded on the principles of person-centered care and flexible service delivery that is 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.

In 2012 and again in 2014, DMH reviewed the data on the race and ethnicity of adults authorized to receive DMH services and compared these data to Massachusetts census data. This review found that 67% of the adults (ages 19-64) served by DMH were White; 14% were Black/African American; 3% were Asian; 7% were Hispanic and 5% were non-Hispanic some other race. When compared to Massachusetts census, there were two populations with significant differences. While Blacks/African Americans (ages 19-64) represent 6% of the Massachusetts population, they represent 14% of the DMH population in this age group. Conversely, non-Hispanic, Whites (ages 19-64) represent 76% of the Massachusetts population, but 67% of the people served by DMH in this age group. For older adults (age 65 and over), 76% of people served by DMH were White, 7% were Black/African American, 5% were Asian, 3% were Hispanic and 5% were non-Hispanic some other race. 48% of ages 0-18 served by DMH were White; 7% were Black/African American; 1% were Asian; 11% were Hispanic and 3% were non-Hispanic some other race and non-Hispanic 2 or more races were 5%: The race and ethnicity data that are available for DMH clients ages 0-18 are not representative due to a higher percentage of client records that indicate unknown race and clients who choose not to identify their race. Less than a hundred American Indians and Alaska Natives enrolled in DMH services. All data were broken down further by geographic area and by service type to identify areas where people of cultural minorities were underserved.

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;
- Approximately 20% of MA residents age 65 and older had a diagnoses behavioral health disorder; it is estimated that by 2020 there will be 177,000 people age 65 and over with a behavioral health disorder;
- Over half of older adults receive mental health care from primary care
- People age 65 and over represent 13% of the population but account for 20% of reported suicides; the highest rate of suicide is in the 65+ age group; and
- In 2009, there were 1,383 people age 65 and older who received a DMH service, of which 1,217 were authorized for at least one DMH continuing-care service. 85% of these people were 65-74 years old and 15% were over 75 years of age. The majority (61%) lived in private residences; 15% were in residential care and 14% were in institutions

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.

<u>LGBTQ Populations (Lesbian, Gay, Bisexual, Transgender, & Questioning)</u>

The Massachusetts Youth Risk Behavior Survey (MYRBS) is conducted every two years by the Massachusetts Department of Education with funding from the U.S. Centers for Disease Control and Prevention. The survey monitors behaviors of high school students that are related to the leading causes of morbidity and mortality among youth and adults in the United States. The 2013 MYRBS, the most recent survey for which data are available, was conducted in 57 randomly selected public high schools. In total, 2,718 students in grades 9 - 12 participated in this voluntary and anonymous survey. The MYRBS found that:

- 5% of students surveyed described themselves as gay, lesbian or bisexual;
- 7.7% percent of all students described themselves as gay, lesbian, or bisexual and/or reported same-sex sexual contact; and
- Students who described themselves as gay, lesbian, or bisexual were significantly more likely than their peers to report attacks, suicide attempts and drug and alcohol use. When compared to peers, this group was:
    - over five times more likely to have attempted suicide in the past year,
    - eight times more likely to have required medical attention as a result of a suicide attempt,
    - over five times more likely to have skipped school in the past month because of feeling unsafe,

- over three times more likely to have been threatened or injured with a weapon at school in the past year, and
- over three times as likely to have been or gotten someone pregnant.

DMH does not systematically collect data on sexual orientation (SO). Nor does it collect data on gender identify (GI) that aligns 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. In 2013, 80% of people reported that staff are respectful of their sexual orientation, gender expression, and gender identity.

The Massachusetts Commission on Gay, Lesbian, Bisexual, Transgender, Queer and Questioning Youth asked DMH to assess whether its services were meeting the needs of its GLBTQ youth in its Annual Recommendations for FY2011. Research and data have shown that GLBTQ youth are at higher risk than the general population for poverty, homelessness, depression and suicide, discrimination, stigma and increased risk of substance use. Staff training was identified as the first step to ensuring the needs of GLBTQ youth, young adults and their families are met. In collaboration, DMH and the Department of Public Health (DPH) sponsored an all-day training for DMH staff and providers in May 2011 focused on "Supporting GLBTQ Youth, Young Adults and their Families." This was DMH's first gay, lesbian, bisexual, transgender, questioning (GLBTQ) training. The DMH LGBTQ Committee (as described above) was developed as a result of this initial training.

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.

DMH does offer culturally and linguistically competent case management services and some CBFS services providers have developed the capacity to serve clients who are deaf. 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.

Options for structured and meaningful day activities are less available as well. There are also gaps in the acute-care system as there are no Deaf-specific programs for emergency services, outpatient therapy, partial programs and substance abuse services. DMH is working with other state agencies and advocacy groups to explore the provision of accessible behavioral health Emergency Service Programs (ESP). DMH participated in a training for ESP providers in January 2013.

The quality and dependability of interpreters is also 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. Lastly, there are no evidence-based practices that have been researched with people who are deaf. DMH is participating in several collaborative efforts to address this gap. DMH is working with the Boston University Psychosocial Rehabilitation Department to pursue funding to adapt one module of the Illness Management and Recovery curriculum for use by Deaf/HoH in a visual format. DMH was also recently awarded a Transformation Transfer Initiative (TTI) grant from SAMHSA, administered through the National Association of State Mental Health Program Directors (NASMHPD), to develop a pilot for promoting peer support in the Deaf/HoH community.

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. 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. There are approximately 400,000 veterans and family members in Massachusetts. Approximately 35% of returning veterans get their health and mental health services directly through the VA system. At least one in five veterans returning from Iraq and Afghanistan will develop post-traumatic stress disorder (PTSD), other trauma-related disorders and addiction. 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) awarded in 2008 and 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. State funding began in SFY14 to assume the activities previously funded via the SAMHSA grant.

DMH collects data on veteran status, including armed forces other than USA, but does not collect data on service-disabled, active military or family members of veterans or active military personnel. In SFY12 there were 756 people with a veterans status receiving DMH services; 397 of these people were served in CBFS programs.

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).

Nationally, 83% of offenders with mental illness are dually diagnosed (BJS 2001). Hartwell (2004) reports that nearly two-thirds or 70% of individuals with serious mental illness (SMI) incarcerated in Massachusetts have substance abuse histories. Individuals with co-occurring substance use problems are at an increased likelihood to commit any type of crime due to exacerbating multiple pathways into the criminal justice system (Swartz and Lurigio 2007). Criminogenic risk factors (e.g., antisocial influences, poor relationship connections, along with significant substance use) are increasingly being recognized as important targets for intervention for offenders with mental illness (Peterson et al. 2010).

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). What remains elusive and fragmented, however, is an interagency coordinated approach toward service development and provision for the targeted population of individuals who have co-occurring disorders and criminal justice involvement that is informed by existing state agency data and research evidence. Initiatives that exist at the police, court, and re-entry intercept points exist largely in isolation. To enhance coordination, DMH applied for and received a 2012 Planning Grant through the Justice and Mental Health Collaboration Program of the Bureau of Justice System. This grant led to state level systems mapping using the Sequential Intercept Model, and a train the trainer opportunity to learn about mapping. In SFY14, DMH led the first regional mapping workshop as part of the launch of the Quincy Mental Health Court. Further mappings are being planned.

In SFY14 DMH was awarded a SAMHSA funded grant for the development of a Behavioral Health Treatment Court Collaborative. This grant, called MISSION-CREST (Court-related enhanced services for treatment), will provide for a case manager and peer team to work with an expanded pool of participants in the prior Springfield Mental Health Court, with an ability to target individuals with either mental health, substance use or both challenges using a trauma-informed approach.

Although state agencies may focus on jail diversion and re-entry, each develops service planning without full awareness of other agency activity in which blended or braided funding opportunities may be more effective and efficient. Massachusetts has been fortunate to take a closer look at one particular protocol focused on re-entry that has highlighted some of the existing gaps. In recent years, the National Institute of Health (NIH) has funded a study using data from multiple agencies to evaluate a statewide re-entry program for ex-offenders with serious mental illness, most of whom have co-occurring substance use disorders. The project has allowed agencies to work together to help address these issues as well as examine data collection barriers.

Since 2004, the Massachusetts Department of Correction (DOC) and MassHealth have operated a program that aims to achieve a seamless transition to Medicaid coverage for state prisoners leaving DOC custody. Of those eligible for Medicaid in a pilot program across 18 DOC facilities, 91% of released inmates had MassHealth coverage re-instated within a year post-release. In addition, DMH continues to work with court clinic staff and court personnel to better understand MassHealth services for court involved youth. As part of the Juvenile Justice Policy

Academy and Action Network, there is increased interest in reviewing and tightening linkages to MassHealth providers as part of a strategy to divert youth with behavioral health needs from the juvenile justice system.

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. In SFY99, the DMH Forensic Mental Health Service 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.

There are currently more than 500 individuals with lived experience of mental illness who have been trained as Certified Peer Specialists (CPS). The Transformation Center, a peer-run organization in Massachusetts, has been providing CPS training and certification since 2008. To meet the growing demand for peer specialists, DMH funded additional peer specialist training offered by Recovery Innovations of Arizona in SFY13 and 14. These offerings provided an additional 75 CPSs, of which many were Transition Age Youth participants. 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.

In SFY11 and 12, the Transformation Center conducted a survey of working CPSs to evaluate the strengths and needs of the training program and to identify components needed for a planned supervisor training. The survey found that 60% of CPSs were working 30 hours per week or more. Forty five percent were working for DMH providers, 19% were employed at Recovery Learning Communities, 14% were DMH employees and 22% were employed by non-DMH providers. When asked to identify the most important aspect of their roles, the most commonly cited themes were: one to one peer support, inspiring hope, and spread of a recovery message. An additional theme identified by a number of respondents related to ongoing experiences of isolation, stigma and discrimination in their roles. These data reflect the ongoing need to provide ongoing support and supervision to CPSs as well as to develop strategies to promote positive culture change in the workplace environment.

One example of efforts to provide workforce development is DMH's support for the training of 70 peers to become facilitators for Whole Health Action Management (WHAM). WHAM is an emerging best practice that provides CPSs with the skills needed to help consumers develop, implement and sustain a whole health goal. Three classes in Boston and Western MA were conducted through a collaboration led by DMH, and including the Massachusetts Behavioral Health Partnership (MBHP) and the Transformation Center. These trainings were led by Larry Fricks, Deputy Director of the SAMHSA/HRSA Center for Integrated Health Solutions, and Ike Powell, of Appalachian Consulting Group. DMH utilized Block Grant Funds to sponsor a three-day WHAM Master Trainer class to develop an internal

capacity to train additional facilitators. DMH Area offices currently coordinate regional WHAM trainings offered to peers served by any behavioral health provider in the region. Massachusetts was also chosen to pilot WHAM for Asian American and Pacific Islander Peers and bi-lingual Community Health Workers, in conjunction with the National Asian American and Pacific Islander Mental Health Association and the National Asian American and Pacific Islanders Empowerment Network.

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. In SFY15, DMH utilized Block Grant technical assistance funds to sponsor a Deaf Certified Peer Support Specialist Training session. This intensive 40-hour training focused on providing Deaf, Hard of Hearing, and DeafBlind individuals who are recovering from mental health challenges with the tools necessary to mentor others who are experiencing similar life challenges. Eleven people participated in the training session and passed the exams.

Many supervisors of CPSs who are not themselves a CPS are also in a process of learning about mental health recovery and the CPS role. The Transformation Center produced and published an on-line training with written and video components to orient supervisors to the CPS role and to the nationally recognized role competencies around which job descriptions and supervision is organized. This training was viewed on-line over 3,200 times. In addition, two federal grants, along with the Western Massachusetts Recovery Learning Community, provide for forensic peer specialists to assist with court-based diversion and/or reentry programs. As a result of the positive experience with the forensic peer in the federally-funded DMH re-entry program, the Department of Correction adopted an inmate-peer model in the women's correctional facility to assist with female offenders with trauma histories.

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. DMH contracted with the University of Massachusetts to develop a Recovery Outcomes Survey specific to RLC Activities. This survey was developed as a collaborative effort of the six RLC directors, DMH leadership, and a UMass researcher with lived experience. The survey was completed by 263 individuals at all six RLCs. A large majority of respondents (73%) reported substantive recovery, including reduced hospitalizations, crisis visits and contact with the criminal justice system at least in part due to RLC participation. 60% of respondents had been involved with RLCs for two years or less. The results also suggest that there is room for improvement in increasing access to natural community.

As a recipient of a SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) award, 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. As a result, this project has allowed

for consistent reflection on similarities and differences in peer activities and their relative systems, ultimately creating a strong foundation for future collaboration to improve the overall quality of recovery services. Of special interest to the project 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. The BRSS-TACS Action Plan included four recommendations:

1. Recognize Peer Specialists/Workers and Recovery Coaches as essential, foundational elements of existing and developing models of health care delivery.
2. Through the new models of integrated care, develop a comprehensive, recovery-focused system of care for people with co-occurring mental health and addiction disorders
3. Establish guidelines/requirements for the successful integration of peer workers and recovery coaches in all health care delivery models.
4. Improve the Quality of Peer Support within the Commonwealth

DMH funded TransCom to host an "Invitational Summit" with peer leaders from the mental health and substance abuse communities in June 2015. The purpose was to identify common themes supporting peer support in both systems and to share lessons learned.

In response to advocacy from the peer community, DMH procured a new service, Peer-Run Respite in SFY12 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. During SFY14, 97 people, ranging in age from 18 to more than 60 years old, stayed at Afiya for a total of 142 stays. Most stays were for 7 days or less. Afiya House was full more than 90% of the time, with vacancies usually accounted for by transition periods as one person leaves and another person prepares to enter. Afiya team members had more than 800 phone or in-person contacts with people in the community. The reasons for these contacts varied, but the most common reason was that people wanted to stay at the program and were calling for information and availability. In 440 of these cases, people were not able to be admitted because there was no space available. The vast majority of stays (77%) concluded with the person returning to their own home. An additional 15% concluded with the person staying with a friend or family. Less than 4% of stays ended with a person entering a medical or psychiatric hospital. People staying at the program are also asked to complete a survey at the end of their stay to assist in tracking outcomes, including hospital diversion rates. Most people (84%) reported having at least one prior hospitalization and 58% said they would have gone to the hospital if Afiya was not available.

Finally, there is a 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. DMH worked with MassHealth to establish a consumer panel that participated in the review of proposals for the procurements for the MassHealth PCC Plan and the Demonstration Project to Integrate Care for Dual Eligible Individuals (Duals), now One Care. In addition, DMH worked with MassHealth and EOHHS to establish an Implementation Council that plays a key role in monitoring access to healthcare and compliance with the Americans with Disabilities

Act (ADA), tracking quality of services, providing support and input to EOHHS, and promoting accountability and transparency. The roles and responsibilities include advising EOHHS; soliciting input from stakeholders; examining Integrated Care Organization (ICO) quality, the One Care health plans; reviewing issues raised through the grievances and appeals process and ombudsperson reports; examining access to services (medical, behavioral health, and Long Term Supports and Services (LTSS)); and participating in the development of public education and outreach campaigns. At least half of all Implementation Council members are MassHealth members with disabilities or family members or guardians of MassHealth members with disabilities. DMH is currently working with MassHealth to appoint members to a second term. Members of the Implementation Council presented their experiences with the implementation of One Care to the State Mental Health Planning Council in SFY14.

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. As of July 2014, 28% of people receiving DMH case management services were identified as homeless. When using the federal definition of homelessness, this number decreases to 2%. The majority (62%) of people identified as homeless are in temporary situations with friends or family. In addition, 33% had a documented history of homelessness; and 17% were identified as having one or more risk factors for homelessness. DMH reports housing status in the URS tables utilizing the narrower federal definition of homelessness and reports for all people served by DMH during the state fiscal year. The 2014 URS tables reported that 5% of people served were homeless and that 73% of people were residing in private residences.

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. DMH obtains data on the number of people who are discharged from acute-care psychiatric units to shelters. In calendar year 2014, 1,456 people were discharged to shelters.

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 have 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.

As a direct result of this need for a culture shift, the DMH Office of Training and Development sought to introduce new curricula into its training programs, beginning with its orientation requirements. A Workgroup reviewed DMH's existing curriculum which was designed primarily to reduce restraint and seclusion use in its inpatient facilities, teaching concepts from SAMHSA's Six Core Strategies. The workgroup extensively researched the existing literature in order to retool that curriculum to expand and integrate concepts of Trauma Informed Care and to include more opportunity for practicing primary prevention skills toward promoting a recovery oriented environment for persons served. Building upon that new training focus, the Personal Safety Workgroup simultaneously began development on a similar curriculum for community-based programs. This curriculum also promotes a collaborative recovery oriented focus while providing site specific information regarding safety for staff and persons served. Both curricula have been completed, Master Trainers have been trained and full roll-out across the agency is underway.

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. In addition, DMH contracted with Recovery Innovations from Arizona to provide two 2-week Peer Employment trainings, in Dorchester and Springfield with up to 20 participants in each. 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. Five sections were offered across the state for a total of 43 participants.

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 polices 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. Master Trainers were trained in May, 2014 and roll-out of the curricula began in March 2015.
- 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 staff have developed an interagency agreement with Bridgewater State Hospital (BSH)/Department of Corrections regarding data sharing to track individuals formerly served by DMH now at BSH.
- 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.

<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 and adolescent services.

DMH child and adolescent services are also intricately tied to and aligned with the Commonwealth's interagency Children's Behavioral Health 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. DMH is re-procuring its residential and community-based services. These procurements reflect this emphasis on 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.

Data from the National Longitudinal Transition Study of Special Education Students highlights the importance of focusing on these outcomes for youth with SED: young people with SED fare poorly compared with youth with disabilities as a whole and with youth in the general population on high school performance, social experiences, postsecondary educational experience, labor market participation, and residential independence (Wagner, 1995). Additional data suggesting the importance of focusing on these outcomes for children and youth with SED include:

- Forrestt et al (2011) examined school outcomes for a sample of fourth through sixth-grade students and found that children who screen positive for a special health care need because of functional limitations or behavioral health problems are at risk for low student engagement, disruptive behaviors, poor grades, and below average performance on standardized achievement tests.
- Students with emotional disturbance typically have co-occurring disorders relating to mood, anxiety, conduct, and other psychiatric disorders, as well as ADHD (Forness et al., 1994; Mattison and Felix, 1997). In a study of school outcomes for children with ADHD, Beiderman et al (2004) found an increased risk for grade retention and a decrease in academic achievement.
- In Massachusetts, children with behavioral/emotional/developmental health conditions are more likely to miss eleven or more days of school than their counterparts without these conditions (National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 02-11-13) from www.cshcndata.org.
- In a study of 353 adolescents with SED, ages 12 - 18, and their parents, both parents of and adolescents with SED perceived their family relations as more disengaged and less connected than those of adolescents without SED. (Prange, et al; 1990).
- Massachusetts data from the Department of Elementary and Secondary Education show that in 2010, 15% of students with an emotional disability dropped out of school (grades 9-12) and 48% graduated in four years.

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. Data is limited on the scope of the challenges that families of children with SED face in accessing services from multiple parts of the system, however data on families receiving Massachusetts Medicaid-reimbursed services (MassHealth) is informative:

- Of the approximately 585,000 children and youth between birth and 22 years old receiving MassHealth benefits in January 2010, approximately 25,000 received services from another EOHHS agency, primarily the Department of Children and Families (DCF). However about 1,000 of these children and youth were also involved with a third agency, for example, the Department of Mental Health or the Department of Transitional Assistance.
- Although quantitative data is not available, key informants from EOHHS agencies estimate that based on the populations they serve and their identified needs at least 50% of these children and youth also receive IDEA and/or 504 entitlement services through their Local Educational Authority (LEA), i.e., approximately 13,500 children and youth.
- The number of MassHealth enrolled children up to age 21 who received Intensive Care Coordination through the CSAs in SFY11 was 9,056, with a monthly average number of hours of service received ranging from 8.3 – 10.3 hours per month. The estimated number of utilizers is slightly inflated because members who switch between health plans are counted more than once.

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); MassHealth Mobile Crisis Service; Department of Mental Health Child and Adolescent Services; Department of Children and Families; MassHealth Patient-Centered Medical Home Initiative; SAMSHA 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.

In 2012, DMH collaborated with the Parent/Professional Advocacy League (PAL) to conduct a survey of parents of children with mental health needs about respite services. Respite care is frequently identified by parents whose children have mental health needs as one of the most needed yet least available services for families. The goal of the study was to inform public policy regarding respite services with a better understanding of the needs of Massachusetts families, and the value and barriers to accessing these services.

DMH and DCF child and adolescent residential services have been re-procured as a single residential system: *Caring Together: Strengthening Children and Families Through Community-Connected Residential Treatment*. Phased implementation of these services began in SFY13. 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.

In SFY12, MassHealth expanded the FS&T Family Partner service into its In-home Therapy and Out-patient Therapy service 'hubs' for MassHealth eligible children with SED. The expansion of Family Partners through two different state funding sources (MassHealth and DMH/DCF) poses opportunities and challenges relating to system integration across the Massachusetts system of care. The need for broad integration and coordination of all services to children and families is apparent. DMH recognizes these challenges and continues to collaborate with other child and family serving public agencies within EOHHS and the state educational authority to improve the coordination and integration of services to children and youth with SED and their families. DMH, in its role as the State's Mental Health Authority, provides leadership and consultation to all EOHHS agencies and the State's educational authority regarding policy and program development relating to child and adolescent behavioral health. DMH is also an active participant in efforts to improve the integration of behavioral health and primary care services for children, youth, and families with the State Medicaid system and within the private insurance market.

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. Yet challenges remain. With the creation of the Children's Behavioral Health Initiative, the disengagement of young adults from treatment has been highlighted. In SFY10, CBHI estimated that 3,800 TAY with SED were in need of services, yet only 120 transition age youth ages 18-20 were served in their CSA's. To respond to the need, in SFY12 DMH applied for and received a SAMSHA grant to identify strategies for improving and strengthening services to this population. Six MassHealth CSAs collaborated with DMH and supported an extensive self-assessment and strategic planning process that has positioned Massachusetts to improve how the Massachusetts statewide system of care engages and serves TAY. The SAMSHA grant sponsored several training sessions for its Planning Team that focused on the needs and service designs for youth and young adults delivered by national experts, including Dr. Janet Walker (Portland Research and Training Center), Gwen White, and Dr. Maryann Davis (UMass Research and Training Center). CSA Providers, consumer organizations, and TAY involved in the SAMSHA grant and other DMH advisory groups as well as agencies from the communities served by the pilot CSA's also participated – as well as the Interagency Council on Housing and Homelessness.

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 (FST); MassHealth Mobile Crisis Service; Department of Mental Health Child and Adolescent Services; Department of Children and Families; MassHealth Patient-Centered Medical Home Initiative; SAMSHA 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. 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 Substance Abuse and Mental Health Services Administration. The subcommittee has identified the need to improve understanding of trauma in the inpatient setting, 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 recognizes that these needs to understand trauma, increase collaboration and communication, and provide training and ongoing workforce development also exist in its community-based system.

As DMH completes re-procurement of its child and adolescent 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. The provision of training and ongoing supervision and support related to the practice is also resource intensive. The significant expansions of the Family Partner workforce will require significant investments in training and workforce development efforts, such as recruitment of culturally and linguistically competent Family Partners, the development of consistent training curricula, and the potential certification of Family Partners. To 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. Addressing the needs of specific populations, including:

- Cultural/linguistic minorities (see above)
- GBLTQ (see above)
- Deaf/HOH (see above)
- Court involvement (see above)

5. 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 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; 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.

Although data on the total number of DMH youth receiving special education services is not available, the following data suggest that the majority of DMH youth are involved in special education services:

- In SFY10, key informants from EOHHS agencies estimated that based on the populations they serve and their identified needs, at least 50% of these children and youth received IDEA and/or 504 entitlement services through their Local Educational Authority (LEA). Using this proportion , it is estimated that approximately 1,500 DMH-served youth receive special education services in a year.
- 100% of youth in DMH Statewide Programs are on IEPs.

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. Since 2008, DMH has collaborated with the MA Child Psychiatry Access Project (MCPAP) in two pilot projects to provide child psychiatry consultations to school personnel in Western MA and in Southeastern MA. 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 Service Integration Specialists on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and the parent support coordinators provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers and systems integration specialists 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.

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. This subcommittee recently finalized their mission statement, and will focus on the secondary and post-secondary needs and concerns of young adults. Research has shown that only 50% of youth

and young adults with a serious mental health condition graduate from high school compared to their peers. 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.

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.

The unaccompanied young adult homeless population is also emerging as a new segment that needs particular programming and access availability. DMH is working with the Unaccompanied Homeless Youth Commission to identify the service needs and supports as well as barriers to care.

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.

In SFY14, DMH was awarded a SAMHSA/CMHS System of Care Expansion Implementation Grant as a continuation of its "Success for Transition Age Youth" (STAY) planning grant, a one year planning grant awarded in FY13. This planning grant focused on developing a Strategic Plan in partnership with multiple stakeholders to increase access, relevance and success for transitional age youth and young adults (ages 18-21) through sustainable practice enhancements within the statewide Children's Behavioral Health Initiative (CBHI), particularly the Community Service Agencies (CSA). The Steering Committee and all subcommittees were co-chaired by young adult facilitators to ensure young adult voices and perspectives were integrated into the Strategic Plan. Additional key components of the STAY grant included:

- Pilot Community Service Agency (CSA) projects – 6 CSA's across the Commonwealth were invited to participate in creating their own Youth Advisory Groups (YAGs) as a way to enhance engagement of transition age young adults and their families.
- Young Adult Assessment Team – young adults were trained as research associates by Consumer Quality Initiative (CQI, Inc) and conducted surveys with youth related to their experiences with mental health and CBHI services
- CSA Self-Assessment and strategic planning process
- Trainings with local and national content experts – Community of Practice Series on Cultural & Linguistic Competence with Dr. Ed Wang; Using Achieve My Plan (AMP) Wraparound with Dr. Janet Walker; and Creating Collaborative Connections with Dr. Maryann Davis and Gwen White.

This project is also described in Step 1.

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.

<u>Parents with Mental Illness</u>

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. Relevant data supporting the needs of parents are:

- 67% of women with SPMI and 75% of men with SPMI are parents (Nicholson, et al, 2004)
- 29% of young adults with SPMI are parents (Government Account Office, the 2001 – 2003 National Co-morbidity Survey Replication, Young Adults with Serious Mental Illness, June 2008)
- 60% of children receiving mental health services have a history of family mental illness, and 40% of these children have experienced a parent hospitalization (Manteuffel et al., 2002, Hinden et al., 2006)

- Children have poorer outcomes (e.g., worse CAFAS scores after 12 months) in Systems of Care when parents have mental health conditions than children whose parents have no psychiatric diagnosis. (National Evaluation Outcomes Study, CMHS 2007).

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.

In March 2009, the State Mental Health Planning Council heard a presentation on "Supporting Parents with Mental Illness and their Families." This presentation provided data on the needs of parents with mental illness and information on an innovative program run by Employment Options at a Clubhouse in Massachusetts. The program, the Family Options project for custodial parents, provides care management for the entire family unit, both parent and child, and offers a resource center for families involved in the program. The presentation highlighted that people with psychiatric disorders, including serious and persistent mental illness, are as likely, or more likely, to be parents than people without a psychiatric disorder. DMH data indicates that 11% of people receiving DMH services are parents. The presentation also provided information on a study of women who had been involved with the Family Options project. The study found that the average age of onset of a mental health problem for these women was at 17 years of age; 68% had at least one prior psychiatric admission; 77% had used illicit drugs and 87% had used alcohol. Half of the study participants self-reported diagnoses of PTSD; 59% reported major depressive disorder; 32% bipolar disorder; 27% anxiety disorder and 14% a psychotic disorder. The mothers had on average 2.5 children; 34% of the children in the home were between the ages of 0 to 5; 32% were 6 to12 years of age; and 34% were between 13 and 17 years of age. The children in these families were also identified to have needs. Nearly three quarters (72%) had an IEP; 56% has emotional or behavioral problems and 48% had a mental health diagnosis; 24% had at least one psychiatric hospitalization; 79% had been involved with child welfare; 29% had recurring health problems and 55% had witnessed family violence. Following participation in the Family Options project, 73% of mothers reported improved well-being; 68% reported functioning and 100% reported receiving supports and resources.

Following the March 2009 presentation, the Planning Council voted to establish a Parent Support subcommittee. The subcommittee began monthly meetings in May 2009 and routinely provides updates and information to the Planning Council. 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.

2. 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 2009, the DMH Deputy Commissioner of Clinical and Professional Services asked DMA Health Strategies and Consumer Quality Initiatives, Inc., to conduct a series of focus groups as well as a thorough review of recent mental health related research studies and current Web sites in an effort to determine the recommendations of stakeholders regarding priorities for DMH research funding. Adult focus groups included consumers; transition-aged youth; parents of child consumers; and providers who participated in a total of seven focus groups. In addition, conversations were held with researchers at the two COEs.

The report on this work identified that the most important research topics for consumers were: employment (by far the highest priority); housing; communication between clients and providers; alternatives to psychiatric services, especially peer support; access to care; physical health (wellness); stigma (public education) and criminal justice, especially for transitional-aged youth (TAY). The parents of youth with mental health needs expressed particular interest in research on: safety (child and parent); support and education for parents; schools; system fragmentation; diagnosis confusion; education and training of professionals; emergency services and the ER; and stigma.

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.

3. Funding and coordination of prevention and early identification/treatment related activities with other state agencies, academic institutions, and others.

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, provides a 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 2015 modifications reflect the state's commitment to adopt and promote Zero Suicide as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

According to data from the Injury Surveillance Program on the Massachusetts Department of Public Health, there were 624 suicides in Massachusetts in 2012. The number of suicides 4.6 times higher than the number of homicides. The suicide rate has been increasing over the last 10 years at an average of 4.2% each year. The increase in suicide rates is primarily among White, non-Hispanic males whose rates increased an average of 5% per year over the last ten years. Most Massachusetts' suicides occur in the middle age population; 60% of all suicides in 2009 were among those ages 35-54 years. Male suicides exceeded female suicides 3 to 1. Nonfatal self-injury also burdens the Commonwealth's health care system. There were 4,258 hospital stays related to suicide in SFY12. Data from the Massachusetts Youth Risk Behavior Survey, an anonymous written survey of youth in public high schools in MA, indicated that in 2013, 14% of high school students reported a non-suicidal self-injury; 12% seriously considered suicide; 11% made a suicide plan; and 6% attempted suicide.

In addition, DMH supports national efforts to strengthen state mental health authorities' role in promoting a public health approach to addressing mental and behavioral health needs in state populations. Central to this strategy is a focus on mental health promotion, prevention, and early intervention and treatment. This is of particular interest to the child and adolescent division as 50% of lifetime cases of mental and emotional disorders begin by age 14 years and 75% begin by age 25 (Kessler et al., 2005). In 2009, Beth Israel Deaconess Medical Center's Commonwealth Research Center, one of the two DMH-funded Centers of Excellence, prepared a white paper for DMH on early intervention and prevention of serious mental illness. According to this report, 14% of young people aged 12-17 and 27% of young people aged 18-24 experience a mental health problem in any 12 month period (Sawyer et al 2000, Andrews et al 1999, ABS 2008). Mental illness and substance use disorders account for 60% of the illness burden among young people aged 15-34 (Public Health Group 2005). Yet over 80% of youth and young adult mental illness will not be properly detected and treated. The Institute of Medicine estimates that untreated youth mental disorders generate $247 billion per year in public expense (educational systems, juvenile courts, social services, families).

Mental health disorders are currently diagnosed by symptoms that emerge at a late stage of illness, often long after normal development has veered off course (Insel, 2009). The most serious mental health disorders, like schizophrenia, depression, and bipolar disorder, don't happen over night: "prodromal" or sub-threshold symptomatic stages are typical and are associated with significant distress and functional impairment. However, because public literacy regarding these early signs is low, "early warning signs" are often misunderstood or dismissed. Young people or their families may avoid screening or assessment by mental health services due to long waitlists and fear of stigma. Although perhaps the best situated to begin the process of identifying youth with emerging mental health problems, school personnel and primary care practitioners often have limited access to screening tools or professionals with appropriate training to assist them with behavior and mental health detection and referral issues (Perrin, 1998). According to available research, primary care physicians recognize less than 30% of children with substantial problems and dysfunction, despite the fact that mental health issues are

far more common in this age group than physical problems (Glascoe, 2001). These data highlight the need for programs such as MCPAP (described above), including the MCPAP school pilot project, in using natural settings, such as schools and pediatricians offices to identify at-risk youth and provide supports and timely access to needed services.

Early referral and treatment can reduce disability and save money. Specialized early intervention programs are superior to standard care on a broad range of outcomes including lower symptoms, reduced inpatient care and treatment dropout, reduced risk for suicide (and other violence), and improved social and vocational functioning. Specialized early psychosis programs can deliver a high recovery rate at one-third the cost of standard public mental health services (McGorry et al., Schizophrenia Bulletin, in press, 2009). Many early intervention programs around the world report that increased use of these specialized outpatient services reduces the need for inpatient hospitalization, even if individuals becomes psychotic, because they are already in treatment.

Mental illnesses, particularly depression, disruptive behavior disorders, and substance abuse, have been repeatedly associated with higher risk for suicide in young people, with individuals recently diagnosed with psychosis being one of the highest risk groups (Gould et al., 2003). In fact, the primary strategy identified in Healthy People 2010 for reducing suicide was to increase treatment for depression (US Department of Health and Human Services, 2000). Furthermore, many scientists and clinicians have interpreted epidemiological data regarding rates of youth suicide and pediatric antidepressant use to suggest a link between increased treatment and reduced suicide rates (Olfson et al., 2003). Importantly, suicide attempts and completions in young people have been associated not only with mental illness and substance abuse, but with specific mood states such as depressed mood, anger, and anxiety. By focusing on support, early symptom management, stress reduction, and enhancement of protective factors, early intervention strategies may improve affect management and other coping skills that also reduce risk (e.g., DBT, Robins & Chapman, 2004). In schizophrenia, nearly 50% of all suicides occur within the first 5 years of illness. Many attempt suicide prior to treatment. Specialized early psychosis treatment programs have been shown to reduce the risk of suicide (Addington, et al., 2004).

Although major mental illness, in particular, schizophrenia, has been associated with reduced rates of violence, the risk of violence, including homicide, among mentally ill individuals is highest for those with no, delayed, or inadequate treatment. Over the past decade, we have learned that the risk of murder is highest before initial treatment (called "duration of untreated psychosis") (Nielssen & Large, 2009). Thus, early treatment and prevention of major mental illness and co-morbid substance abuse disorders may decrease the risk for violence. In young people who become parents, this includes risk for child maltreatment, itself a risk factor for negative outcomes in adolescence and adulthood, including the onset of serious mental health disorders. Despite potent biological-genetic influences on the onset of disorders like schizophrenia, researchers have found links between childhood exposure to violence, trauma, and bullying/harassment and psychosis (Read et al., 2005).

Please refer to the following sections for information on DMH's initiatives related to prevention, early identification and treatment including the 5% Set-Aside in the following sections: Prevention for Serious Mental Illness and Evidence-Based Practices for Early Intervention.

4. Improved coordination within the behavioral health system and integration between primary care and behavioral health.

As the first state in the nation to implement health care reform in 2007, Massachusetts has made significant strides in increasing access to health care services through near universal health care coverage. In 2014, 96.3% of Massachusetts residents were insured. 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". This law places significant emphasis on improved care coordination and behavioral health integration.

An important step in this process is the ongoing analysis of the current behavioral health system. Massachusetts began this effort through the work of two key groups, both created by Chater 224, the Behavioral Health Integration Task Force and the Health Planning Council. The Health Planning Council's membership is comprised of the chief executives of various state agencies that deal with health care, including the EOHHS, Department of Public Health (DPH), Executive Office of Elder Affairs (EOEA), DMH, Health Policy Commission, the Center for Health Information and Analysis (CHIA) and MassHealth. The Health Planning Council is charged with developing the State Health Resource Plan to assess the needs of Commonwealth residents and the current health care resources available to those residents.

The Council chose behavioral health as its first priority and DMH was actively involved in the workgroup that oversaw the analysis and prepared the report. The Behavioral Health Plan was completed in December 2014. The report presents an estimation of need, based largely on data from the National Survey of Drug Use and Health (NSDUH); inventory of services across eight major service categories; data on access and utilization across payers; and makes recommendation for future data collection and analysis and to ensure access to behavioral health services. It is included as an attachment. The development of the Plan yielded important information for the planning of behavioral health services. The analysis found that individuals enrolled in Medicare have the highest rate of ED utilization (22%) and inpatient utilization (15%) compared to MassHealth (16% ED and 9% inpatient utilization) and commercial (4% ED and 2% inpatient). Medicare utilization of ED services increased over a three year period (2010-2012) while MassHealth and commercial rates remained relatively constant. The high utilization within the Medicare population was largely the result of the under 65 disabled population. Medicare utilization for individuals 26-65 was 5.5 times higher in the ED and 7.5 times higher for inpatient care than for those 65 and older. The 26-65 Medicare utilization was also 4.5 times higher than for individuals with MassHealth in the same age group. One of the biggest findings from the analysis is the information that is not available. The project was challenged by inability to analyze outpatient claims data and to obtain information on an inventory and utilization of outpatient services, especially clinics, independent professionals, group practices and other specialty organizations that are not under contract with state agencies. The initial analysis of the outpatient data found significant differences in coding and benefit plans between payer groups, which prevented the Council from completing an analysis of outpatient data.

The planning process also included interviews with key informants and a Request for Information (RFI). This process yielded 18 key informant interviews and 27 RFI responses, representing provider organizations, statewide organizations, government agencies, payers, and consumers. The input covered five main points: 1) Limited coverage of residential recovery or treatment and other community services by commercial providers, compared to public payers; 2) Limited capacity of residential and community care and some types of inpatient care affects access to an optimal continuum of care; 3) Low payment rates and funding adversely affect system capacity and access; 4) Divided responsibilities and a lack of statewide planning capacity

inhibit comprehensive understanding and improvement of behavioral health services; and 5) Need for further development of data sources to document the extent of the unmet demand for community service.

The Plan provides recommendations in two broad areas: data collection and analysis, and access to care. The data collection and analysis recommendations focus on the importance of continued analysis of outpatient data, implementing an interagency behavioral health data planning group, leveraging existing Registration of Provider Organizations (RPO) and licensing renewal processes to streamline and improve data collection and making information about service availability more accessible. The access recommendations address removing regulatory barrier to integration, supporting resources for a robust community system that prevents and diverts the need for acute levels of care.

The Behavioral Health Task Force was a 19-member group chaired by the DMH Commissioner. The Task Force met from December 2012 through June 2013 and filed its final report with the Legislature following its final meeting. The Task Force made recommendations in six topics: Clinical Models of Integration, Reimbursement, Privacy, Education and Training, Workforce Development, and Other Recommendations. In the course of developing these recommendations, the Task Force identified systemic barriers to address. These include: reimbursement issues related to equity in behavioral health payments, restrictive billing policies and non-aligned payment systems that inhibit integration and the inclusion of behavioral health professions, peers and family partners on care teams; outdated regulations that are based on separate systems for physical health and behavioral health; difficulty accessing behavioral treatment; the need for significant training and education of both primary care and behavioral health providers; lack of interoperability and connection of the behavioral health system to electronic record and both real and perceived privacy concerns. The report also included a set of recommendations for care integration from the Children's Behavioral Health Advisory Council, addressing behavioral health screening, behavioral health consultation, peer support (Family Partners and Youth Peer Mentors), and care coordination. The final report of the Task Force is attached.

DMH is also cognizant of the need to improve the integration of services for individuals with co-occurring substance abuse and mental health conditions. According to the National Survey on Drug Use and Health (NSDUH) only 3% of persons with co-occurring substance abuse and mental disorders received treatment for both disorders in 2008. DMH and BSAS do not track the number of people who need and receive co-occurring substance abuse and mental health treatment. However, BSAS does capture self-report data on prior history of mental health counseling or hospitalizations, and involvement with other state agencies. According to recent BSAS data, less than 2% of people enrolling in a BSAS service report they are currently receiving DMH services. Of the people discharged from a BSAS service in SFY11, 26% reported receiving mental health counseling in the past, 7% reporting having at least one prior psychiatric hospitalization and 9% reported having at least two hospitalizations. Both agencies have service standards requiring training on co-occurring disorders and treatment and the capacity to provide these services. While Massachusetts specific data are not available, the national data from the NSDUH suggests that there is significant opportunity to improve the coordination of substance abuse and mental health treatment services.

DMH recently analyzed mortality data of people who received DMH services and found that early mortality deepens for individuals with co-occurring serious mental illness and substance abuse. This analysis revealed that individuals with co-occurring disorders are dying on average 10 years younger than individuals with only serious mental illness. A previous analysis found that people with serious mental illness are dying an average of 25 years younger

than the general population. Taken together, the data suggests that a potential loss of 35 years of life for people with substance abuse and serious mental illness. DMH is partnering with the Bureau of Substance Abuse Services (BSAS) to implementing recommendations from the Governor's Opioid Addiction Working Group.

In addition, DMH and BSAS are partnering with the Massachusetts Child Psychiatry Access Project (MCPAP), the Massachusetts Screening, Brief Intervention, and Referral to Treatment Training and Technical Assistance (MASBIRT TTA) program, and the Adolescent Substance Abuse Program of Boston Children's Hospital to implement a statewide Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) training initiative. This project is targeting the 435 pediatric primary care practices throughout the state that are enrolled in MCPAP. With funding support from the Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model grant, Dr. Sharon Levy, a national pediatric SBIRT expert from Children's Hospital Boston, revised the 2008 DPH SBIRT toolkit for primary care providers. The new toolkit entitled "Adolescent SBIRT Toolkit for Providers" is the centerpiece for the training and includes updated best practices in adolescent SBIRT and a new validated screening tool called the S2BI (Screening to Brief Intervention). MCPAP hub staff will train all PCPs using this toolkit. For practices that express a need for more in-depth training, the MASBIRT trainers will conduct sessions on SBIRT implementation.

DMH also collaborated with MassHealth, BSAS and the University of Massachusetts on a hospital readmission project to identify patterns and characteristics related to readmissions that may assist in the planning and administering of mental health and substance abuse services. This project developed a shared data set of people who have received services from DMH and/or BSAS and who have experienced readmissions to acute-care psychiatric and/or detoxification facilities. The data analysis revealed that the majority of the people with admission during the three-year study period (70%) had detoxification visits only, 21% experienced psychiatric admissions only and 10% experienced both detoxification and psychiatric admission. One half of the study population had no readmissions during the period. Of those with multiple admissions, the mean number of admissions was 4.7, with a median of 3. 13% of the people had 6 or more admissions. The number of admissions for individuals with detoxification admissions only and with psychiatric admissions only is similar. Individuals with both types of admission had higher numbers of admissions.

Within the child and adolescent system, there is a need to improve integration between primary care (pediatricians) and behavioral health specialists, particularly in regard to prescription practice. Child primary care providers have been the most frequent prescribers of psychotropic medications for children. Yet, many Massachusetts primary care physicians (PCPs) report that they do not feel comfortable or well-prepared to prescribe psychotropic drugs or manage behavioral health conditions. They also report limited access to formal psychiatric consultation programs. These limitations affect the quality and effectiveness of care they provide, as evidenced by parental reports of low satisfaction with behavioral health services received from PCPs. (Holt, 2009)

In 2008, the Parent/Professional Advocacy League (PAL) conducted a survey of 471 families on access to care. This report, "Overcoming Barriers in the Community: How Are We Doing?", similarly found that a significant proportion of individuals surveyed indicated that they had experienced long waits to get an appointment with a child psychiatrist or other pediatric behavioral health clinician for their child, difficulty in obtaining useful information about the options available to them, difficulty in finding providers who were local, and issues with making copayments and affording medications.

The Massachusetts Health Policy Commission, an independent state agency created under Chapter 224, monitors the health care market and produces reports on health care cost trends, the most recent being the July 2014 Supplement to the 2013 Cost Trends Report. Utilizing Massachusetts claims data, this report documents the prevalence and cost of co-morbid behavioral health and chronic medical conditions. The report identified the subset of people with behavioral health conditions and found that 34% of those with commercial insurance and 81% of those with Medicare also had a chronic medical condition. In addition, approximately half of the people with a substance use disorder also had a mental health condition. Depending on insurance type, total health care spending for members with a behavioral health and chronic medical condition is 1.8 to 2.9 times higher than for those with a chronic medical condition alone. When both mental health and substance use disorders are present (along with a chronic medical condition) the cost increases to 2.7 to 3.7 times that of a chronic medical condition alone. Finally, the analysis found that much of this increased spending in attributed to greater use of the emergency department and inpatient care. The Behavioral Health Plan described above found that only 17% of licensed outpatient clinics provide co-located behavioral health and medical services.

These data confirm the opportunities that Massachusetts is pursuing under the ACA and Chapter 224 to promote primary care and behavioral health integration. These actions are described in detail in other sections of this application. The Health Care System and Integration section describes the current initiatives DMH is pursing with state partners to improve care coordination and integration. These include: the Behavioral Health Integration Task Force, Patient Centered Medical Home Initiative (PCMHI), and Primary Care Payment Reform (PCPR), Dual Eligibles Demonstration/One Care, the Massachusetts Child Psychiatry Access Project (MCPAP) and ongoing collaboration with MassHealth and the Massachusetts Chapter of the American Academy of Pediatrics.

The table below provides information on how the needs identified above are addressed in the priorities established 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 best practices
Addressing the needs of specific populations	Enhance service system to promote recovery, resiliency and positive outcomes Implement and promote use of best practices
Increased access to peer support and peer-run services.	Ensure that all services are person and family centered Implement and promote use of best practices
Affordable housing and coordinated services for people who are homeless	Enhance service system to promote recovery, resiliency and positive outcomes Promote community living
Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system, and implementing evidence-based practices	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 Ensure that all services are person and family centered
Addressing research priorities of consumes 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 Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DMH previously submitted responses to the Quality and Data Collection Readiness questions.

Footnotes:

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Implement and promote use of best practices

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Support the implementation of 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. Sustain and support the Individual Placement and Support (IPS) model of Supported Employment master trainer program.
2. Expand person-level employment data collection processes to all adult services and increase frequency of reporting.
3. Coordinate statewide employment activities and resources to include dissemination of best practices, development of protocols between state agencies providing employment services and support of job development networks.
4. Establish Children's Behavioral Health Research and Training Center to support integration of research into policy and practice.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 12%

First-year target/outcome measurement: 15%

Second-year target/outcome measurement: 17%

Data Source:

DMH Data Warehouse

Description of Data:

Clubhouse providers report employment as an "event", providing start and end dates of employment. Competitive employment is defined as worked at a job for pay in the competitive labor market in which the person is hired and paid market wage directly by the employer, including self-employment.

Data issues/caveats that affect outcome measures::

DMH began collecting Clubhouse employment data in this manner in SFY15. DMH is actively working with Clubhouse providers on the data collection process to improve data quality, including decreasing the number of people with an unknown employment status.

Indicator #: 2

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

Baseline Measurement: 63%

First-year target/outcome measurement: 65%

Second-year target/outcome measurement: 67%

Data Source:

Family Member Satisfaction Survey

Description of Data:

Annual survey of family members of children and adolescents receiving DMH services.

Data issues/caveats that affect outcome measures::

DMH contracted with a new vendor to administer the survey and analyze results in SFY16. Previously, the survey had only included families of children/adolescents receiving DMH case management services. They survey sample was expanded to include other DMH child and adolescent services.

Priority #: 2

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

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Enhance adult and child 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 improved 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. Procure Homeless Support Services by reviewing existing contracts and developing a procurement plan to include service model and pricing in alignment with Chapter 257
4. Continue inclusive planning process, including engagement of multiple stakeholders, for CBFS rate development and service enhancements
5. Implement recommendations from the SAMHSA/CMHS System of Care Expansion Planning Grant for Transition Age Youth and their Families by creating Transition Age Youth (TAY) Peer Mentor positions in Community Service Agencies (CSAs).
6. Implement MOU with Department of Early Education and Care (DEEC), as part of the Race to the Top federal grant, to develop training approaches for staff working in early childhood settings; implement a training/support model.
7. Jointly implement Caring Together Residential Services with the Department of Children and Families based on the Building Bridges framework and System of Care model to strengthen families, support children, and achieve positive outcomes for both children and families.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 76%

First-year target/outcome measurement: 78%

Second-year target/outcome measurement: 80%

Data Source:

Consumer Satisfaction Survey

Description of Data:

Annual survey of adults receiving Community Based Flexible Supports utilizing a state-modified version of the MHSIP survey tool.

Data issues/caveats that affect outcome measures::

DMH contracted with a new vendor to administer the survey and analyze results in SFY16. The vendor implemented new sampling methods, resulting in a larger sample. The survey does not include people receiving DMH services other than CBFS.

Indicator #: 2

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

Baseline Measurement: 77%

First-year target/outcome measurement: 79%

Second-year target/outcome measurement: 81%

Data Source:

Family Member Satisfaction Survey

Description of Data:

Annual survey of family members of children and adolescents receiving DMH services.

Data issues/caveats that affect outcome measures::

DMH contracted with a new vendor to administer the survey and analyze results in SFY16. Previously, the survey had only included families of children/adolescents receiving DMH case management services. They survey sample was expanded to include other DMH child and adolescent services.

Priority #: 3

Priority Area: Increase access to treatment for early psychosis

Priority Type: MHS

Population(s): SMI

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 a second PREP® program in the state (in Western MA).
2. Provide technical assistance and training on the treatment of early psychosis.
3. Develop website for PREP® program to facilitate outreach

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: 100

First-year target/outcome measurement: 125

Second-year target/outcome measurement: 150

Data Source:

PREP outcome reporting

Description of Data:

PREP providers report of the number of people served by the program.

Data issues/caveats that affect outcome measures::

DMH procured a second PREP program in SFY16. DMH will work with both programs to expand reporting requirements. Targets are estimates of the new capacity as the second program is implemented.

Priority #: 4

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

Priority Type: MHS

Population(s): SMI, SED

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 older adults and clients who are Deaf and Hard of Hearing
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: 76%

First-year target/outcome measurement: 78%

Second-year target/outcome measurement: 80%

Data Source:

Consumer Satisfaction Survey

Description of Data:

Annual survey of adults receiving Community Based Flexible Supports utilizing a state-modified version of the MHSIP survey tool.

Data issues/caveats that affect outcome measures::

DMH contracted with a new vendor to administer the survey and analyze results in SFY16. The vendor implemented new sampling methods, resulting in a larger sample. The survey does not include people receiving DMH services other than CBFS. DMH developed a person-centered planning sub-scale in SFY09, which was validated by the previous survey vendor.

Indicator #: 2

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

Baseline Measurement: 77%

First-year target/outcome measurement: 79%

Second-year target/outcome measurement: 81%

Data Source:

Family Member Satisfaction Survey

Description of Data:

Annual survey of family members of children and adolescents receiving DMH services.

Data issues/caveats that affect outcome measures::

DMH contracted with a new vendor to administer the survey and analyze results in SFY16. Previously, the survey had only included families of children/adolescents receiving DMH case management services. They survey sample was expanded to include other DMH child and adolescent services. DMH and the current survey vendor modified the family-centered planning sub-scale that was previously developed and validated in SFY12. This new sub-scale will be reviewed and validated in SFY16.

Priority #: 5

Priority Area: Promote community living

Priority Type: MHS

Population(s): SMI

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. Monitor admission and incarceration trends and conduct ongoing management of community service contracts.
3. Promote alternatives to hospitalization including respite and non-hospital based crisis services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of people who are discharged from DMH inpatient continuing care to the community within 180 days of admission.

Baseline Measurement: 60%

First-year target/outcome measurement: 63%

Second-year target/outcome measurement: 66%

Data Source:

DMH Mental Health Information System (MHIS)

Description of Data:

The denominator is the total number of admissions during the year; the numerator is the total number of those admitted clients who were discharged within 180 days of their admission.

Data issues/caveats that affect outcome measures::

None

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

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

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$174,985,164	$0	$1,676,512
6. Other 24 Hour Care		$0	$0	$0	$285,049,113	$0	$14,109,046
7. Ambulatory/Community Non-24 Hour Care		$18,793,101	$0	$8,373,142	$969,162,341	$0	$23,896,281
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$998,000	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$36,527	$0	$904,128	$51,766,702	$0	$1,202,951
13. Total	$0	$19,827,628	$0	$9,277,270	$1,480,963,320	$0	$40,884,790

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

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

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

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

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

Consultation to Caregivers;	
Medication Services	$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$7,242,315
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

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

Interactive Communication Technology Devices;	
Intensive Support Services	$12,548,786
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$
Total	$19,791,101

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

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

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	$5,000
MHA Administration	$31,527
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$36527
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Health Care System and Integration

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.

Within DMH community-based adult services, CBFS 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 health and wellness as a priority and encourage providers to develop innovative strategies to engage people served in wellness promotion activities. The 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 15 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. The Healthy Changes Task Force developed a Nicotine Assessment that in 2007 began to be completed at the time of patients' admission to Massachusetts state mental health inpatient facilities. The Nicotine

Assessment documents the patient's level of nicotine dependence and stage of change, and also assists in determining appropriate nicotine replacement therapy.

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 tobacco cessation. The Massachusetts Departments of Mental Health (DMH) and Public Health (DPH) are currently collaborating on a survey of staff and patients at two facilities on attitudes and observations about tobacco cessation treatment and enforcement at the facilities. The results will be used to improve tobacco treatment and enforcement procedures at all Department of Mental Health facilities.

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 outcome measures which include numbers of those desiring change, and the stage of change, for clients for whom smoking cessation is determined to be an area of current need. 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.

In 2014, Massachusetts was invited to participate in SAMHSA's 2014 State Policy Academy on Tobacco Control in Behavioral Health, and followed up with the Massachusetts State Leadership Academy on Tobacco-free Recovery, jointly sponsored by the Massachusetts Departments of Mental Health and Public Health, which was held on June 16, 2015. Participants included representatives from insurers, providers, legislators, professional and advocacy associations, and champions of the peer recovery movement, besides staff from DMH and DPH. Providers of both substance abuse and mental health services were included. The initial action plan consists of committees formed to address Organizational Change through Education and Training, Payer Issues, Peer Workforce, Policy and Legislation, and Data pertaining to tobacco cessation. These committees will continue to be guided by the Leadership Academy planners from DMH and DPH.

As the first state in the nation to implement health care reform in July 2007, all residents of the Commonwealth ages 18 and older are required to obtain and maintain a minimum level of health insurance. Parents are responsible for children under age 18. The Health Care Reform Act of 2006 established the Health Connector as an independent quasi-governmental entity which provides individuals and small business employees with multiple health insurance product choices and administers a subsidized insurance program, the "Commonwealth Care Health Insurance Program". Commonwealth Care provides a sliding-scale subsidy towards the purchase of private health insurance products for legal residents of Massachusetts with incomes between 100 and 300% of the

Federal Poverty Level and now serves as the states Health Exchange under the ACA. MassHealth has also participated in Medicaid Expansion consistent with its leadership in providing health coverage. The Connector is working to develop new requirements as an ACA compliant marketplace, including any needed changes to the EHB package. There is also an inter-agency effort to develop a legislative package of changes needed to the state law to implement the ACA, including reconciling differences between state and federal law with regard to employer responsibility, individual responsibility and private insurance protection.

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 payors. 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 Task Force, chaired by the DMH Commissioner, filed a report to the Legislature in July 2013. The report is included as an attachment.

Chapter 224 also created the Health Planning Council, which is comprised of the chief executives of various state agencies that deal with health care, including the EOHHS, Department of Public Health (DPH), Executive Office of Elder Affairs (EOEA), DMH, Health Policy Commission, Center for Health Information and Analysis and MassHealth. The Health Planning Council is charged with developing the State Health Resource Plan to assess the needs of Commonwealth residents and the current health care resources available to those residents. The Council chose behavioral health as its first priority and DMH was actively involved in this process. The Behavioral Health Plan was completed in December 2014. The report presents an estimation of need, inventory of services across eight major service categories, data on access and utilization across payers and makes recommendation for future data collection and analysis and to ensure access to behavioral health services. Data from the Behavioral Health Plan is presented in Step 2 and included as an attachment.

Massachusetts is pursuing several opportunities under the ACA and Chapter 224 to promote primary care and behavioral health integration, including the Patient Centered Medical Home Initiative (PCMHI), Primary Care Payment Reform (PCPR), Health Homes benefit for seriously mentally ill adults and children and the Dual Eligible Demonstration (One Care) Project. The emphasis on behavioral health, including scope of services, integration with primary care, network adequacy, and outreach and enrollment strategies is strong in each of these projects. These projects are also informed by the Behavioral Health Integration Task Force. Each of these endeavors contains a strong emphasis on primary care and behavioral health integration and is discussed further below.

The Primary Care Payment Reform (PCPR) is an initiative under Chapter 224 which builds on the medical home model and integrates behavioral health utilizing alternative payment methodologies to promote care delivery innovations. It evolved from the Patient Centered Medical Home Initiative (PCMHI), which was a three-year medical home demonstration project. The PCMHI began in April 2011 with 46 competitively-selected primary care practice sites from across the Commonwealth and a multi-payer group of Massachusetts health plans working collaboratively to support primary care practice transformation. PCMHI provided technical assistance for behavioral health integration, including integration measurement, further development of a coordinated

transformation curriculum and training of Medical Home Facilitators on integrated care. Most practices in this project became part of PCPR, which is expected to align payors around a dramatic shift in payment structures. MassHealth is currently engaging other state agencies, including DMH, in the design of this initiative.

The Dual Eligibles Demonstration/One Care aims to provide integrated care to MassHealth's most vulnerable members. The project is designed to address the fact that Dual Eligible members cost more than twice the average for Medicaid patients and need greater medical and community-based support. 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. DMH was actively involved in the design and procurement of the Integrated Care Organizations (ICO)s, the One Care health plans, and routinely collaborates with MassHealth on the implementation of this project.

Massachusetts is also planning to pursue the Health Home benefit under the ACA as an amendment to the Massachusetts Medicaid State Plan. The proposed focus is to designate Health Homes to deliver the six Health Home services to individuals of all ages with serious and persistent mental illness (SPMI) and to children with serious emotional disturbance (SED). DMH is an active participant in the planning and implementation of these key initiatives.

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 in recent years 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 continues to collaborate with MassHealth on the management of MassHealth's contract with the Massachusetts Behavioral Health Partnership (MBHP), the behavioral health carve-out vendor of the Primary Care Clinician Program (PCCP). DMH and MassHealth collaborated on the rebid of this contract in 2011 which was awarded again to MBHP. The new contract added a focus on the integration of primary and behavioral health care, a care management program and enhanced primary care network management. DMH continues to work with MBHP on one of the vendor's performance incentive projects, which was development at DMH's request with the goal of improving access to primary care for DMH clients, particularly those with diabetes.

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."

2013

Behavioral Health Integration Task Force

July, 2013

Report to the Legislature and the Health Policy Commission

I. Executive Summary

Chapter 224 of the Acts and Resolves of 2012 is a comprehensive law designed to bring health care spending in balance with the state's economy. At its core, the goal of Chapter 224 is to contain health care costs. Within that legislation, Section 275 established "a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."[1]

The Behavioral Health Integration Task Force (Task Force) was charged under Section 275 to examine the following six topics:

- the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care;
- how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes;
- the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols;
- how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services;
- how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and,
- the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

In addition to its own deliberations, various guests were invited to present on important issues related to behavioral health integration, including the Children's Behavioral Health Advisory Council, experts from health care providers with experience in models of primary and behavioral health integration, and individuals with lived experience. The Task Force also benefited from responses to a request for information (RFI) issued by the Department of Mental Health (DMH), and by community-based stakeholder-feedback session.

[1] Section 275 of Chapter 224 of the Acts and Resolves of 2012, enacted August 2012.

The Task Force established working principles as a foundation to address the six topics identified in the enabling legislation and to build on the existing assets in the behavioral health delivery system. These working principles draw from the proven results in behavioral health care that emphasize the potential for recovery from substance abuse and chronic mental illness, the value of peers and family partners with lived experience in working with individuals and their families as part of care planning and care coordination, and the central place of the individual in participating in the design of his or her care plan.

In the course of the development of these recommendations, the Task Force noted that efforts to integrate primary care and behavioral health services have shown promising but mixed results so far, while also noting that they have revealed a number of persistent barriers to integration, many of which pervade throughout our health care system and are not unique to specific populations. These barriers include, but are not limited to:

- numerous reimbursement issues, including but not limited to lack of equity in behavioral health payments and restrictive billing policies and non-aligned payment systems that inhibit integration and inclusion of behavioral health professionals, peers and family partners on care teams;
- outdated regulations that are based on separate systems for physical health and behavioral health;
- difficulty accessing behavioral treatment;
- the need for significant training and education of both primary care and behavioral health providers;
- lack of interoperability and connection of the behavioral health system to electronic records; and,
- privacy concerns, real or perceived.

The Task Force focused its work on these systems barriers and on solutions that would work for all populations. In doing so, it developed 29 recommendations for consideration by the Legislature and the Health Policy Commission, which not only answer the questions posed with Section 275, but also suggest additional strategies aimed at the successful integration of primary care and behavioral health care to improve health care outcomes and contain health care cost growth. Implementation of a number of the Task Force recommendations will require financial investments. The Task Force recognizes the challenge of considering additional costs in the context of a healthcare cost containment initiative; however it believes that these investments will result in improved health outcomes and an overall reduction in health care costs. The Task Force also acknowledges the need to balance new investments with the equally urgent need to assure that current services are adequately funded.

Together the recommendations put forth in this report address the barriers to integration noted above by broadly providing strategies for:

- A clinical model that expands from a one-to-one relationship between the practitioner and the individual to:
    - a team-based clinical model of integrated care that acknowledges the value of behavioral health professionals, peers and family partners as key members of the team in an integrated primary care setting;
    - interventions that underscore the importance of the team to coordinate a host of services for the individual that will fill the "space between" the health care interventions, work with the individual to identify his/her individual strengths and natural community supports and address the social determinants of health care that often exacerbate the effects of cardiovascular disease, diabetes and obesity among person with serious mental illness; and,
    - an emphasis on prevention and early intervention with children and their families to prevent or mitigate the effects of Adverse Childhood Experiences that often result in chronic medical conditions among adults.
- alignment of incentives to promote provision of integrated care;
- adequate reimbursement for behavioral health services and transparency in alternative payment systems to ensure adequate reimbursement for professionals and non-professionals that are part of a care team;
- enhanced and redeployed behavioral health provider capacity;
- modifications to medical necessity, prior authorization and credentialing criteria and processes;
- balancing of privacy concerns with treating providers need to share and view minimum necessary treatment information;
- training and education focused on integration, including use of persons with lived experience as part of the training and education process; and,
- continued workforce development.

The report does not provide all of the answers to the challenge of successful integration of primary and behavioral health care. Issues of stigma, access to behavioral health services; workforce development and financing, among others, will require the concentrated effort of healthcare providers, policy makers and legislators in the months and years to come. However, the Task Force is confident that as a whole this report sets the Commonwealth on a path towards successful integration.

II. Introduction

Chapter 224 of the Acts and Resolves of 2012 is a comprehensive law designed to bring health care spending in balance with the state's economy. At its core, the goal of Chapter 224 is to contain health care costs. Within that legislation, Section 275 established "a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."[2]

The statute specifies the membership of the Behavioral Health Integration Task Force (Task Force) and names the Commissioner of the Department of Mental Health (DMH) as its chair. In addition to the membership identified within the legislation, representatives from the Department of Public Health's (DPH) Bureau of Substance Abuse Services (BSAS) and the Office of Medicaid were invited to participate in the Task Force. A full listing of Behavioral Health Integration Task Force members is included as Appendix A to this report.

The Task Force was charged under Section 275 with examining the following six topics:

- the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care;
- how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high qualify behavioral, substance use and mental health outcomes;
- the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols;
- how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services;
- how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and,

[2] Section 275 of Chapter 224 of the Acts and Resolves of 2012, enacted August 2012.

- the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

To address the topic of behavioral health integration into primary care generally, and the specific questions posed by Section 275, the Task Force met nine (9) times between December 2012 and June 2013.

In addition to the organizations represented on the Task Force, the recommendations of the Task Force were informed by stakeholder and expert feedback collected through three primary sources: a request for information (RFI) issued by the DMH, community-based stakeholder-feedback sessions, and through invited guest speakers to the Task Force meetings.

The RFI was issued by DMH in February 2013. Sixty-five responses from peers, providers, hospitals, trade associations, health plans, licensed independent practitioners and advocacy organizations responded to the RFI in writing. The Task Force members received a copy of each of the responses. In addition, two public forums were held in the communities of Boston and Holyoke. Over 100 participants attended and provided testimony.

The DMH Commissioner also solicited recommendations from two groups. The Children's Behavioral Health Advisory Council, established by *Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental*, provided recommendations to the Task Force related to child and adolescent behavioral health. The Council is a unique public-private partnership representing child-serving agencies, parents, and professionals with knowledge and with expertise in the field of children's behavioral health. The DMH Medical Director convened a Physician Work Group, with representatives from internal medicine, pediatrics, and child and adult psychiatry. Representatives of both groups presented their recommendations to the Task Force, which incorporated many of them into this report.

The Task Force invited several guests to speak representing themselves, organizations, standing advisory committees or ad-hoc groups formed to provide input into the Task Force. Guest and invited speakers included:

- Julian Harris, MD – MassHealth
- Thad Schilling, MD and Dan Gallery, PsyD – Harvard Vanguard Medical Associates
- Sarah Gordon Chiaramida, Esq – Massachusetts Association of Health Plans
- Sandy Blount, EdD – UMass Medical School
- Valerie Konar, UMass Medical School, and Frances O'Hare, MD, Martha Eliot Health Center, representing the MA Child Health Quality Coalition
- Marie Hobart, MD – Community Health Link

- Lester Blumberg, Esq – Department of Mental Health
- Bill Beardslee, MD (Children's Hospital), Michael Yogman, MD (MA AAP), John Sargent, MD (Tufts Medical), Carol Trust (MA NASW), and Lisa Lambert (PPAL), representing the Children's Behavioral Health Advisory Council
- Karen Hacker, MD, MPH (Cambridge Health Alliance), and Janet Osterman, MD, (Boston University and President of Massachusetts Psychiatric Society) representing the Ad-Hoc Physician Work Group to the Task Force
- Linda Naimie – individual with lived experience representing herself
- Deb Delman – the Transformation Center
- Naomi Pinson – Advocates, Inc.

See Appendix B for meeting summaries and presentation materials, including background presentations on current integration efforts, recommendations to the Task Force from Advisory Groups and a combined summary of feedback from the Request for Information (RFI) process and public forums described below. Appendix B also includes a listing of additional materials shared by Task Force members.[3]

III. Definitions

Behavioral Health: an umbrella term that refers to mental health and substance use disorders and their treatment and prevention, and behavioral interventions in physical disease management, health promotion and/or the system of care.

Collateral Contacts: a contact between an individual's treating behavioral health provider and other providers, school, supports, and/or family members relative to the behavioral health treatment of an individual.

Family: any person defined by an individual who plays a significant role in that individual's life. This may include a person not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor's parents, regardless of the gender of either parent. The concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parent, step-parents, those serving in loco parentis, and other persons operating in caretaker roles.[4]

Individuals: a child, youth, or adult who has a behavioral health issue or disorder. "Individual" is used throughout this report because the Task Force intends and believes that the integration challenges addressed in this report are system wide and largely not

[3] All of these materials will be made available to the Legislature on CD-ROM and will be posted on DMH's website.

[4] Definition source adapted from http://www.hrc.org/resources/entry/lgbt-inclusive-definitions-of-family.

unique to specific populations. Where important distinctions do exist for specific populations, they are noted and specific reference is made to children or youth or adults.

Integrated risk bearing provider organization: a broad term to define organizations that provide both behavioral health and physical health services in a coordinated fashion and accept financial risk for the provision of healthcare to the individuals it serves. This term encompasses all organizations that operate in an integrated way, regardless of the model of integration they choose or the extent to which they are at financial risk for the services they provide.

Persons with lived experience: individuals who have had or currently have behavioral health issues or disorders and have accessed some portion of the health care, mental health care or the substance use delivery system. These individuals include adults, children and family members caring for children with behavioral health issues or disorders.

Provider: any licensed or non-licensed health care professional, provider or peer supporter who has the potential to be part of an integrated care team. Such providers include, but are not limited to: physicians, nurse practitioners, psychologists, psychiatrists, advanced practice psychiatric nurses, alcohol and drug use counselors, licensed independent clinical social workers, licensed mental health counselors, peer counselors, visiting nurses, family therapists and family partners. The term "provider" can also refer to community-based organizations, hospitals, and schools that provide mental health and/or substance use services and employ many types of individual providers.

IV. Background

Historically, physical and behavioral health care (used throughout this report to refer to substance use and mental health services) have been provided through separate systems by separate providers, with separate financing streams. Although some behavioral health care has always been provided within the general medical care system by acute care general hospitals and primary care and other providers, this care is often provided without the benefit of providers with specialized training and without the resources for consultation and integration. Much has been written about the need for greater behavioral health integration within the provision of physical health care and improved physical healthcare within behavioral health settings. Numerous professional organizations have issued white papers on primary and behavioral health integration. There are innovations and promising practices in Massachusetts in both the child and adult systems: the Patient-Centered Medical Home Initiative, MY CHILD / Project LAUNCH, the Massachusetts Child Psychiatry Access Project (MCPAP), and the Dual Eligible Initiative.

Over the course of a year, nearly 30 percent of the adult population in the United States suffers from a behavioral health disorder, with a high prevalence of mood, anxiety and substance use disorders.[5] Behavioral health problems are 2-3 times higher in patients with chronic conditions, including diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease.[6] Untreated behavioral health disorders lead to functional impairment and complications with physical health care issues, and result in higher health care costs.[7] Further, treatment of behavioral health conditions with pharmaceuticals may increase the likelihood of some chronic conditions.[8] Moreover, individuals with a serious mental illness live, on average, 25 years less than individuals without behavioral health issues in part due to treatable medical conditions including smoking, obesity, substance use, and inadequate access to medical care.[9] Similarly, individuals with substance use disorders live, on average, 22.5 years less than those without the diagnosis.[10] In addition, there are behavioral factors which influence physical disease management and health promotion.

Children are not "cost drivers" when compared to some groups of adults, such as adults eligible for both Medicaid and Medicare. However, both childhood physical and mental health problems result in poorer adult health. Furthermore, childhood mental health problems have much larger impacts than do childhood physical health problems on four critical areas of socioeconomic status as an adult: education, weeks worked in a year, individual earnings, and family income. Without intervention, child and adolescent psychiatric disorders frequently continue and worsen into adulthood and are increasingly associated with disability and increased medical costs. For example, mental health problems in childhood are associated with a 37 percent decline in family income, three times greater than the decline related to having physical health problems.[11]

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[5] Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 617-627.

[6] Katon, Wayne, Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness, Society of Biological Psychiatry, 2003;54:216–226; Katon, W. Lin, EH, and Kroenke, K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. Gen. Hosp. Psychiatry. 2007; 29:147-155.

[7] Kessler et al., 2005.

[8] Muench J and Hamer A. "Adverse effects of antipsychotic medications." *American Family Physician* 617-622 (2010) and O'Riordan M. et al. "Antidepressant use linked with increased atherosclerosis." *Medscape* April 14, 2011.

[9] Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.

[10] Neumark, Y.D. et al. "Drug dependence and death: Survival analysis of the Baltimore ECA sample from 1981 to 1995." Subst Use Misuse 2000;35(3):313-327

[11] Delaney L and Smith J. "Childhood health: trends and consequences over the life course." *Future Child.* Vol. 22, No 1, Spring 2012.

The first signs of mental illness often occur in childhood. Half of all lifetime mental illnesses begin by age 14 and three quarters begin by the time an individual is 24.[12] Approximately 20 percent of children and adolescents experience signs and symptoms of a diagnosable mental health disorder during the course of a year. For children between the ages of 9 and 17, 11 percent experience "significant impairment" and five percent experience "extreme functional impairment."[13] Adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence some time in their lives compared with those who have their first drink at age 20 or older.[14] Moreover, the Adverse Childhood Events literature underscores the impact of the consequences of adverse childhood events on adult physical and behavioral health morbidity, mortality and costs.[15] There is clear and expanding scientific evidence that toxic stress, associated with adverse child events, can permanently alter brain maturation broadly and particularly in the prefrontal cortex, hippocampus and amygdala, as well as the nerve interconnections between them. These brain changes may be permanent and once established, may not change easily, underscoring the importance of prevention and early intervention. [16]

While individuals with behavioral health needs may obtain behavioral health care through a specialty behavioral health provider, most behavioral health treatment for adults is provided in primary care settings[17] or in acute care general hospital systems of care. A larger number of adults with a behavioral health disorder receive their treatment in primary care (22.8 percent) than in a specialty mental health setting (20 percent). Many adults (49 percent) only receive medication and no further treatment.[18] Moreover, over 60 percent of adults with a diagnosable disorder and 70 percent in need of treatment do not receive any mental health services.[19] On the other hand, children and adolescents are less likely than adults to receive behavioral health care in medical

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[12] National Institute of Mental Health (NIMH) Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.
See also, Mental Health Surveillance Among Children – United States, 2005-2011, The Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Supplement Volume 62, No. 2, May 17, 2013.
[13] Mental Health: A Report of the Surgeon General, NIMH, 1999.
[14] Califano, Joseph. Center on Addiction and Substance Abuse (CASA) press release, 2-26-02; NIAA Alcohol Alert #59, April 2003, Grant, B.F. et al Journal of Substance Abuse 9:103-110, 1997.
[15] http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html
[16] Shonkoff JP et al. "Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention." *JAMA* 2009: 301(21): 2252-2259.
[17] Wang, PS., Lane, M., et al. "Twelve-month use of mental health service in the United States: results from the National Comorbidity Survey Replication" *Arch Gen Psychiatry*, 2005 June, 62(6):629-40 and Wang PS, et al. "Changing profile of service sectors used for mental health care in the U.S." *American Journal of Psychiatry*, 163(7), 1187-1198. 2006.
[18] *Mental Health Financing in the United States*, Kaiser Family Foundation, April 2011. Accessible at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8182.pdf
[19] Ibid.

settings and more likely to receive care through their school or through a behavioral health provider.[20]

Multiple barriers prevent primary care providers (PCPs) from providing optimal care especially for individuals with more complex behavioral health needs. To truly serve the whole patient, it is important for the PCP to have the capacity to identify and treat or refer, as appropriate, individuals with behavioral health needs. Research demonstrates the value of integrating behavioral health services with primary care, including for anxiety and substance use disorders[21] and basic bio-psycho-social factors in the health care delivery system. Likewise, there is a pressing need to improve the quality of physical health care in behavioral health settings.

There is no "one size fits all" approach to caring for individuals with behavioral health needs, and the approach to effective care may differ by care setting and population. The Task Force considered several clinical models of behavioral health integration that are applicable to the primary care and outpatient behavioral health setting, and recognizes that it is important to support integration across a spectrum of settings and populations. A description of clinical models of behavioral health integration is included as Appendix C.

Increased focus on improving quality while reducing the cost of health care across the United States has heightened interest in the integration of behavioral health and general medical care, particularly where provider groups are beginning to take on financial risk for a group of patients under alternative payment methods. However, efforts to integrate primary care and behavioral health services have shown promising but mixed results so far, and have revealed a number of persistent barriers to integration, including:

- numerous reimbursement issues, including but not limited to lack of equity in behavioral health payments and restrictive billing policies and non-aligned payment systems;
- outdated regulations that are based on separate systems for medical health and behavioral health;
- difficulty accessing behavioral treatment;
- the need for significant training and education of both primary care and behavioral health providers;

[20] Burns BJ et al. "Children's mental health service use across service sectors." *Health Affairs*, 14, no. 3 (1995): 147-159.
[21] For anxiety: Price D et al. "The treatment of anxiety disorders in a primary care HMO setting." *Psychiatr Q.*, Spring 2000, 71(1):31-45; For substance use: Parthasarathy, S. et al., "Utilization and cost impact of integrating substance abuse treatment and primary care, medical care" *American Public Health Association*, March 2003- Volume 41, Issue 3, pp. 357-367.

- lack of interoperability and connection of the behavioral health system to electronic records; and,
- privacy concerns, real or perceived.

Many of these barriers are system-wide and not unique to specific populations. The Task Force has viewed its work as focusing on these systems barriers and developing solutions that would work for all populations. In developing its recommendations, the Task Force explored these barriers; a more in-depth discussion of each topic area is presented below.

Reimbursement

There are three major categories of barriers to integration related to reimbursement – the first is related to rates of reimbursement that do not cover the actual cost of providing such services, the second is related to administrative barriers and the third is the non-alignment of payment systems.[22]

A key barrier to the integration of behavioral health with primary care is low reimbursement rates for behavioral health services and the historical failure of the fee-for-service model to pay for care management services, consultation among providers, collateral contacts, and for some, the electronic systems needed for an integrated environment. Some behavioral health providers are not reimbursed by insurers or are restricted to a limited subset of their statutory scope of practice.

There is a concern among some in the behavioral health community that as integrated provider networks form and more services are paid through alternative payment methodologies, behavioral health services will continue to not be adequately utilized nor reimbursed within primary care settings, without appropriate measures. There is also a concern that behavioral health services in the behavioral health setting will continue to be inadequately reimbursed. In addition, some behavioral health providers note that pay-for-performance incentives can be a barrier to reimbursement as outcome measures are harder to quantify in behavioral health than in physical health care.

There are several administrative barriers to reimbursement, including prohibitions on billing for more than one visit in a day and limitations on which providers can bill different codes. In addition, while behavioral health carve-outs were initially developed in order to ensure provision of behavioral health services, there is now concern that the carve-out of behavioral health to separate vendors may become a barrier as the different

[22] Mauch D, Kautz C, Smith S. "Reimbursement of Mental Health Services in Primary Care Settings". Prepared for the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center Mental Health Services, February 2008.

organizations potentially try to shift coverage to the other vendor and not pay for provision of services.

The non-alignment of payment systems is a complex topic. There is recognition that behavioral health services, if provided under integrated funding models, can significantly contribute to improvement of total health care costs. Under such models all providers would be attentive to the importance of improving total health, including behavioral health, and could share together in shared savings models. At the same time there is general recognition of the importance of preserving special funding streams for specialty behavioral health and ensuring that in any integrated funding system, quality measures and funding metrics would be set in such a way as to protect the funding for behavioral health services.

Privacy

One of the primary barriers to behavioral health integration is the persistent stigma and discrimination to which society subjects individuals receiving behavioral health services. The reaction to this discrimination results in a desire for more privacy and a reluctance to share clinical information. This stigma has been persistent over many decades and extends beyond the health care system. Health care professionals are not above reproach. In one study, for example, nurses were found to act as "stigmatizers," carrying negative attitudes founded on the belief that individuals with mental health issues are dangerous, weak and to blame for symptoms.[23] These attitudes are most often directed toward individuals with previous hospital admissions, those who are actively presenting symptoms, or those who are diagnosed with what is perceived as a long-term illness, such as schizophrenia, as opposed to individuals who do not exhibit significant symptomatology.[24] While theoretically, better health care decisions would be the result of complete information about the person receiving services, this is not always the case in practice.[25]

Many health care plans and primary care providers, however, think that privacy laws, regulations and policies and the interpretation of such within the behavioral health and physical health system hinder integration and the provision of quality health care. Primary care providers can be challenged by the behavioral health system not sharing important information that may be necessary to support the treatment of an individual or family (e.g., medications prescribed by a psychiatrist, discharge notification from an inpatient psychiatric unit or detoxification program.) Behavioral health providers may apply the strictest interpretation of privacy laws to protect the people they treat from

[23] C Ross and E. Goldner. "Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature." 16. *J Psychiatric and Mental Health Nursing*. 558-568 (2009).
[24] H. Roa et al. "A study of stigmatized attitudes towards people with mental health problems among health professionals." 16 *J. Psychiatric and Mental Health Nursing*. 279-284 (2009.)
[25] P. Corrigan, *How Stigma Interferes with Mental Health Care*, 59 American Psychologist 614, 621 (Oct. 2004) .

unintended consequences of revealing personal information which might actually impede the provision of quality healthcare or be overly intrusive or because of fear of liability of releasing information. Primary care providers are often unaware of additional federal privacy protections for persons with substance use disorders and require training in the use of appropriate release of information in order to facilitate integration. This push-pull of individual health care information needs to be balanced in order for behavioral health integration to be successful.

In addition all members of the Task Force acknowledge that it is important to consider the individual's view of privacy. The Task Force learned that some individuals avoid seeking care from trained behavioral health providers or sharing behavioral health concerns with medical providers due to the stigma previously described. The Task Force learned from Dr. Frances O'Hare, an internist from Boston Children's Hospital, that confidentiality is of utmost importance in engaging adolescents in behavioral health treatment.[26] Indeed, there are unique concerns related to privacy and confidentiality for adolescents and their families. In addition, the sharing of information with healthcare providers in schools (i.e., school nurses, counseling personnel) in order to address children's behavioral health issues must be considered.

The Task Force heard from individuals with lived experience who experience stigma in the health care system. They shared their experience and the experience of their friends and loved ones who have had physical health symptoms ignored because of their behavioral health diagnosis. While this stigma is often one of the reasons some persons with lived experience prefer to not have their behavioral health diagnoses or record information shared with medical providers from whom they may seek care, others report wanting trusted health care professionals to have access to their entire health care record. However, they uniformly wanted to be able to make the choice about with whom to share this information themselves.

The Task Force responded to the issues of stigma in the Education and Training recommendations and responded to the information-sharing concerns in the Privacy recommendations.

Regulatory

There are many outdated regulations that are based on dated and separate medical, mental and substance use health systems. These regulations impede integration. For example, some Plan Review Guidelines applicable to new construction or renovations might require separate waiting rooms for physical health and behavioral health patients, which may contribute to stigma and discrimination (addressed in the privacy barrier

[26] Frances O'Hare. Presentation to the Behavioral Health Integration Task Force. April 16, 2013. For more information, see Appendix B.

below). Furthermore, the regulation poses a potential burden on integration efforts as typically providers do not have extra space for separate waiting rooms. However, the Department of Public Health (DPH) may and has waived such requirements to facilitate integration. In addition many intensive behavioral health settings cannot currently qualify for the cost-based reimbursement found provided to community health centers (CHCs).

These barriers exist today within a mostly fee-for-service system, and become increasingly problematic in a shift to alternative payment methodologies. The Task Force recognizes that the DPH has established a procedure for identification and waiver of regulatory barriers, in appropriate cases, for organizations interested in integrating services and the Task Force supports the continuation of this work in its recommendations.

Education and Training of the Workforce

The Task Force considered the barriers to education and training of the workforce and noted that the health care workforce is not trained sufficiently to work together in an integrated environment. Under current reimbursement systems, PCPs are paid in such a way that the pressure to be productive may result in the provider having little time to receive education on integration and no time or resources to deliver integrated care.

Many behavioral health providers also lack training in providing integrated care. Many medical conditions have significant behavioral components (e.g., diabetes in adults) or root causes (e.g., trauma and toxic stress experienced by children) that could be positively impacted by integrated health interventions. However, most behavioral health providers lack the necessary training to be able to offer such interventions in an integrated care setting or to oversee medical care needs in a behavioral health setting. They suffer from even greater pressures for productivity due to inadequate payment, resulting in similar lack of time for such training.

While time and funding for educational programs can help mitigate some of the barriers, the normal human reactions to changes in the environment (the health care system) also pose a barrier. There are often misperceptions about the other provider type and their role in an integrated environment and significant cultural differences in style of practice - which leads to a fear that individual roles in new and alternative payment models will be threatened.

To help mitigate these concerns, the Task Force provided recommendations to: improve training for all health care professionals on integration; integrate peers into the primary care and other health settings; train traditional medical professionals to recognize behavioral health conditions and behavioral factors in health promotion and disease management; provide treatment within the scope of their practice; enhance the training

of behavioral health professions to recognize the importance of medical issues in the behavioral health setting and for all to recognize the inter-relationship between physical health and behavioral health conditions for both children and adults.

V. Guiding Principles

The Task Force developed and unanimously adopted on April 8, 2013 a set of guiding principles for including behavioral health integration in alternative payment models. The fifteen guiding principles are as follows:

1. Integrated behavioral health services should include a continuum of all prevention, screening, assessment, diagnosis, support, care management, recovery self-management, consultation and treatment services, which can be reasonably provided within any care, community, or recovery-oriented setting for mental health and substance use disorders and the development and maintenance of a healthy lifestyle.

2. The services listed and implied within Principle #1 should be provided in a multi-disciplinary team approach by a wide variety of skilled individuals in accordance with their practice license, certification, accreditation or common practice.

3. Models for the delivery of services listed and implied within Principle #1 should be based on evidence when available.

4. The services listed and implied within Principle #1 should be based on evidence of safety and effectiveness as derived from research, expert consensus, and lived experience. The services should be culturally competent and developmentally appropriate.

5. There are multiple acceptable models and locations for including and providing the services listed and implied within Principle #1, and payment for those services should reflect the variety of models and locations.

6. All models that include and provide the services listed and implied within Principle #1 should be person- and family-driven and recognize the unique needs of the population served.

7. All models that include and provide the services listed and implied within Principle #1 should respect the goals of persons receiving services, as well as their preference for clinician and mode of treatment.

8. Persons with lived experience should be involved in the policy development, evaluation, and training of models of care and delivery of services listed and implied within Principle #1.

9. Payment for all services listed and implied within Principle #1 and that occur in various settings should be sustainable, transparent, support service delivery and

infrastructure development. The payments should reflect the importance of these services to integrated health care organizations.

10. Payment for all services listed and implied within Principle #1 should not limit access to emergency, inpatient and intensive services in specialty mental health settings.

11. Payment for all services listed and implied within Principle #1 should include support for the acquisition of and integration of EMR from specialty behavioral health providers.

12. Financial incentives and the distribution of payment within alternative payment models should be tied to quality of care and include all medical and behavioral providers in an integrated manner.

13. The Task Force recommendations should balance the clinical interest for bi-directional communication between those who provide the services listed and implied within Principle #1 and the privacy of individuals and their families receiving services.

14. The Task Force recommendations of the models and locations for including and providing the services listed and implied within Principle #1 should be based on demonstrated evidence-based care and where such evidence is not available, based on a consensus of the medical community, behavioral health community, mental health community and/or substance use disorder community, on practice experience or informed by lived experience.

15. The Task Force recommendations should have measurable outcomes, where such outcome measures exist.

VI. Recommendations

The recommendations of the Task Force focus primarily on answering the six specific questions included within the legislation, and build off of the guiding principles described above. There are additional recommendations that are relevant to the successful integration of behavioral health and primary care that are not specific to the legislation. Those recommendations are included at the end of this Report.

Implementation of a number of the Task Force recommendations requires an additional financial investment. The Task Force recognizes the need to consider any additional costs in the context of improved health outcomes and an overall reduction in health care costs. It also acknowledges the difficulty in requesting additional funding for new services and innovations when current services may not be appropriately funded. The Task Force has strived to include recommendations which appropriately align incentives to result in provision of integrated care to meet the ultimate goal of Chapter 224.

A. Clinical Models of Integration

The most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care.

1. Massachusetts providers should move toward new and emerging models of integration with the most practice-based, evidence-based effectiveness, recognizing diversity in model-type and the needs of individuals and families with lived experience.

Rationale: There are many acceptable models for integration, including new and emerging models that include behavioral health services, being delivered in many loci of care. The most effective and appropriate approach to including behavioral health services is dependent upon the population of individuals being served by each provider. Providers should have the flexibility to provide integrated services in a manner which fits the skills, readiness and appropriateness of their organization and the health care system in which they practice and where the person or family served is most comfortable. A broad range of care options should be available to all patients and used as clinically appropriate. To the extent possible, models of integration should rely on the best published evidence or emerging practice for effective care. A range of provider types must also be available to patients. The move towards integration should continue to allow for and promote innovation in care delivery. In addition, it should include a strong evaluation component in order to assess their cost-effectiveness and to promote continuous quality improvement.

Implementation Action Steps: The models for integration chosen by any given provider (including but not limited to primary care provider, community mental health center, community health center, addiction treatment provider, schools, and hospitals), should take into account the needs and diversity of the individuals who obtain care in that setting. Once individuals have been identified as having a behavioral health disorder, providers can use a number of models, including the National Council's Four Quadrant Model, included as Appendix D), as a way of identifying where individuals or families could potentially receive the most appropriate level of care within various integrated care settings. The Four Quadrant Model represents a population-based

planning framework for the clinical integration of health and behavioral health services[27] as does the work of the Substance Abuses and Mental Health Services Administration (SAMHSA) funded AIMS center at the University of Washington. [28]

Patient Centered: All models of integration should be based on the concepts of patient-centeredness. Patient-centered care is respectful of and responsive to individual preferences, needs, and values and ensures that individual values guide all clinical decisions.[29] Task Force members agreed that choice of individuals seeking services must be a guiding principle in the delivery of behavioral health services. They also agreed that individuals must have access to all provider disciplines licensed to provide services under insurance laws and regulations. However, some Task Force members believe that individuals and families should have the opportunity to select the type of care setting[30], the composition of the care team and the care services received – regardless of what providers and services are available within an integrated care setting.[31] Others felt that individuals and families should have the opportunity to select from available settings, providers and services within an integrated care system and that the benefits of seeking care from within an integrated care system should be made known. Services in general should include those not found in traditional medical models of care.

Peer Supports: Peer supports, including family partners with "lived experience" raising a child with behavioral health challenges and youth mentors, should be a standard service that is readily available. Peer supports are critical for initial and on-going engagement of families and youth who might be reluctant to or lack knowledge about and/or skills for engaging with behavioral health care. Engaging families and youth is more than just the receipt of services for their children. Patient and family engagement should include patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, evaluation, and policy-making – to improve health and healthcare.[32]

Screening: Providers must use nationally recognized, evidence-based and age-appropriate screening tools[33] (e.g., Screening, Brief Intervention and Referral to

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[27] National Council for Community Behavioral Healthcare. "Four Quadrant Model." http://www.thenationalcouncil.org/galleries/resources-services%20files/5.%20Four%20Quadrant%20Diagram.pdf. *SAMHSA-HRSA Center for Integrated Health Solutions.*

[28] http://uwaims.org/

[29] Institute of Medicine. "Crossing the quality chasm: a new health system for the 21st century." 2001.

[30] Including the home.

[31] J. Hibbard and J. Greene, *What The Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs,* 32 Health Affairs 207-214 (2013).

[32] Carman KL, et al. "Patient and family engagement: a framework for understanding the elements and developing interventions and policies." *Health Affairs* 32. No. 2 (2013): 223-23.

[33] Providers should also use consensus-based screening tools that may not have a strong evidence-base.

Treatment (SBIRT) for substance use disorders, PHQ-9 for depression screening, CRAFFT for adolescent addiction screening) to identify individuals who may have behavioral health disorders. MassHealth has endorsed nine evidence-based screening tools for children and youth.[34] Despite the potential benefits of universal screening, full implementation has been met with some resistance. Some cite the low yield of true cases, while others cite the costs associated with follow-up of positive screens, and insufficient resources for subsequent behavioral health evaluation and treatment. These limitations should be considered and addressed.

Care Teams: Care teams within integrated care settings should include broad types of primary care and behavioral health providers. In addition to the primary medical team, this should include, but is not limited to, licensed mental health clinicians, alcohol and drug counselors, certified peer specialists and recovery coaches. Behavioral health consultation should be readily accessible to primary care providers including by, but not limited to, qualified psychiatric physicians as in the MCPAP model. A range of options which support strong working relationships between behavioral health providers and primary care providers should be developed and promoted. These options include, but are not limited to, coordinated services, co-location of services and fully-integrated services. The core elements of a successfully integrated model in cases where a behavioral health concern is identified, include, but are not limited to:

- the primary care provider having access to a behavioral health provider for clinical consultation, when needed; and
- connecting an individual or family either for a diagnostic evaluation, brief intervention or longer term services with a behavioral health provider of their choice, regardless of whether the provider is part of the integrated model.

Behavioral Health Consultations: A licensed behavioral health provider whether on site or not should provide "curbside" consultation to the primary care provider. These consultations might be brief. Access to psychiatric consults will likely be through a combination of on-site and off-site (including the potential for "virtual" or telemedicine consults – see Recommendation #22), since most primary care practices will not generate enough need to support a full-time licensed behavioral health care professional on site. In addition, provisions must be made to insure that all non-prescribing behavioral health practitioners have access to prescribers for those individuals for whom medication is indicated.

Care Coordination: Care coordination should also be available as a standard of care for all individuals receiving both primary and behavioral health care from multiple providers. For some, the PCP's on-going relationship means that they will be best able to provide

[34] http://www.mass.gov/eohhs/docs/masshealth/cbhi/mh-approved-screening-tools.pdf

care coordination. However, behavioral health providers might be better able to coordinate care for individuals with significant behavioral health conditions. One approach to coordination is the MA Child Health Quality Coalition's Care Coordination Task Force's Care Coordination Framework, which identifies a structure for implementing care coordination as a standard of care. The Framework was developed by a multi-stakeholder task force with strong family representation and builds on implementation experiences nationwide. It offers a foundational set of care coordination services that is broadly applicable independent of condition, severity/acuity, or age, including adults, with the obvious additions of references to schools and transitions from pediatric to adult care.

Key Elements of High-Performing Care Coordination Linked to Process, Structure, and Outcome Measures to Monitor Their Adoption

1. Needs assessment for care coordination and continuing care coordination engagement
2. Person-centered care planning and communication
3. Roles of peer supports as member of the care team
4. Facilitating care transitions (inpatient, ambulatory)
5. Connecting with community resources and schools
6. Transitioning to adult care

The care coordination model seeks to assist primary care clinicians and behavioral health providers to fill "the space between"[35] the appointments that the child and family need in order to address the primary care, behavioral health, social, and educational needs of the child. The success of this model is dependent on the engagement of the providers with the family, which in turn, can best be achieved by working with the parent, child and family as a whole to identify their strengths and preferences and by helping them build skills to have an active voice and choice in the services they receive. The value of "family voice and choice" is a foundation of the Wraparound model (a care planning approach) that is integral to the Children's Behavioral Health Initiative.

Prevention: Prevention of behavioral health disorders and the promotion of health, wellness and emotional wellbeing should be core components of an integrated model. Prevention should focus both on young people as well as adults. Research has shown the promise and potential lifetime benefits of preventing behavioral health disorders are greatest by focusing on young people and that early intervention can be effective in delaying or preventing the onset of such disorders.[36] Children's development into healthy adulthood should be supported through prevention and early intervention

[35] Richard Antonelli, MD. Presentation to the Children's Behavioral Health Advisory Council.
[36] National Research Council and Institute of Medicine. "Preventing mental disorders and substance abuse among young people: progress and possibilities. Washington, DC: 2009. National Academies Press.

services and supports. Families with risk factors for distress and impairment in the child should have access to, as well as support for, engagement with, helpful resources that are community-based and culturally competent.

Monitored for Effectiveness: Models of integration that are pursued by Massachusetts providers should be studied to monitor effectiveness and for the purposes of building an evidence-base. Monitoring should include studying the behavioral health and medical health outcomes of patients as well as patient and provider satisfaction. Outcomes should be measured using standards that support healthy development (in children) and recovery (for adults). Recommendations to assess the cost outcomes of alternative payment models used to support these clinical models are outlined in Recommendation #6. Until such an evidence base is developed, the Task Force encourages ongoing pilots of integrated care settings,[37] including those focused on the biopsychosocial models and the impact of including peers as part of a care team and careful attention to national demonstration projects and evidence based recommendations.

B. Reimbursement

The extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including: (1) how mental health parity and patient choice of providers and services could be achieved, and (2) the design and use of medical necessity criteria and protocols.

The Task Force recognizes that the financial structure of the fee-for-service system in the current health care delivery system does not reward improved health outcomes or responsive stewardship of private insurance premiums or the public dollars paid through Medicare and Medicaid. The Task Force supports the development of alternative payment methodologies to advance these goals. For instance, global payments that reimburse providers a fixed fee based on their enrolled patient panel allows more autonomy to allocate professional staff time tailored to the intensity of needs of the individual or family. This model is being implemented in commercial, Medicare and Medicaid settings and allows providers to assign non-clinical staff to coordinate care and to provide additional support to individuals and families outside of direct service time. In particular, the Task Force believes that the use of peers and family partners adds value to health care delivery in two ways: their presence helps the individual engage more fully in care, and they provide an additional resource to the clinician to address gaps in "the spaces between" the care the individual or his/her family receive.

[37] Including, but not limited to, the Patient Centered Medical Home, integrated risk bearing provider organizations, and the Behavioral Health Home.

The Task Force recognizes that several key components of a high quality integrated program – behavioral health screening, care coordination and deployment of peers and family partners – are missing in the current fee-for-service reimbursement structure and need to be added in the absence of a global payment model that is comprehensive enough to improve outcomes and achieve cost savings through reduced use of more restrictive and costly health care services.

In addition to specific services to be reimbursed and alternative methods for paying for them, the Task Force also recommends investing in important systems infrastructure and supports, e.g., MCPAP and community-based prevention and wellness programs.

2. Ensure reimbursement for behavioral health screening for all children across all payers.

Rationale: Nationally, the average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years – critical developmental years in the life of a child.[38] Behavioral health screening using validated tools provides an effective, evidence-based approach for increasing early identification and intervention, which can both improve outcomes and reduce the costs of mental illness.[39] Since 2008, MassHealth has required and reimbursed PCPs to conduct behavioral health screening at well child visits (up to age 21) as required by Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) provision.[40]

Implementation Action Steps: All payers should be required to reimburse PCPs for administration, scoring, and interpretation of behavioral health screening at every well child visit for children up to age 21. All PCPs must be educated about their obligation to provide behavioral health screening; particularly providers in the adult system who care for transition-age youth (18 to 21) and might be unfamiliar with this requirement. Reporting must occur on a frequent and on-going basis in order to monitor and improve practice at this critical first step in accessing behavioral health care services.

The behavioral health screening requirement should be broadened in two ways. First, post-partum screening at well child visits for parents of children ages 0 to 6 months should be covered by the behavioral health screening requirement. Some providers have explained the low rate of screening for this age group as due to the lack of an

[38] Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, American Academy of Child and Adolescent Psychiatry. 2012

[39] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

[40] http://www.mass.gov/eohhs/docs/masshealth/cbhi/mh-approved-screening-tools.pdf

appropriate screening tool.[41] Postpartum depression has a significant adverse effect on young children's cognitive and emotional development in the preschool years. Treating maternal depression improves the cognitive and social emotional development of young children even in the absence of any direct intervention with the child.[42]

Second, reimbursement for both a mental health screening and a substance abuse screening in a single visit should be allowed when the PCP deems it necessary for a youth's health. Currently, providers are limited to one screening and must choose between screening tools that may not cover both mental health and substance abuse.

Despite the potential benefits of universal screening, its limitations, including low yield of true cases, costs associated with follow-up of positive screens, and insufficient resources for subsequent behavioral health evaluation and treatment, should be considered and addressed. Moreover, providers must be informed about the limits of screens and have access to more thorough diagnostic and assessment services when indicated.

Some Task Force members are concerned that too often, medication is prescribed to children too quickly and that care should be taken to ensure that a positive mental health screen does not automatically lead to treatment with medication alone. Some Task Force members believed that there must be safeguards to require that any child screened positive for mental health needs receives a thorough psychosocial evaluation including a family evaluation before medication is administered. However, other Task Force members disagreed with this argument noting that it is within the scope of a PCP's practice to prescribe medication to treat target symptoms (e.g., those that may appear with ADHD) and it is a medical judgment that PCPs are trained and qualified to handle. In addition, some believed that by requiring a thorough psychosocial evaluation, it is possible that clinically and necessary appropriate treatment would be withheld or delayed while awaiting this evaluation. The Task Force ultimately agreed that, where possible, a full evaluation of the child and his or her environment should be undertaken prior to prescription of psychiatric medication. Where it appears in the child's best interest to begin medication immediately, a full evaluation should occur as soon as possible after the start of the medication regimen.

[41] Rosie D. and Mental Health Screening. A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University, Fall 2010.
[42] Beardslee WR et al. "Children of affectively ill parents: A review of the past 12 years." *J of Am Academy of Child and Adol Psychiatry*, 50, 1098-1109, 2011.

3. Peer supports, including family partners and youth mentors, should be a standard of care. Programs to assist the training and credentialing of peers should be developed and standardized.

Rationale: Peer supports, family partners and youth mentors (broadly referred to as peers in this recommendation) provide a unique and important role in the delivery of behavioral health care and can enhance the care that is provided in integrated settings. [43] Studies have shown that the use of peers can improve health outcomes including decreased hospitalizations,[44] improve quality of life and reduce the number of major life problems.[45] Peers also play an important role in increasing access as they have the potential to reach individuals who may not otherwise receive care, especially behavioral health care and are viewed as more credible by some individuals.[46] Studies suggest that use of peers reduces the overall need for behavioral health services over time and, when used as part of hospital-based care, results in shorter hospital stays, decreased readmissions and overall reduction in cost.[47]

The Task Force recommends that payment cover the cost of, promote and encourage the use of, peer support, certified peer specialists and long-term support services, including those traditionally outside the medical model of care subject to appropriate training and credentialing.[48] Twenty-two states provide reimbursement for peer support through their Medicaid program.[49] Today, MassHealth reimburses family partners as part of the Children's Behavioral Health Initiative (CBHI). On a smaller scale, MassHealth has funded "Therapeutic Mentor" services to support skill building and effective use of treatment by youth.

Implementation Action Steps: Provider organizations should use peers as part of normal day-to-day patient care to reduce stigma and support individuals in treatment of their behavioral health disorder. Peers should come from the communities of the people

[43] The expanded presence of peer providers in the health care system has the added benefit of combatting stigma that contributes to health disparities faced by persons with behavioral health histories.
[44] Simpson E and House A. "Involving users in the delivery and evaluation of mental health services: systematic review." *BMJ* 2002, November 30; 325 (737): 1265.
[45] Felton CJ et al. "Consumers as peer specialists on intensive case management teams: impact on client outcomes." *Psychiatr Serv.* 1995 Oct; 46(1): 1037-44.
[46] Amy Woodhouse and Ashley Vincent. "Development of peer specialist roles: a literature scoping exercise." Scottish Recovery Network and the Scottish Development Centre for Mental Health. August 2006.
[47] Chinman, M., Weingarten, R., Stayner, D., and Davidson, L. (2001). Chronicity reconsidered: Improving person-environment fit through a consumer run service. *Community Mental Health Journal, 37(3)* 215-229.
[48] For other services typically offered outside of the medical model of care see L. Goodman et al., "Within and Beyond the 50-Minute Hour", 69 *J. of Clinical Psychology* 182-90 (2013).
[49] Daniels, A., et al. "Pillars of peer support – 2: expanding the role of peer support services in mental health systems of care and recovery. February 2011. http://www.pillarsofpeersupport.org/POPS2010-2.pdf

that are served. As a first step, commercial and public health insurers must recognize the role that trained peer supporters play and allow for their services to be reimbursed as a unique provider type. Many Task Force members prefer that credentialing or certification be a requirement for reimbursement as a unique provider type under the fee-for-service payment system. These Task Force members note that without certification requirements, the standard of peer support provided could vary. However, within an integrated risk bearing provider organization that receives global payments, the Task Force agreed that a provider organization should bear the responsibility of training and be encouraged to use trained peer supports, whether certified or not. The Task Force recommends that at a minimum, training of peer supports (either by integrated risk bearing provider organizations or as part of a certification process) include:

- education on privacy and their responsibility for maintaining confidentiality;
- how to provide information and support for physical health conditions or concerns;
- how to give assistance with independent living skills and productivity issues;
- developing social and recreational skills;
- crisis planning; and,
- developing recovery and resiliency skills.[50]

Integrated risk bearing provider organizations must make a reasonable attempt to hire peers who are culturally similar to the population served.

4. Behavioral health services should be included in alternative payment methodologies.

Rationale: Where integrated service models are focused on providing holistic care, behavioral health services are an essential component of an integrated model. Because integration models may differ in levels of integration, the scope of behavioral health services to be provided and reimbursed will also differ based on the model. The provision of integrated behavioral health services, including peer supports, is likely to generate cost containment and improved health outcomes through reduction in unnecessary emergency room usage, avoidable hospitalizations, avoidable re-admissions, and unnecessary office visits. Where a comprehensive set of behavioral health coverage is included within an integrated model, payment should also reflect a comprehensive level of funding for behavioral health services and shared savings models for the total cost of care must include behavioral health providers.

[50] Certified peer support worker training program. Office of Consumer Affairs. New Mexico Behavioral Health Collaborative. http://www.bhc.state.nm.us/BHConsumers/OCACertPeerSpecialistTraining.html

Many Task Force members expressed concerns with identifying funding for new services when many behavioral health providers do not receive adequate compensation for services that are currently provided.

Implementation Action Steps: Reimbursement or the provision of the following services (in the case of global payments) should be standard within an integrated risk bearing provider organization:

- preventive screenings;
- prevention services and supportive services in primary care settings;
- short term behavioral health intervention (at a minimum), with provisions for appropriate referrals for diagnostic assessments, longer term treatment, specific evidence-based treatments and access to community-based behavioral health services;
- peer support;
- visits with parents without their child present when the focus of the visit is the child's healthcare needs;
- care management;
- care coordination;
- collateral contacts with schools and significant members of the individual's social network;
- long-term support services, including those traditionally outside the medical model of care; [51]
- consultative services including telephonic and by other electronic means; and,
- family consultation and social network therapy.[52]

Rates for consultation time by behavioral health providers must be set commensurate with rate for direct care provision for the identical service which may be based on licensure category, training experience and scope of practice. For instance, MA Licensed Alcohol and Drug Counselors I (LADC I), hold licenses that require education, training and experience on par with other reimbursed behavioral health clinicians such as Licensed Independent Clinical Social Workers (LICSW) and Licensed Mental Health Counselors (LMHC), and their services should be reimbursed accordingly.

Reimbursement methods must cover the cost of adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment

[51] *See, e.g.,* L. Goodman et al., *Within and Beyond the 50-Minute Hour*, 69 J. of Clinical Psychology 182-90 (2013) for other services typically outside the medical model of care
[52] Such as Open Dialogue

services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care.[53] Accordingly, reimbursement methods must cover the cost of adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. To ensure that the integration of current or new services is successful, the state should study the success of these integration models and inclusion of broader reimbursement on the overall health care spending trend and individual outcomes for both physical and behavioral health care.

Commercial insurers should be required to pay for outpatient methadone treatment services for persons with opiate addiction. Currently, this evidence-based treatment is primarily reimbursed by Medicaid and BSAS dollars pay for persons with commercial insurance. In the context of global payment methodologies, payment for these services may reduce overall health care spending. As a first step in the process, the Legislature should direct the Massachusetts Center for Health Information and Analysis (CHIA) to conduct a study of the cost/benefit of an additional mandate as required by M.G.L. c. 3 § 38C which requires an upfront review of the impact of mandated benefit bills.

Achieving Chapter 224's quality and cost goals requires a broader view of what it means to treat behavioral health and physical health conditions on par with each other. Focusing solely on the amount of services will not be sufficient as PCPs become dependent on the quality of and access to behavioral health services. Quality behavioral health services can help improve primary care outcomes and costs if they are broadly available as well as reimbursed sufficiently and in a manner that allows them to be delivered as recommended in this document. There must be a full array of community-based behavioral health services available to individuals s regardless of where they live and what health insurance they have. Currently, MassHealth offers more services than private insurers, particularly for children. Commercial insurers will need to offer an equally broad array in order to achieve quality and cost outcomes for all individuals. Parity also needs to include support for behavioral health interventions (e.g. talking to the patient or family) at a rate based on time and complexity commensurate with rates that support physical health interventions. Reasonable rates will help ensure a sufficient number and range of behavioral health providers and services.

As new payment methodologies are put into place it is important to note that there are many behavioral health providers who are interested but not currently ready to accept risk, and will need assistance in building infrastructure and reserves. The state should make technical and financial assistance available to interested solo practitioners and groups regarding the adoption and use of interoperable EHRs, and the management structures necessary to collaborate with integrated risk bearing provider organizations.

[53] Ibid.

5. Insurance Carriers must comply with the Massachusetts parity laws, which state that "…neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services." Ch. 80 of the Acts of 2000; Division of Insurance Bulletin 2000-06.

Rationale: Although the law, Chapter 80 of the Acts of 2000, An Act Relative to Mental Health Benefit, (Parity Law), and subsequent Bulletins released by the Division of Insurance, clearly state that Neuropsychological Testing (NPT) must be treated as a medical benefit and must be covered to the same extent as all other medical services, there are serious challenges that establish barriers and prevent access to care. These include inconsistent standards among payers which result in unnecessary barriers to evaluation and treatment for children in need of NPT; and processing problems and delays that result in unnecessary barriers to evaluation and treatment.

Implementation Action Steps: The Division of Insurance (Division) should issue a Bulletin for insurance companies under the Division's regulatory domain clarifying Neuropsychological Testing as a medical benefit for diagnostic, baseline and follow up of disorders that meet medical necessity criteria. In the Bulletin, the Division should direct health plans to follow section 207A of Ch. 224 of the Acts of 2012 and use standardized prior authorization forms for NPT and render decisions on prior authorization as directed by law.

In addition, the Division should require uniform standards for all insurers, including:

- Credentialing psychologists and neuropsychologists who administer NPT as medical and mental health providers. Make these names readily accessible to insurance personnel, so parents are not told that a provider is "out of network" or not on the insurance panel;
- Consistent/ uniform prior authorization forms and standards. The process should be similar to that used for any other medical study or specialist visit; and,
- Authorizations of adequate hours, based on a clinician's professional judgment, to administer, evaluate, integrate findings, and follow up with families.

6. Alternative payment systems must include quality and financial measures of behavioral health integration. Whenever possible these measures should reflect some uniformity across integrated risk bearing provider organizations so that the long-range goal of sharing best practices and determining which models are successful can be done on the basis of meaningful comparisons.

Rationale: In order to promote and support behavioral health integration among alternative payment systems, quality and financial measures that assess the level of the integration, and it ability to impact and improve health outcomes for individuals with medical and behavioral co-morbidity, should be part of the model.

Implementation Action Steps: All alternative payment models should include measures of quality, health outcomes and cost effectiveness, in both the short-term and in the long-term. Quality measures should include outcome in addition to process measures. They should reflect the goals of the service delivered and the goals of the treatment plan. Outcomes measures based on standardized tools that have been developed to assess improvement in recovery should be included, e.g., Milestones of Recovery (MOR) Scale[54]; Recovery Measurement Tool (RMT) as well as to the degree services are recovery-oriented. Those alternative models must include some measurement of behavioral health integration and the outcomes expected from a well-integrated care setting, including process and outcome measures, including the impact on medical – behavioral co-morbidity.

Measures must be valid, reliable and non-onerous, and available for all services and levels of care to the extent such measures exist. As much as possible, measures should be standardized and aligned with other large measure sets such as those identified within the Affordable Care Act, by the Joint Commission and Healthcare Effectiveness Data and Information Set (HEDIS) or overall Massachusetts health quality initiatives. Uniformity of measures would assist in the ability to determine best practices. The Department of Mental Health, Department of Public Health, and the Health Policy Commission should strive to develop recommendations, with input from providers and people with lived experience, as well as other stakeholders and experts, on a set of uniform measurements.

Financial measures should include long term measures on the cost outcomes of integration, including explicitly the effect on the medical-behavioral comorbidity of the population. They should also include the impact of behavioral health services on short

[54] http://www.milestonesofrecovery.com/

and long-term physical health care costs. In addition, the outcomes measures should be monitored over time to assess any unintended consequences.

7. Alternative payment systems should be funded adequately to support insured populations, must be transparent and must prohibit incentives to limit access to behavioral health care. Provisions for gain-sharing with integrated risk bearing provider organizations must include all providers, including behavioral health.

Rationale: Integrated behavioral health care can be cost effective. One study found that reimbursing primary care clinics for up to 10 mental health visits and 20 substance use visits per year resulted in a 57 percent decrease in inpatient psychiatric days per thousand days and a 12 percent decline in emergency room visits within the treatment group.[55] In addition, integrated behavioral health care can reduce the cost of medical care. For example, treating depression among individuals with diabetes has been found to reduce the overall cost of diabetes care.[56] Those who provide integrated behavioral health services need to be recognized for their contribution to decreases in costs by ensuring the opportunity to gain in any shared-savings programs within integrated care settings.

While behavioral health providers should have the opportunity to benefit from any shared- savings programs, financial incentives within alternative payment systems should promote and not inhibit access to quality care. In the 1990's, managed care organizations, which had financial incentives to keep costs under their capitation payments, earned a reputation for keeping their costs low by denying necessary care. To protect the public, financial incentives under alternative payment arrangements should be monitored closely to ensure that they do not impede best practices and that they are tied to quality, not just cost. Individuals receiving services also deserve to know under what financial incentives their providers operate.

Implementation Action Steps: Alternative payments to providers must have sustainable funding that takes into account the rate of reimbursement under non-integrated fee-for-service models, includes a risk adjustment for the patient population served, and allows for flexibility in the types of services delivered in order to meet patient and family needs. Payments should promote access to behavioral health services, as appropriate. Any shared savings or gain-sharing must include the return to behavioral health providers of an explicit portion of the savings that accrue to either behavioral health or medical budgets as a result of integration. Integrated systems' gain

[55] CMSP Behavioral Health Pilot Project – Brief Findings Summary. The Lewin Group. 2011
[56] Katon, W et al. "Cost effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression." *Diabetes Care.* 29: 265-270, 2006.

sharing including those of primary care physicians should include meaningful and significant measures of integration and improvement in behavioral health measures in addition to traditional measures of medical care. Bonuses or outcomes for alternative payment arrangements must be based on outcomes of progress towards healthy development, recovery and wellness, and the quality of care provided. Financial incentives to providers must be transparent to the public and monitored overtime to assess any unintended consequences.

8. Commercial plan medical necessity should be transparent and expanded to include payment for services that are designed to assist individuals attain or maintain functioning, such as recovery and transitional support services, residential recovery homes for persons with substance use disorders, and funding for long term services and supports, rehabilitation and support.

Rationale: A broader definition of medical necessity is in keeping with the ten components of recovery published by SAMHSA as an outcome of the New Freedom Commission on Mental Health. Such a definition would protect the reimbursement of services and supports by peers working to assist persons in their roles as wellness, job, and life coaches, which optimize their recovery and wellness. It would also create an opportunity for peers to work as personal care assistants. Some Task Force members raised concerns that this expansion may divert needed clinical funds to non-clinical interventions and that existing services, such as vocational rehabilitation already exist and do not need to be completely recreated.

In addition, portions of Chapter 224 such as parity monitoring, external appeal to the Office of Patient Protection (OPP), behavioral health integration and transparency of cost and quality are to be implemented currently; however, their implementation requires access to the medical necessity and utilization review criteria in order to be effectively implemented.

Implementation Action Steps: Section 199 of Chapter 224 of the Acts of 2012 requires the public disclosure by insurers of utilization review criteria. Task Force members believe that these criteria are used by payers to determine the medical necessity of services, and hence relate directly to access to healthcare. The release of these criteria is set for October 1, 2015. The Task Force recommends an immediate release of this information to assist in behavioral health integration, including assisting providers in knowing which conditions will be covered under health insurance. Transparency of medical necessity criteria and protocols is also necessary to the oversight of parity.

In addition to the release of commercial medical necessity criteria and protocols, there should be an expansion of Massachusetts' Medicaid medical necessity definition to be

closer to Michigan's Medicaid definition of medical necessity, which includes: "Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment [which are]: Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity." Michigan received a waiver from the Centers for Medicare and Medicaid Services (CMS) to implement this definition.

9. There should be no prior authorization required by insurers for admissions to inpatient psychiatric or inpatient detoxification facilities, or for Clinical Stabilization Services.

Rationale: Prior authorization requirements for behavioral health patients who need intensive levels of service as determined by the treating health care provider raise the specter of violations of federal and state mental health parity laws, and for emergency medical conditions – including behavioral health emergencies – of EMTALA. Task Force members note that while there may be some basis for such requirements for elective procedures, federal and state parity law clearly state that insurers are required to treat behavioral health patients no more restrictively than medical-surgical patients. Patients who are deemed medically appropriate for intensive levels of mental health and/or substance abuse services along the continuum of care have already undergone an evaluation and determination by the treating healthcare provider that the patient has a serious condition requiring an intensive level of care. Such patients should be treated no differently from any patient suffering from a serious medical condition (e.g., pneumonia, acute cardiac condition, stroke, trauma), for whom there is no requirement that the patient or provider seek prior authorization to provide the necessary intensive level of care. However, both public and private health plans require additional authorization for inpatient and step-down levels of care for serious mental health and substance abuse conditions. Therefore, this recommendation proposes that the requirement for prior authorization for inpatient and step-down mental health and/or substance abuse services be removed by all insurers, including MassHealth. The recommendation is not meant to change the role of Emergency Service Providers (ESPs) in helping to determine diversionary levels of care nor is it meant to eliminate a pre-screening prior to an involuntary psychiatric admission.

Implementation Action Steps: The Task Force recommends elimination of payer practices requiring prior authorization for coverage of inpatient and step-down level of services for the care and treatment of mental health and substance abuse services that are not imposed on equivalent physical health care services through the adoption of statutory, regulatory or contractual provisions as necessary to accomplish this

recommendation. Some Task Force members expressed concern that elimination of prior authorization could result in post-admission denials of coverage. These members urged that implementation of this recommendation include protections for providers, particularly inpatient providers, who accept patients based on the referring clinician's determination of medical necessity. Although not all Task Force members support the requirement of assessment by an Emergency Services Program (ESP), as is currently in place for MassHealth members, the Task Force does recognize the importance of assuring that alternatives to hospitalization, especially involuntary hospitalization, are fully explored and made available where appropriate. Whatever form this process takes, the Task Force recommends that it not be in the nature of prior authorization.

As part of this discussion, some members of the Task Force voiced concerns about the number and frequency with which involuntary psychiatric admissions occur. They are concerned that without any oversight of the inpatient psychiatric admission process more involuntary admissions will take place. Instead of eliminating prior authorizations, these Task Force members recommended a process whereby advanced directives would be required for all individuals enrolled within a risk-bearing integrated provider organization in order to be referenced prior to any admissions. However, the majority of Task Force members disagreed with this notion, noting that the process described would be difficult to achieve. To ensure that elimination of this barrier does not inadvertently lead to instances of unwarranted involuntary admission, Task Force members agree that the Commonwealth should undertake a public information campaign to increase awareness about the use of advanced directives and other alternative programs and services that promote care in the least restrictive setting.

How current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high-quality behavioral substance use and mental health outcomes.

10. The Massachusetts Department of Public Health (DPH) should expand its current efforts to review regulations to identify and remove barriers to integration, and MassHealth should undertake a similar process to review its regulations to identify and remove barriers to integration, such as provider and site specific payment structures and payment equity.

Rationale: The Task Force commends the Department of Public Health for setting up a system to allow for a multi-agency review of regulations. In that review, DPH found one of the largest barriers facing primary care practices is the inability to bill for same-

day visits, that is, reimbursement for a primary care visit and behavioral health visit on the same day. This, in addition to other MassHealth regulations, is a barrier to the integration of primary and behavioral health care. The Association of Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) outlined what they considered to be DPH and MassHealth regulatory barriers. Summaries of both are provided in Appendix F.

Implementation Action Steps: DPH should be encouraged to continue its internal high-level review of regulations. It should begin to develop recommendations on how to overcome the most common barriers faced by primary care providers who are attempting to integrate with behavioral health providers. In addition to removing barriers, DPH, in concert with MassHealth, should consider the financial impact of regulatory changes and the Legislature must ensure adequate funding to support the time and effort required to promulgate regulatory changes.

In order to promote integration, MassHealth should allow for the reimbursement of behavioral health care and physical health care on the same day. This can help facilitate a smooth hand-off and ensure continuity and coordination of care. In addition, MassHealth should activate its fee-for-service billing codes for brief assessment and intervention services, using the federally-approved Health and Behavior codes.

Task Force members also recommend a number of related changes to MassHealth reimbursement, including:

- Current procedural terminology (CPT) codes as recognized by the AMA and CMS should be reimbursed regardless of which licensed discipline provides the service, as long as the service is in their statutory scope of practice.
- Massachusetts should increase its Medicaid reimbursement to equal Medicare payment rates, as is available under the ACA for primary care physicians and other specialty providers.[57]
- MassHealth should reimburse all behavioral health CPT codes, including the following codes which at present are inconsistently reimbursed despite the importance of these services to integrated care: diagnostic evaluation with medical services (90792), crisis (90839 and 90840), family therapy without patient (90846), multiple family group therapy (90849), evaluation of records (90885), preparation of report (90889), new (99201-99205) and established (99211-99215) office care, initial (99221-99223) and

[57] While the ACA does allow for enhanced rates for physicians to meet current Medicare payment rates, this provision of the ACA has not been implemented to date, even though the legislation called for implementation for a two year period beginning on January 1, 2013.

subsequent (99231-99233) hospital care, office consultation (99241-99245), inpatient consultation (99251-99245), emergency department visit (99281-99285), interactive complexity (90785) codes, and all psychological and neuropsychological assessment codes and health behavior codes.

- MassHealth should allow psychologists to provide services to the full extent of their statutory scope of practice.
- Providers of behavioral services for integrated medical-behavioral care and for health promotion and behavioral factors in physical disease management should be able to utilize all diagnostic codes in the ICD and not be forced to assign inappropriate behavioral health diagnoses.
- When behavioral health providers are co-leading a medical group visit with a medical provider, both providers should be able to receive reimbursement for such a group to encourage this type of collaboration, not just one-on-one interventions.
- All payers should reimburse for 2-3 hours of 96116 (brief neurocognitive assessment) by psychologists. Some currently do and others do not. This is a cost-effective option for patients who may need more than just a cognitive screen by their PCP, but less than a full neuropsychological battery.
- Medicaid should develop a cross walk between the DC: 0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition) to the DSM-V for use in seeking payment for services for children from birth to five years of age. Mental health clinicians treating young children and their families utilize DC:0-3R for diagnostic guidance, yet cannot use these codes for billing purposes. Instead, they are required to bill under generic codes that do not fully reflect the treatment they are providing. A tool such as a crosswalk is needed to link DC: 0-3R with the DSM, in order to standardize diagnosis and to increase transparency between clinicians, administrative staff, and payers.

11. Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day. Allow for brief intervention services to be billed before a full assessment is completed.

Rationale: When a primary care provider identifies a potential behavioral health disorder, individuals are more likely to receive recommended follow-up care or referral visits if they occur on the same day as the initial visits through a "warm hand-off" or

personalized introduction by a primary care provider to a behavioral health provider.[58] Identifying behavioral health disorders and treating them prior to a crisis situation may provide significantly improved outcomes and reduced overall spending. This recommendation proposes that prior authorization for initial behavioral health visits be removed by all insurers.

Implementation Action Steps: The Task Force recommends that MassHealth[59] and other payers adopt a policy limiting insurers' abilities to require prior authorization for initial behavioral health visits.

12. Quality and outcome measures should be developed that consider the impact of payment methodology on caseload numbers; organizations that are responsible for integrated behavioral health services should be held accountable for quality and outcome measures that are caseload sensitive.

Rationale: As alternative payment methodologies are being developed, it is important to consider the unintended consequences of certain population-based methodologies, such as global payment, on quality of care. Some argue that global payments reward providers for volume by incentivizing them to have higher caseloads. One study suggested that there is a link between high caseloads, the time spent with the person receiving services, and the quality of care.[60] However, in many alternative payment arrangements, quality or outcome standards must be achieved in order to share in savings or receive bonus payments.[61] For example, the 2012 NCQA ACO Standards and Guidelines require that risk-bearing provider organizations ensure the availability of practitioners who provide primary and specialty care by requiring the provider organization to establish quantifiable and measurable standards for the number and type of each practitioner providing care, the geographic distribution of those providers and analyzes the provider performance against the standards and patient experience with the availability of those providers. Quality measures could be developed to assess compliance with this standard. Without standardized quality and outcome metrics focused upon behavioral health, it is possible that the incentive for providers to carry unnecessarily high caseloads may still exist. High caseloads also do not account for new work required in an integrated setting – including case collaboration with primary care providers, collateral contacts with families, or individual support systems and accurate

[58] Mauch, D., Kautz, C., and Smith, S., "Reimbursement of Mental Health Services in Primary Care Settings" U.S. Department of Health and Human Services, Substance Abuses and Mental Health Services Administration, February 2008.
[59] MassHealth does not require prior authorization for the first twelve visits. After that, authorization for additional visits is required.
[60] H. Balkrishnan et al. "Capitation payment, length of visit, and preventive services." *Am J. Managed Care.* 332-340 (2002).
[61] Robinow, A. "The potential of global payment: insights from the field." *The Commonwealth Fund.* February 18, 2010.

record keeping. Therefore, the Task Force recommends that quality and outcome measures be developed that consider the impact of payment methodology on caseload numbers and that organizations that are responsible for integrated behavioral health services be held accountable for those quality and outcome measures.

Implementation Action Steps: As a first step to implementation, the Health Policy Commission should convene an independent body of experts to include, but not be limited to behavioral health providers, provider organizations, payers, and persons and families with lived experience to research and study the implications of population-based payment methodologies on the caseloads of behavioral health providers. Research should include the examination of other caseload standards in the health care field, especially those that may have been developed or used by behavioral health providers.

As part of its research, the independent body of experts should look to existing formulas utilized by the Center for Health Information and Analysis (CHIA) under Chapter 257 of the Acts of 2008 in the development of unit rates for EOHHS purchase of service (POS) contracts. These formulas take into account expected types of interventions and desired outcomes, types of providers delivering the intervention and caseload as determined by utilization as well as any regulatory and/or contractual requirements in certain care settings purchased by EOHHS agencies. Such formulas are utilized, for example, in all contracted and licensed inpatient and outpatient addiction recovery programs operating under the auspices of the DPH, Bureau of Substance Abuse Services (BSAS). It is expected that caseload standards would vary by behavioral health provider type and care setting type. In addition, different factors might need to be incorporated into formulas for children and adult caseloads. The standards need not result in a single ratio, but in a range and should be subject to modification over time.

The quality and outcome measures should be encouraged to be used by integrated risk-bearing organizations to ensure their capacity to provide high quality behavioral health care. As part of the certification process, risk-bearing organizations should be required to report on arrangements with behavioral health providers (exclusive vs. non-exclusive), the ratio of behavioral health providers to enrollees (broken down by specialty and enrollee type) and geographic accessibility to those providers. Data should be collected relative to the impact on the health and robustness of the provider network within these new care models with particular attention to the impact on the network's ability to meet the clinical needs of the population served.

13. Ensure full and appropriate funding for MCPAP based on a contribution from commercial insurers for the percentage of their members who benefit from the program.

Rationale: The Massachusetts Child Psychiatry Access Project (MCPAP) provides broad access to child psychiatry consultation and has become the statewide solution for the current and projected shortage of child psychiatrists, which in the past led to significant problems for families to access child psychiatry. On an annual basis MCPAP provides assistance to 80 percent of the Commonwealth's primary care practices serving 98 percent of the state's youth. In FY 2013, MCPAP is projected to serve over 10,000 youth with over 20,000 encounters. It has improved provider satisfaction with their ability to access psychiatric care for their patients and has achieved high rates of parent and family satisfaction. MCPAP has become a model for the country, with over 25 states implementing similar consultation programs. It has received national recognition in the literature[62,63] and by the Agency for Healthcare Research and Quality.[64]

MCPAP provides its services to any PCP, regardless of a child's insurance source. Sixty percent of youth served have commercial insurance and 40 percent of youth served have public insurance. Today, one hundred percent of its funding is supported by the Massachusetts Department of Mental Health.

Implementation Action Steps: A "user fee" should be assessed on commercial insurers, commensurate with providers' use of MCPAP.

As integrated risk bearing provider organizations become established, their global payments should be calculated to support their providers' continued use of psychiatric consultation. MCPAP provides a cost-effective statewide resource that should continue to be leveraged.

14. Expand the role and fund the capacity of communities to identify local needs and promote health and wellness and other prevention programs.

Rationale: Communities play a unique role in their ability to change the systems and organizations that impact people's lives every day, including the schools, worksites and the community itself. The community in which a person lives can have profound

[62] The Commonwealth Fund. Case Study: High Performing Health Care Organization: The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care, March 2010;
[63] Barry Sarvet et al. "Improving access to mental health care for children: The Massachusetts child psychiatry project. *Pediatrics*, Volume 126, Number 6, Dec 2010
[64] "Regional teams enhance ability of primary care clinicians throughout Massachusetts to serve children and adolescent with mental health issues." *Agency for Healthcare Research and Quality.* http://www.innovations.ahrq.gov/content.aspx?id=3058&tab=1

impacts on his or her medical and behavioral health outcomes. It is incumbent upon the communities and community leaders of Massachusetts to devote attention to prevention and the promotion of health and wellness.

Chapter 224 created a Prevention and Wellness Trust Fund (the Fund), administered by DPH. All activities paid for by the fund must support Massachusetts' goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming. The Commissioner of DPH must award at least 75% of the fund each year through a competitive grant process to community-based organizations, public and private sector health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need.[65]

Implementation Action Steps: Funds from the Fund should be earmarked for programs that target particular high-risk groups and programs that intervene with those already involved in high risk behaviors. As a first step, DPH should take a strategically long-term approach to managing this Wellness Fund by investing, in part, in children's well-being. Funds should be distributed toward childhood prevention strategies of exposure to toxic stress and adverse childhood experiences (ACE). The Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations. DPH could utilize ACE data, along with other sources, to guide its grant-making and leverage existing initiatives that incorporate a recovery and trauma-focus into service delivery.

Distribution of funds to promote wellness in children and families should be prioritized to grantees who demonstrate the capacity to use evidence-based or emerging practices such as the Strategic Prevention Framework, a five step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span.[66] It has been designed to assist communities in identifying specific prevention needs and tailoring prevention messages to those needs.

At the same time, there must be investment in wellness activities that are culturally and linguistically sensitive and competent, and designed to address recognition and

[65] Anna Gosline and Elisabeth Rodman "Summary of Chapter 224 of the Acts of 2012." *Blue Cross Blue Shield of Massachusetts Foundation*. September 2012

[66] Substance Abuse and Mental Health Services Administration. Strategic Prevention Framework. http://www.samhsa.gov/prevention/spf.aspx

integration of physical and behavioral health at the level of routine care, so that issues are recognized and treated before they become severe. These activities would have the double advantage of mitigating health care costs with early intervention and diminishing the stigma of mental illness and substance use disorders that has been discussed elsewhere in this report. For example, funds could be used to develop and research innovative strategies to provide integrated and behavioral health care, such as the expansion of peer run providers and the expansion of training of peer providers throughout the Commonwealth, or to expand the use of emotional CPR (eCPR) in the workplace and in schools.

The Fund's investments should be evaluated for return on investment (ROI).

C. Privacy

What are the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable health records?

There are differences in privacy concerns across populations, but as noted in the background section above. There are particular concerns regarding the use of information from behavioral health treatment both within and outside of the health care system, particularly in schools and the legal system. There are numerous state and federal privacy laws that provide parameters to what can and cannot be shared. For example, the Health Insurance Portability and Accountability Act (HIPAA) together with numerous provisions of Massachusetts law provides broad protection of individually identifiable health information. In addition, the Federal Drug and Alcohol Confidentiality Law (42 CFR Part 2) provides additional protection relating to individuals with or who seek treatment for alcohol or other substance use problems. 42 CFR Part 2 applies broadly to any program that provides alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention and is "federally-assisted" and requires specific written authorization by an individual to share information on substance use, diagnosis and treatment at the point of each potential disclosure.

The Task Force recognizes that stigma and discrimination are significant problems for individuals with behavioral health disorders. The recommendations below aim to balance stigma and consumer choice, current federal privacy laws, and the importance of providers understanding the totality of a patient's needs in order to provide optimal care and obtain optimal health results.

15. There must be a respectful equilibrium, or balance, between what information providers need to deliver quality care and what the individual needs to seek and receive appropriate care.

Rationale: Electronic health records (EHRs) are a potentially useful tool in providing effective, efficient, integrated and safe health care. Electronic health records are broadly defined as longitudinal electronic records of patient health information generated by one or more encounters in any care delivery setting and can include information such as: patient demographics, diagnosis progress notes, problem lists, medications, vital signs, past medical history, diagnostic results and more.[67]

Since the majority of mental health and substance use needs are addressed within the primary care practices, EHRs, and information sharing generally, are especially critical for a primary care physician to provide safe high quality care to patients, particularly in managing the care of these complex patients. EHRs can assist primary care teams in providing important components of primary care, including complex care management, medication management, reminders for timely care (like administration of screening tools), and warnings for adverse interactions, outcome reports and follow-up lists for a population of patients. For example, physicians in Massachusetts with access to electronic problem lists performed better on quality measures related to depression (as well as other measures) compared to physicians not using electronic health records.[68]

However, barriers to including behavioral health information within the electronic health record exist – including lack of standardization for inclusion of behavioral health care processes within the electronic record, and important privacy and confidentiality concerns. As reported by both individuals and family members, as well as providers, confidentiality is a basic requirement of persons seeking behavioral health services and the lack of such confidentiality may result in individuals avoiding care or being less forthright while engaging in services. Individuals with behavioral health disorders and some providers are also concerned by the impact of real and perceived stigma on the quality of integrated health care. The Task Force heard from individuals with lived experience that were inappropriately treated for physical health conditions based on a provider's knowledge of a behavioral health diagnosis. A new survey of providers found that providers, including mental health providers, view patients with serious mental illness more negatively than those without and that these attitudes impact treatment decisions, including referrals.[69]

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[67] Healthcare Information Management Systems http://www.himss.org/ASP/topics_ehr.asp
[68] EG Poon et al. "Relationship between use of electronic health record features and health care quality: results of a statewide survey." *Medical Care* March 2010, Volume 48, Issue 3, pp 203-209.
[69] Jeffrey, S. "Psychiatrists not immune to mental health bias." *Medscape*, May 21, 2013.

The Task Force spent much time deliberating the issue of privacy and balancing the need to protect individual rights and consumer choice with the clinical need for information sharing to provide high quality integrated care. These privacy issues exist in the absence of electronic health records but become more pressing as more providers utilize electronic health records that include most information about a patient.

Studies have shown that individuals with mental health conditions die 25 years earlier due to largely preventable and treatable physical health conditions[70] and that having appropriate access to all pieces of an individual's health history could improve those outcomes. In addition, primary care physicians report that the lack of (and difficulty of obtaining) information from an individual's behavioral health record can lead to adverse consequences on the health and outcomes of an individual. As an example, not knowing which medications a patient may be taking or what conditions they live with, primary care physicians might risk prescribing medications that may negatively interact with existing medications or produce side effects that exacerbate a behavioral health issue.

Implementation Action Steps: There was general agreement that, except in emergency situations where the individual is unable to give consent, persons receiving care should have the authority to determine with whom that information is shared. There was also general agreement that information sharing should be categorized into tiers, and each tier should have a set of rules governing the disclosure of information within the tier, including provisions for patient choice of opt-in (individual affirmatively agrees to share information across providers) or opt-out (information is shared across providers unless the individual specifically requests for it not to be shared) of standard disclosure practices.

The Task Force agreed on three categories of bi-directional[71] information sharing:

- Tier 1: medication, lab results and mental health diagnoses
- Tier 2: all other behavioral health information not in Tiers 1 or 3, for example, treatment plans, functional and risk status (e.g., suicidal ideation), psychological and neuropsychological assessments, stress factors, community supports, and substance use diagnoses
- Tier 3: diagnostic evaluation and treatment notes

A majority of the Task Force agreed that Tier 1 information be shared with other treating providers within the confines of existing law without prior written consent, which is the

[70] Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.
[71] One Task Force member noted that medical providers should not restrict access to any information related to the behavioral health needs of the patient to a behavioral health provider.

case for other specialties.[72] The individual would have the ability to revoke the sharing of information at any time. A minority of Task Force members voiced strong opinions that, due to stigma, sharing of Tier 1 information presents a documented risk of denial of physical health care and may discourage individuals from seeking behavioral health care, and that informed consent should be sought prior to the sharing of this information. While all Task Force members agreed that stigma among medical and behavioral health professionals negatively affects care, the majority felt that the problem of stigma needs to be addressed separate and apart from the benefits of integrated information sharing and that greater information sharing may help to reduce the burden of stigma by not continuing to create two different systems of care.

The Task Force unanimously agreed that Tier 3 information does not need to be shared to appropriately treat an individual and should only be shared if the individual affirmatively agrees to its sharing through the execution of a signed standardized release of information form and an informed conversation with their provider prior to the release of information.

Task Force members engaged in meaningful discussion of the benefits and concerns of how information in Tier 2 should be shared, but remained split on whether the category of information should be opt-in or opt-out. Given that the Task Force was not able to reach consensus, we recommend continued discussion of the appropriate level of information sharing for Tier 2. Task Force members raised viable arguments for both opt-in and opt-out in Tier 2. To further this discussion, it will be helpful to collect data on individual patient choice in terms of information sharing under an opt-in model, and whether the individual would have objected to this information being shared under an opt-out provision. This could potentially be included as part of the standardized forms to be developed.

One particular discussion among Task Force members centered on whether psychological and neuropsychological assessments should be in Tier 2 or Tier 3. Some Task Force members noted that the results of these assessments were very important to medical providers and barriers to reviewing the information should be mitigated. However, other Task Force members felt that the privacy of the personal nature of what is contained within a psychological and neuropsychological assessment must be maintained at the strictest standards given in Tier 3. The Task Force recommends continued discussion of the particulars of Tier 2 information sharing in other forums, including the subcommittee of the Health Policy Commission recommended as part of Recommendation #27.

[72] As noted, special rules apply to substance use information under 42 CFR Part 2. In addition, some mental health information is further restricted pursuant to G.L. ch. 123 § 6.

A standardized release of information form needs to be created to accommodate the different tiers of information sharing. For Tier 1, the form should clearly state the potential risks as well as the benefits of not sharing this information. For Tiers 2 and 3, a standardized release form with an opt-in provision should be created that clearly states the potential risks as well as benefits of sharing this information. The form must comply with the provisions of 42 CFR Part 2, as discussed above.

In addition to the form and perhaps more important, Task Force members felt it was important that providers have a detailed conversation with individuals about what information will be shared, with whom, and the implications for doing or not doing so. Person-driven healthcare should be supported by ensuring that individuals receiving care are active participants in all phases of their care and that the records document this participation: from a description in narrative as well as diagnostic terms, to the formulation of goals, to the recording of progress, to the evaluation of outcomes.

Task Force members agreed that in emergency situations, it was essential that full medical records be available to properly assess diagnoses, medical and behavioral disorders and risks to patients from any and all possible disorders in accordance with federal and state laws.

In order to do business with Massachusetts providers, the Legislature should require EHR vendors to include certain elements to support affordable and interoperable behavioral health records and the granularity to make certain information private, particularly treatment notes. The Task Force recognizes that many providers have implemented various EHRs. Vendors should advise where possible system modification could occur to allow for increased granularity to only show certain information based on an individual's decision to opt-in or out of information sharing.

Inpatient psychiatric providers should be required to communicate in a timely fashion with integrated risk bearing provider organizations information about the date of admission, the reason for admission, medical-behavioral conditions, and in a timely fashion prior to discharge, the discharge plan and hospital record, at a minimum.

As noted above, one of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, the Department of Children and Families (DCF), and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to

the sharing of information by parents and/or young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances. The MA Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues.

16. Certification requirements for integrated risk bearing provider organizations should include training of health care providers on privacy and confidentiality and such organizations should be required to have a privacy officer.

Rationale: Given the importance of privacy within integrated settings, the Task Force believes it is essential that integrated risk bearing provider organizations be required, as part of their certification, to conduct training on privacy and confidentiality. In addition, these organizations should be required to include a privacy officer to monitor its ability to meet privacy and confidentiality requirements, and obtain feedback from both individuals and providers of the impact of the privacy requirements.

Implementation Action Steps: The Legislature should direct the Division of Insurance (DOI) to develop and consider privacy requirements consistent with Task Force recommendations, as well as policies, procedures and training requirements as part of its review and certification of an integrated risk bearing provider organization. The DOI should provide sample training materials upon request.

17. Massachusetts should establish criteria in statute or regulation that would limit the circumstances under which a behavioral health care provider can restrict an individual's access to his or her records to those situations that present a clear and articulated harm.

Rationale: Electronic health records are often hailed for their ability to rapidly transmit medical information to a vast array of providers with a click of the mouse. Unfortunately, this means that misinformation can be spread just as rapidly.[73] While

[73] There is reason to be concerned about errors in electronic health records. A pilot study found that inaccuracies in medication lists were reported in 51% of records reviewed with 32.1% of all medications being inaccurately recorded. Tse J, You W. "How accurate is the electronic health record? - a pilot study evaluating information accuracy in a primary care setting." *Stud Health Technol Inform*. 168:158-64. Royal Melbourne Hospital Clinical School, The University of Melbourne, Parkville, Victoria. 2011.

Massachusetts law grants an individual broad access to his or her physical health records, it does permit withholding at least portions of behavioral health records, under certain circumstances, if the provider determines that release of such records could cause harm to the individual or others. However, existing statutes and regulations do not provide clear guidance on the standards under which this authority may be exercised, and to what extent such records may be withheld.

Implementation Action Steps: The state should adopt legislation reaffirming a broad right of access, establishing narrow criteria for withholding behavioral health records, and documentation of the rationale for the failure to provide an individual with access to his or her own records. Such criteria should be applicable to all covered entities under HIPAA. The legislation should make it clear that only those parts of the record that meet the criteria established may be withheld, and that, to the extent possible, a summary of the withheld information must be provided. Persons denied records should be given notice of why (the individualized documentation in the record) and their avenues of internal appeals and external complaints. In addition, a speedy means of appealing the denial of records should be mandated and, if possible, an external complaint procedure (other than the federal Office of Civil Rights (OCR)) should be established. Finally, a meaningful way of addressing errors in electronic health records must be developed (both corrections and, upon request of the patient, distribution of those corrections to parties to whom the erroneous records had been provided).

D. Education and Training

How best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services.

18. To the extent possible, require Massachusetts-based schools that prepare students for careers in medicine, nursing and allied behavioral health professions to educate students about behavioral health and related medical care issues.

Rationale: Many Task Force members expressed concern that providers do not receive appropriate education or training while in school to prepare them to treat individuals and families with lived experience or to begin to address stigma issues. Many Task Force members believed it was important to enhance the current school curricula to incorporate training on: providing trauma-informed care; behavioral health issues as a treatable disease; the concepts of recovery and wellness; and how to identify, treat and refer individuals with behavioral health challenges and their families to appropriate levels of behavioral health care.

However, some Task Force members recognized that school curricula are often dictated in large part by national standards and it may be difficult for Massachusetts to require schools to provide this education. Further, some believed that this recommendation would not be implementable given the existing tension between national standards and other curricula setting bodies. One Task Force member expressed concern that if integration is successful, more people may need health care services, placing a burden on the capacity of the system to address the clinical needs of individuals and that the recommended training may take too much time away from service delivery. Ultimately, this recommendation is not meant to have a chilling effect on the requirements for providers, but the Task Force recommends that to the extent possible, Massachusetts-based schools that prepare students for careers in medicine, nursing and allied behavioral health professions be required to educate students about behavioral health and related medical care issues in an effort to prepare them to work in an integrated setting.

Education and training is important for all provider types, because individuals with behavioral health issues present in many settings for many different services that may either be impacted by or impact a behavioral health condition. Integrating behavioral health care and physical health care allows for diagnosis and treatment of behavioral health factors that contribute to development of chronic health conditions such as obesity, cardiovascular disease, Hepatitis C and diabetes and that interfere with patients' engagement with recommended treatment and recognition of common chronic medical disorders in behavioral health settings. People with a range of psychiatric, substance use or cognitive symptoms are at increased risk for not adhering to prevention or treatment plans. This includes individuals who have severe and chronic mental illness and those who have cognitive disorders as a result of neurologic conditions, along with the much larger group of people who have conditions such as depression, anxiety, or ADHD or who have ingrained or burgeoning unhealthy lifestyle habits.

Implementation Action Steps: To the extent possible, including adopting a requirement for state licensure, or for taking any state-funded support, professional schools or undergraduate schools that prepare future health care professionals (e.g., nursing) must show proof of the following elements as active pieces of its curriculum, whether on its own or included as part of another relevant part of the curriculum.

- Enhanced educational training on behavioral health conditions as often preventable and always treatable conditions that lend themselves to being effectively prevented and treated with evidence based interventions and

promising practices[74] depending on the individual's circumstance and age, and particular condition.

- Broad curriculum focused on behavioral health and the importance of its overall integration into the entire practice of medicine.
- Anti-stigma education and recommend its completion as a graduation requirement, regardless of the provider's focus. As part of that effort, persons with lived experience should participate in the development of the education and should participate in the actual educational sessions to describe their experience with the health system, and how they experience stigma. An example of such training is the National Alliance on Mental Illness (NAMI) *In Our Own Voice,* a unique public education program in which two trained persons with lived experience share compelling personal stories about living with mental illness and achieving recovery.[75] Other information on mental health recovery, as developed by the National Empowerment Center from SAMHSA's components of recovery from mental health and substance abuse conditions should be offered. There are analogous programs for persons with lived experience who are in recovery from substance use disorders including persons from the MA Organization for Addiction Recovery (MOAR).
- Training must include provider education of primary care and other medical providers regarding behavioral health screening mechanisms. Screening mechanisms are not diagnostic and training must also include evidence based guidelines on consultation and referral with behavioral health providers for further diagnosis and treatment.
- Enhanced education of medical and behavioral health providers in common medical disorders and their screening, management and referral options.
- Enhanced education of primary care providers and other non-behavioral health care providers on the relationship between behavioral health medications to chronic conditions, recognizing that psychiatric medications may bear the risk of inducing chronic conditions.[76]

The Task Force recognizes that this recommendation may be difficult to implement due to the inability to influence the curricula of undergraduate and graduate schools that train future medical professionals. Absent that ability, special financial incentives could be offered to providers who are trained in the items mentioned above. Such financial

[74] For example, an evidence-based practice may include the use of medication assisted treatment for persons with opiate disorders.
[75] For more information, see http://www.nami.org/template.cfm?section=In_Our_Own_Voice. Other information on mental health recovery is also available, including information developed by the National Empowerment Center from SAMHSA's components of recover from mental health and substance use conditions.
[76] Muench J and Hamer A. "Adverse effects of antipsychotic medications." *American Family Physician* 617-622 (2010) and O'Riordan M. et al. "Antidepressant use linked with increased atherosclerosis." *Medscape* April 14, 2011.

incentives could include enhanced reimbursement or loan forgiveness for behavioral health providers with demonstrated certification, where available, or sufficient training and experience in the competencies mentioned above. Alternatively, a Certificate of Excellence program can be established whereby the state awards certification to schools that achieve the above elements of behavioral health integration education. Incentives for achieving excellence in behavioral health integration education could result in certified schools or programs receiving priority recognition for state funding or grants.

19. Develop and fund education and training tools for providers on how to identify behavioral health conditions and co-morbid medical conditions or issues, and treat or refer (as appropriate), recognizing there are a range of solutions and treatments that work, including models that emphasize the value of prevention, models that encourage the healthy development of children, training on recovery models of care, and emotional CPR.

Rationale: As described above, there are opportunities to improve the curricula of undergraduate and graduate schools to more adequately prepare providers to identify or serve individuals with behavioral health conditions. This recommendation mirrors the recommendation to enhance the educational focus on behavioral health conditions and reducing stigma, by enhancing the training available to and required of practicing providers on these issues. Education can and should be provided in a variety of settings using a wide array of tools to educate providers. This is critical to the successful education of our diverse corps of health care providers. A minority of Task Force members expressed concern about this recommendation and those thoughts are reflected in Recommendation #18.

Implementation Action Steps: To encourage providers to participate in continuing education and training programs, the offering of continuing education credits necessary for maintaining a license or gaining a particular certification is an important incentive to make continuing education a priority. Educational opportunities should take many forms, providing a flexible way to allow for health care providers to receive training when they can. Educational materials should be developed in concert with persons with lived experience. Such education and training tools may include:

- Monthly abstracts
- Access hours (similar to MCPAP)
- Lunch seminars
- Trainings delivered by people with lived experience
- Webinars
- Home study programs

- Web-based programs, such as the MA PCMHI Behavioral Health Integration Toolkit and the SAMHSA Training to certify buprenorphine providers
- Integration certificate programs, such as the UMass Center for Integrated Primary Care

As noted above, combating stigma must be a key component of educational efforts. The most effective means to eliminate stigma in the health care system is the inclusion of successful persons with lived experience as colleagues within the delivery system and within care teams.[77] In addition, we recommend that the state work with advocacy organizations to sponsor educational campaigns to confront ongoing stigma of behavioral health disorders, promote individuals with lived experience and promote that behavioral health issues are treatable. As part of this effort, the state should leverage and promote the National Recovery Month campaign in September to educate providers and people with lived experience on availability for and successful treatment of mental health and substance use issues. The National Recovery Month promotes the societal benefits of prevention, treatment and recovery for mental and substance use disorders, celebrates people in recovery, lauds the contributions of treatment and service providers, and promotes the message that recovery in all its forms is possible.[78] Similarly, the state should continue to support and leverage National Children's Mental Health Month each May.

Additionally, to provide ongoing education, the Task Force recommends that the Legislature provide the EOHHS with funding to support the ongoing, public and web-enabled availability of the Behavioral Health Integration Toolkit that was developed by the Massachusetts Patient Centered Medical Home Initiative. The Toolkit is a collection of strategies, training materials and resources that primary care practices can access to assist them in their efforts at integrating mental health and substance use treatment and/or referral in the primary care setting. (A summary of the Toolkit is available in Appendix E).

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[77] See Corrigan P. and Gelb B. "Three programs that use mass approach to challenge the stigma of mental illness." *Psychiatric Services* 393-398 (2006); M. Hugo. "Mental health professionals' attitudes towards people who have experienced a mental health disorder" *Journal of Psychiatric and Mental Health Nursing* 419-25 (2001); Pettigrew T and Tropp L.. "How does intergroup contact reduce prejudice? Meta-analytic tests of three mediator", *Eur. J. Soc. Psychol*. 922-934 (2008); *see also,* Kolodziej M and Johnson B. "Interpersonal contact and acceptance of persons with psychiatric disorders: A research synthesis." *Journal of Consulting and Clinical Psychology* 1387-1396 (1996).

[78] National Recovery Month. http://www.recoverymonth.gov/ SAMHSA.

How best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness

20. Develop and fund continuing education tools, including information on behavioral health disorders as drivers of and barriers to effective treatment of chronic health conditions, and provide access to these tools and other resources for both behavioral health and primary care providers. Require this training as part of state licensure requirements, where appropriate.

Rationale: In concert with the education and training required in the recommendations above, it is important to also include training on the intersection of behavioral health and physical health conditions, as well as the contributions of social context to both. Statistics show this overlap for adults quite clearly. For instance:

- depression is found to co-occur with 17% of cardiovascular chronic conditions, 27% of individuals with diabetes, and more than 40% of adults with cancer;[79]
- smoking is also a major driver of chronic health conditions;[80] and,
- substance use disorders are associated with increased risk of certain cancers, HIV and Hepatitis C.[81]

For children, the issues of concern are more often in reverse: it is the effect of emotional or psychological trauma, or toxic stress, on their physical health over their lifespan into adulthood about which healthcare providers need to be educated, as well as the childhood and adolescent onset of many behavioral health conditions. There is ever-expanding basic science research demonstrating how ongoing stress of sufficient intensity can cause enduring changes in brain maturation across childhood into young adulthood, as well as in circulatory, endocrine, digestive, and neurological functioning. The most compelling evidence of this impact has been produced by the landmark Adverse Childhood Experiences (ACE) study. The ACE Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC). It includes 10

[79] "Mental Health and Chronic Diseases." National Center for Chronic Disease and Health Promotion, Division of Population Health. Issue brief No. 2, October 2012. Centers for Disease Control and Prevention. Atlanta, GA. http://www.cdc.gov/nationalhealthyworksite/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf

[80] Ehrlich, Emily; Kofe-Egger, Heather; Udow-Phillips, Marianne. Health Care Cost Drivers: Chronic Disease, Comorbidity, and Health Risk Factors in the U.S. and Michigan. Center for Healthcare Research & Transformation. Ann Arbor, MI. August 2010.

[81] See information related to link between alcohol use and cancer from the American Cancer Society at http://www.cancer.org/cancer/cancercauses/dietandphysicalactivity/alcohol-use-and-cancer; see also basic information on relationship of drug use and HIV and Hepatitis C at http://aids.gov//hiv-aids-basics/prevention/reduce-your-risk/substance-abuse-use/

types of adverse childhood experiences: childhood abuse (emotional, physical, and sexual abuse), neglect (physical and emotional), and family dysfunction (growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, a parental separation/divorce, or a family member incarcerated). Over 20% of respondents experienced three or more categories of trauma, or ACEs. The ACE Study examined the relationship between these experiences during childhood and reduced health and well-being later in life. It showed dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of death.

Sociocultural stressors that accompany the material deprivations of poverty affect adults as well children and are strongly associated with mental health difficulties. Education about the relation of poverty to health concerns and appropriate behavioral health interventions are recommended.[82]

Implementation Action Steps: As with the training recommended above in Recommendation #19, to ensure that providers participate in training programs, it is essential that continuing education programs offer credits necessary to maintain a license or gain a particular certification. In addition, educational opportunities should take many forms, and should include persons with lived experience and their families in its development and delivery as delineated in Recommendation #3, providing a flexible way to allow for health care providers to receive training when they can.

Additional Education and Training Recommendations

21. Expand the role of individuals and families to participate in, direct or accept responsibility for their care, including in choosing wherever possible from whom among qualified providers to receive their care or the care for their children, and to also select other supports to be involved in planning and care coordination with the providers identified above.

Rationale: A necessary factor in the treatment of behavioral health disorders is the engagement of individuals and their families. Studies show that where there is engagement there is improvement in both behavioral health and physical health issues.[83,84,85] Individuals and their families are not engaged for a number of reasons,

[82] Goodman L et al., "Within and beyond the 50-minute hour." *J. of Clinical Psychology* 182-90 (2013). *See also*, Saren J. et al., "Relation between household income and mental disorders." *Arch. Gen. Psychiatry* 419-427 (2011).
[83] James, J. "Health policy brief: patient engagement," *Health Affairs.* February 14, 2013.
[84] Gawrysiak M et al. "Neural changes following behavioral activation for a depressed breast cancer patient: a functional MRI case study." *Case Reports in Psychiatry.* Volume 2012.

including not seeking care because of the real or perceived stigma of behavioral health disorders, due to restrictive networks that limit the available provider network or restrict access to certain types of providers, or financial barriers. In addition, individuals and families may not engage in care based on inability to choose a provider that connects with them and understands how they feel based on their own lived experience. Finally, there is evidence that engagement is particularly low among underserved and minority populations, suggesting the need for increased emphasis on culturally competent and linguistically appropriate care. Working with individuals and families to identify their preferences and then providing the individuals with the opportunity to choose care that fits with their personal preferences, such as the setting, time of day, and where to receive care, increases engagement and enhances the likelihood that care will enhance personal meaning, satisfaction and quality of life.

Not only is continuity of care with a trusted provider critical to effective care, particularly for youth, generally respecting individual provider preference for a behavioral health care has the potential for lowering costs of care because a good therapeutic alliance improves the likelihood of care being successful.[86]

Implementation Action Steps: Individuals and, where appropriate, their families should be active participants in treatment decisions and in the treatment team. Person-centered care requires such participation, which should be documented in treatment records. In addition, the use of peer supports should be expanded to enable meaningful participation in treatment planning by individuals, as peer supports advocate that individuals take responsibility in their recovery.[87]

The Task Force recommends that the Health Policy Commission, DMH and other policy makers be directed and funded to develop a public education campaign on the benefits of integrated care, including the identification, treatment and available resources for behavioral health disorders, and their co-morbidity with medical disorders and how integration might impact an individual's care. This campaign should utilize a host of community settings, social media, and public service announcements on television and radio. The campaign should be planned and developed with assistance from persons

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[85] Hibbard, J et al. "Do increases in patient activation result in improved self-management behaviors?" *Health Services Research*. 2007 August; 42(4): 1443-1463.

[86] The therapeutic alliance may be more important than the mode of treatment in determining the effectiveness of care. Safran et al. "Alliance, negotiation and rupture resolution." Handbook of Evidence Based Psychodynamic Therapy. (R. Levy & J. Ablon, eds.) pp. 201, 208 Humana Press 2009.

with lived experience. The message should include the value of peers and family partners as key elements of integration and re-design of health care delivery.

To further the realization of the potential benefits of integrated care, ongoing mechanisms should be established for the engagement of persons with lived experience in the process of healthcare policy development. The use of peer supports who can advocate that individuals take responsibility in their recovery should be expanded.[88]

E. Workforce Development

While the Legislature did not specifically pose a question focused on workforce development, the Task Force makes five recommendations related to workforce as we believe it is essential to address workforce capacity as part of the successful integration of behavioral health and primary care.

22. Require access to behavioral health services, directly or by contract, by a hospital and federally qualified health centers (FQHCs) as part of licensure

Rationale: A goal of any integrated system should be to provide a system of care that improves access to behavioral health care across the spectrum of intensity. Requiring the offering of behavioral health services by licensed providers, either directly or by contract, will help reinforce integration and perhaps assist in expanding access. MassHealth requires FQHCs to have comprehensive services on site or by referral.

Implementation Action Steps: State licensure requirements for hospitals and federally qualified health centers should include the ability to serve the behavioral health needs of members of their communities. In performing its licensing function, DPH should assess whether the provider has the ability to provide care for emergent behavioral health needs as well as routine needs and screening, as appropriate for the care setting. Such services may be provided by the licensed organization or the licensed organization must demonstrate the ability to access the services in a timely manner. In certain circumstances, telemedicine may be an option small licensed organizations can use to fulfill this requirement.

Given the varying sizes of primary care practices, telemedicine will be an important mechanism to support integration. In the absence of increased trained behavioral health providers throughout Massachusetts, small PCPs or those located in non-urban areas may need to access behavioral health consultation virtually. The Massachusetts Child Psychiatry Access Project (MCPAP) provides a successful model for solving this problem for pediatric primary care clinicians by providing them with virtual access, via

[88] Woodhouse A. and Vincent A. "Development of peer specialist roles: a literature scoping exercise." *Scottish Recovery Network and the Scottish Development Centre for Mental Health*. August 2006.

telephone, to child psychiatry consultation. The Task Force recommends the continued and sustained funding of MCPAP in Recommendation #13 and the expansion of similar models to the adult population.

23. Review scope of practice rules to determine whether they can be effectively and appropriately broadened to provide the care necessary in an integrated environment.

Rationale: In an effort to combat workforce shortage and expand access to behavioral health services, some Task Force members wish to expand the practice rules for certain professionals and to expand reimbursement to match statutory scope of practice in Massachusetts. For example, thirteen states and the District of Columbia have passed independent practice laws for psychiatric clinical nurse specialists. The Institute of Medicine report, The Future of Nursing (2011), recommends federal and state action to update regulations to ensure that all advanced practice nurses practice to the full extent of their education and training. The Rand Report for the Massachusetts Division of Health Care Finance and Policy has recommended independent practice for advanced practice nurses.[89] However, the Massachusetts Psychiatric Society (MPS) through its Task Force representative, strongly opposed the expansion of the scope of services and the removal of physician supervision of advanced practice nurses. MPS does not endorse this recommendation in its entirety. MPS believes expanding the scope of practice for independent practice for psychiatric clinical nurse specialists may not effectively contain costs in an underfunded behavioral health system or necessarily be an effective solution to expanding access to psychiatric medications.

Many Task Force members endorse a review of the scope of practice rules, but do not recommend whether certain professionals' scope of practice should be expanded.

Implementation Action Steps: A thoughtful and thorough review of scope of practice rules for certain professions should be conducted by DPH and the Office of Consumer Affairs and Business Regulation to determine whether expanding the scope of practice rules for advanced practice nurses is a reasonable way to address workforce shortage and the expansion of behavioral health services. Such review should examine the training and ongoing certification requirements of these professionals to determine whether the skills and knowledge expected to be gained from such training and certification would allow for the continued safe and effective delivery of care. If such training and ongoing certification is not sufficient, the review should identify what additional requirements would be necessary and whether those additional requirements would lead to a more advanced degree. In particular, the review should examine the

[89] Eiber, Hussey, Ridgely and McGlynn, Controlling Health Care Spending in Massachusetts: An Analysis of Options, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

states that have passed independent practice laws for psychiatric clinical nurse specialists and identify any consequences (either intended or unintended) as a result of the legislation.

In addition, payers should provide reimbursement for all services that can be conducted under Massachusetts's statutory scopes of practice including non-discriminatory use of all CMS approved CPT codes by psychiatric physician and advanced practice nurses.

24. Licensing boards or agencies for the medical and behavioral health professions should review licensure statutes and regulations to ensure that training requirements are consistent with the skills needed to practice effectively in integrated settings.

Rationale: The Task Force members believe that behavioral health care can be delivered by many different types of providers, including individuals that may not be currently licensed under state statute (e.g., peer support). Task Force members felt it important to identify and remove barriers that prevent professionals such as recovery coaches and peers from participating in care provided to individuals and families under new payment reform models. In addition, some licensure laws and/or regulations do not allow for training sites used towards licensure to be located in sites where integrated services can now be delivered such as school health clinics.

Implementation Action Steps: DMH, DPH and the Office of Consumer Affairs and Business Regulation should be encouraged to identify training and/or certification programs that ensure that a minimum standard of training is met by those providing services not currently under regulatory authority.

25. Actively foster and fund leadership development among all segments of the workforce, including peers.

Rationale: Leaders are needed in all levels of the field from practice administration to peer and family support services to support the transformation of the behavioral health system to be one that is less siloed and more coordinated with the medical system. For example, leadership is a key factor to the adoption of evidence-based and emerging promising practices in the mental health and addiction treatment systems.[90]

Implementation Action Steps: Leadership qualities that are necessary to assist in achieving higher quality of care and lower costs through transformation of the behavioral health system of care must first be identified. Such qualities should include

[90] National Association of State Mental Health Program Directors Research Institute, Inc. "Results of a survey of state directors of adult and child mental health services on implementation of evidence-based practices." Alexandria, VA 2005. http://www.nri-inc.org/reports_pubs/2005/EBPLillyFullReport2005.pdf

the skills needed for organizational transformation as well as community transformation. After leadership qualities are identified, programs that support leadership training in Massachusetts should be funded to train behavioral health providers. Leaders invited to participate in training programs should be chosen with the intent to pull a diverse group of leaders together for learning.

One important forum in which leadership will be critical is the leadership of Accountable Care Organizations (referred to as integrated risk bearing provider organizations, throughout this report). Chapter 224 requires that these organizations include a consumer representative in their governing structure. While many Task Force members believe that persons with lived experience are often left out of governing bodies, one Task Force member expressed the concern that too many individuals within a governing body will make an ineffective governing organization and that integrated risk-bearing provider organizations should have the flexibility to determine whether more than one individual with lived experience be represented on a governing body. Therefore, the Task Force recommends that integrated risk-bearing provider organizations consider appointing more than one person with lived experience from the population served including a representative of at least one person from each of the following groups: families whose children receive both primary and behavioral health care, transition age youth who receive both primary and behavioral health care, and adults who receive both primary and behavioral health care.

26. Organizations that accept financial risk for provision of services, including integrated risk bearing provider organizations, should automatically be given designated status from a managed care entity to take on responsibility for the credentialing of its providers panel.

Rationale: Credentialing is agreed to be a patient safety protection that is in place to ensure that providers are qualified to perform within the scope of their practice, to identify medical malpractice instances, and to ensure providers are appropriately licensed. There is a belief in the Task Force that managed care organizations sometimes use the credentialing process to limit the growth of provider panels, including limiting access of smaller behavioral health practices to their provider networks. Task Force members believe that, to the extent that there is not a public credentialing body independent of managed care organizations, delegating providers with the responsibility to credential may promote efficiency, as most provider organizations already conduct credentialing activities prior to hiring a new provider. The current system of credentialing can be slow, often requiring many months before a provider can be credentialed which renders them unable to provide care during that time. Under this recommendation, provider organizations also would have greater flexibility to

target the needs of their populations and expand their networks of participating behavioral health providers and promote integration, both in terms of numbers and use of emerging providers such as peer specialists, enabling the organization to include providers best suited for the needs of the individual. In addition, Task Force members believe that credentialing may be completed more quickly at a provider organization which feels a greater urgency to add new, qualified providers. However, there is still a need to have a credentialing process for some behavioral health providers in certain individual or group practices that contract independently.

The Task Force recognizes that health plans are required under Massachusetts law to achieve accreditation from the National Committee on Quality Assurance (NCQA) and the Board of Registration in Medicine (BORM). NCQA requires credentialing of providers and applicable oversight by plans. While plans may continue to be accredited if a subset of its providers are delegated entities, the plans must retain the ultimate responsibility for the credentialing and ensure that delegated entities meet all credentialing standards.

For the past several months, health plans, hospitals and the Massachusetts DOI have been meeting on a regular basis to develop uniform credentialing criteria that will reduce administrative burden on providers. Work must also be done with these groups to identify and eliminate barriers to timely credentialing.

Implementation: As a first step in implementing this recommendation, the DOI should be charged with determining the impact of this recommendation on plans' ability to receive NCQA accreditation to ensure that delegation does not jeopardize that accreditation. In concert with current efforts to simplify and centralize the credentialing process, DOI should work with its current working group to determine the amount of delegation, if any, that occurs today, consider the criteria for delegated entities and whether and how that differs from the credentialing requirements for plans themselves. Where delegation does occur today, the DOI, plans and potential delegated entities should review the performance of provider organizations that have accepted this responsibility and try to ascertain the organization's overall quality and diversity of providers and overall performance, including a combination of health outcomes and financial measures. As additional organizations become delegated entities, the DOI should continue to monitor the impact of this recommendation in increasing integration of behavioral health care within organizations that accept risk, including progress in hiring new types of providers, the quality of providers within the organization, and ability to meet health outcome and financial performance standards. Ultimately, with public input, the DOI should develop uniform credentialing standards that do not restrict behavioral health providers.

F. Other Recommendations

In addition to the recommendations above, the Task Force makes the following three recommendations for the consideration of the Legislature and the Health Policy Commission.

27. The Health Policy Commission should be charged with developing further recommendations, clarifications and proposals to assist the Legislature and the Health Policy Commission to operationalize and subsequently evaluate the integration and reimbursement of behavioral health care in a new climate of integrated care.

Rationale: With a continued focus on behavioral health integration across the state and throughout different agencies, the Task Force believes that it is important to align the different stakeholders and workgroups into one common body that reports to the Health Policy Commission. Some of the recommendations of the Task Force involve actions by state agencies (e.g., Division of Insurance) and stakeholders (e.g., commercial health insurers) who did not participate in Task Force discussions but who are actively involved in workgroups and activities of the Health Policy Commission. This will require the participation of all relevant state agency and external stakeholders to allow for a coordinated and sustained approach to ensure that the Task Force recommendations are implemented.

Implementation: A subcommittee to the Health Policy Commission should be developed that incorporates representatives of existing behavioral health initiatives, including the MA PCMHI, MassHealth PCPR, and the CBH Advisory Council. In addition, persons with lived experience of mental health and addiction issues, family and transition-age youth should be represented on this new subcommittee. Continued participation of interested Behavioral Health Integration Task Force members is recommended.

The new subcommittee should be responsible for monitoring the implementation and evaluation of the recommendations made by the Task Force. It should also be tasked with evaluating the success of integration under alternative payment methodologies and integrated model types and be given the authority to make additional recommendations to improve the integration of care in Massachusetts.

28. Management of payment for behavioral health services should promote coordinated and integrated care that prevents fragmentation and redundancy. There should be further study of whether a Behavioral Health Carve-Out model continues to be appropriate and is able to deliver integrated care.

Rationale: Given the renewed focus of integrated care, the role of carve-outs going forward should be examined and discussed. This Task Force was unable to have a detailed discussion of the topic.

Implementation: The Task Force recommends that a study about behavioral health carve-outs be conducted by the Health Policy Commission under the direction of the subcommittee called for in Recommendation #27.

29. Medically necessary behavioral health services, including collateral contacts, should be reimbursable outside of the medical/behavioral health care setting (e.g., in educational, child welfare, juvenile justice, and community and home settings) as equivalent services delivered in medical/behavioral health care settings and should be included in publicly and commercially available health care benefits.

Rationale: Currently in Massachusetts, there are nearly 1 million students enrolled in public elementary and secondary schools; of these, over 160,000 receive special education services, often for emotional or behavioral disabilities. Moreover, there are nearly 10,000 youth in foster care in Massachusetts and an estimated 6,000 children are court-involved. These youth have much higher rates of behavioral health disorders than the general population of youth; yet they often experience many barriers to the receipt of quality behavioral health services. Behavioral health services provided in these settings have the potential to improve learning, family reunification, and exit from juvenile delinquency. The cost of providing behavioral health services in these settings does not differ from outpatient settings, and in fact, may be less expensive in the absence of high medical care facility fees. Accordingly, Task Force members support equal professional payment rates for medically necessary behavioral health services delivered in alternative settings such as those delineated above.

Implementation Action Steps: The Legislature should require MassHealth and commercial insurers to pay for medically necessary behavioral health services by a particular provider, regardless of the setting for the services.

VII. Conclusion

The recommendations provided above answer the specific questions asked by the Legislature within Section 275 and provide additional recommendations aimed at the successful integration of primary care and behavioral health care with the goal of enhancing access to behavioral health within primary care to improve health care outcomes and contain health care cost growth. The Task Force believes that successful integration requires the implementation of strategies to appropriately reimburse for provision of behavioral health services within primary care and elsewhere within the health care system, to thoughtfully address privacy to balance individual and provider concerns, to appropriately develop the workforce to provide integrated care, including through expansion of types of providers, and to train all types and levels of providers on models of integration and best practices. We look forward to participating in continued discussion of these important issues.

VIII. Resources

Integrated Behavioral Health and Primary Care Resources

1. **Substance Abuse and Mental Health Services Agency, Center for Integrated Health Solutions**
   http://www.integration.samhsa.gov/

2. **National Council for Behavioral Health**
   http://www.thenationalcouncil.org/cs/home

3. **Health Reform and Behavioral Health Services in Massachusetts: Prospects for Enhancing Integration of Care**
   http://masshealthpolicyforum.brandeis.edu/forums/Documents/health-reform-and-behavioral-health-services-in-ma.pdf

4. **Integrated Care Resource Center**
   http://www.integratedcareresourcecenter.com/

Alternative Payment Models

1. **Center for Healthcare Quality and Payment Reform**
   http://www.chqpr.org/

2. **Catalyst for Payment Reform**
   http://www.catalyzepaymentreform.org/

IX. Appendix A. Behavioral Health Task Force Members

Department of Mental Health	**Marcia Fowler, Commissioner**
Massachusetts Psychiatric Society	**Janet Osterman, MD**
Massachusetts Psychological Association	**Elena J. Eisman, EdD, ABPP**
National Association of Social Workers - MA Chapter	**Bruce A. Maloof, PhD, LICSW, BCD, LADC**
Massachusetts Mental Health Counselors Association	**David McAllister, LMHC**
Nurses United for Responsible Services	**Virginia Tay, PhD, RN, CS**
Massachusetts Association of Registered Nurses	**Karin Narkun, RN-BC, BSN**
Massachusetts Association of Behavioral Health Systems	**David Matteodo**
Association for Behavioral Healthcare	**Vicker DiGravio**
Mental Health Legal Advisors Committee	**Susan Fendell**
National Alliance on Mental Illness of MA	**Laurie Martinelli**
Children's Mental Health Campaign	**Mary McGeown**
Home Care Alliance of Massachusetts	**Donna Vaskelis**
National Empowerment Center	**Daniel Fisher, MD, PhD**
Massachusetts Organization for Addiction Recovery	**Maryanne Frangules**
Recovery Homes Collaborative	**John McGahan, LADAC I, CAS**
Massachusetts Hospital Association	**Heather J. Walter, MD, MPH**
School Nurse	**Mary Ann Gapinski, MSN, RN, NCSN**
Provider with Experience Serving a Difficult to Reach Population	**Monica Bharel, M.D., M.P.H.**

Behavioral Health Integration Task Force Participants

Lahey Health Behavioral Services	**Mona Bastide, LICSW**
DPH Bureau of Substance Abuse Services	**Hilary Jacobs, LICSW, LADC I**

X. Appendix B. Meeting Topics and Materials Presented to Task Force Meetings or Shared By Task Force Members

Date	Meeting Topic
December 18, 2012	• Welcome and introductions • Discussion of scope, identification of key issues (and definitions) • Presentation of project plan
January 14, 2013	• Behavioral health integration activities in Massachusetts
February 26, 2013	• Clinical models for behavioral health integration
April 8, 2013	• Workforce and Reimbursement
April 30, 2013	• Communication and Privacy
May 7, 2013	• Children's Behavioral Health Advisory Council • Physician Work Group Recommendations • Persons with Lived Experience
May 21, 2013	• Review of recommendations
June 4, 2013	• Review of draft report
June 18, 2013	• Vote on final report

List of Presentations and Materials Given to the Behavioral Health Integration Task Force

Presentations and materials will be made available on CD-ROM to the Legislature

Background Materials

Behavioral Health Integration Task Force Briefing Book

Prepared by Bailit Health Purchasing.

General HIPAA and Privacy Laws

Prepared by DMH Legal Office.

Presentations

Behavioral Health Integration: Kick Off Meeting

Presentation by Bailit Health Purchasing

Behavioral Health Integration: Meeting 2

Presentation by Bailit Health Purchasing

Behavioral Health in Primary Care Payment Reform and Health Homes

Presentation by Julian Harris, MD, Medicaid Director

Behavioral Health Integration

Presentation by Daniel Gallery, PsyD

Chief of Behavioral Health, Medford - Harvard Vanguard; and

Thad Schilling, MD

Medical Director, Patient-Centered Medical Home

Associate Chief of Internal Medicine, Medford - Harvard Vanguard

Massachusetts Association of Health Plans: Presentation for Behavioral Health Integration Task Force

Presentation by Sarah Gordon Chiaramida, Massachusetts Association of Health Plans

Behavioral Health Integration: Progress and Challenges

Presentation by Alexander Blount, Center for Integrated Primary Care, University of Massachusetts Medical School

MA Child Health Quality Coalition's Task Force on Communication and Confidentiality

Presentation by Frances O'Hare, MD

White Papers

Consumer Control of Mental Health Information

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Eradicating Stigma in Healthcare Systems

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Caseloads, Time, and Quality of Care

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Importance of Choice of Provider and Treatment

Prepared by Mental Health Legal Advisors Committee (www.mhlac.org)

Reports & Recommendations

Children's Behavioral Health Advisory Council Recommendations to the Behavioral Health Integration Task Force

Children's Behavioral Health Advisory Council, May 2013.

Physician Work Group Recommendations to the Behavioral Health Integration Task Force

Physician Work Group, May 2013.

An Integration Model for Medicaid-Financed Behavioral Health Services

Recommendations to Joshua M. Sharfstein M.D., Secretary of Maryland Department of Health and Mental Hygiene, 10/1/12.

Shared Principles on Integration and Dual Eligible Demonstration, December 19, 2012

Prepared by Disability Advocates Advancing Our Healthcare Rights (DAAHR) and

The Association for Behavioral Healthcare (ABH).

A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care

American Academy of Child & Adolescent Psychiatry, Committee on Collaboration with Medical Professionals, May 2010.

Best Principles for Integration of Child Psychiatry into the Pediatric Health Home

American Academy of Child and Adolescent Psychiatry, June 2012.

Chronic conditions and comorbid psychological disorders

Milliman Research Report, July 2008.

Recommendation from the Community Preventive Services Task Force for Use of Collaborative Care for the Management of Depressive Disorders

(Am J Prev Med 2012;42(5):521–524) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine.

Behavioral Health Homes For People With Mental Health & Substance Use Conditions: The Core Clinical Features

SAMHSA-HRSA Center for Integrated Health Solutions, May 2012.

The Annual Cost of Brain Disease in 2012

PricewaterhouseCoopers LLP, Summer 2012.

Health Reform In Oregon: An Opera Grand/Buffa? (in Four Acts)

David Pollack, MD

Professor For Public Policy

Oregon Health & Science University

With supporting materials from OHA

Behavioral Health Integration RFI and Public Forums Summary/Themes

Prepared by DMH, May 1, 2013.

Dan Fisher's Notes from March 26, 2013 Behavioral Health Integration Public Forum

Physician Supervision of Prescriptive Practice for Psychiatric Clinical Nurse Specialists

Prepared by Virginia Tay.

Articles/Journal Publications

How I Helped Create a Flawed Mental Health System That's Failed Millions - And My Son

Health Affairs, 31, no.9 (2012):2138-2142.

Collaborative Depression Care Models From Development to Dissemination

Am J Prev Med 2012;42(5):550–552.

Mental Health Treatment Should Focus On Recovery
The Hartford Courant, January 25, 2013.

Sharing Psychiatric Records Helps Care

New York Times, January 7, 2013.

Clinics bring together doctors and psychiatrists to cure physical, mental health ailments

Washington Post, February 18, 2013.

Time to Advance the Confidentiality Conversation

March/April 2013, vol. 33, no. 2, Behavioral Healthcare.

Long-term Antipsychotic Treatment and Brain Volumes

Arch Gen Psychiatry. Author manuscript; available in PMC 2012 October 19.

Published in final edited form as: Arch Gen Psychiatry. 2011 February; 68(2): 128–137.

Poverty and Mental Health Practice: Within and Beyond the 50-Minute Hour

Journal of Clinical Psychology: In Session, Vol. 69(2), 182-190(2013).

Psychiatrists Not Immune to Mental Health Bias

Medscape. May 21, 2013.

Earning a Teenager's Trust

Medscape. Apr 01, 2013.

Promoting Recovery

(In: T Stickley and T Basset (Eds.) Learning About Mental Health Practice. Chichester, England: John Wiley and Sons.2008.) Chapter written by Daniel B. Fisher, M.D., PhD.

Letters

MassHealth Programs Compliance with Mental Health Parity Laws

March 2013 letter to Julian Harris, MD, Medicaid Director, from healthcare provider trade associations and advocacy organizations.

Joint Provider Comments on Implementing Chapter 224 of the Acts of 2012 provisions related to Mental Health Parity (Section 23 & 254)

September 2012 letter to Kevin Beagan, Division of Insurance, from healthcare provider trade associations.

MassHealth Compliance with MHPAEA

April 2012 letter to Julian Harris, MD, Medicaid Director, from the Center for Public Representation.

Other Documents

Statement by David Kupfer, MD, Chair of DSM-5 Task Force Discusses Future of Mental Health Research

May 3, 2013 Release No. 13-33.

MA Child Health Quality Coalition's Task Force on Communication and Confidentiality

Presentation to Behavioral Health Integration Task Force

4-16-13

Presented by

Frances O'Hare, MD,

Pediatrics, Transition Coordinator,

HMS Center for Primary Care Academic Innovation Collaborative Transformation Grant,

Martha Eliot Health Center, Boston Children's Hospital

The MA Child Health Quality Coalition is a public-private partnership with broad-based, cross-stakeholder representation championing and advocating for child health care quality and measurement statewide, funded through a CMS CHIPRA Quality Demonstration Grant, with Massachusetts Health Quality Partners serving as its operational home.

Handouts:

Background information on the MA Child Health Quality Coalition and its Task Forces on Care Coordination and Communication and Confidentiality

Status report from the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Membership list for the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Outline of topics proposed for inclusion in a Communication and Confidentiality Resource Guide being developed by the MA Child Health Quality Coalition's Communication and Confidentiality Task Force

Suggestions to the Child Behavioral Health's Advisory Council to consider for inclusion in the Council's recommendations to Behavioral Health Integration Task Force on Confidentiality/Privacy Issues

MA Child Health Quality Coalition

Vision Statement

To achieve and sustain transformational gains in child health care and outcomes, across the care continuum, for all children in Massachusetts.

Mission Statement

The mission of the Massachusetts Child Health Quality Coalition is to champion and advocate for child health care quality and measurement, facilitate a shared understanding of pediatric health care quality priorities across a broad-based set of stakeholders in Massachusetts, create a platform for formulating system-wide goals and objectives, and implement activities to support those goals and objectives.

Key Coalition Objectives

Promote improvements in health care outcomes for children in Massachusetts by developing consensus around priorities for action and supporting the implementation of activities in those priority areas;

Advocate for inclusion of child health issues in broader statewide activities;

Provide direction on the development of new measures to evaluate and track progress related to children's health care;

Create synergies among existing child health measurement and improvement activities to increase impact; and

Develop and implement plans to ensure the Coalition's long term sustainability.

Care Coordination Context:

Improving care coordination for children has been demonstrated to improve quality of care while controlling costs. Effective care coordination can also lead to improved care integration for children with behavioral health care needs. Coalition members have emphasized the gaps in the coordination of care for children with behavioral health needs, and the benefits that can accrue from more integrated care.

The Coalition developed a Care Coordination Key Elements Task Force to define and support the implementation of a set of foundational elements of high-performing pediatric care coordination. The Coalition also developed a Communication and Confidentiality Task Force to support effective communication between and among those who make up the child's "coordination network," while addressing issues of confidentiality. The first Task Force's work is resulting in a set of key elements of care coordination and associated measures, and the second Task Force's work is resulting in a resource guide. The Coalition's cross-stakeholder representation offers an excellent forum for developing consensus around useful, feasible strategies to support the effectiveness of care coordination.

MA Child Health Quality Coalition

Task Force #2: Communication and Confidentiality

Task Force Objective: *Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.*

Current Status

The Communication and Confidentiality Task Force has identified a number of challenges to communication, including:

- difficulty in attaining and maintaining trusting relationships between parents/youth and providers
- a misunderstanding of the importance of information sharing to facilitate the delivery of coordinated care
- a lack of understanding of rules governing information sharing (which becomes all the more challenging when schools are involved)
- a lack of structures and methods to support information sharing among providers, families/youth, schools, and other members of the child's coordination network

Additionally, the Task Force wanted its work to also address the issues of confidentiality that are important to consider in any communication facilitation effort, and to highlight those confidentiality issues that are of particular concern when behavioral health issues are involved.

The Task Force noted that tools do exist to address these communication challenges, but that many of these are not well known or easily discoverable to most families, providers and community-based programs. Thus, the Task Force determined that collecting and compiling these tips, tools and resources in one place, in a format that can be easily used by the various members of the child's coordination network, would be of value, and it therefore decided to work on creating a Resource Guide.

The group is currently working on refining the concepts and components to be included in this Resource Guide, and determining what format and content might make the Guide most useful to potential users. The target date for completion of the Guide is December 2013.

Task Force #2: Communication and Confidentiality Members

Name	Title	Organization
Chair		
Kathy Hassey	Director, School Health Institute	Northeastern University School of Nursing
Task Force Members		
Craig Bennett	Attorney/Family Law	Boston Children's Hospital
Elena Eisman	Executive Director/Director of Professional Affairs	Massachusetts Psychological Association
Lloyd Fisher, MD	Site Chief/ Assistant Medical Director for Informatics	May Street Pediatrics/Reliant Medical Group
Heather Frohock	Lead Youth Advocate	YouthMOVE Massachusetts and PPAL
Linda Grant, MD	Provider, Adolescent Pediatrics Medical Services Director/Special Education	Boston Medical Center, Boston Public Schools
Cathy Hickey	Information Specialist	Mass Family Voices/ Family to Family Health Information Center at Federation for Children with Special Needs
Lisa Lambert	Executive Director	Parent/Professional Advocacy League
Frances O'Hare, MD (Kitty)	Pediatrics, Transition Coordinator, HMS Center for Primary Care Academic Innovation Collaborative Transformation grant	Martha Eliot Health Center Boston Children's Hospital
Beth Pond	Family Integration Specialist	Parent/Professional Advocacy League
Jennifer Reen	School Psychologist/Clinical Counselor	Lincoln-Sudbury Regional High School
Staff Lead		
Valerie Konar	Project Manager, CHIPRA Quality Demonstration Grant	University of Massachusetts Medical School

MA Child Health Quality Coalition

Communication and Confidentiality Task Force

Suggestions for the Behavioral Health Integration Task Force Recommendations

on Confidentiality/Privacy Issues

(3-18-13)

The MA Child Health Quality Coalition has an active **Communication and Confidentiality Task Force** created to support its work promoting improved care coordination for children in Massachusetts, including addressing special issues for children with behavioral health needs.

Task Force Objective: *Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.*

This Task Force has been identifying issues impacting communications and confidentiality across the Coalition's different stakeholder groups and identifying resources that can help in addressing those issues. Based on the task force work to date, the following recommendations for confidentiality and privacy considerations should be considered:

(1) Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

(2) Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages.

Provide guidance on the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.).

Strategies that encourage information sharing (e.g. "opt out") still need safe guards that ensure informed consent.

Special issues of confidentially must be considered for adolescents

Peer networks offer important opportunities to support youth in understanding privacy protections and promote **strategic sharing**

(3) Sharing behavioral health information with families/youth can improve accuracy and patient safety.

(4) Look at privacy as a whole, not just within electronic health records.

Behavioral Health Integration

Request for Information and Public Forums

Summary

May 1, 2013

Section 275 of the Health Care Cost Containment Law established a Behavioral Health Integration Task Force chaired by the Commissioner of the Department of Mental Health (DMH). To help inform Task Force members, DMH published, in February, 2013, a Request for Information (RFI) and, in March, held two public forums; one in Boston and one in Holyoke. The RFI and forums focused on questions posed in Section 275, including the integration of behavioral health and primary care.

The following is a summary of themes that emerged from the 65 RFI responses (peers, providers, hospitals, trade associations, health plans, licensed independent practitioners, advocacy organizations) and more than 100 participants who attended one of the public forums. This summary is a compilation of the suggestions and comments of the RFI respondents and represents the Department's best attempt to summarize these comments. It is not a complete list of all comments submitted or expressed at the public forums, nor does it constitute or imply endorsement or acceptance of any such suggestions and comments by DMH or the Task Force.

Behavioral Health Integration RFI/Public Forums Themes

1. **Clinical Models**
    a. Significant support for integration through a variety of clinical models including full integration, co-location within primary care, reverse co-location of primary care within behavioral health clinics and coordination. There was also some support for developing full integrated health care clinics within school based clinics and integration within the acute mental health setting.
    b. Many respondents specifically referenced the National Council's Four Quadrant model as a reasonable approach to identifying which consumers could potentially receive the most appropriate level of care within varied integrated care settings.
    c. With respect to full integration, many respondents indicated that they believe that individuals whose healthcare needs match Quadrant I (low to moderate behavioral health and low to moderate physical health) may be best matched to benefit from brief behavioral health intervention and care coordination within primary care. This type of integration supports individuals in accessing and adhering to behavioral health treatment; it does not replace the outpatient behavioral health provider.
    d. Many respondents indicated support for across-the-board behavioral health screening for conditions for which there is a validated and standardized screening tool (e.g. PHQ-9, SBIRT, CAGE, etc.). In addition, many respondents indicated brief intervention, motivational interviewing, behavioral activation, stress management and referral to treatment should be used to follow-up to screening.
    e. Maximizing use of integrated care planning.
    f. Inherent to all models, concerns were expressed about the need to assure adequately trained behavioral health clinicians are available to meet the needs of individuals who screen positive for a behavioral health service. If there isn't a supply of trained personnel within the Primary Care setting and outside, the responsibility for care will be unfairly shifted from the PCP to behavioral units without resources to match.
    g. With the emergence of office based treatment for opioid addiction and screening for early detection of problematic substance use, behavioral health specialists who are experienced and certified in addiction treatment based in primary care settings may reach a broader population who may not otherwise have sought treatment.
2. **Reimbursement**
    a. Almost unanimously, concern was expressed about need to ensure that behavioral health rates are adequate to support the full range of services whether or not part of an alternative payment model (capitation or bundle) or fee for service.
    b. Care coordination- many different layers and staff have been identified to deliver care coordination without clear guidelines for prioritization, volume and rate of reimbursement.

c. Clear recommendations were expressed to ensure that screenings and appropriate follow-up meet the definition of a covered service. In addition, service planning should be a covered service.
d. Reimbursement for psychiatry consultation to primary care providers was widely supported, particularly for child/adolescent and areas that have low resource availability.
e. Many respondents expressed deep concern that performance incentives in risk adjusted models that use behavioral health screening as a measure need to be monitored for behavioral health follow up rate not just screening and referral.
f. Some respondents specifically indicated that behavioral health providers who practice in integrated systems or a part of a coordinated system should be included in any shared savings model.
g. Many respondents expressed need to have restrictions that prohibit billing for same day primary care and behavioral health and that prohibit billing for behavioral health without a mental health clinic license eliminated as these are inconsistent with integration.
h. As Massachusetts moves toward a matrix of payers with very different payment structures, the administrative rules for meeting the varied network requirements is creating increased administrative burdens not simplification.
i. Independent practice behavioral health clinicians are looking for strategies to coordinate but not integrate and are concerned about preserving adequate reimbursement streams in rate capitation models where they may be out of network.
j. In reimbursement models for behavioral health that remain fee for service or are included within an alternative payment model (capitation or bundles), many respondents expressed need to create a reimbursement rate category for peer/family partner services as well as other health outreach worker and navigator roles.
k. Several respondents recommended examination and/or elimination of prior authorization requirements for standard behavioral health (akin to referral from primary care for other medical specialty services) to support a more natural work flow between primary care and behavioral health.
l. There was a desire for clear policies and mechanisms for reimbursement for non-face-to-face aspects of care (e.g., "collateral contacts," telephone interventions, coordination between providers and between providers and community supports.)
m. Reimbursement should be available for longer visits.

3. Workforce

a. There was almost unanimous support for expanding the 'trained' peer, family partner, and health outreach and navigator workforce. In some responses 'trained' was directly associated with certification while in others it was associated with lived experience or training in whole health resiliency models.

b. Access to and supply of trained licensed behavioral health professionals of all specialties was frequently discussed as a challenge to meeting the full demand that increased screening may produce.
c. There were a number of specific recommendations about the value of training both medical and mental health specialists in the delivery of screening and treatment for problematic substance use and addiction. Encourage certification where possible. Offer substance use disorder CMEs.
d. Many respondents expressed concern that closed networks may force patients who may have strong therapeutic alliances to choose between their providers and health coverage requirements.
e. Access to psychiatry in some areas and for child/adolescent groups, in particular will challenge the health care system to develop creative solutions (e.g. MCPAP) to meet demand.
f. Many respondents expressed need to ensure that networks had robust referral relationships to psychological and neuropsychological resources to ensure timely access to specialized assessments and for follow-up to universal screening. Several respondents noted concerns about the heavy administrative authorization requirements to seek reimbursement for such specialty referrals.

4. Freedom of Choice

a. Many respondents who self identified as engaged in behavioral health treatment expressed concern that they will lose trusted providers in the evolving health care system.
b. Many behavioral health clinicians expressed concern that either by network structure or loss of revenue, they will be forced out of practice or moved into a private pay market share.
c. Some respondents expressed concerns that integration would mean an inability for the patient to choose their behavioral health provider, or that seeking care in an integrated environment would prevent them from seeking behavioral health care outside of the integrated environment.

5. Privacy

a. There was a full range of comments regarding confidentiality/privacy laws and electronic health records access. Comments ranged from absolutely no access to behavioral health records to limited sharing with consent to full sharing with and not explicitly with consent to 'opt in' and 'opt out' options.
b. In health care environments where there is shared electronic health records access, there were many recommendations for requiring technological solutions, like firewalls and password access to behavioral health records along with clear written consent protocols.
c. History of and risk for continued discrimination on the basis of behavioral health status were most frequently cited as the reasons for concerns about sharing behavioral records.
d. For respondents who were commenting from the perspective of family and child/adolescent care perspectives, additional concern was expressed regarding health care information about parents that may be present in a

child health record posing exposure risk in custody hearings. In addition, there was concern about adolescent and teen issues (e.g., substance use, pregnancy) being exposed to the parents without permission.

6. **Regulatory**
    a. Several respondents requested review and elimination of clinic license regulations that directly conflict or are contradictory to the integration effort (e.g. requirement for segregated waiting room spaces).
    b. Some respondents expressed desire for a greater degree of alignment of state oversight bodies, specifically DPH, DMH and MassHealth. As varied healthcare reform initiatives are being tested through demonstration projects, multiple reporting requirements may create need for redundant systems.
    c. There needs to be consumer education, transparency, and strong enforcement of state and federal parity laws. Integrated models of care will require additional standards to ensure parity compliance. Some respondents expressed concerns with compliance by behavioral health "carve-outs".
7. **Performance Measurement**
    a. Many respondents recommended alignment of performance measures across the varied demonstration projects (e.g. PCMH, Duals Demonstration, Health Home).
    b. One respondent importantly noted that there is a difference in measuring the extent of integration and measuring the quality of services in integrated settings.
    c. Recommendations for performance measures in integrated settings included:
        i. # of individuals who received behavioral health screening in the primary care setting and rate of follow through in treatment
        ii. Length of time on referral waitlists
        iii. Medication reconciliation at each transition of care
        iv. Satisfaction with services
        v. HEDIS 2012
        vi. NQF Behavioral Health Integration
        vii. ED use for behavioral health / mental health needs

8. **Care Coordination**
    a. Close partnerships between primary care providers (and their care management staff) and behavioral health providers is necessary to ensure ready access to services, coordination and continuity.
    b. Disease registries, tracking registries or use of an informatics system were suggested as ways to help enhance care coordination across multiple settings and reduce duplication of services. These systems could also be used to track symptom and functional improvement.
9. **Education and training**

a. Importance of mandatory education/training of PCPs in relation to treating physical conditions of those with BH needs can't be overstated, but needs to be targeted.
b. Should educate about Metabolic Syndrome – b/c greater impact on overall physical health (MAMH); particularly true for patients with schizophrenia.
c. Training on screening and use of assessment tools (for PCPs).
d. Training for BH providers to manage some medical issues.
e. Training for PCPs should include people with lived experience.
f. Training on person-centered care.
g. Training in addiction medicine.
h. Destigmatizing mental health.
i. Suggestion that PCP settings provide focus groups/sessions on impact of drug/alcohol/tobacco; sponsoring recovery support activities; mindfulness groups to reduce stress; etc.
j. Educate consumers about purpose and benefits of integrated care.

Children's Behavioral Health Advisory Council
Recommendations to the Behavioral Health Integration Task Force

The Children's Behavioral Health Advisory Council is pleased to provide the Behavioral Health Integration Task Force with advice and recommendations on the issues identified in Section 275 of Chapter 224 as they affect behavioral health care for children.

The Council was established by *Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental Health* as part of a comprehensive set of reforms in the children's behavioral health system. The Council is a unique public-private partnership representing child-serving agencies, parents, and professionals with knowledge and with expertise in the field of children's behavioral health. Council activities have ranged from viewing initial data on service utilization and penetration, including In-home Therapy, Intensive Care Coordination and Family Support and Training, to a detailed and thorough review of commercial insurance practices; from examining the challenges of workforce development to the research and development of culturally-informed best and promising practices, and the reduction and elimination of racial and ethnic disparities. We take a broad view of child health as encompassing healthy development over time, not just the amelioration of problems. Although much of our work has focused on reforms in the public children's behavioral health system, our purview encompasses the entire children's behavioral health system, both public and private payers.

We welcome the opportunity to assist the Behavioral Health Integration Task Force (BHTF) in completing its charge as outlined in *Section 275 of Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*. We view Chapter 224 as the next critical phase in the ongoing improvement in the children's behavioral healthcare system. Over the past few years, significant effort and investment have been made to improve the MassHealth children's behavioral health system, which serves approximately one-third of the children in the Commonwealth. Some of that investment has extended into the privately insured healthcare system, e.g. the Massachusetts Child Psychiatry Access Program.

Our recommendations are informed by our work together over the past five years as a Council. In addition, we invited leaders from MassHealth's Patient-Centered Medical Home Initiative, the Child Health Quality Coalition, and Boston Children's Hospital to share their expertise with us. Some Council members also attended the Task Force's early meetings in order to learn from its expert guests. Several Council members have shared their professional organizations' (e.g., AACAP, AAP) white papers on primary and behavioral health integration. We are excited to see an emerging consensus about the key principles and strategies for improving healthcare quality and cost through primary and behavioral health care integration. We hope our advice helps to move the conversation from conceptual to operational.

CHILDREN AND HEALTHCARE REFORM

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience "significant impairment" and 5 percent experience "extreme functional impairment."[91]
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.[92]
- About 36% of youth with any lifetime mental health disorder receive services, and only half of these youth who were severely impaired by their condition received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime.[93]

It would be easy, but a mistake, to overlook the needs of children in the context of the healthcare reform efforts required by Chapter 224. Children are not "cost drivers" when compared to some groups of adults, e.g. adults eligible for both Medicaid and Medicare. However, without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults.[94] Moreover, the Adverse Childhood Events literature (discussed below in Section V) underscores the impact of the consequences of adverse childhood events on adult physical and behavioral health morbidity, mortality and costs.[95] There is clear and expanding scientific evidence that toxic stress, associated with adverse child events, can permanently alter brain maturation broadly and particularly in the prefrontal cortex, hippocampus and amygdala, as well as the nerve interconnections between them. These brain changes may be permanent and may not change easily, once established, underscoring the importance of prevention and early intervention. [96]

GUIDING PRINCIPLES

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[91] Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999

[92] NIMH, Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.

[93] NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011

[94] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

[95] http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html

[96] Neuroscience, molecular biology and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. Shonkoff JP et al. *JAMA* 2009: 301(21): 2252-2259

In addition to an abiding commitment to children's health and well-being, our recommendations are guided by the following beliefs.

- Children's development to become healthy adults should be supported through prevention and early intervention services and supports. Families with risk factors for distress and impairment in the child should have access to, as well as support for engagement with, helpful resources that are community-based and culturally competent.
- Healthcare services should be organized and delivered in a manner that helps families and youth become better health consumers and builds their self-efficacy skills and independence. Healthcare providers must partner with families and transition age youth at all levels in the behavioral health care system.
- No one size fits all. Pediatric and family medicine practices vary in size, communities vary in available resources, and families, youth, and children have different strengths, needs, and cultures. Integration strategies must be sufficiently robust and flexible to address racial and ethnic disparities in access, treatment, and outcomes.
- Current investments and initiatives should be leveraged for their operational capacity and emerging promising practices. These initiatives include the Children's Behavioral Health Initiative (CBHI)[97], the Massachusetts Child Psychiatry Access Program (MCPAP)[98], the Patient Centered Medical Home Initiative (PCMHI)[99], and the Child Health Quality Coalition (CHQC)[100].
- The move to integrated care will and should be an evolution. Moving from fee-for-service to alternative payment methods might require some short-term bridging strategies. Extending the empirical evidence base to support innovations and refinement of current precedents such as CBHI and MCPAP will take time and require systems that can adapt to emerging evidence about what works with the populations served.
- Pediatric behavioral healthcare costs and return on investment (ROI) are dispersed into other systems (e.g., schools, child welfare, juvenile justice) and into the future (e.g. physical health, substance abuse, prison, employment, parenting competence). However, the inability to fully capture that ROI to fund healthcare reforms today should not deter us from investing in improving the quality of children's healthcare. While the ROI within healthcare over the short term might be minimal, ROI to society as a whole over time and across generations will be substantial.

[97] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/

[98] Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatry Access Project. B. Sarvet et al. *Pediatrics* published online Nov 8, 2010; DOI: 10.1542/peds.2009-1340

[99] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/

[100] http://www.mhqp.org/collaboration/chqc.asp?nav=063700

RECOMMENDATIONS

In order to facilitate the BHTF's work, our recommendations are organized according to the six questions posed by the Legislature in Section 275 of Chapter 224. In some cases, we have taken the liberty of addressing the general issues raised, rather than specifics, in a manner that best applies to children and their families.

I. The most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care.

Integrating behavioral health services with primary care requires several structural mechanisms to bridge these two care delivery systems. We view the patient-centered medical home (PCMH) model and System of Care (SOC) [101] models as compatible with each other and as strong platforms on which to build these integrating mechanisms.

We acknowledge that these mechanisms have not yet been established through empirical research as "effective and appropriate." However, there is expanding evidence and consensus from a variety of sources, including references cited in this document as well as innovators' experiences and the professional experiences of Council members, which has informed our deliberations. Implementation of these integrating mechanisms should include a strong research / evaluation component in order to assess their cost-effectiveness and to promote continuous quality improvement.

Care Integration Recommendations

1. Behavioral health screening, using evidence-based standardized tools, at every well child visit should be required and reimbursed for all primary care providers for all children up to age 21. When a PCP deems necessary, both a mental health screening and a substance abuse screening should be allowed in a single visit. Post-partum depression screening should be included in well-child visits for parents of children under six months in age. Primary care providers in the adult system should provide age appropriate behavioral health screening to their transition age youth patients.
2. Behavioral health consultation should be readily accessible to primary care providers. A range of arrangements supporting strong working relationships between behavioral health providers and primary care providers should be allowed. These arrangements include, but are not limited to, co-location.
3. Peer supports, including family partners with "lived experience" raising a child with behavioral health challenges and youth mentors, should be a standard

[101] The System of Care Handbook: Transforming Mental Health Services for Children, Youth and Families. Stroul BA and Blau GM. Paul H. Brookes Publishing Co., Baltimore, 2008.

service that is readily available. Peer supports are critical for initial and on-going engagement of families and youth who might be reluctant to or lack knowledge about and/or skills for engaging with behavioral health care. Reimbursement should be sufficient to allow for ongoing coaching and support for the emerging workforce.

4. Care coordination should be a standard of care and reimbursed for all children receiving both primary and behavioral health care. For most children, the PCP's on-going relationship means that they will be best able to provide care coordination. However, behavioral health providers might be better able to coordinate care for children with significant behavioral health conditions.

1. Behavioral Health Screening

The first step in integrating behavioral health care is identifying the need for it. Nationally, the average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years – critical developmental years in the life of a child.[102] Behavioral health screening using validated tools provides an effective, evidence-based approach for increasing early identification and intervention, which can both improve outcomes and reduce the costs of mental illness.[103]

Since 2008, MassHealth has required and reimbursed PCPs to conduct behavioral health screening at well child visits (up to age 21) as required by Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) provision. MassHealth established a list of clinically appropriate standardized screening tools from which providers select, based on the age of the child. The data below illustrate that it takes time to make significant progress and that, even with reimbursement available, screening does not occur at all visits for all children, as it should. Frequent public reporting and monitoring are important and should be expanded beyond MassHealth.

	Jan-March 2008		Jan – March 2011	
	% visits with BH screens	% BH need identified	% visits with BH screens	% BH need identified
< 6 months	8%	6%	43%	2%
6 mo to 2 years	17%	6%	73%	5%

[102] Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, American Academy of Child and Adolescent Psychiatry

[103] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

3 years to 6 years	18%	9%	76%	9%
7 years to 12 years	20%	11%	77%	11%
13 years to 17 years	18.5%	12%	71%	11%
18 years to 20 years	7%	24%	34%	11%
ALL	15%	11%	67%	8%

Source: CBHI website

For children under six months in age, the low screening rate has been explained by some as due to the lack of an appropriate screening tool. Primary care providers have advocated for the substitution of postpartum depression screening for a child mental health screen.[104] The Council recommends requiring and reimbursing post partum depression screening, in addition to developmentally appropriate screens, at well-child visits for parents of children under six months in age. Identifying and treating post-partum depression is critical. Postpartum depression has a significant adverse effect on young children's cognitive and emotional development in the preschool years. Treating maternal depression improves the cognitive and social emotional development of young children even in the absence of any direct intervention with the child.[105]

At the other end of the age spectrum, screening rates are likely lower among 18 to 20 year-olds because they are frequently seen in adult care, rather than pediatric settings, where providers are more often unfamiliar with the screening requirement.[106] The Council recommends educating primary care providers in the adult practices about the importance of behavioral health screening. In addition, reimbursement should be allowed for both a mental health screening and a substance abuse screening in a single visit. Currently, providers are limited to one screening and must choose between screening tools that do not cover both mental health and substance abuse.

[104] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

[105] Children of affectively ill parents: A review of the past 12 years. Beardslee WR, Gladstone TRG, and O'Connor E. Jl of Am Academy of Child and Adol Psychiatry, 50, 1098-1109, 2011

[106] Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit. TeenScreen National Center for Mental Health Checkups at Columbia University. 2010

2. Behavioral Health Consultation

One quarter of pediatric primary care visits address behavioral issues.[107] When a behavioral health concern is identified, the primary care provider must have access to a behavioral health provider for (1) clinical consultation, if needed, and (2) connecting a child / family either for a brief intervention or longer term services. A licensed behavioral health provider should, ideally, be on site to provide "curbside" consultation to the primary care provider. These consultations might take as little as ten minutes. Access to psychiatric consults will likely be through a combination of on-site and virtual, since most primary care practices will not generate enough need to support a full-time psychiatrist on site.

Based on the consult, a referral might be needed for direct services. Some children will need only a brief intervention, which could be provided by the on-site behavioral health provider using a brief solution-oriented treatment approach. Other children will need longer-term care provided by a community-based organization. The on-site behavioral health provider or a care coordinator could locate an appropriate community-based provider and make the referral. The MCPAP teams include care coordinators for this purpose. [MCPAP is described below under "Telemedicine".]

3. Peer Support: Family Partners and Youth Peer Mentors

Every healthcare professional has a responsibility to engage families and children in the care delivery process. However, engaging with families and children presents unique challenges. Unlike adults where engagement is with the identified patient, for children (the identified patient) engagement is primarily with the parents. Engaging parents around family behavior change and use of community supports can be challenging. Some parents don't think their young children could have a behavioral health problem, so they see no reason to consult a behavioral health provider. Some may view other needs in the family, such as employment, housing, childcare or transportation, as requiring priority attention before or concurrent with mental health treatment for their child and family. Others may be wary of involvement with the "system" based on previous negative experiences with providers. Others are burdened with their own medical, behavioral health and/or substance use disorders.

A variety of engagement strategies are necessary, with choices available to families. Some families may prefer to engage with professionals with expertise in subject matter

[107] Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

and exceptional family engagement skills. Evidence-based strategies for family engagement by clinicians and behavioral health settings have shown excellent results.[108] However, some families will benefit from and want the support of a person, a Family Partner, who has lived experience caring for a child with behavioral health needs. For older adolescents and young adults, young adult peer support, analogous to parent to parent support for parents, may be critical to promote the youth/young adult's engagement in care coordination and treatment.

A Family Partner service (called "Family Support and Training" services) and workforce has been built in the MassHealth system over the past five years. Family Partners are individuals who have raised children with special health care needs (usually behavioral health needs) and who have been specially trained to work with other caregivers. Initially, this service was available only to families whose children received intensive care coordination (ICC). Approximately three-quarters of the ICC users also accessed Family Partner services in FY2011. Based on numerous requests by families, this service has been expanded to cover families whose children receive in-home therapy or outpatient services without receiving ICC. Anecdotal evidence from MassHealth services shows extremely high family satisfaction with Family Partners and good success in engaging families who might otherwise not follow though with care.

On a smaller scale, MassHealth has funded "Therapeutic Mentor" services to support skill building and effective use of treatment by youth served within Intensive Care Coordination. As noted above, half of all lifetime mental illness develops by age 14 and three-quarters by age 24. Good behavioral and primary care at this age can change the trajectory of their adult well-being. Yet, as youth transition to adulthood, the safety net of family is receding leaving them to manage health risks on their own with limited experience with self-care (e.g., making or keeping appointments). Reaching out to and supporting transition age youth in accessing and engaging in behavioral health care is critical and deserves dedicated resources.

Peer supports have value even beyond their work with families and youth. They can be critical in promoting engagement by supporting cultural competence, by helping the workforce reflect the population served, as well as by serving as cultural "bridges" to other providers working with the family and youth. They can also help educate their healthcare colleagues and de-stigmatize behavioral health conditions by sharing their lived experiences.

[108] Integrating Evidence-Based Engagement Interventions Into Real World Mental Health Settings. McKay, M. et al. Brief Treatment and Crisis Intervention, Oxford University, 4, 2, 177-186, 2004.

The Council also endorses engaging families and youth beyond just the receipt of services for their children. Patient and family engagement should include patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, evaluation, and policy-making – to improve health and healthcare.[109]

The Council lauds the Chapter 224 requirement that Accountable Care Organizations include a consumer representative in their governing structure. We recommend that ACOs appoint more than one consumer representative. At least one should represent families whose children receive both primary and behavioral health care and one should represent transition age youth. Examples worth noting include the Pediatric Primary Care Organization at Children's (PPOC), which is working with several of its practices to establish family advisory councils, and the PCMHI Workgroup on Behavioral Health Integration and the CHQC Task Force on Care Coordination whose members include parents of youth with physical and behavioral health chronic conditions.

4. Care Coordination

Care coordination should be a standard of care for all children. We have benefited from the significant effort of our colleagues on the Child Health Quality Coalition in defining how care coordination functions as a key integrating mechanism. The Council endorses the definition of care coordination put forth by Dr. Richard Antonelli and his colleagues[110]:

> Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

The MA Child Health Quality Coalition's Care Coordination Task Force's Care Coordination Framework identifies a structure for implementing care coordination as a standard of care. The Framework was developed by a multi-stakeholder task force with strong family representation and builds on implementation experiences nationwide. It offers a foundational set of care coordination services that is broadly applicable independent of condition, severity/acuity, or age, including adults, with the obvious additions of references to schools and transitions from pediatric to adult care.

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[109] Patient and Family Engagement: A Framework For Understanding The Elements and Developing Interventions and Policies, K. L. Carman, P. Dardess, M. Maurer, S. Sofaer, K. Adams, C. Bechtel, and J. Sweeney. *Health Affairs* 32. No. 2 (2013): 223-23.

[110] Making Care Coordination A Critical Component of the Pediatric Health System: A Multi-disciplinary Framework. R. Antonelli, J. McAllister, and J. Popp. Commonwealth Fund pub no. 1277. May 2009

Key Elements of High-Performing Care Coordination Linked to Process, Structure, and Outcome Measures to Monitor Their Adoption

7. Needs assessment for care coordination and continuing care coordination engagement
8. Care planning and communication
9. Facilitating care transitions (inpatient, ambulatory)
10. Connecting with community resources and schools
11. Transitioning to adult care

Antonelli and colleagues delineate the following functions incorporated into care coordination. They also note that these functions are applicable across all ages (i.e., children and adults).

1. Provides separate visits and care coordination interactions
2. Manages continuous communications
3. Completes / analyzes assessments
4. Develops care plans with families
5. Manages / tracks tests, referrals, and outcomes
6. Coaches patients / families and promotes family engagement in treatment
7. Integrates critical care information
8. Supports/ facilitates care transitions across both settings and ages
9. Facilitates team meetings
10. Uses health information technology to organize care coordination activities

These functions could be performed by any member of a care team. Some (likely larger) practices might establish a dedicated care coordinator position. Others will distribute these functions among members of the care team. The competencies that are needed by whomever provides care coordination are:

1. Develops partnerships
2. Proficient communicator
3. Uses assessments for intervention
4. Facile in care planning skills
5. Integrates all resource knowledge
6. Possesses goal/outcome orientation
7. Approach is adaptable and flexible
8. Desires continuous learning
9. Applies solid team building skills
10. Adept with information technology

Instruments to assess the need for care coordination for behavioral health needs as well as the need to enhance patient or provider engagement ("activation") are needed.

Examples of the former are the AACAP Child and Adolescent Service Intensity Instrument (CASII)[111] and the Patient Activation Measure.[112]

Locus of Care Coordination

For most children, it is the primary care provider who has an on-going connection and, thus, will be best able to serve as their medical home. However, there may be periods of time during which children with more intensive and chronic behavioral health needs could be better served by their behavioral health provider as their medical home. In fact, MassHealth is exploring how its 32 Community Service Agencies (CSAs) could serve as a health home (a special kind of medical home) for children with intensive behavioral health needs. A recent publication, "Customizing Health Homes for Children with Serious Behavioral Health Challenges", provides some helpful guidance on this, making the following points about how and why health homes are different from medical homes[113]:

- Health homes are intended for populations with chronic conditions, including those with serious behavioral health conditions, while medical homes are intended for every individual.
- Medical homes historically have focused on the coordination of medical care, while health homes are intended to build linkages to community and social supports and coordinate medical, behavioral and long-term care.
- Medical homes tend to use physician-led primary care practices as the coordinating entity or team. Health homes may use other types of entities, such as behavioral health provider organizations.
- General estimates are that two-thirds of the children served in intensive care coordination models like the CSAs are involved in child welfare and/or juvenile justice and sixty percent are involved with special education. The coordination among these systems along with behavioral health services consumes most of the care coordinators' time rather than the interface with primary care.
- This extensive systems involvement as well as the need to work closely with caregivers creates a complexity that has implications for care coordinator staffing ratios and qualifications as well as reimbursement rates.

Design and Operational Flexibility

[111] www.AACAP.org

[112] www.insigniahealth.com/solutions/**patient-activation**-measure

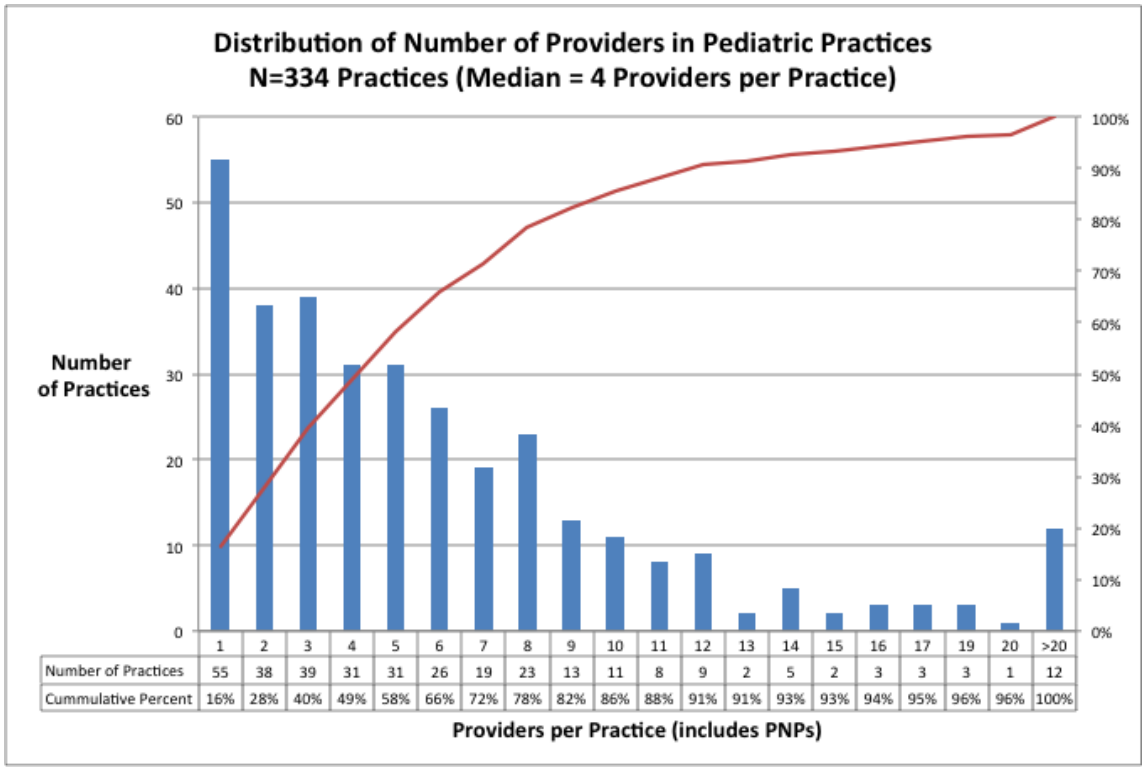
[113] Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

It is difficult to predict how many behavioral health providers, care coordinators, and peer partners would be needed at a PCP practice, an ACO, or system-wide. We asked our guest experts about the ratio of these staff to a primary care pediatrician's caseload within their practices. They generally estimated five primary care pediatricians would generate a full time workload for one care coordinator, but cautioned that testing and refinement of processes and relationships is needed. The demographics of the population served by each practice or ACO will have significant impact on the care coordinator and peer partner capacity needed. For minority populations and/or families living in poverty, there will likely be a relatively greater need in order to reduce disparities in access, treatment, and outcomes.

The varying size of primary care practices indicated in the chart below means that a number of arrangements will be necessary. These arrangements include: coordinated but not co-located, co-located and coordinated, and co-located and fully integrated. Small group practices and solo practitioners will likely need to develop arrangements to share capacity. Even a medium-sized group practice might not be able to afford a dedicated care coordinator but rather have a behavioral health specialist and peer partner share care coordination responsibilities. MCPAP is a good model for sharing capacity virtually. The CSAs could provide a base of support for Family Partners and Youth Peer Mentors, as they currently do for CBHI Family Partners.

Several experts shared with us the benefit of co-location in allowing a primary care provider to introduce the family/child to a behavioral health specialist, noting that a referral from a trusted provider increased comfort level with a behavioral health provider. They also noted the strong working relationships that develop because of co-location. They were careful to note that care coordination and co-location do not necessarily mean that care is integrated. Co-location eases integration, making it more likely, but doesn't guarantee it.

There is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. Care coordination, which is the key process for integrating care, should not be defined solely by its physical location. Primary care providers will need to be able to develop effective relationships with family therapy teams and with care management entities to support a significant portion of their patient populations. **Attachment A** provides vignettes of three children, their families, and their healthcare needs that illustrate the range of integration arrangements that will be needed in a well-functioning system.



Providers per Practice (includes PNPs)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	19	20	>20
Number of Practices	55	38	39	31	31	26	19	23	13	11	8	9	2	5	2	3	3	3	1	12
Cummulative Percent	16%	28%	40%	49%	58%	66%	72%	78%	82%	86%	88%	91%	91%	93%	93%	94%	95%	96%	96%	100%

Data from the MCPAP database. Provided courtesy of the Massachusetts Chapter of the American Academy of Pediatricians

Telemedicine

Given the varying sizes of pediatric practices, telemedicine will be an important mechanism to support integration. Small PCPs will likely need to access behavioral health consultation, peer supports, and care coordinators virtually.

The Massachusetts Child Psychiatry Access Project (MCPAP) solves this problem by providing primary care clinicians with virtual access, via telephone, to child psychiatry consultation. Funded by the Department of Mental Health and managed by the Massachusetts Behavioral Health Partnership, MCPAP is comprised of six regional teams of 1 FTE of a child psychiatrist, 1.5 FTE of a licensed social worker, and 1 FTE of a care coordinator. The regional focus helps foster relationships between PCP practices and their MCPAP team and promotes a teaching orientation. The program is designed to give primary care providers consultative support to manage children with less complex behavioral health needs, freeing the limited child psychiatry workforce to manage children with more complex needs. Services include: answering a PCP's diagnostic or therapeutic question, assistance in accessing behavioral health services, transitional care until those services begin, and acute psychopharmacologic or diagnostic consultation. PCPs may access MCPAP for any child regardless of insurance

type; more than half of the encounters are for privately insured children. [114] Commercial insurers have resisted requests to pay their fair share for MCPAP; we recommend that they be required to do so.

Workforce Development

Our Council membership represents a range of disciplines, each one committed to working through the challenges of primary and behavioral health care integration. We recognize that each of our disciplines has its own language, practice culture, professional licensure, and professional development resources.

Whether working on an integrated team, co-locating, or coordinating care between two provider sites, all primary care and behavioral health providers will need to become "bi-lingual", able to speak the language of both the primary and behavioral health care systems. Behavioral health specialists who work in primary care practice will likely be the solo practitioner and thus need to be a seasoned and skilled professional. Primary care practices will need to be welcoming and supportive of behavioral health providers.

We encourage the training programs and credentialing bodies of each discipline to take a leadership role in preparing and supporting professionals to collaborate with colleagues in order to deliver integrated care. Training programs to produce skilled behavioral health specialists to work in primary care settings are needed, as are training programs for pediatricians in working with behavioral health specialists. An example is the AACAP "Toolkit in Training for Systems-Based Practice" developed to support training of child and adolescent psychiatrists in these areas.[115] Licensing boards for the behavioral health professions should review licensure statutes and regulations to ensure that they do not create obstacles for training and supervised practice in innovative settings and practice models.

Ongoing professional development and learning opportunities will be needed to help health care providers continue to develop their abilities to work in an evolving integrated healthcare system. Continuing education requirements (e.g., CEUs) must reflect the specific knowledge and competencies needed to be an effective practitioner. In addition to formal training, real-time learning opportunities and communities of practice will be important. Payment methods and productivity expectations must allow for the time to participate in these opportunities.

Peer supports need specific training and ongoing coaching and supervision, as well as a "home" where they can support each other. Accreditation for peer support specialists is

[114] The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care. Wendy Holt. Commonwealth Fund pub. 1378, Vol. 41. March 2010.

[115] http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

supported the National Federation of Families for Children's Mental Health.[116] Resources are needed to develop this new workforce.

Performance Measurement

The Council believes strongly in the importance of outcomes. Ultimately, the significant effort and investment in integrating primary and behavioral health care is worthwhile only if it results in better health and wellbeing outcomes for children. We believe that the integration mechanisms that we recommend will do so; however, we acknowledge that they have not been rigorously studied and should be. Thus, we recommend that initial efforts focus on measuring and studying the quality and cost effectiveness of any integration mechanisms used. We need to know how these mechanisms are operating in order to understand their impact on quality, cost, and outcomes. The Council points to work of the Child Health Quality Coalition in inventorying measurement domains as a useful starting place for developing and testing measures of care coordination. Since care coordination measurement is in its earliest stages of development, we recommend that measures be promoted for usability and feasibility testing prior to requirements for pay-for-performance.

We also recommend measuring key process milestones towards good clinical outcomes (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction). Payers should invest in creating a culture of reporting by providing incentive payments to providers for collecting and using data to improve their performance. Reporting should allow providers to demonstrate their quality, especially those in new areas of performance, as well as to identify areas needing improvement.

Linking Pediatric Care with Care for Parents

Parents of children with a behavioral health condition are often under great stress and /or burdened with their own physical and/or psychological disorders. This can impede their ability to fully care for and to manage care for their children. Care coordinators and family partners can help the parent become more aware of how their unmet healthcare needs may adversely impact their best efforts to care for their children. Care coordination for children's health care should be prepared to develop linkages with the parents' medical care, in conjunction with the parent and the child's PCP, as needed.

II. How current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes.

[116] http://certification.ffcmh.org/resources

Our advice and recommendations come at a time of significant transition in healthcare payment methods. Some health insurers have already or are in the process of implementing alternatives to the traditional fee-for-service payment methods. We see great potential in using payment methods as a means to facilitating integration and achieving higher quality. We caution against using payment methods simply as a means to drive down costs. Investing in quality will be cost-effective over the long term. That said, we anticipate that fee-for-service payment will exist for a while longer, whether at the provider organization level or at the individual practitioner level. Therefore, our recommendations are intended to address both traditional and emerging payment methods.

Whether by supplementing fee-for-service rate schedules or by incorporating an alternative payment method, the integration mechanisms described above must be reimbursed / funded in order to achieve cost effective, quality care for children. In addition, reimbursement barriers to primary and behavioral care integration must be reduced so that we can learn what the service need really is and what it will take to deliver it. The real cost of behavioral health services is not currently known since behavioral health services have historically been under-utilized and underfunded. We caution against developing alternative payment methods that include behavioral health in a comprehensive rate until there is sufficient data available to inform utilization and pricing targets. Aligning billing requirements with the routines of integrated care, rather than with separated primary and behavioral health care as they are now, will help reveal actual need and cost.[117]

- Care integration services should be reimbursed as a bundle that incorporates the ten functions and the CHQC care coordination framework elements listed above. PCP practices will need leeway to determine the best way to staff those functions, given the size of their practice and the potential partners and resources available in their communities.

- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of behavioral health screening at every well child visit. Providers should not be limited to one screening per visit, as is the case currently. If they deem necessary for assessing a youth's health, they should be reimbursed for conducting both a mental health and a substance abuse screening. In particular, reimbursement for behavioral health screening should be mandatory for any adolescent who screens positively for substance use disorder (SUD), given the very high rate of co-morbidity of a mental health diagnosis in the context of a SUD.

[117] The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

- All payers should be required to reimburse pediatric primary care providers for administration, scoring, and interpretation of post partum screening in pediatric well child visits for parents of children under six months in age.

- Several other changes are needed to make it possible to support and refine the integration of primary and behavioral health care.[118] [119]
    - Eliminate any restrictions on same-day billing between behavioral health and primary care providers.
    - Allow both primary care and behavioral health providers to bill for overlapping time.
    - Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day.
    - Allow for brief intervention services to be billed before a full assessment is completed.
    - Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
    - Set rates for consultation time to a PCP commensurate with rate for psychotherapy direct service.
    - Pay primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without their child present when the focus of the visit is the child's healthcare needs.
- Reimbursement methods should support the adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care. Parent training programs have a particularly strong evidence base and we call attention to two: the Family Talk Preventive Intervention and the Positive Parenting Program (Triple P). Developed by our colleague and Council member Dr. Beardslee, Family Talk is designed to help families identify the effects of parental depression, share individual experiences with parental depression, build on family strengths, improve family communication about depression, build coping skills and develop strategies to promote resilience in parents and children. [120] Triple P gives parents simple and practical strategies to help them confidently manage their

[118] The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

[119] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

[120] http://fampod.org

children's behaviors, prevent problems from developing, and build strong, healthy relationships.[121]

- We recommend measuring structure and process (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, family and youth satisfaction) before paying for outcomes. Managing any alternate payment method will require good measurement of process and proximal outcomes. It also requires fully defining care coordination and measuring when it is occurring as appropriate in order to assess its contribution to improved outcomes.
- Children will vary greatly in the amount of care coordination they require. Payment mechanisms need to accommodate this variation and must be structured so that payers and providers share risk for the cost of care, particularly for children with complex health needs and costs. Care coordination for children with modest needs for care coordination might be paid through a PMPM rate to the PCP, for example, while children with intensive needs requiring dedicated, low-caseload care coordination might receive this through a per diem rate.
- Establishing rates for a new service model, without a payment or utilization history, is hard to get right the first time. There must be sustained commitment and effort to review and adjust rates to ensure that they support both the service standards and the organizational supports required to manage the services (e.g., information technology). Insurers and providers must work together to review and adjust payment rates and/or methods to ensure high quality care is provided in a cost-effective manner.
- In addition to alternative payment methods for healthcare, it might be fruitful to explore alternative financing methods across child-serving systems. There are two points of access for children to receive behavioral health care services: pediatric primary care and schools. However, funding is siloed and healthcare reform doesn't impact some of the financing sources for school-based care. Some school-based care is provided by community-based agencies and reimbursed by insurance, while some services are provided directly by school personnel and financed by the school (e.g. municipal Medicaid, Federal grants). Methods that integrate healthcare financing across child-serving systems might allow for even more effective healthcare delivery integration and reduced healthcare costs.

III. The extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols.

Parity

Ensuring that behavioral health treatment is covered in the same way as treatment for physical health conditions, as legally mandated, is a critical foundation for the integration of behavioral health and primary care. Clear guidance for both providers and consumers and enforcement regarding parity will remain necessary as new health care delivery arrangements are developed. We support the numerous recommendations

[121] http://www.triplep-america.com/index.html

that our colleagues leading the Children's Mental Health Campaign have provided to the Division of Insurance.

Achieving Chapter 224's quality and cost goals requires a broader view of what it means to treat behavioral health and physical health conditions on par with each other. Focusing solely on the amount of services will not be sufficient as primary care providers become dependent on the quality of and access to behavioral health services. Quality behavioral health services can help improve primary care outcomes and costs if they are broadly available as well as reimbursed sufficiently and in a manner that allows them to be delivered as we have recommended in this document.

First, there must be a full array of community-based behavioral health services available to children and families regardless of where they live and what health insurance they have. Currently, MassHealth offers a richer array than do private insurers. Commercial insurers will need to offer an equally rich array in order to achieve quality and cost outcomes for children.

Second, parity also needs to include support for behavioral health interventions (e.g. talking to the patient or family) at a rate based on time and complexity commensurate with rates that support physical health interventions. For example, PCPs should not continue to be reimbursed more for the few minutes required to freeze off a wart than a half hour talking with the child or parents about a behavioral health issue such as the impact on the child of parental divorce when parents are putting the child in the middle of their conflict with each other. Reasonable rates will help ensure a sufficient number and range of behavioral health providers and services.

Choice

The Council believes strongly that families should be able to choose their healthcare providers. However, we recognize the tension between the value of according broad choice to families and the strategy of co-locating primary care and behavioral health.

Allowing families to choose to receive behavioral health from a provider that does not have a relationship with their PCP undermines the integration mechanisms that we recommend above. In an integrated system, when families choose a primary care provider, they will increasingly also be choosing a behavioral health provider.

Therefore, they should have access to information about how primary care providers integrate behavioral health services, how this might impact their children's care, and the expected benefits of coordinated or integrated care. Our hope is providers will offer primary care and behavioral health care services that are so responsive to and effective in meeting families' needs and concerns that families will choose these new integrated

arrangements. Peer supports can help families understand their options, and make well-informed choices, and be educated consumers of these new health arrangements.

IV. How best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services.

We believe that the functions and positions described in our response to Question I are key strategies for helping primary care providers recognize behavioral health conditions and to make appropriate referral decisions. Using standard screening tools to identify behavioral health concerns, consulting with behavioral health providers, and working with peer supports and care coordinators to access appropriate services are important patient-level strategies.

There are strategies at the macro level as well. First, professional development and licensure /credentialing bodies must reflect the knowledge and competencies required to be effective in a more integrated healthcare system. Experts in integrated care delivery could identify specific topics and competencies. Second, primary care providers will need to establish clear referral pathways and relationships with community providers. PCPs will need knowledge about and confidence in the organizations to which referrals could be made. Primary care and behavioral health care providers must work together to ensure that the right service capacity exists to meet the needs of children and their families. This means that the behavioral health service array should be equally robust as physical health services.

V. How best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness.

The co-morbidity issues for children are different from those of adults with serious mental illness. Children with serious behavioral health challenges do have high rates of expensive co-morbid physical health conditions. Recent estimates suggest that about one-third of Medicaid-enrolled children who use behavioral health care have serious medical conditions, principally asthma. However, Medicaid expenditures for children who use behavioral health care – even the most expensive of these children – are driven more by behavioral health service use than by use of physical health care – in contrast to the adult population.[122]

For children, the issues of concern are more often in reverse: it is the effect of emotional or psychological trauma, or toxic stress, on their physical health over their lifespan into

[122] Customizing Health Homes for Children with Serious Behavioral Health Challenges. Sheila Pires. March 2013.

adulthood about which healthcare providers need to be educated. There is ever-expanding basic science research demonstrating how ongoing stress of sufficient intensity can cause enduring changes in brain maturation across childhood into young adulthood. The most compelling evidence of this impact has been produced by the landmark Adverse Childhood Experiences (ACE) study. The ACE Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC).

Adverse Childhood Experiences (ACEs) include 10 types of adverse childhood experiences: childhood abuse (emotional, physical, and sexual abuse), neglect (physical and emotional), and family dysfunction (growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, a parental separation/divorce, or a family member incarcerated). Over 20% of respondents experienced three or more categories of trauma, or ACEs. The ACE Study examined the relationship between these experiences during childhood and reduced health and well-being later in life. It showed dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of death.

As the ACE Study gains traction across the nation, some states have collected statewide, population level ACE data gathered through the Behavioral Risk Factor Surveillance System (BRFSS). The MA Department of Public Health should explore the feasibility of incorporating the ACE questions in its annual BRFSS survey.

Investing in Wellness

According to the National Academy of Sciences, several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral disorders are greatest by focusing on young people. Interventions before the disorder occurs offer the greatest opportunity to avoid the substantial costs to individuals, families, and society that these disorders entail. [123]

Chapter 224 created a Prevention and Wellness Trust Fund, administered by DPH in collaboration with the Prevention and Wellness Advisory Board. All activities paid for by the fund must support Massachusetts's goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective

[123] Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. National Research Council and Institute of Medicine. Washington, D.C.: The National Academies Press. 2009

health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming. The Commissioner of DPH must award at least 75% of the fund each year through a competitive grant process to community-based organizations, health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need. [124]

DPH should take a strategically long-term approach to managing this Wellness Fund by investing, in part, in children's well-being. The Council recognizes that responding to ACEs and childhood trauma is not solely the purview of the healthcare system but also of the broader social services and public health systems. This Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations. It could utilize ACE data, along with other sources, to guide its grant-making and leverage existing initiatives that incorporate a trauma-focus into service delivery. Wellness Fund investments should be studied for their ROI.

VI. The unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records.

The Council recognizes that all of the above strategies for integrating care will have little impact if health information cannot be shared among all providers on a care team (regardless of physical location). We fully acknowledge the tension that exists between promoting communication among all members of a child's care team and ensuring that confidentiality and privacy protections are in place. Our colleagues on the Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues. The Council supports their emerging recommendations, provided in Attachment B.

One of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, DCF, and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to the sharing of information by parents and/or

[124] Summary of Chapter 224 of the Acts of 2012. Anna Gosline and Elisabeth Rodman, *Blue Cross Blue Shield of Massachusetts Foundation*. September 2012

young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances.

ATTACHMENT A: Three Vignettes Illustrating Primary Care and Behavioral Health Integration

The following three vignettes illustrate pediatric primary care and behavioral health integration at different levels of intensity of care coordination. We believe that family-driven care coordination, at all levels of intensity, is they key element of service integration as experienced by the youth and family. These vignettes are fictitious and are not based upon any specific child or family.

These vignettes are meant to demonstrate how a well-functioning system might respond to various levels of family need for care coordination. The system should meet whatever level of need the family experiences. We do not mean to suggest that there should be three fixed models or that families should be assigned to fixed tiers of service intensity.

Sara

Sara is an 11 year old fifth-grade girl seen in a group pediatric practice. Her mother brings Sara to see her PCP with a chief complaint of recurrent headache of recent onset. Sara has always shown signs of shyness, and recently has been complaining of headaches, often on school mornings. On these mornings she refuses to go to school. Sara has also been coming home from school in tears saying the other kids make fun of her; this is not altogether new but is happening more often this year. Sara is highly verbal and historically has been very successful academically, but sometimes appears to be "off" in her social interactions. She's also beginning to have difficulty in some of her academic subjects. Sara is medically well and appears to have no notable family or neighborhood stressors. Her 8 year old sister is doing fine.

Sara's mother is worried about Sara's headaches as she herself has a history of debilitating migraines (for which psychotherapy was prescribed but was not perceived as helpful). She is also concerned about Sara's social frustration and newly emerging academic problems.

Sara's mother brings her to her PCP with the complaint of recurrent headache and stresses at school. The PCP suspects that Sara's recent headaches and school refusal are related and after conducting a physical exam defers further medical workup. The PCP practice is large enough, with 7 FTE primary care clinicians, to support a full time on-site psychologist who has a policy of being interruptible for PCPs "warm hand-offs". The psychologist provides training, curbside consults with PCPs, and offers assessment and brief treatment for patients like Sara with relatively simple and mild to moderate behavioral health conditions. He also makes referrals to community BH providers for children with more complex or acute conditions, and coordinates care of those children with those providers. In this case, the psychologist meets briefly with Sara and her mom and arranges a return appointment later in the week. Although Sara's mom is concerned about a possibly serious headache syndrome that might require further medical evaluation, she finds it easier to accept a psychological consultation with a provider to whom

she has been already introduced by Sara's PCP, and who offers a quick follow-up consultation in PCP office.

The psychologist meets with Sara and her mother the following week. He, Sara, and Sara's mother are quickly able to agree that fifth grade is proving a stressful year for Sara and that she might benefit from learning some new skills to manage stressful moments. Over the next four months he meets six times with Sara and with Sara's mom or dad, teaching relaxation skills to Sara and the parents. He also suspects that Sara has some deficits in cognitive processing of social cues, and helps her parents request an evaluation of Sara for special education services. They are eager consumers of medical information and gladly read materials he provides on non-verbal learning disorders. He has time for several phone calls with Sara's school to assist in setting up her evaluation, and phone calls to her parents to coach them through the process of having Sara testing and IEP process. He also suggests to her parents that they explore some social skills groups in the community and he provides reference materials for two programs. With the parents, he is also able to explore with the school whether Sara is being bullied at school.

School testing reveals that Sara does has some cognitive deficits that affect her reading of social cues, and of her own emotions, and that could affect her developing awareness of her own psychological functioning. The school offers special educational support with organizational tasks, and a social skills group. The school adjustment counselor also works with the Sara, Sara's parents and the school nurse to develop and support strategies that Sara can use when feeling "stressed out" by peer issues or academic challenges. The school acknowledges that some bullying has occurred and includes a component in Sara's IEP to provide greater supervision and intervention if bullying occurs.

Commentary on integration with Sara:

Sara has a mild / moderate level of behavioral health acuity, and some complexity evident in the involvement of a non-medical service sector (education). It is clear that her difficulties could quickly escalate without the help provided in this scenario. The care Sara receives is timely and appropriate, and receiving counseling in the PCP setting may also reassure Sara's mother that the medical aspect of Sara's headaches is not being ignored. Sara's parents are willing consumers of the education offered by the co-located psychologist.

The co-located practice model in this illustration is drawn from Dr. Glenn Focht's description of a very promising model being piloted at PPOC. This model is designed to work for practices with at least 6 PCPs; if Sara's PCP belonged to a smaller practice, full co-location would not be practicable. Also, if evidence arose that Sara would work better with a female therapist, or if cultural or linguistic factors favored a behavioral health clinician with different competencies, her behavioral health care would need to be referred out. This model is based on behavioral health services lasting for a short duration and not requiring a high level of care coordination as the behavioral health clinician is expected to see 15 (out of a total caseload of 30) new cases per

week. Fortunately, Sara's need for treatment and care coordination in this illustration fit within these requirements. In general this model for integration appears to work best with children and families with relatively low acuity and complexity, and might be especially helpful when behavioral health problems have a strong somatic component. While medication was not considered for Sara, the co-location of the psychologist and the PCP could have helped to facilitate communication with a consulting psychiatrist if this had been needed.

Kalina

Kalina is an 11-year old girl attending sixth grade at a suburban middle school. She lives with her mother and younger brother and sister and has weekend visits to her father in another town, which she usually enjoys. Kalina is medically well, has routine PCP well child visits, and no behavioral health services. Her mother, to whom Kalina has historically been very close, is undergoing treatment for cancer and Kalina's two maternal aunts are frequently in the home to help out and to supervise the kids when Kalina's mother needs rest. Kalina's mother is worried she will lose her full-time job due to medical absence and has shared this with Kalina. Kalina is bright and has always been successful in school. She often tries to dominate her younger sisters and seems to compete with her aunts for control when they try to help out. Kalina's mother is more angry than usual with Kalina's father and when Kalina visits her father she rebuffs his attempts to cheer her up, and increasingly feels cut off from him. She also feels worried because her father has been sober for two years and she fears he will relapse if she upsets him.

Kalina's teacher has become concerned about changes in Kalina's behavior: she seems increasingly irritable in class, has gotten into feuds with other girls, which in one case erupted into a physical fight, and her journals and poetry contain explicit suicidal imagery. She has also gotten into confrontations with a couple of teachers and is not turning in her work consistently. Last week she confided to her teacher that one of her aunts had repeatedly slapped her; the school nurse filed a 51A. A DCF worker contacted the PCP seeking information and trying to determine how to help Kalina and her family. Later the PCP learns that DCF has screened out the report of abuse.

Commentary on integration with Kalina:

Kalina's situation is not unusual: a child with no recent history of behavioral health care but with fulminating behavioral health problems. Although the child and family have many strengths, things seem to be falling apart. Clearly Kalina has need for psychological support, but there are also family needs that must be addressed. The mother's medical crisis has realigned the family hierarchy resulting in disruption of Kalina's relations with her aunts, her father, her peers, and teachers. Initiating individual therapy would not address the family needs that are precipitating Kalina's behavior changes.

The well-targeted intervention of limited intensity and duration that works for Sara (behavioral health clinician co-located within the PCP practice) will probably be insufficient for Kalina. Kalina needs resources mobilized quickly and intensively to assess the family situation, address concrete needs, and provide rapid treatment to de-escalate and stabilize the developing crisis.

Someone needs to open a conversation immediately with Kalina's mom and Kalina, leading to subsequent conversations with Kalina's aunts, father, and siblings. In-home visits may be the best way to accomplish this. They must also get consent to talk with the PCP, DCF, and Kalina's school to understand her support system. Then they must be able to develop a plan with Kalina's mother that can unite various stakeholders in working to support the family through the crisis.

Unlike Jacob (the vignette below), with his long history of problems and his need for long-term planning and coordination, Kalina and her family need a rapid mobilization of resources including both treatment and care coordination. This type of resource is typically provided by a family therapy team with the capacity to do intensive outreach. Currently, MassHealth provides this resource through the In-home Therapy service. Some commercial plans pay for similar services, particularly on an individually-negotiated basis. Usually such teams are located in organizations that provide other behavioral health services.

A co-located clinician in a PCP practice will probably not have the time needed to meet Kalina's needs. However, PCPs could contract with behavioral health teams to provide treatment and coordination for their clients with high-intensity treatment need. The behavioral health team would maintain close contact with the clinician in the PCP practice throughout Kalina's treatment and while stepping her down, eventually, to less intensive treatment.

Jacob

Jacob is an 11-year old boy, attending fourth grade at his local public school, adopted at age 8 through the Department of Children and Families. His adoptive family was previously his foster family; he has two adoptive siblings who are in their late teens and functioning well. Jacob has a long history of special educational services and behavioral health services including six stays in institutional settings (inpatient hospitalization twice, CBAT three times, and a DCF STARR program once). Jacob has a full-scale IQ of 85, is believed to have had significant fetal alcohol exposure, is of very short stature for his age, and is about two years behind grade level in reading and math. He is an affable and outgoing boy who is somewhat impulsive and inattentive and has difficulty following complex verbal instructions. He loves sports and with some support has been able to participate with great enthusiasm, despite being small, in his town's youth football program. He has occasional contact with his birth mother, which is regulated by his adoptive parents, and which often results in some behavioral decompensation. Jacob's adoptive parents and therapist agree that these contacts, while stressful to Jacob, are also very important to him and should be facilitated when possible.

Historically Jacob has responded to stress and loss by running away, exploding with rage, and fabricating stories (confirmed untrue) of being abused. Since becoming adopted his behavior has stabilized considerably but his parents worry about his transition into adolescence and his ability to maintain a place in a pro-social peer group. After a CBAT admission last year, following particularly disruptive contacts with his birth mother, Jacob began boasting in school about drug use and sexual exploits, narratives that he apparently acquired from peers at the CBAT.

Jacob is medically well and has had extensive medical workups for his short stature in the past, as well as neuropsychological assessment and psychiatric evaluations for medication. Despite concerns about his growth, he is currently on a regime of Adderall managed by his pediatrician. He has a counselor at a local clinic who has known him for two years and also consults frequently with his parents. During the past three years he has also had In-home Therapy, Intensive Care Coordination (ICC), and Therapeutic Mentoring at various points through his MassHealth plan. While in ICC, Jacob's family was connected with a Family Partner who has continued to work with them even since graduating from ICC eight months ago. ICC helped to bring together all the known information from Jacob's complex history, to prioritize the family's goals for treatment, and to organize a plan of care that coordinates multiple services and supports (including medical services, Crisis Intervention, and CBAT discharge planning), putting the family in the driver's seat as much as possible. The family continues to work on the goals although no longer actively involved in ICC. The goals include: repeating Jacob's neuropsychological evaluation and meeting with the school to consider plans to help him catch up on critical academic skills; finding positive social and peer supports through sports, church and extended family; reevaluation of his medication on a regular basis. The family considers their Family Partner to have been one of the most significant components of the CBHI system in helping them learn to be empowered consumers who understand how to communicate effectively with other system partners, becoming as a result more independent and self-sufficient in managing Jacob's care.

Commentary on integration with Jacob:

Jacob is a boy with moderate acuity, high complexity, and a fairly strong support system. He is likely to have significant emotional / behavioral challenges during every major life transition or period of loss. Although he has had some medical concerns relating to his short stature, most of his medical services have been behavioral health services, and his care has been coordinated primarily by behavioral health providers (previously ICC and Family Partner, currently outpatient therapist and Family Partner).

The care coordination that integrates medical and behavioral care for Jacob is based on the model of CBHI services for MassHealth members (age birth to 21). Intensive Care Coordination provides a high level of care planning and care coordination, referring to other services for treatment. When the child's need for intensive planning and coordination declines, this function can shift to another level of care (such as outpatient, in Jacob's case). In this model the PCP is an important partner in the process, while the locus of planning and coordination lies outside the PCP. Strengths of this model include the ability to deal with children and families with very complex needs (cultural and linguistic competence, crisis management, extensive efforts to engage the family and natural supports, liaison with state agencies and schools), and a very strong emphasis on culturally-informed family-driven care. The use of an external organization which is dedicated to care coordination and provider Family Partners gives the PCP an enormous resource for supporting and following the most complex and high risk

children and their families. Challenges inherent in this model include the fact that it is not currently supported by commercial payers, the systemic need to train more behavioral health workers in the novel and demanding model of Intensive Care Coordination, and the need for primary care to develop relationships and role understanding to work effectively with external care management entities.

Summary comments

These vignettes suggest that there is no single model of primary care and behavioral health care integration that addresses all levels of need for treatment and care coordination. A co-located behavioral health clinician in a primary care practice is convenient for the PCP and can help with the large number of PCP clients who need a relatively light level of behavioral health intervention and coordination. Depending on the population served by the practice, however, there will be a segment whose needs are not fully met by this model. This includes children and families who need services mobilized intensively and quickly, and children with long-term needs for coordination of care for complex needs. Cultural complexity and caregiver impairment also create needs that are not easily met by brief intervention.

As a result, care coordination, which is the key process for integrating care, cannot be defined by its physical location. PCPs will need to be able to develop effective relationships with family therapy teams and with care management entities to support a significant portion of their patient populations. Internally located behavioral health clinicians can facilitate those relationships but cannot take their place. External care management resources will help PCPs with family engagement, with mobilization of appropriate levels of treatment and care coordination resources, and with community engagement to meet families' non-medical needs.

ATTACHMENT B:

MA Child Health Quality Coalition

Communication and Confidentiality Task Force

Suggestions for the Behavioral Health Integration Task Force Recommendations

on Confidentiality/Privacy Issues

(3-18-13)

The MA Child Health Quality Coalition has an active Communication and Confidentiality Task Force created to support its work promoting improved care coordination for children in Massachusetts, including addressing special issues for children with behavioral health needs.

Task Force Objective: Support effective communication between and among those who make up the child's "coordination network", while addressing issues of confidentiality.

This Task Force has been identifying issues impacting communications and confidentiality across the Coalition's different stakeholder groups and identifying resources that can help in addressing those issues. Based on the task force work to date, the following recommendations for confidentiality and privacy considerations should be considered:

(1) Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

(2) Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages.
- Provide guidance on the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.).

- Strategies that encourage information sharing (e.g. "opt out") still need safe guards that ensure informed consent.
- Special issues of confidentially must be considered for adolescents
- Peer networks offer important opportunities to support youth in understanding privacy protections and promote **strategic sharing**

(3) Sharing behavioral health information with families/youth can improve accuracy and patient safety.

(4) Look at privacy as a whole, not just within electronic health records.

Recommendations on Confidentiality/Privacy Issues for Behavioral Health Integration

Expanded Detail on CHQC Task Force Input from Child/Adolescent Perspectives

Identify the set of information different members of the care team need to ensure the child's safety and ensure appropriate treatment and follow-up care. Limiting the set of information that is shared is fundamental to addressing privacy/confidentiality.

- Leverage work already done that identifies the communication needs in a way that will transfer just enough information. See for example:
  - *Combined MCE Behavioral Health Provider/Primary Care Provider Two-Way Communication Form* in use for children receiving services under the Children's Behavioral Health Initiative.
  - *Re-entry planning for students returning to school following hospitalization for a behavioral health crisis* developed by the MetroWest Foundation/Framingham Public Schools and the Brookline Resilient Youth Team.
  - *Boston Public Schools Superintendent's Circular on Sharing Student Health Information* that offers guidance including expressing all diagnoses, especially those related to mental health, as a functional diagnosis.
- Provide specific training/guidance around what types of information pediatricians/MDs want and/or need from behavioral health providers and what types of information behavioral health providers need/want from MDs.
  - The Task Force puts special importance on improving information sharing when a child is getting psychotropic meds prescribed by a BH provider, but the pediatrician is providing ongoing monitoring of the medication. Sharing best practices in this area would be especially useful.

Build rigor into the process of obtaining signed release forms to ensure they reflect true "informed consent" while promoting information transfer.

- Release forms should include a time dimension to protect against sharing information that is no longer relevant as the child ages. This is especially true for behavioral health care where there is often an evolutionary process in settling on the correct diagnosis.
- Providers need training on how to explain the confidentiality protections that exist under the different federal, state and local laws governing treatment of minors (HIPAA, FERPA, etc.). Best practices including scripts and checklists should be disseminated widely.
- Strategies that encourage information sharing such as having sharing as the default with families signing only if they want to "opt out" need important safe guards that ensure enough context is shared that the families know what they are agreeing to.
- Special issues of confidentially must be considered for adolescents, including how and when to transition from having their parent/proxy as the signer and also addressing the sensitivity in putting a diagnosis or confidential services delivered to a teen into the medical record to avoid being seen by the teen's family. Suggestions for how to document that, so that payers can have a record, and other providers can become aware, without risking release of confidential information would be helpful.

  - See for example issues raised in the MCPAP/DPH BSAS alcohol and substance abuse screening toolkit www.mcpap.com/pdf/CRAFFT%20Screening%20Tool.pdf, p. 15-16.
- Peer networks offer important opportunities to support youth in understanding privacy protections that exist in different settings and promote **strategic sharing** that identifies what is appropriate information to share

Sharing behavioral health information with families/youth can improve accuracy and patient safety.

- Adolescents and families often do not see a lot of the information that is in their behavioral health records as well as information that is shared among staff at the primary care provider's office and with the medical care team. Having providers consistently share information with the youth/family should be viewed as a fundament component to protecting patient safety and preventing sharing of incorrect information.
- Share best practices where youth have been empowered to review their medical records.

Look at privacy as a whole, not just within electronic health records.

- New modes of communication (remote servers, email, the cloud…) offer important opportunities to improve communication among disparate members of a child's care team. Strategies for promoting effective use of these technologies should be part of the recommendations.
- Still, it is important to recognize that electronic medical records make it so easy to share without thinking, so suggestions for how to ensure that only minimally necessary information is generated from an EHR, that still allows providers to take advantage of the ease of electronically generating records/forms, are crucial.

References available on request.

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ATTACHMENT C: SOURCES

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Workforce Development

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http://www.aacap.org/cs/root/physicians_and_allied_professionals/training_toolkit

National Federation of Families for Children's Mental Health
http://certification.ffcmh.org/resources

Innovative and Evidence-Based Programs

Children's Behavioral Health Initiative: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/
Patient Centered Medical Home Initiative: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/

Child Health Quality Coalition: http://www.mhqp.org/collaboration/chqc.asp?nav=063700

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Physician Work Group Recommendations

to the

Cost Containment Behavioral Health Task Force

(Chapter 224, Section 275)

The Physician Work Group includes physicians from internal medicine, pediatrics, child and adult psychiatry who are invested in our healthcare delivery system and are actively engaged in clinical work. We met twice to discuss and prioritize recommendations for consideration by the Behavioral Health Task Force in planning its recommendations to the State Legislature in fulfillment of Section 275. The Physician Work Group applauds the principles outlined by the Behavioral Health Integration Task Force and offers the following to optimize the likelihood of success.

1. **The definition of behavioral health integration must include the coordination of care across all areas of medical and mental health (including substance abuse).** A structural framework which would support this redesign is the Chronic Care Model. It is critical that an accountability framework be articulated and adopted, since success will only occur as a result of full engagement at all levels of the community. Specifically, this requires leadership at the highest levels (Governor, Legislature, State Agencies, and the administrative leaders throughout the healthcare delivery system) to embrace Behavioral Health Integration as fundamental to creating new models of healthcare delivery that will be sustainable and cost containing. Without this level of understanding, buy-in, and championship, Massachusetts will not be able to implement an integrated model of care that is accountable, cost containing, team based, and patient/family driven. *The political will must be there to lead the nation.*

   We ask those in authority not only to command integration but to model its spirit by identifying and working to mitigate laws, statutes, regulations, policies, departmental divisions, payment practices, and other structural and cultural elements of the system which, though meaningful in their creation, may serve to prohibit, inhibit, obstruct, and/or disincentivize the very processes necessary for care integration.

2. Management of payment for behavioral health services should promote coordinated and integrated care that prevents fragmentation and redundancy. **The concept of Behavioral Health Carve-Out models is antithetical to integration.**

3. **Parity and equity of payment must support team based care**. There needs to be an equitable distribution of finances (including cost savings and bonus/incentives) across the entire medical care team to value and include currently unfunded services such as care coordinators, screening, recovery supports and community/family/peer involvement to name some. Fee-for-service arrangements work against parity for all the mental health provider types within the team. A fee-for-service approach that pays each

practitioner individually will never lead to team based care. The loss of "carve outs" must not endanger the robust participation of mental health providers on the team as integration requires.

4. **Initial implementation should be incremental and target specific patient populations**. In order to change the system, we must start with success. To do this, we encourage adopting a process that is incremental, adequately funded, and targets specific populations with significant opportunity for cost savings. These would include high utilizing populations as well as large populations with moderate utilization, but whose care is amenable to collaborative care models between primary and behavioral health care providers. Examples are already underway in Massachusetts and include the Duals Demonstration (Medicare and Medicaid insured population), Primary Care Payment Reform (targeting chronic medical conditions co-occurring with behavioral health conditions) and Health Homes (targeting the Severe and Persistently Mentally Ill). These targeted programs will require new infrastructure, new shared accountabilities, and implementation of measures to drive transformation. We aim to show cost savings early on, with the expectation that success will encourage leaders and care delivery systems to adopt these new models. Adequate funding alongside movement away from fee-for-service within the integration models is crucial for leading the way as a Commonwealth and as a Nation.

5. **In the initial years of implementation of new models, both process and outcome measures should be used** until we learn from our experience with these new models and can develop appropriate outcome measures. We need to understand how these new models are impacting patients and families so they can be appropriately adapted as needed. The state of evidence for coordinated care and integrated care (especially in children) is in the early phases of development.

6. **Care coordination will be essential to achieve high quality care integration**. Currently, robust measures of care coordination (the activities in the "space between" visits and providers) are insufficiently tracked. We recognize the many "Saints in the System" who have historically provided these kinds of services without quantifying their time and its cost. We therefore promote the notion that a framework of care coordination that identifies the elements, activities, and its measures be adopted across all systems of care and adequately funded.

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XI. Appendix C. Description of Clinical Models of Behavioral Health Integration

To describe the different clinical models of behavioral health integration, this briefing book summarizes the most concise and comprehensive review of integration models presented in a publication written by the Milbank Memorial Fund. "Evolving Models of Behavioral Health Integration in Primary Care," outlines eight different models ranging from a simple approach of increasing communication between providers to a fully integrated individualized care plan that spans the continuum of services.[125] While these models are described in a discrete way, primary care practices and outpatient behavioral health settings can adopt more than one model simultaneously or adopt a few key components of any one model to fit their needs. The models of behavioral health integration are described below.

Improving collaboration between separate providers[126]

Improving collaboration between separate providers is the act of increasing communication within the existing structure of health care delivery. It is the model that requires the least amount of change and may sometimes be the only viable model given financial and external constraints. Some examples of improved collaboration include the use of a care manager for care coordination for a specific chronic condition like depression, telephonic consultation between behavioral health providers (BHPs) and PCPs, and increased use of other ways of sharing clinical information. There is no evidence to support the effectiveness of this model, but it can be a good first step toward further integration.

Medical-provided behavioral health care[127]

Medical-provided behavioral health care is the use of evidence-based clinical principles by medical physicians to care for the behavioral needs of a patient with minimal, if any, collaboration with a BHP. For example, a PCP can use a variety of screening tools and techniques that have been effective in treating some behavioral health conditions. The tools include the Patient Health Questionnaire (PHQ-9) and the Screening, Brief Intervention, eferral and Treatment (SBIRT) programs implemented by SAMHSA and the Office of National Drug Control Policy (ONDCP).

In some instances, this model can also be combined with the improved collaboration model to give primary care physicians an opportunity to consult with a BHP for clinical guidance.

[125] C. Collins. Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund. 2010.
[126] Ibid.
[127] Ibid.

While evidence supports the use of screening tools and brief intervention counseling, the barriers to implementation include lack of time during an appointment and availability of training for the PCPs. Use of this model may highlight the lack of the behavioral health care support elsewhere in a community. First, the available resources in the community may not be able to support the increased identification of patients with higher behavioral healthcare needs. Second, PCPs need to provide more behavioral health care when there is inadequate access to behavioral health services in a community.

Co-location[128]

PCPs and BHPs who are co-located, are able to provide comprehensive medical and behavioral health care to patients under one roof. This model builds upon the first two by combining office space and in some cases, staff. Co-location does not include the integration of the medical record, but can increase information sharing capabilities. Patients with low-level behavioral health needs may prefer this model of integration because it lessens the stigma associated with "therapy." Certain benefits of this model include the physical presence of BHPs with PCPs which allows for a forum conducive to increased training and education of PCPs, perhaps influencing diagnosis and treatment for patients.

Chronic care model[129]

The Chronic Care Model developed by Ed Wagner[130] serves as the basis for this integration model. It is a model of care management that is practiced within the primary care setting to address populations of patients with chronic illnesses. Familiar to many PCMH initiatives, this integration model requires early identification (through the use of evidence-based screening tools), intensive care management, the use of a patient registry and evidence-based clinical guidelines in the treatment of care. This model enhances all of the models already described above. There are a variety of well-funded and well-conducted research studies that show positive clinical outcomes and reduced costs. In addition, specific programs built off of this model (see Depression Care in Minnesota in Section C of this Chapter) have proven to be successful. This model works effectively when used in combination with more integrated approaches (described below.)

Reverse co-location[131]

As its name suggests, reverse co-location is similar to the co-location model with the exception that a medical health professional (e.g., MD, CRNP) provides care within the behavioral health care setting. This model can be effective when treating patients with serious behavioral health

[128] C. Collins. Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund. 2010.
[129] Ibid.
[130]Bodenheimer T, Wagner E, Grumbach K. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2," *JAMA*, October 16, 2002, 288:15, 1909-1914.
[131] Ibid.

needs and those whose mental health needs priority attention. Reverse co-location often occurs in more intensive mental health settings like day treatment or rehabilitation programs, but is also found in some community mental health center (CMHC) settings. Collins et al. reference evidence that this model has reduced costs through the reduction in emergency room visits.

Unified primary care and behavioral health[132]

One of the most fully integrated models, unified primary care and behavioral health, combines the benefits of co-location with an integrated medical record, treatment plan and financing. This model is sometimes used in federally qualified health centers (FQHCs) where patients can expect to receive full physical and mental health care in one setting. Providing psychiatric services as part of a primary care visit has shown to improve health status and reduce ED visits.[133]

Achieving this level of integration is a complex transition to manage with many barriers. Some insurance carriers will reimburse providers less if behavioral health and physical health care are provided in one setting. If insurance carriers do provide reimbursement, what services are covered will vary from one to the next – some may allow same-day billing, others may not. In the Medicaid program, pediatric and adult patients are typically reimbursed under different payment methodologies making it difficult for a family practice office to achieve this level of integration.

Primary care behavioral health[134]

Primary care behavioral health is the combination of three models – co-location, disease management and unified primary care and behavioral health. Users of this model provide behavioral health care in a more seamless way than in any of the models discussed thus far. BHPs are fully integrated into the care of a patient and are often sharing clinical management responsibilities with the PCP. A common approach to care coordination is through the "warm hand-off" - where a patient is introduced to a BHP by the physician within one visit. The population-based approach allows for all patients to receive brief interventions and provides needed care real-time.[135] Another highlight of this model, according to Hunter and Goodie, is the unique goal to transfer behavioral health skills to a primary care physician through co-management and repeated consultative interactions.[136] As expected, this model requires system-level and practitioner-level change. It is no longer just the provision of behavioral health services in the primary care setting; it is a seamless collaborative approach to patient care.

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[132] C. Collins. Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund. 2010.
[133]Ibid.
[134] Ibid.
[135] C. L. Hunter and J. L. Goodie. Operational and Clinical Components for Integrated-Collaborative Behavioral Healthcare in the Patient-Centered Medical Home. *Families, Systems & Health.* Vol. 28, No. 4 308-321. 2010.
[136]Ibid.

Collaborative system of care[137]

The collaborative system of care model is not necessarily a fully-integrated approach. It is the use of an individualized care plan that spans the continuum of services (including health-critical community supports like housing). It is often used for patients with high behavioral health care needs and can exist outside of the primary care setting. The evidence for this model is mixed and according to Collins et al. the findings may be due to the highly varied nature of implementation of this model.

Select examples of clinical models of integration in Massachusetts

Massachusetts Patient Centered Medical Home Initiative (MA PCMHI)

The MA PCMHI is a state-wide, multi-payer, three-year medical home demonstration project sponsored by the Executive Office of Health and Human Services involving 46 primary care practices. Nearly 200,000 members are included, the majority of whom are MassHealth recipients. The Patient-Centered Medical Home model is designed to promote comprehensive, coordinated, patient-centered care delivered by teams of primary care clinicians.[138] The foundation of many medical homes is the **disease management** clinical model. In addition, to disease management, enhanced behavioral health integration is an essential feature of a patient-centered medical home.

In order to assist practices achieve behavioral health integration, MA PCMHI created a Behavioral Health Work Group (Work Group). The Work Group created a flexible approach to behavioral health integration achievable by all practices within the initiative, **regardless of which clinical model used**. The Work Group developed a set of key characteristics ("Elements of Integration") that describe an essential integration activity to support the behavioral health needs of patients within a primary care practice.[139] The Elements of Integration are organized into five clinical domains. Included within the Elements of Integration are foundational elements that are believed to be essential to achieving behavioral health integration. Non-foundational elements advance behavioral health integration, but are typically only achievable by practices with advanced clinical integration models.

Accompanying the Elements of Integration is a toolkit of strategies to assist practices in achieving each element and a suggested approach for prioritizing the elements. (See Sub appendix A for the MA PCMHI Elements of Integration).

MassHealth Primary Care Payment Reform Program (PCPR)

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[137] C. Collins. Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund. 2010.
[138] "Overview of PCMHI" Massachusetts Patient-Centered Medical Home Initiative" Massachusetts Executive Office of Health and Human Services http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/. Last accessed 12-3-2012.
[139] MA Patient Centered Medical Home Behavioral Health Work Group, Dr. Alexander Blount, Mountainview Consulting.

The goal of MassHealth's Comprehensive Primary Care Payment Reform strategy is to improve access, patient experience, quality, and efficiency through care management and coordination, and integration of behavioral health primary care.[140] The program achieves its vision through the adopting a payment mechanism for care provided within a fully-integrated patient-centered medical home. In addition to the organizing principles of the patient-centered medical home, the PCPR adopted the Massachusetts PCMHI-specific approach to behavioral health integration by further refining the Elements of Integration (mentioned above) and expecting that participants will have the functional capacity to provide, at a minimum the foundational elements of integration. (See Sub appendix B for PCPR revised Elements of Integration).

Massachusetts Child Psychiatric Access Project (MCPAP)

MCPAP is a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with psychiatric problems.[141] Funded through the Department of Mental Health, MCPAP assists providers in treating children by providing telephone access to child psychiatrists, clinical nurse specialists, licensed therapists and care coordinators. Primary care clinicians may use MCPAP to obtain information necessary to treat children with behavioral health needs effectively or receive advice on appropriate referrals. MCPAP is an effective approach to **improving collaboration between separate providers** and assisting in achieving **medical-provided behavioral health care.**

Massachusetts Dual-Eligibles Capitation Demonstration Program

Massachusetts is the first of twenty-six states to enter into a joint Medicare and Medicaid financial alignment demonstration to manage the health care services of individuals between 21 and 64 who are eligible for both Medicare and Medicaid services. (For more information on the financial model, see page 14). Integrated behavioral health services are a chief component of the program, with health plans required to provide not only integrated behavioral health and primary care, but also behavioral health through community-based and long term support services. Each health plan is expected to support the foundational Elements of Integration delineated by the MA PCMHI Behavioral Health Work Group (See Appendix A). Unlike the clinical integration models previously described, this model is health plan focused. Enrollment is expected to begin in the spring of 2013.

Children's Behavioral Health Initiative (CBHI)

CBHI is a program of the Executive Office of Health and Human Services that requires primary care providers to administer standardized behavioral health screenings at well child visits, mental health clinicians to use a standardized behavioral health assessment tool, and provides

[140] MassHealth Comprehensive Primary Care Payment Reform Clinical Delivery Model. Unpublished.
[141] About MCPAP. http://www.mcpap.com/about.asp Last accessed 12-3-2012.

new or enhanced home and community-based behavioral health services.[142] CBHI has made significant investments in improving the care provided by behavioral health providers and in developing an integrated system of state-funded behavioral health services for children, youth and their families.[143] In addition, CBHI provides a potential platform for integrating primary care so that providers would have some level of **medical-provided behavioral health care.**

Wellness Center at Community Health Link

The Wellness Center at Community Health Link is an outpatient behavioral health clinic with an integrated primary care clinic. The primary care clinic focuses specifically on the medical needs of patients with serious and persistent mental illness. This model, commonly referred to as **reverse co-location**, typically serves the most complex (medically and behaviorally) patients who are frequent utilizers of health care.

Select examples of clinical models of integration in other states

Missouri Health Homes

Missouri has implemented "Health Homes," which are "person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community based services and supports."[144] Health Homes are similar in concept to Patient Centered Medical Homes, with the exception that Health Homes focus upon the specific needs of low-income individuals with complex and chronic needs. Health Homes provide enhanced complex care management, care coordination, patient and family support and referral to community and long term support services.

Missouri chose to implement Health Homes as a means to reduce hospitalization and emergency department visits, enhance the behavioral health consultation available at primary care centers and enhance the State's ability to provide transitional care between institutions and the community.[145]

Depression Care in Minnesota (DIAMOND)

The DIAMOND[146] project is a depression chronic care management program focused on the primary care delivery system. DIAMOND offers specific payment for the use of evidence-based depression care management, rooted in the collaborative care model. The model includes the standard and consistent use of evidence-based depression screening tools for assessment and management of depression, the follow-up and tracking of patients with depression through

[142] Children's Behavioral Health Initiative. http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-initiative-overview.html Las accessed 12-3-2012.
[143] Ibid.
[144] "Medicaid's New 'Health Home' Option" January 2011. *Kaiser Family Foundation* http://www.kff.org/medicaid/upload/8136.pdf
[145] Joe Parks. "Health Homes in Missouri" January 2012. Unpublished presentation.
[146] DIAMOND stands for "Depression Improvement Across Minnesota Offering a New Direction"

the use of a registry, use of evidence-based guidelines for treatment, relapse prevention, education and psychiatric consultation.[147]

The model has been successful and has shown improvements in the percentage of patients assessed with an evidence-based screener at the time of depression diagnosis and the percent of patients seen for follow-up at three and six months. In addition, studies have shown that over 40 percent of patients who experience the DIAMOND model are in remission within 6 months and another 10 percent have had a drastic reduction in symptoms.

Iowa's Integrated Health Homes

Iowa contracts with a statewide Medicaid BHO to deliver behavioral health needs to the seriously mentally ill. Included within the capitation to the Medicaid BHO is 2.5 percent dedicated to funding initiatives to improve health care. One such initiative is the Integrated Health Home program, a **reverse co-location** concept that brings primary care to the behavioral health care site. With the behavioral health site as the point of entry, patients with serious and persistent mental illness are able to receive integrated treatment with the behavioral health provider leading the treatment team.[148] Behavioral health services are currently paid for under the Medicaid BHO capitation rate, while the primary care services are paid on a fee-for-service basis.[149]

[147] Oftedahl, G et al. "DIAMOND Initiative Depression Improvement Across Minnesota Offering a New Direction" Presentation to *ICSI Colloquium* May 17, 2007.
[148] "Magellan launches integrated health home in collaboration with state of Iowa to improve access to care, control costs." Magellan health services. http://ir.magellanhealth.com/releasedetail.cfm?ReleaseID=594039 Last accessed 12-6-2012
[149] Hamblin A et al. "State Options for Integrating Physical and Behavioral Health Care." *Integrated Care Resource Center* October 2011.

XII. Appendix D. The National Council's Four Quadrant Model

The National Council's Four Quadrant Model

Quadrant II **BH↑ PH↓**	**Quadrant IV** **BH↑ PH↑**
• Behavioral health clinician / case manager w/ responsibility for coordination w/ PCP • PCP (with standard screening tools and guidelines) • Outstationed medical nurse practitioner / physician at behavioral health site • Specialty behavioral health • Residential behavioral health • Crisis / ED • Behavioral health inpatient • Other community supports	• PCP (with standard screening tools and guidelines) • Outstationed medical nurse practitioner / physician at behavioral health site • Nurse care manager at behavioral health site • Behavioral health clinician / case manager • External care manager • Specialty medical / surgical • Specialty behavioral health • Residential behavioral health • Crisis / ED • Behavioral health and medical/surgical inpatient • Other community supports.
Quadrant I **BH↓ PH↓**	**Quadrant III** **BH↓ PH↑**
• PCP (with standard screening tools and guidelines) • PCP-based behavioral health consultant / care manager • Psychiatric consultation	• PCP (with standard screening tools and guidelines) • PCP-based behavioral health consultant/care manager (or in specific specialties) • Specialty medical / surgical • Psychiatric consultation • ED • Medical/surgical inpatient • Nursing home / home based care • Other community supports

Behavioral Health (MH/SA) Risk/Complexity →

Physical Health Risk / Complexity →

XIII. Appendix E. Summary of the MA PCMHI Behavioral Health Integration Toolkit

The Massachusetts Patient-Centered Medical Home Initiative (MA PCMHI) is a state-sponsored and facilitated multi-payer effort involving 46 primary care practices, representing a diversity of practice settings, geography and patient populations served. Fifty-two percent of practices are community health centers; others are academic or large and small private practices. As part of the MA PCMHI, the state launched a Behavioral Health Integration Work Group (Work Group) in April 2011 for the purpose of assisting MA PCMHI practices to overcome the system and practice-level challenges that they face when providing primary health care to patients of all ages with mental health disorders, unhealthy substance use, and/or health behavior change needs, including behavioral health and primary care integration. The Work Group is comprised of representatives of health plans, MA PCMHI practices, outpatient behavioral health providers, various state health and human service agencies, and provider faculty of the University of Massachusetts Medical School. The deliverables of the Work Group include a toolkit for behavioral health integration for the participating primary care practices and a practice self-assessment to establish baseline integration status and to monitor progress toward integration.

39 Elements of Integration

To create the self-assessment and toolkit, the Work Group researched models of integration. Using "Behavioral Health Integration Needs Assessment" authored by Mountainview Consulting and Work Group member Dr. Alexander Blount as a guide, the Work Group defined 39 unique elements of integration.

The 39 elements of integration are organized within 5 domains: (1) Relationship and Communication Practices, (2) Patient Care and Population Impact, (3) Community Integration, (4) Care Manager Practices, and (5) Clinic System Integration. Within each domain, the Work Group identified foundational elements of integration, that is, those elements of integration the Work Group felt to be primary to achieving the cornerstones of behavioral health integration within a PCMH practice.

The elements of integration were then translated into a practice self-assessment survey by assigning a scale of integration for each element. Typically, the scale ranged from "rarely" achieving the particular element of integration to "routinely." The self-assessment was intended to be completed by the primary care team in conjunction with one or more behavioral

health providers within the practice at regular intervals to establish a baseline and to track individual practice progress toward integration over time.

Toolkit of Strategies

The Work Group created a toolkit of evidence-based strategies and resources designed to help practices achieve the highest level of integration for each of the 39 elements. The strategies and resources are presented as a dynamic online tool with a mixture of video, exercises, templates, web links and step-by-step instructions within each domain. After each practice prioritizes the elements of integration according to its needs, the practice can access the online toolkit for tips and strategies. The toolkit was completed in March 2013 for MA PCMHI practices and is scheduled to be made publicly available in the summer of 2013.

XIV. Appendix F. ABH / Mass League Regulatory and Reimbursement Barrier

DPH Regulations that Hinder the Integration of Behavioral Health and Primary Healthcare[150]

November 30, 2011

Primary care settings routinely provide detection, prevention and treatment of a wide range of chronic diseases and health conditions in patients of all ages, however, services related to the prevention and treatment of mental health and substance use disorders remain the exception. Behavioral health providers similarly face obstacles in trying to address the physical healthcare needs of their clients. The result is a fragmented system of care and missed opportunities for the prevention and treatment of mental health and substance use disorders.

For a behavioral health outpatient center to provide health care by *building-in* medical services into their outpatient clinics, the provider must become credentialed, obtain hospital privileges and be part of an Independent Practice Association (IPA), which are significant obstacles for behavioral healthcare providers to overcome.

For a medical site, such as a Community Health Center, private practice or hospital to contract with a behavioral healthcare provider to co-locate behavioral health services at their facility, there are restrictions around contracting and limitations regarding the *outreach site* which permits only a maximum of 20 hours of service per week, with further complications related to record storage and requiring the behavioral health clinic to be established as a satellite clinic, which is a complicated and expensive undertaking.

The Association for Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) joined forces to identify and develop some of the steps that must be taken to promote the integration of behavioral health and primary healthcare, with the overarching goal of improving client outcomes. Our first initiative has been to identify the Department of Public Health's regulatory roadblocks to integration, and to work with the state to address them.

Some specific DPH regulatory barriers to the integration of care are outlined as follows:

[150] *CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects*, Center for Health Policy and Research, UMASS Medical School, January, 2008

1. **Staffing:** There are conflicting licensure regulations regarding the type of staff that can be employed for different facility types, which impedes integration. For example, see 105 CMR 140.310 to 330: General Requirements for all Clinics/Staff, 105 CMR 140.530 Subpart E Mental Health Services/Staffing, and 105 CMR 140.800 Subpart H for Substance Abuse Services which refers licensees to DPH/BSAS regulations at 105 CMR 164 *Licensure of Substance Abuse Treatment Programs*, and its staffing requirements.
2. **Architectural Drawings:** A behavioral health organization trying to establish a health center is required by DHCQ to find the location's original architectural drawings, which often are decades old and cannot be located.
3. **Out-of- Date Requirements:** DHCQ has many out-dated requirements for establishing a primary health clinic, such as requiring a *flushrim sink* (at a cost of $6,000), which is appropriate for collecting tissue samples; but that practice is no longer utilized by even primary health care practices. All such requirements need to be reviewed.
4. **Subcontracting:** DHCQ clinic licensing regulations do not allow community health centers to subcontract with a behavioral health provider to deliver behavioral health services at the community health center.
5. **Record Keeping and Information Sharing:** DHCQ licensing requires that clients have separate physical health and behavioral health records. DPH/BSAS regulations regarding records requirements and information sharing limit the capacity of providers to share information that is needed for care coordination. This is one barrier which needs considerable thought.
6. **Paperwork Disincentives to Brief Interventions:** BSAS licensing paperwork requirements are extensive and may be a disincentive to the brief assessment and treatment that are necessary to support collaborative care with behavioral healthcare. For example, if a physician sends a patient to a behavioral health provider for a *lifestyle* session, the behavioral health provider must open a case and complete about 40 pages of documentation (e.g., intake assessment, evaluation form, treatment plan, release of information forms, and substance and nicotine and TB assessment) in order to work with that client.
7. **Shared Waiting Rooms:** Regulations prohibit behavioral health and primary care services from sharing waiting rooms. Although this regulation was an effort to minimize stigma for behavioral health clients, it has actually resulted in the opposite response by increasing stigmatization through separate waiting rooms. Obtaining a waiver from this requirement can take a year or more, if granted at all.
8. **Architectural Limitations:** The architectural requirements in 105 CMR 140.200 are difficult for many behavioral health clinics to comply with. For example, drug storage and pharmacy requirements, different types of lab services and maintenance, additional bathrooms/sanitation, drug shelf life, disinfection and sterilization, etc. Behavioral health providers may not have the space or plumbing available to make such changes, and retrofitting an existing space is extremely costly.

RECOMMENDATIONS

1. **Staffing:** Coordinate regulations regarding Staffing requirements at 105 CMR 140.310 to 330: General Requirements for all Clinics/Staff, 105 CMR 140.530 Subpart E Mental Health Services/Staffing, and 105 CMR 140.800 Subpart H for Substance Abuse Services which

refers licensees to DPH/BSAS regulations at 105 CMR 164 *Licensure of Substance Abuse Treatment Programs*, and its staffing requirements.

2. **Record Keeping:** Modify medical record requirements mandated under DPH licensing for behavioral health services provided in a primary care setting. We recommend that amending the DPH regulations regarding the separation of the patient behavioral health and physical health record be prioritized.
3. **Deemed Status**: Community health centers, primary care and behavioral health care facilities are governed by different licenses and state and federal authorities and subject to duplicative licensing processes, record reviews and site visits, making a strong case for granting *Deemed Status* to all organizations which have obtained national accreditation or licensure/certification.
4. **Architectural Barriers**: Allow flexibility and/or grant waivers from some of the more onerous architectural requirements for behavioral health clinics, to promote the integration of primary health care.
5. **Demonstration Projects:** Grant waivers to a select number of demonstration projects to allow DPH and/or MassHealth to determine costs and benefits of new codes to determine if a statewide policy is financially feasible. Other potential waivers for consideration include:
    - DPH waiver(s) to allow CHCs to subcontract with Community Mental Health Centers and Substance Abuse Outpatient Clinics to provide behavioral health services at the CHC.
    - Modification of the CMHC medical record requirements mandated under DPH licensing for behavioral health services provided in a primary care setting.
    - Grant DPH waivers for licensure requirements regarding space and integrated care practices.

ABH and the MLCHC recommend that DPH establish a task force in the near future to that can immediately undertake a formal review and discussion of these barriers, and the development of short and long-term remedies. We look forward to working with DPH to address these barriers to the integration of care.

MassHealth Regulations that Hinder the Integration of Behavioral Health and Primary Healthcare[151]

July 3, 2012

Primary care settings routinely provide detection, prevention and treatment of a wide range of chronic diseases and health conditions in patients of all ages. However, services related to the prevention and treatment of mental health and substance use disorders remain the exception. Behavioral health providers similarly face obstacles in trying to address the physical healthcare needs of their clients. The result is a fragmented system of care and missed opportunities for the prevention and treatment of mental health and substance use disorders.

For a behavioral health outpatient center to provide health care by *building-in* medical services into its outpatient clinics, the provider must become credentialed, obtain hospital privileges and be part of an Independent Practice Association (IPA), which are significant obstacles for behavioral healthcare providers to overcome.

For a medical site, such as a community health center, private practice or hospital to contract with a behavioral healthcare provider to co-locate behavioral health services at its facility, there are restrictions around contracting and limitations regarding the *outreach site* which permits only a maximum of 20 hours of service per week, with further complications related to record storage and requiring the behavioral health clinic to be established as a satellite clinic, which is a complicated and expensive undertaking.

The Association for Behavioral Healthcare (ABH) and the Massachusetts League of Community Health Centers (MLCHC) joined forces to identify and develop some of the steps that must be taken to promote the integration of behavioral health and primary healthcare, with the overarching goal of improving client outcomes. Our initiative on this front has been to identify the Department of Public

[151] *CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects*, Center for Health Policy and Research, UMASS Medical School, January, 2008

Health and MassHealth regulatory roadblocks to integration, and to work with the state to address them.

Some specific MassHealth regulatory barriers to the integration of primary and behavioral health care are as follows:

1. MassHealth has not yet activated billing codes for brief assessment and intervention services, using the federally-approved Health and Behavior codes.

2. Direct billing and global capitation rates do not cover the array of tasks that are needed to provide collaborative care, such as making referrals, informal communication, care and service coordination. The Community Health Center (CHC) global capitation rate does not take into consideration the high level of social needs of behavioral health patients. There are no MassHealth billing codes to support integration and collaboration, such as a care management case rate or a case rate to bill for clients with multiple social, medical, and/or behavioral health needs.

3. Funding silos, categorical funding, and a multitude of differing billing and credentialing requirements for different payers are significant barriers to collaborative care. There is a lack of clarity about what provider types can bill for what services in various settings for individuals enrolled in the FFS, MCO and PCC plans.

4. Primary care access to psychiatric consultation is limited by the rate of reimbursement, and by no reimbursement mechanism when a patient is uninsured. The current rate does not cover the time it takes to open a case.

5. Innovative consultation methods such as videoconferencing, telepsychiatry and telehealth are not reimbursable by MassHealth.

6. Primary care providers do not have the time to sort out a patient's insurance status in order to make a referral to a Community Support Program (CSP). The MassHealth MCOs have different authorization processes for CSPs and provide different amounts of CSP services. Uninsured patients cannot receive CSP services because CSP services are not eligible for UCP reimbursement.

7. There are no reimbursement codes for processes that support *bi-directional* physician-clinician interaction, such as clinical team meetings and CHC physician-Community Mental Health Center (CMHC) clinician trainings.

8. Funding and technical assistance is needed by integration projects to develop and implement the processes needed to support joint collaboration.

9. CHCs and CMHCs need a reimbursement mechanism for providing outpatient behavioral health services for uninsured community health center patients. Currently, CMHCs cannot be reimbursed from the Safety Net for services provided to uninsured patients; and CHCs are required to serve the uninsured, who represent a substantial proportion of their patient population.

10. CMHCs cannot bill for a physician or Nurse Practitioner placed at a licensed mental health clinic to provide primary healthcare services.

11. Same-day service billing restrictions are a big barrier to the delivery of coordinated primary and behavioral healthcare.

Recommendations:

To achieve the goal of enhancing CHC and CMHC provider-capacity to deliver collaborative care will require significant systems change to align policies, regulations, and reimbursement mechanisms. MassHealth must provide the leadership in elevating the need for collaborative care that is safe, timely, patient-centered, efficient, effective, and equitable. Leadership, visibility and commitment of resources are required to address the myriad of issues that serve as barriers to the delivery of integrated care. Specific recommendations include:

1. MassHealth should activate the federally-approved Health and Behavior codes and Substance Abuse Assessment and Treatment codes to create reimbursement streams to support the co-location of all levels of behavioral health disciplines in CHCs, and primary healthcare disciplines in CMHCs. Such codes are billable in a number of states and by some commercial insurers in selected states. The cost to MassHealth to activate these codes is unknown. Granting waivers to a select number of projects would allow MassHealth to determine costs and benefits of these new codes, and determine if such a statewide policy is financially feasible.

2. Collect and analyze billing requirements across the FFS System, MCO, and PCC Plans to address the question, "Who (primary care, mental health, addiction treatment staff) – at various clinical levels – (MD, PhD, PA, RN, LICSW, LCSW, etc) can be paid, how much, by whom, under which benefits, in which settings, and for how long."

3. Program development and integration requires funds and technical assistance to support planning, meeting, technical assistance, project management, and training. Currently, there is no revenue stream to fund these activities over time.

4. Explore the granting of waivers to eliminate barriers and evaluate the sustainability of collaborative care models. Granting waivers to a select number of projects would allow MassHealth to determine costs and benefits of new codes to determine if such models are financially feasible.

5. Establish a funding mechanism for Suboxone® and Vivitrol at CHCs and CMHC's, including both billable and non-billable services.

6. Review MassHealth same-day service billing restrictions, and remove those that serve as barriers to the delivery of quality care in a coordinated primary and behavioral healthcare system.

ABH and the MLCHC recommend that MassHealth establish a task force in the near future that can immediately undertake a formal review and discussion of regulatory and rate barriers, and the development of short and long-term remedies. We look forward to working with MassHealth to address these barriers to the integration of community-based primary and behavioral health care.

XV. Sub Appendix A. MA PCMHI Elements of Integration

Massachusetts Patient Centered Medical Home
Behavioral Health Work Group
Elements of Integration

The following are the Elements of Integration that signify integration of primary care and behavioral health in each of five practice areas or domains of care delivery. These elements were defined by the Massachusetts Patient-Centered Medical Home Initiative (PCMHI) Behavioral Health Work Group in consultation with Mountainview Consulting and Work Group member Dr. Alexander Blount, as essential for a primary care provider to effectively integrate behavioral health services.

I. Relationship and Communication Practices Domain

***Triaged Access at Emergent, Urgent and Routine Times**

The behavioral health service providers have a reliable positive working relationship and regular communication exchange with primary care providers.

***Smooth Hand-off**

PCPs routinely discuss patient care issues with behavioral health service providers prior to and after same-day hand-offs or prior to a scheduled initial visit.

***Sharing Expertise**

PCPs are comfortable requesting advice from behavioral health service providers about intervening with patients who present with behavioral health issues and medical issues.

***Training Activities**

Behavioral health service providers also provide periodic training and education for medical staff on behavioral health topics (e.g., at a provider meeting, through a monthly newsletter or a lunch time training on a topic of interest to PCPs).

***Program Leadership**

My practice has a defined steering group and medical champion for the behavioral health integration activities.

Team Membership

Behavioral health service providers are considered part of the care team.

II. Patient Care and Population Impact Domain

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with a standardized tool for both depression and alcohol.

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with standardized tools for PTSD, anxiety, drug abuse, domestic violence, and tobacco.

***Routine Screening and Referral for Pediatric / Adolescent Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with MassHealth approved screening tools for pediatric conditions and meet the CBHI screening requirements.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team have been trained in patient activation and health behavior change methodologies.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team deliver evidence-based interventions in consultation with behavioral health service providers.

Integrated Clinical Pathways

The practice targets two or more specific patient populations for the development of evidence-based behavioral health services, registries and care management (e.g., patients with chronic disease, depression, etc.)

Family Focus Care - Pediatrics

The practice collaborates with parents, youth and key caretakers to develop a care plan.

Supporting Health Behavior Change

Patients are referred to behavioral health service providers for support with lifestyle changes and management of medical problems. Patients considered for this referral include patients exhibiting specific medical markers of illness or complexity (e.g., obesity, diabetes, chronic

illness, chronic pain, sleep, heart disease, and other medical problems), patients reporting unhealthy lifestyle behaviors and patients who have somatic complaints that have a lifestyle or stress component.

III. Community Integration Domain

***Self-Help Referral Connections**

The practice has available and regularly uses referral information for self-help groups, and offers books, pamphlets and websites that foster patient self-help.

***Community Group and Resources Connections**

The practice provides linkages that facilitate the connection of patients with community resources such as gyms, churches, housing and food support.

***Specialty Mental Health and Substance Abuse Referral Connections**

The practice has referral and information-sharing protocols with an array of mental health and substance abuse specialty services.

Engagement with Specialty Mental Health and Substance Use Disorder Agencies

The practice has regular problem-solving meetings with high use agencies like the local CMHC.

Peer or Patient Participation in the Administration of the Practice

The practice has patients or consumers actively involved in quality improvement efforts.

Peer or Patient Participation in Services of the Patient

The practice has patients or peers actively involved in mentoring or health coaching for other patients and / or their family members (e.g., community health workers, patient volunteers, family members, peer educators, patient navigators, support groups).

Practice Offers Behavioral Education Programs

The practice offers group behavior-educational programs (e.g., parent training, healthy living, group medical visits).

IV. Care Management Practices Domain

***Coordination of an Integrated Treatment Plan**

Integrated treatment plans (plans that include medical and behavioral health goals) are effectively coordinated by the clinical care manager.

***Use of Behavioral Health Skills**

Behavioral health skills (e.g., patient activation) are used by the clinical care manager when working with patients.

***Use of Community Resources**

The clinical care manager is aware of behavioral health-focused community resources and regularly utilizes them (e.g., by referring patients to them).

V. Clinic System Integration Domain

***Schedule Accessibility**

The practice can facilitate the scheduling of a behavioral health visit for a patient at the time of a patient visit.

***Leaders are committed to integrated care**

Practice leadership understands the value of the behavioral health service to patients and is committed to maintaining it.

***Non-clinical staff (e.g., registration, billing, management)**

Understand the value of the behavioral health service to patients and are committed to maintaining it.

***Program Staffing**

PCPs find that the practice's behavioral health provider staffing and / or referral opportunities provide sufficient behavioral health services.

***Chart Note Integration**

The behavioral health service provider chart notes are placed in the same location as PCP chart notes.

***Process Integration**

PCPs and individual behavioral health service providers use the same screeners and outcome instruments to follow progress.

Team Awareness of Behavioral Health Services

All members of the primary care team understand the role of the behavioral health service provider(s) and how to utilize him / her.

Shared Appointment Systems

There is one system for making both primary care and behavioral health appointments."

Same-Day Access

The practice has the ability to provide same-day behavioral health care when the need arises during a primary care visit.

Same-Day Access

The practice has the ability to provide same-day medical care when the need arises during a behavioral health care visit.

Open Scheduling

The practice has the capability to schedule behavioral health appointments electronically.

Extent of Co-location Integration

The behavioral health service providers and primary care providers are located in the same exam room area of the practice and provide service there. Please respond by indicating the highest-level of co-location from none to behavioral health service providers are in the same exam room.

Coordinated Scheduling

The practice's schedule allows for patients to be seen by the medical and behavioral health provider on the same day, in or near the same location.

Operational Support for the Behavioral Health Clinician

The practice's behavioral health service provider(s) perceives that he/she has adequate scheduling, reception, administrative and medical assistant support.

Facilities

The practice has adequate space needed to conduct on-site psycho-educational classes and group appointments.

XVI. Sub Appendix B. MassHealth PCPR Elements of Integration

Participants in the MassHealth PCPR are expected to have the functional capacity to provide the foundational elements of integration, which are **bolded and starred (*).**

1. Relationship and Communication Practices Domain

***Triaged Access at Emergent, Urgent and Routine Times**

Patients have timely access based on need and acuity, to behavior change support, mental health, substance abuse and primary care services**.**

***Smooth Transitions**

Primary care providers (PCPs) and behavioral health providers (BHPs) routinely communicate about patient care issues prior to and after same-day or scheduled initial visits. Practices demonstrate a commitment to provide in-person introductions of team members**.**

***Team Membership**

PCPs and BHPs are part of the same care team.

Sharing Expertise

PCPs and BHPs have a frequent regular forum for teaching and learning, including holding clinical case reviews of patients with complex behavioral and medical issues.

Program Leadership

Primary care and behavioral health practice leaders collaborate on developing protocols, standards of practice and interventions to ensure successful communication and integration. Interventions may include the designation of primary care and behavioral health champions who foster communication and collaboration across the two disciplines.

2. Patient Care and Population Impact Domain

***Health Care Team Leader**

A leader of the health care team is identified based on patient preference and the patient's primary locus of care. The team leader is responsible for ensuring that team members are fulfilling their roles in support of the patient's care**.**

***Routine Screening and Referral for Adult Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with a standardized tool for depression, anxiety, substance use, intimate partner violence, suicide risk and symptoms of trauma. Screening also includes bio-psychosocial and quality of life assessments**.**

***Routine Screening and Referral for Pediatric/Adolescent Behavioral Health Issues**

Patients are routinely screened prior to or during annual physical exams with MassHealth approved screening tools for pediatric conditions and meet the Children's Behavioral Health Initiative (CBHI) screening requirements. Screening also includes bio-psychosocial and quality of life assessments**.**

***BHPs Role in Monitoring Patients' Physical Condition**

As members of the care team, BHPs routinely play a role in monitoring patients' physical condition on behalf of the team. This might include asking about and monitoring for adverse effects of prescribed medications and new physical symptoms that have not been reported to the team, or addressing patients' understanding of their diagnoses and treatments.

***Behavioral Health Skills Used by the Whole Primary Care Team**

PCPs and other members of the primary care team routinely screen for common behavioral health conditions as above and have been trained in skills to promote positive behavioral health change. Skills include motivational interviewing, relapse prevention planning, and basic knowledge of behavioral health referral sites to enhance delivery of evidence-based interventions, in consultation with BHPs**.**

***Family Focused Care**

The practice collaborates with parents, legally authorized representatives, youth, and key care takers in pediatrics, and, in accordance with patient wishes, encourages the participation of spouses, significant others, and appropriate family members in the development and implementation of treatment plans.

***Integrated Clinical Pathways**

The practice implements evidence-based protocols or treatment pathways that include behavioral health elements in the assessment and plan, as appropriate for their patient populations**.**

***Patient safety practices**

The practice focuses on patient safety activities by: (1) establishing protocols, (2) training their team members on safe medication practices, and (3) screening and managing patients for

suicide and public safety risks. Safe medication practices include comprehensive medication reconciliation for both physical and behavioral health medications.

***Patient Feedback and Input on Care Delivery**

The practice regularly solicits feedback from patients on its care delivery, as well as its quality improvement and patient safety activities. Feedback may be received through patient survey, the establishment of a patient/consumer advisory council, consumer participation in a practice's board of directors, patient participation in quality improvement teams and/or other modalities.

Supporting Health Behavior Change

Patients have access to BHPs to support lifestyle changes and self-management. Patients considered for this referral include those with or having risk factors for chronic medical or behavioral health conditions, patients reporting unhealthy lifestyle behaviors and patients who have somatic complaints that have a lifestyle or stress component.

3. Community Integration Domain

***Self-Help and Community Resource Connections**

The practice has organized resources to help patients identify their strengths and to understand and utilize existing community supports to complement the medical and behavioral health services provided. Community supports may include self-help groups, social service and civic agencies, spiritual supports, etc. The practice offers books, pamphlets and websites that foster patient self-help.

***Specialty Mental Health and Substance use Referral Connections**

Primary care, specialty mental health, and substance use providers have referral and information-sharing protocols, which stipulate access expectations and include plans for problem solving and coordination.

Peer/Community Support Services for Patients

The practice has group medical visits or deploys patients/family members as peers (individuals with lived experience with medical and or behavioral health conditions). Peers mentor, coach and share lived experiences with patients and their family members.

Behavioral Education Programs

The practice offers population based and/or group approaches to patient education for at least two common behavioral needs of their patient population.

4. Clinical Care Management Practices Domain

***Development, Implementation and Coordination of an Integrated Treatment Plan**

The designated Clinical Care Manager for each patient effectively coordinates integrated treatment plans, i.e. plans that include medical and behavioral health goals and which delineate roles and responsibilities of care providers**.**

The CCM:

- Manages the development, implementation and monitoring of a multidisciplinary care plan, created jointly by the patient/family and the health care team. The plan of care includes patient/family identified self-management goals for chronic illnesses or conditions.
- Documents the plan of care in the patient's record and updates the plan as necessary.
- Coordinates care among providers (medical, behavioral and addictions), including providers from systems of care, such as Department of Mental Health, Department of Children and Families, etc**.**

***Use of Behavioral Health Skills**

Behavioral health skills, as described above ("Behavioral Health Skills Used By the Whole Primary Care Team") are used by the Clinical Care Manager when helping patients implement their treatment plan**.**

***Use of Community Resources**

To fully implement the treatment plan, the Clinical Care Manager is aware of behavioral health-focused resources within the practice and community and regularly connects patients to them as per the above (Self Help and Community Resource Connections).

5. Clinic System Integration Domain

***Schedule Accessibility**

The practice can facilitate the scheduling of a behavioral health and/or primary care visit for a patient at the time of a patient visit.

***Program Integration**

Primary care and behavioral health practices collaborate to promote integration at every level of the organization(s). This includes primary care and behavioral health practice leaders collaborating on developing protocols, standards of practice, memorandums of understanding, and interventions to ensure successful communication and integration. In addition, practice leadership ensures that clinical and non-clinical staff members are trained on the importance of

integration and their roles in supporting it, and provides operational support for integration in terms of scheduling, reception, administration, staffing and facilities**.**

***Health Information Exchange**

To the extent possible, given required compliance with federal and state privacy laws, information from primary care and behavioral health service provider visits and communications with patients are shared. This could involve having a single patient health record utilized by both the PCP and BHP. Such information exchange may require practices to actively seek MassHealth members' consent**.**

***Coordinated Scheduling and Same Day Visits**

The practice's scheduling allows for routine appointments with medical and behavioral health providers on the same day and has the capacity to access same-day urgent behavioral health and medical visits when needed. The practice also has the ability to access same-day mobile crisis services and other emergency evaluations**.**

Extent of Co-Located Integration

The BHPs and PCPs can provide services in the same area of the practice regularly or when necessary.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Health Disparities

The DMH Office of Multicultural Affairs (OMCA) has the structural and functional responsibility and accountability for reducing mental health disparities among diverse racial, ethnic, and linguistic populations in Massachusetts by improving access to quality care. OMCA serves as the catalyst and synthesizes the recommendations of the Department's Cultural Competence Action Team, Multicultural Advisory Committee, and mental health stakeholders to create the DMH Cultural and Linguistic Competence Action Plan. http://www.mass.gov/eohhs/docs/dmh/p-cultural-action-plan.pdf. The Action Plan operationalizes the Department's mission of providing culturally and linguistically competent care to ensure that the state mental health system is attentive to the needs and effective care of culturally and linguistically diverse populations.

Examples of accomplishments and activities by DMH that occurred during SFY14-15 under the leadership of OMCA include:

- Participated in the planning and implementation of several SAMHSA-funded projects to increase access to culturally and linguistically competent care.
  - MyCHILD
  - Project LAUNCH
  - Success for Transition Age Youth & Young Adults (STAY)
- Expansion of Community of Practice in SFY15 to connect and provide support for cultural and linguistic competence in ten Community Service Agencies, which perform Intensive Care Coordination for children and youth with severe emotional disturbance.
- Provided technical assistance for the identification of needs and development of action steps to increase participation of diverse populations in three consumer, family, and community focused programs.
  - Multicultural outreach with Parent Professional Advocacy League
  - Multicultural outreach and Voices for Change with Transformation Center
  - Community Collaborative for Health Equity: One Care
- Conducted two Boston Community Conversations on Mental Health, which were called "Many Faces of Mental Health: Sharing Our Stories" and "Many Faces of Mental Health: Connecting the Mind, Body and Spirit", based on the SAMHSA Community Conversations toolkit and the White House National Conference on Mental Health.
  - The third Boston Community Conversations on Mental Health is being planned for SFY16. MAC co-chairs and DMH Metro Boston Area staff are collaborating with the Boston Centers for Youth and Families to conduct a listening session with Boston teens ages 13-17 years old.
- Hosted the East Coast Asian American Students Union conference in Boston with the National Asian American Pacific Islander Mental Health Association and University of Massachusetts Boston.
- Provided "Clinical Competence in Working with Culturally and Linguistically Diverse Clients" training to DMH staff and providers.
- Partnered with Boston Public Health Commission, Tufts Medical School, Simmons College School of Social Work, UMass Lowell and over ten community-based organizations, to plan and implement the annual Asian American Pacific Islander Mental Health Forum.

- Collaborated on multicultural and disparities research with two Centers of Excellence funded by DMH, including an Asian American Psychological Association-funded project called the Chinese American Mental Health Literacy Project.
- Updated the Multicultural Populations Resource Directory in 2014 and posted the directory on the DMH internet website for dissemination.
- Coordinated the translation of survey materials to increase participation by consumers and family members who do not have English as their primary language for the annual consumer and family member satisfaction survey. The introductory letters, each of the surveys, the first and second survey mailing cover letters, the postcard reminders, and the thank you letters were all translated into eight languages.
- Provided integrated clinical and cultural consultations on clients served by DMH staff and providers.
- Offered information and referrals to DMH staff, providers, individuals and families seeking behavioral, health and social services.
- Organized community focus groups to address community concerns and psychological first aid trainings for post-Boston Marathon Bombing event with the Office of Refugees and Immigrants and External Affairs in the Office of the Governor.
- Partnered with the Office of Refugees and Immigrants, resettlement, and community agencies on the New American Welcoming Network.
- Presented workshops and participated on local and national panels and training institutes, including the National Technical Assistance Center for Children's Mental Health at Georgetown University Center for Child and Human Development; Annual Massachusetts Psychiatric Rehabilitation Association Conference; White House National Conference on Mental Health; Asian American Integrated Care, Office of Minority Health, US Health and Human Services; and the Mental Health Legal Advisors Committee Conference.
- Participated in the development of the Request for Response for Homeless Support Services.

DMH developed and implemented the 2013 Language Access Plan, which defines the actions DMH takes to ensure meaningful access to DMH services, programs, and activities by persons who have limited English proficiency (LEP). The 2013 Language Access Plan provided guidance during SFY14-15. Included in the Plan are OMCA activities such as the coordination of statewide interpreter and translation services that provide interpreter and translation services for all DMH Areas, Sites, inpatient facilities, forensic functions, investigations, and human rights office activities. OMCA also handles translations of DMH materials. OMCA works closely with state-contracted translation and interpretation agencies to fill requests for interpreters and translations, processes payment vouchers, and analyze utilization data.

DMH uses a comprehensive and integrated strategy to address the needs of culturally and linguistically diverse populations, whether the clients speak English moderately well, very well, or not at all. DMH continues to develop its language access

assistance program based on census data, clients' self-reported preferred language, and observations from DMH staff who work directly with clients. As specified by the federal regulations, DMH takes "reasonable steps to ensure meaningful access to programs and activities by LEP persons." In accordance with the U.S. Department of Health and Human Services guidelines, DMH makes an individualized assessment that balances the following four factors:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
2. The frequency with which LEP individuals come in contact with the program;
3. The nature and importance of the program, activity, or service provided by the program to people's lives; and
4. The resources available to the grantee/recipient and costs.

DMH notifies contracted vendors of standards for LEP access and expects that the Department's Language Access Plan will be applied to the activities the vendors conduct on DMH's behalf. DMH has incorporated the language access assistance requirement in service standards and vendor contracts. In addition, some of the Department's contracted vendors are also recipients of federal resources, and as such will have independent obligations to comply with the U.S. Department of Health and Human Services guidance.

To the extent possible using available resources, all services are conducted in the client's preferred language by DMH staff fluent in the language or through competent interpreters. For example, DMH employs staff fluent in American Sign Language as Deaf Case Managers to assist deaf clients. DMH prioritizes the use of bilingual and bicultural staff before the use of interpreters. When bilingual staff is not available, professional interpreters will be used. With current resources for interpreter and translation services, DMH has prioritized inpatient service as the most important service to have interpreters available due to the clinical severity of mental illness or emotional disturbance of clients in the hospitals. In-person interpretation is the modality for clients and staff whenever interpreter services are deemed necessary.

DMH has standardized the collection of clients' race, ethnicity, and preferred language information in the agency's medical record system called Mental Health Information System (MHIS) basing the manner of collection on the Institute of Medicine's recommendations and Office of Management and Budget's guidelines. OMCA regularly collects population census data for DMH's service areas and the major cities in Massachusetts. OMCA also reviews service enrollment data and studies on prevalence rates of mental illness by race and ethnicity. DMH has worked closely with its two Center of Excellence research facilities 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. Multicultural mental health and disparities research became an integral part of the research agenda of DMH's two contracted Centers of Excellence. OMCA continues to collaborate with the two Centers of Excellence on their research related to racially and culturally diverse populations.

DMH continues to maintain its services to Deaf and Hard of Hearing clients. DMH utilizes American Sign Languages and provides services to Deaf and Hard of Hearing as accommodations under the American Disability Act. DMH has established procedures that require that access issues be addressed in Individual Service Plans and during the process of eligibility. DMH has received technical assistance from

Massachusetts Commission for Deaf and Hard of Hearing in establishing guidelines and using technology to enhance access. DMH maintains the provision of specialized case management, CBFS services for Deaf and Hard of Hearing clients and a statewide Respite program. The DMH Worcester Recovery Center and Hospital provides Deaf services within one its unit. Training efforts and other accommodations are being pursued to address the challenges of providing linguistic and cultural access and treatment within this setting.

In addition, one specialized Community Services Agency (CSA) was procured by MBHP as part of the Rosie D implementation plan to provide Intensive Care Coordination to youth who are deaf or hard of hearing and primarily serves the Metropolitan Boston Area. The other 31 CSA's are also expected to be able to address the needs of children and their caretakers who are deaf.

DMH is working with the Department of Public Health, Bureau of Substance Abuse Services (BSAS) to improve access to substance abuse services. Currently there are on-going AA meetings that will always be open and interpreted. DMH is also working with Bureau of Substance Abuse Services (BSAS) at the Department of Public Health and MCDHH to revise the BSAS screening tool to a Deaf-friendly format and find funds to produce it. DMH also worked with the National Alliance for The Mentally Ill to add American Sign Language (ASL) interpreting to their "In Our Own Voice" DVD. This DVD presents the recovery stories of clients. It can be used to promote recovery, reduce stigma, and educate the community, family and friends.

DMH undertook a pilot project to use Person Centered Planning with Deaf clients. Trainings were provided to DMH and vendor staff. Case managers were trained in facilitating PCP meetings and the relevant tools revised, with several clients participating in the process. DMH worked with the Transformation Center, a peer–operated agency to increase access for Deaf and Hard of Hearing DMH clients to recovery concepts and opportunities. In SFY11, DMH worked with the Transformation Center and Deaf peers to plan and sponsor two events on "Deaf/Hard of Hearing Recovery: A Journey of Hope". These events provided workshops about recovery, coping skills and peer support. The participants were Deaf/HoH DMH clients, staff, family members and the general community.

DMH is also working with other state agencies and advocacy groups to explore the provision of accessible behavioral health Emergency Service Programs. DMH participated in a training for ESP providers in January 2013.

In addition, DMH is participating in several collaborative efforts to address remaining gaps in the system. DMH is working with the Boston University Psychosocial Rehabilitation Department to pursue funding to adapt one module of the Illness Management and Recovery (IMR) curriculum for use by Deaf/HoH in a visual format. In SFY14, funds were secured and the first module of IMR adapted for Deaf ASL users was produced. As mentioned above, DMH funded a vendor agency to operate a 3-bed Respite program which is Deaf accessible and affirmative. DMH was also recently awarded a Transformation Transfer Initiative (TTI) grant SAMHSA, administered through the National Association of State Mental Health Program Directors (NASMHPD), to develop a pilot for promoting peer support in the Deaf/HoH community. This project is ongoing and through this grant DMH and the Transformation

Center provided forums across the state to discuss the concepts of peers support and recovery. The project team is currently working on several videos for this project.

The Massachusetts Commission on Gay, Lesbian, Bisexual and Transgender, Queer and Questioning (GLBTQ) Youth asked DMH to assess whether its services were meeting the needs of its GLBTQ youth in its Annual Recommendations for SFY11. Research and data have shown that GLBTQ youth are at higher risk than the general population for poverty, homelessness, depression and suicide, discrimination, stigma and increased risk of substance use. Staff training was identified as the first step to ensuring the needs of GLBTQ youth, young adults and their families are met. In collaboration, DMH and the Department of Public Health (DPH) sponsored an all-day training for DMH staff and providers in May 2011 focused on "Supporting GLBTQ Youth, Young Adults and their Families." This was DMH's first gay, lesbian, bisexual, transgender, questioning (GLBTQ) training.

In FY12, DMH offered this training in 3 regional areas (Worcester, Boston and Brockton) for area/local DMH and provider staff. In addition, 2 afternoon training sessions were designed specifically for young adult peer mentors/peer leaders. In SFY13, this training was extended to three additional areas: Springfield, Lawrence and Framingham. In addition, a Speakers Bureau training will was offered for young adults interested in learning how to prepare a narrative for sharing their experiences and how to incorporate their narratives into a training for staff. DMH will continue to offer this training as requested, and will also develop a Networking Summit so that training participants can provide their experience as a result of the trainings and advise on next steps (e.g. additional training topic needs).

DMH 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 Persons Served; 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.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

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

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

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

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

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

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

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

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

d. Provider involvement in planning value-based purchasing.

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

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

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

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

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

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

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[59] Ibid, 47, p. 41

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

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

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

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

[64] http://psychiatryonline.org/

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

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

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

Footnotes:

Use of Evidence in Purchasing Decisions

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. 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 has engaged in a significant redesign of its community-based service system, beginning in 2009 with the development of a new service model, Community Based Flexible Supports (CBFS). The CBFS 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. While not required, DMH encourages 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. Implementation of evidence-based practices is a standing agenda item at semi-annual contract management meetings with CBFS providers. DMH provides statewide training on the IPS model through a network of DMH and provider master trainers. In SFY14, DMH created the position of Director of Employment to monitor, evaluate, and coordinate the Department's various employment services and staff.

DMH implemented its new contracts for Clubhouse services in July 2013. The Clubhouse services model emphasizes the provision of a full array of employment services, including Independent Employment, Supported Employment (consistent with IPS principles), and Transitional Employment. In addition, DMH supported but did not require bidders to adhere to the standards of the International Center for Clubhouse Development (ICCD).

DMH's provides Assertive Community Treatment through Program of Assertive Community Treatment (PACT) programs. DMH also views PACT as a vehicle for the use of other evidence-based practices, including the Individual Placement and Support (IPS) model of Supported Employment, 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. In addition, DMH convenes statewide meetings with PACT program directors and specialist staff in order to promote shared learning.

In SFY15, DMH procured the Prevention and Recovery Early Psychosis (PREP®) Program in its Western Mass Area using the 5% prevention set aside of SAMHSA Block Grant funds. This evidenced based model will expand DMH's effort to reach young people who are experiencing signs of first episode psychosis and assist in supporting their recovery pathway earlier than traditional outpatient using evidenced based interventions. The Western Mass program expands on a similar program model currently available in DMH's Metro Boston Area and is described further in the Evidence-Based Practices for Early Intervention section.

DMH is also promoting the adoption of evidence-based and emerging practices for peer support. In SFY12, DMH procured a new service, a Peer-Run Respite program

(Afiya House) in the Western MA division. 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. Afiya House is also discussed in Step 2, Crisis Services and Recovery.

A second peer model that DMH is supporting is Whole Health Acton Management (WHAM). WHAM is an emerging best practice that provides CPSs with the skills needed to help consumers develop, implement and sustain a whole health goal. DMH supported the training of 70 peers to become facilitators for WHAM. Three classes in Boston and Western MA were conducted through a collaboration led by DMH, and including the Massachusetts Behavioral Health Partnership (MBHP) and the Transformation Center. These trainings were led by Larry Fricks, Deputy Director of the SAMHSA/HRSA Center for Integrated Health Solutions, and Ike Powell, of Appalachian Consulting Group. DMH utilized Block Grant Funds to sponsor a three-day WHAM Master Trainer class to develop an internal capacity to train additional facilitators. DMH Area offices currently coordinate regional WHAM trainings offered to peers served by any behavioral health provider in the region. Massachusetts was also chosen to pilot WHAM for Asian American and Pacific Islander Peers and bi-lingual Community Health Workers, in conjunction with the National Asian American and Pacific Islander Mental Health Association and the National Asian American and Pacific Islanders Empowerment Network.

DMH promotes the use of evidence-based and best practices within Child and Adolescent services as well. In SFY12, DMH procured Individual and Family Flexible Support Services (IFFSS). IFFSS provides an individualized and targeted set of interventions and services intended to prevent out-of-home placement, sustain youth with his/her family and community, and assist youth to successfully function in the community. IFFSS providers are expected to integrate best practices that are family-driven, youth-guided, strength- and resilience-based, and trauma-informed. The Family Systems Intervention (FSI) component of IFFSS assists families and youth in developing the skills and supports that promote family cohesion and successful community living. DMH requires that FSI is delivered in a manner that is informed by and reflects evidence-based or best/promising practice for home-based family therapy and is consistent with wrap-around principles.

The joint DMH/DCF Caring Together residential procurement also supports and advances a service system wherein Massachusetts children and families have timely access to an integrated network of out of home and in home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully in their local communities. The design of these new services reflects the Building Bridges framework for achieving effective residential service interventions. This framework promotes utilization of evidence based and promising practices which support trauma-informed, strength-based, individualized, family driven/youth guided and community focused care that is evidence and practice-informed, and consistent with the research on sustained positive outcomes.

To further advance family-driven practice and care in the service system, DMH Child and Adolescent Services is procuring a parent support service for parents and caregivers of youth receiving residential services. This procurement is a joint initiative with DCF with expected implementation in SFY16. The model will build upon the Family Partner workforce currently available to parents/caregivers of youth with SED receiving community-based services through MassHealth, the Commonwealth's Medicaid system. This new service will expand access to peer support for parents whose children are receiving the most intensive treatment services, and strive to ensure support to parents and caregivers when the youth is transitioning into and out of residential services.

DMH is a national leader in promoting the use of evidence-based practices that reduce and prevent seclusion and restraint. The Child and Adolescent division has engaged in significant work over the last 12 years in leading statewide restraint and seclusion reduction efforts in inpatient and community residential settings. In the last several years, these efforts have been expanded to include an Interagency Restraint and Seclusion Prevention Initiative. This effort is bringing together leaders from the state Departments of Children and Families (DCF), Mental Health (DMH), Youth Services (DYS), Early Education and Care (EEC), Elementary and Secondary Education (ESE) to work in partnership with the Office of the Child Advocate and parents, youth, providers, schools and community advocates to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing. The initiative is built upon the principles of trauma-informed care, restraint/seclusion prevention and the six Core Strategies, and the Building Bridges Initiative. DMH has provided and will continue to offer free on-going training (every other month) to all provider staff about the impact of trauma and approaches to working with children/adolescents with trauma histories. Janina Fisher, Ph.D has been a primary trainer. The reduction and prevention of restraint and seclusion in DMH adult continuing care inpatient facilities is also a priority. This ongoing effort was originally funded by a SAMHSA State Incentive Grant (SIG) through the National Association of State Mental Health Program and is now embedded within the DMH Inpatient Governance structure with support from the Restraint and Seclusion Elimination Committee of the State Mental Health Planning Council.

DMH is promoting several other approaches to trauma-informed care throughout the inpatient and community systems. As a direct result of this need for a culture shift, the DMH Office of Training and Development sought to introduce new curricula into its training programs, beginning with its orientation requirements. A workgroup reviewed DMH's existing curriculum which was designed primarily to reduce restraint and seclusion use in its inpatient facilities, teaching concepts from SAMHSA's Six Core Strategies. The workgroup extensively researched the existing literature in order to retool that curriculum to expand and integrate concepts of Trauma Informed Care and to include more opportunity for practicing primary prevention skills toward promoting a recovery oriented environment for persons served. Building upon that new training focus, the Personal Safety Workgroup simultaneously began development on a similar curriculum for community-based programs. This curriculum also promotes a collaborative recovery oriented focus while providing site specific information regarding safety for staff and persons served. Both curricula have been completed, Master Trainers have been trained and full roll-out across the agency is underway.

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. In addition, DMH contracted with Recovery Innovations from Arizona to provide two 2-week Peer Employment trainings, in Dorchester and Springfield with up to 20 participants in each. DMH has also piloted 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 is also opened to other young adults with lived experience who are exploring the field of peer support work. Five sections were offered across the state for a total of 43 participants.

The Person-Centered Planning Initiative is another statewide project impacting the inpatient and community systems. This project was originally funded by a SAMHSA Transformation Transfer Initiative (TTI) grant and built on initial training that 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 for an overview training utilizing a train the trainer model to provide training to all DMH staff and launched a statewide effort to train all DMH workforce members in the philosophy of Person-Centered Approaches to Treatment Planning. 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..

DMH works with its two Centers of Excellence; one in Clinical Neuroscience and Neuropharmacology (Commonwealth Research Center at the Beth Israel Deaconess Medical Center, Harvard Medical School) and one in Behavioral and Forensic Sciences (Center for Mental Health Services Research at the University of Massachusetts Medical School) to promote a "Science to Service to Science" perspective. DMH is working collaboratively with the two Centers to identify promising research results that can be used to assist DMH in meeting its mission, and to generally increase the visibility of research as a practical tool throughout the service system. The two Centers co-sponsor an annual conference which brings together consumers, providers, and researchers to hear about current research and to identify future research priorities.

DMH supports research activities and diffusion of evidence-based practice specific to children and youth with the launch of a legislatively-mandated Children's Behavioral Health Knowledge Center. The Center is dedicated to ensuring that clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained, services provided to children are cost-effective and evidence-based, and that new service delivery models are developed and evaluated.

Finally, DMH is actively involved in efforts to assess the Rosie D Remedy Service, the state's Medicaid community-based services for youth with SED. These services were created in 2009 as part of the resolution of an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) lawsuit against the Commonwealth and MassHealth regarding access to community-based services for MassHealth-enrolled youth with SED.

The Court's Remedy Plan included a provision to assess implementation of the services, with oversight provided by a Court Monitor. DMH staff was actively involved in this two-year, multi-stakeholder effort (SFY11-12). DMH continues to collaborate with MassHealth in the transition to a sustainable evaluation process for these MassHealth services utilizing the University of South Florida's System of Care Practice Review model. DMH intends to incorporate key elements of this model into its own quality management and oversight efforts for DMH community-based services.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Prevention for Serious Mental Illness

DMH supports national efforts to strengthen state mental health authorities' role in promoting a public health approach to addressing mental and behavioral health needs in state populations. Central to this strategy is a focus on mental health promotion, prevention, and early intervention and treatment. This is of particular interest to the child and adolescent division as many lifetime cases of mental and emotional disorders begin during adolescent years.

There are numerous activities to promote the mental health of young children. In SFY12, DMH entered into a four-year Interagency Service Agreement with the Massachusetts Department of Early Education and Care (DEEC) to participate in Massachusetts' Race To The Top award. Massachusetts was one of 12 winning states in the national Race to the Top competition, funded by the U.S Department of Education to promote reform in four areas: standards and assessments, great teachers and leaders, school turnaround, and data systems. DMH is charged with increasing awareness, capacity, and access for the mental health care for young children, 0 – 5, and their families through training, professional development, and consultation. Targeted populations within the health and mental health fields include pediatricians, Massachusetts Child Psychiatry Access Project (MCPAP) clinicians, CBHI service teams, early childhood mental health consultants, and other clinical staff. Other populations include early childhood educators and staff within state agencies who work closely with young children (e.g., DCF, DHCD). DEEC (which licenses all childcare programs in the state) and MassHealth have jointly funded clinical positions, based in community clinics selected by childcare programs, to provide consultation, training and triage for children with behavioral problems. Many of these children exhibit symptoms of Post Traumatic Stress Disorder or other early traumas. DEEC also funds clinical consultation to day care programs, inviting DMH to participate in its provider selection process.

DMH has been an active participant in DPH's Project LAUNCH grant program funded by the Substance Abuse and Mental Health Services Administration for promoting the wellness of young children from birth to 8 years of age by addressing the physical, emotional, social, cognitive and behavioral aspects of their development. Massachusetts was one of 12 states awarded this grant for up to $850,000 each year for five years. DMH is also actively engaged in the MYCHILD, SAMHSA Children's System of Care grant which seeks to identify children through age 5 who have or are at high risk for SED, providing them with family-directed, individualized, coordinated and comprehensive services. Target areas include: 1) Early identification and linkage to effective services and supports of children showing warning signs of SED and/or exposed to "toxic stress"; 2) Culturally and linguistically competent support and linkage of children and families to accessible, affordable, coordinated services; 3) Expansion of service capacity to provide community based mental health clinical and consultation services in children's natural environments; 4) Cross-training of early childhood and family support workforces to recognize and respond to infant and early childhood mental health issues using evidence-based, developmentally-appropriate, relationship-based tools and practices; and 5) Evaluation of outcomes for continuous

improvement, and identification of the return on investment of early intervention and treatment.

DMH provides administrative oversight to an EOHHS/Department of Elementary and Secondary Education initiative to introduce school-based Positive Behavioral Interventions and Support (PBIS) in schools. The initiative focuses on schools in Central Massachusetts, selected based on their participation in a SAMSHA funded System of Care grant, Central Massachusetts Communities of Care (CMCC). CMCC was designed to use a public health approach, offering preventive, early intervention, and intensive wraparound services within a family-provider partnership model of service delivery to decrease and prevent youth with serious emotional and behavioral problems from becoming involved with the courts and to reduce the seriousness and duration of juvenile justice involvement. SAMSHA funding for CMCC ended in SFY13, however, CMCC continues its work with funding from the Massachusetts Department of Children and Families (DCF) as a DCF Family Resource Center, with the goal of expanding the service population to include all children and youth from birth to 18.

DMH works closely with the Massachusetts Chapter of the American Academy of Pediatrics, particularly with its mental health task force which includes DMH, the Department of Children and Families, Department of Public Health, and DESE as members, as well as pediatricians, child psychiatrists, psychologists, nurses, social workers, and parents. The Academy has been successful on one of its key agenda items, which was to secure agreement from the state's major HMOs to reimburse for mental health screening. The group is now focusing on several key areas: mental health services in schools, including support for school nurses; early childhood mental health; better integration of primary care and behavioral health; and the implications of national health care reform efforts on the Massachusetts behavioral health service system for children and adolescents, such as implementation of medical homes and Accountable Care Organizations (ACO).

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. Additional information on MCPAP is provided in the Health Care System and Integration and Children and Adolescent Behavioral Health Services sections.

CEDAR (the Center for Early Detection Assessment and Response to Risk), a clinical service for young people (ages 14-30) who are experiencing new or worsening symptoms that may be warning signs for psychosis, operates under the auspices of the DMH Massachusetts Mental Health Center (MMHC) outpatient clinic and the DMH Research Center of Excellence, Beth Israel Deaconess Medical Center, the Commonwealth Research Center (CRC). A private-public partnership, CEDAR is funded through DMH and a private Foundation, the Sidney R. Baer Jr. Foundation. In addition to clinical services for young people and their families, CEDAR staff provide outreach and training to primary care physicians, school nurses, mental health professionals, teachers, guidance counselors, university and school administrators, resident advisors, youth workers, community leaders, clergy, police, and anyone who

interacts regularly with youth. The CRC has organized a Prevention Collaborative, a collaborative comprised of DMH Child and Adolescent and Clinical and Professional Services staff, early detection and intervention researchers, school leaders, and community organizations committed to early detection and intervention of mental illness and substance abuse.

In 2012, with the support of the Sidney R. Baer Jr. Foundation and DMH, the CEDAR clinic launched a pilot cognitive enhancement program for young people (age 16-25) who are showing signs of clinical high risk (CHR) for psychosis. Cognitive impairments (e.g., trouble with attention, memory, ability to understand social situations) are one of the most common symptoms of schizophrenia and are known to be a key factor underlying disability caused by this disorder. Cognitive impairments are also present among most individuals at CHR for psychosis and contribute to decline in social and role functioning. This program, called CLUES (Cognition for Learning and for Understanding Everyday Social Situations) is based on Hogarty and Greenwald's Cognitive Enhancement Therapy (CET), which has been found to be effective in people with schizophrenia. CLUES is designed to meet the developmental needs of adolescents and young adults at CHR. The program involves computerized cognitive training, individual coaching sessions and a group focused on teaching skills for enhancing social and non-social cognition and real world functioning.

There are a number of studies underway at the CRC to better identify individuals who may be most at-risk in order to better understand 1) biological and environmental factors associated with either improvements in mental health or with the development of more persistent concerns, and 2) who is most likely to benefit from early interventions. The North American Prodrome Longitudinal Study (NAPLS III) is a National Institute of Mental Health (NIMH) funded collaborative study partnering researchers at the MMHC and throughout the Harvard Medical School network with those at eight other sites across North America. Its goal is to investigate how schizophrenia and other serious mental illness develop during adolescence and young adulthood and is one of the largest prospective studies ever to do so. NAPLS III is unique in that it uses the results of previous generations of research on risk for psychosis to identify those youths thought to be most at risk then follows them closely over a two year period. Through use of MRI, electrophysiological (EEG/ERP), blood, urine, and saliva analysis, neuropsychological and social cognitive assessments, and clinical evaluation, this work aims to give new insights into the dynamic changes occurring during the lead up to illness. The long term goal is to use such breakthroughs to develop new, more effective preventative interventions. A second study is the Children at Risk for Psychosis, a longitudinal study of children with a 1st degree relative with a diagnosis of psychosis designed to identify markers for the prediction of psychosis, which is central to develop early intervention and prevention strategies for schizophrenia and affective psychosis diagnoses.

Environmental Factors and Plan

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

Narrative Question:

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

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

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

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

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

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

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

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

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

Footnotes:

Evidence-Based Practices for Early Intervention

Description

In SFY15, DMH utilized the 5% set-aside funds to enhance its original Prevention and Recovery in Early Psychosis (PREP®) program in MetroBoston and to procure a second PREP® outpatient program in its Western Mass Area. PREP® is an intensive outpatient clinical service comprised of the core components of Coordinated Specialty Care (CSC) plus a therapeutic peer group program, cognitive remediation services, and family treatment. 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.

Implmentation

There are three components to the plan:

1. Expanding Early Intervention Clinical Services in Massachusetts
    a. PREP East (original PREP® program in MetroBoston): Hiring of substance abuse specialist and education/employment specialist for PREP East. Both staff have been hired, trained, and are providing services within PREP® East.
    b. PREP West: Replicating PREP® East in Western Mass. The Department procured this new service through a competitive bidding process. The contract was awarded to ServiceNet effective May 1, 2015. One of the criteria for selection was a 'store-front' clinic setting. ServiceNet has signed the lease for the new site in early May and build out is due to be completed in July 2015. The PREP® East Clinical Director started 6/1/15 and start dates for remaining staff are planned for July.

2. Extending community outreach to include schools, primary care physicians, etc.
    a. PREP® East has a long tradition of providing educational forums for health care providers and educational institutions.
    b. PREP® West is responsible for providing community education and awareness to the communities of Western Mass. In addition to an extensive network of local health care providers, Western Mass is home to numerous high schools, colleges and universities. PREP® West will partner with these institutions to disseminate awareness and identify potential referrals. Planned activities include First Responder trainings, recovery and peer mental health, and clergy
    c. PREP® Website of information and resources for young adults. The team is in the process of procuring the vendor to design, establish, and maintain this website.

3. Providing training and consultation.
    a. A critical component of both PREP® East and PREP® West is the training program for health care providers. 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. A requirement for selection of the PREP® West provider was demonstrated relationships with academic programs and a commitment to providing training to psychiatry, psychology, social work, and trainees of other health care disciplines.
    b. Additionally, as part of the PREP® services, providers may refer a young adult for a psycho-diagnostic assessment and treatment consultation.

The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators and baseline measures

1. PREP® West implementation. DMH selected an agency with a strong commitment to the values and principles which comprise CSC and PREP®, e.g. including utilization of EBPs and commitment to continuous quality improvement.
    - Establish fully operational clinic with trained staff and steady referral stream
        - Hiring dates
        - Training dates, content, and attendance
        - Track ongoing consultation hours with trainers, PREP® East
        - Community education and outreach efforts
        - Track # of referrals, referral sources

2. Align data collection and reporting processes across PREP® East and PREP® West.
    - Hold bi-monthy (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. Define and operationalize the continuum of PREP® Early Intervention Services and establish the process for wider dissemination of PREP® East service components. PREP® East is a comprehensive service that provides extensive clinical services for people at high risk. PREP® participants benefit from a continuum of care within the larger clinic that hosts PREP® East. PREP® West will have similar capacity. Additionally, the team plans to increase capacity for PREP® Early Intervention Services across the state so that elements of the continuum are available more widely, e.g. Early Intervention services for PREP® participants who are stable and engaged in work and school and would benefit from treatment with a provider knowledgeable about Early Intervention.
    - Define and operationalize PREP® continuum of care components

Establish a PREP® Implementation consultation service.

- Define PREP® implementation processes for each PREP® continuum of care component.
- Identify PREP®-trained and recognized consultants available to provide implementation consultation.

Budget

FFY15

1. The PREP® West program will start up and be in operation for 3 months (7/1/15 to 9/30/15) with a budget of $218, 875. During this startup period the team anticipates a number of additional costs associated with consultation from the PREP® Boston program and training in the EBPs at a cost of $50,000.

2. The two PREP® East positions (substance abuse and education/employment specialist) will be filled for 8 months (2/1/15 to 9/30/15) with a budget of $59,000.

3. The team anticipates that the cost for the development and launch of the young adult website will be $15,000.

FFY16

1. The PREP® West program will be fully staffed and operational with a budget of: $525,000.

2. The additional PREP® East staff: $88,000

3. Maintenance costs for the Early Psychosis website, $5,000

Role	% Time	Annual Salary Rate	Cost
FEP Team Leader	100%	74,242	$74,242
IPS Specialist	50%	40,347	$20,174
Psychologist	80%	74,242	$59,393
Psychiatrist	40%	181,524	$72,610
Social Worker (LICSW)	80%	50,000	$40,000
Peer Worker	80%	29,289	$23,431
Substance Abuse Counselor	25%	44,974	$11,244
RN	25%	64,674	$16,168
Total salary for team	4.8 FTE		**$317,262**
Fringe			22%
Total + Fringe			$387,060

Team, Ongoing	
Support for Management of the Program	
Statewide Program Director	$10,000
Training and Supports	$10,000
Fidelity and performance measurement	$5,000
Administrative Support	$5,000
Funding for Data Infrastructure	
Clinical Expenses	
Medications	$10,000
Labs	$5,000
Flexible Dollars for Client Engagement and Support	$5,000
Part-time receptionist?	$10,000
Infrastructure Costs	$10,000
Local clinical supervision	
Total ongoing costs	**$70,000**
total costs (staff and ongoing)	**$457,060**
Cost plus indirect (15%)	**$525,618.81**

Data Collection

Currently, PREP® East tracks information on PREP® participants upon admission, six months later, and once annually. Data collected includes employment/education status, substance abuse use, health status, subjective quality of life and some cognitive assessments. PREP® West is expected to track the same information. Additionally, the team is planning to develop measure(s) of program fidelity.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

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

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

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

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

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

Footnotes:

Participant Directed Care

Person- and family-centered service delivery is a core value of DMH. Multiple initiatives aimed at promoting self- and family direction are described throughout this plan, including Steps 1 and 2, Use of Evidence in Purchasing Decisions, Recovery and Children and Adolescent Behavioral Health Services. DMH is not currently involved in any initiatives to develop a voucher system.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

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

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

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

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

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

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

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

Footnotes:

Program Integrity

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 SFY15, 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 Set-Aside for Treatment of Early Psychosis. DMH had previously used a "blended" funding model in which numerous contracts had a combination of state and Block Grant funds. DMH made this change to ensure more efficient use of Block Grant dollars and improve tracking of compliance with federal requirements. This distribution also aligns with SAMHSA and DMH priorities and allows the Department to provide detailed reporting at the service level.

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. DMH procured Child and Adolescent Individual and Family Flexible Support Services in SFY12 and Clubhouse Services and Child and Adolescent Residential Services in SFY13 under Chapter 257. It is anticipated that Chapter 257 will be fully implemented by July 1, 2017. As of May 2015 the Executive Office of Health and Human Services prioritized the remaining activities/programs that have unset rates into three tiers. Tier 1 will have rates effective July 1, 2015, tier 2 are scheduled for review and implementation during SFY16, and tier 3 will be reviewed and implemented during SFY17. In SFY16, DMH will be working to establish rates for Homeless Support and Adult Residential and during SFY17, DMH will finish developing rates for its seven remaining program/activities.

Environmental Factors and Plan

8. Tribes

Narrative Question:

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

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

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

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

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

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

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

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

Footnotes:

Consultation with Tribes

The DMH Office of Multicultural Affairs (OMCA) previously met with the North American Indian Center of Boston (NAICOB) for the purposes of community outreach and needs assessment. NAICOB provides community programs that include a preschool Head-Start, employment resources support and a grandparents program to take care of their grandchildren. DMH continues to conduct periodic outreach to NAICOB.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

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

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

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

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

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

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

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

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

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

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

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

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

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

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

Footnotes:
Not Applicable - For SABG only.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

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

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

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

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

Footnotes:

Quality Improvement Plan

DMH utilizes an integrated and systemic approach to quality and performance management, grounded in continuous quality improvement principles to ensure that DMH clients receive high quality services whether delivered by contracted vendors or through state-operated services. This approach results in consistent management of all contracts and state-operated services, statewide evaluation of the effectiveness of these services, and promotion of the use of evidence-based and best practices

The Quality Improvement Plan outlined below utilizes SAMHSA's National Behavioral Health Quality Framework (NBHQF) to present DMH goals, measures and activities. The Plan reflects multi-year efforts to collect data and improve data integrity; redesign services to provide evidence-based and person-centered care; and engage in a continuous quality improvement process to improve client outcomes and safety. The current draft of the Plan also reflects the recent changes in executive administration - a new Governor and Secretary of Executive Health and Human Services in January 2015 and a new DMH Commissioner in May 2015. This Plan is expected to change as the new administration establishes priorities, goals and targets.

NBHQF Goal	DMH Goal	Measure	Planned Activity
#1 – Promote the most effective prevention, treatment and recovery practices for behavioral health disorders.	Design service system to promote recovery, resiliency and positive outcomes	% of adults, and family members of children/adolescents, reporting positively about treatment outcomes	Assess strengths and needs of Community Based Flexible Supports through stakeholder engagement, data analysis and review of contract management findings. Utilize assessment data in the re-contracting of CBFS.
		% of children/adolescents who advance a grade in the past 12 months.	Expand Contract Monitoring Process, with outcome reporting for Individual and Family Flexible Supports (IFFS); Complete data integration between DMH and DCF (child welfare) to effectively manage the Caring Together Initiative.
		# of people receiving	Implement second PREP® program

		evidence-based practices for early intervention	(in Western MA); develop website for PREP® programs.
	Implement and promote use of best practices	% of adults who are employed	Statewide employment training; Revise data collection and analyses to support client rehabilitation services; implementation of Memorandum of Understanding with Massachusetts Rehabilitation Commission (state's VR agency).
		% of children/adolescents showing improvement in or maintaining full school attendance	Implementation of outcome collection on Provider Data Interface (PDI) Completion form for youth receiving IFFSS services, and use statewide family member experience survey data to monitor child/adolescent attendance.
#2 – Assure behavioral health care is person, family and community centered.	Expand and promote a peer and parent workforce	% of adults who report positively about participation in treatment planning	Provide certified peer specialist certification courses and trainings in Whole Health Action Management; continue trainings for peer specialists who work with older adults, deaf and hard of hearing clients.
		% of family members of children/adolescents who report positively about participation in treatment planning	Use statewide family member experience survey data to assess the experience of family members in treatment planning.
	Align DMH inpatient and community	% of adults who	Monitor admission trends; ongoing

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#3 – Encourage effective coordination within behavioral health care and between behavioral health care and community-based primary care providers and other health care, recovery and social support services.	systems	remain in community (without hospitalization or incarceration)	management of community contracts
		% of inpatient clients who are discharged within 180 days of admission	Continue the DMH Inpatient Strategic Planning and Community Expansion Initiatives.
#4 – Assist communities to utilize best practices to enable healthy living.	Implement best practices that support health and wellness	% of clients who are screened for past 30 days' tobacco use within 3 days of admission.	Implement Tobacco Academy recommendations.
	Improve social connectedness	% of adults who report positive social connections	Each CBFS contract will have a quality improvement initiative to promote clients' social connectedness.
		% of family members of children/adolescents who report positive social connections	Use statewide family member experience survey data to assess the experience of family members with social connections.
#5 – Make behavioral health care safer by reducing harm caused in	Implement models of trauma-informed care that promote mutual safety and respect	Adults restrained per 1000 patient days	Continue Department Wide Six Core Strategies' initiative. Make us of Tableau Data Visualization Software to guide facility level QI efforts.
		Adolescents restrained per 100 patient days	

the delivery of care.			Continue monitoring rates of restraint and seclusion and refine intervention strategies as indicated.
#6 – Foster affordable high-quality behavioral health care for individuals, families, employers and governments by developing and advancing new and recovery-oriented delivery models	Reduce wait times for DMH inpatient care	Average # of days on waitlist for DMH inpatient continuing care.	Conduct daily monitoring of Inpatient Census. Conduct weekly reviews of census change and acute hospital and criminal justice system referrals by Senior Executive Team.

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Environmental Factors and Plan

11. Trauma

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

78 *Ibid*

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

Footnotes:

Trauma

DMH recognizes that the provision of trauma-informed care (TIC) and the presence of a coercion-free environment are fundamental to recovery and supports SAMHSA's definition and principles of trauma-informed care. DMH is actively engaging community and inpatient providers throughout the system of care to continuously support and strengthen a trauma-informed approach.

By regulation, all psychiatric facilities in the state must assess a person served for trauma. Massachusetts was the first state to develop a "Safety Tool", created by staff and peers together more than 15 years ago, to assess for trauma and prevent re-traumatization while in care. This practice has been disseminated to community providers and most recently to all child welfare (Department of Children and Families) community providers.

DMH service standards require the provision of trauma-informed care in all service models and sets an expectation that providers will use evidence based practices and best practices, including trauma-informed care and clinical approaches, such as cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT). Several of DMH's largest child and adolescent service providers are part of SAMHSA's National Child Traumatic Stress Network and have advanced the state's trauma-informed care practice and understanding exponentially through training and their direct service. Some providers, such as Glenn Saxe, MD (now at NYU) developed their own model, Trauma Systems Therapy, and have published extensively.

DMH is a national leader is promoting the use of evidence-based practices, including trauma-informed care, to reduce and prevent the use of seclusion and restraint. The Child and Adolescent division has engaged in significant work over the last twelve years in leading statewide restraint and seclusion reduction efforts in inpatient and community residential settings. Every psychiatric inpatient service has been trained on the Six Core Strategies three times and more focal training is planned. Every community residential provider, public schools, detention services, and private schools have been offered the same training. DMH requires that each child/adolescent facility and program develop a strategic action plan to reduce the use of restraint and seclusion and promote trauma-informed care. DMH is also working closely with the private schools, public schools, and school nurses to implement trauma-informed care in the school setting.

In addition, the joint purchasing of all residential services (DMH/DCF) created new standards of practice required of all providers which includes trauma-informed care, restraint and seclusion prevention, and the Six Core Strategies. These standards also address training methods and expectations that providers educate and support families in methods to prevent trauma, quell crises and promote rapid community reintegration. Massachusetts has been a leader in SAMHSA's Building Bridges effort, which promotes service transformation through full inclusion of families, youth, and staff. Massachusetts has provided large scale trainings on the Building Bridges Initiative (BBI).

In the last several years, these efforts have been expanded to include an Interagency Restraint and Seclusion Prevention Initiative. This effort is bringing together leaders from the state Departments of Children and Families (DCF), Mental Health (DMH), Youth Services (DYS), Early Education and Care (EEC), Elementary and

Secondary Education (ESE) to work in partnership with the Office of the Child Advocate and parents, youth, providers, schools and community advocates to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing. The initiative is built upon the principles of trauma-informed care, restraint/seclusion prevention and the Six Core Strategies, and the Building Bridges Initiative. DMH has provided and will continue to offer free on-going training (every other month) to all provider staff about the impact of trauma and approaches to working with children/adolescents with trauma histories. Janina Fisher, Ph.D. has been a primary trainer.

The reduction and prevention of restraint and seclusion in DMH adult continuing care inpatient facilities is also a priority. This ongoing effort was originally funded by a SAMHSA State Incentive Grant (SIG) through the National Association of State Mental Health Program. The Restraint and Seclusion Elimination Committee, which was originally an SIG advisory committee and is now a subcommittee of the Planning Council, continues to provide input into DMH's restraint and seclusion efforts.

Most recently, the DMH Office of Training and Development sought to introduce new curricula into its training programs, beginning with its orientation requirements. A workgroup reviewed DMH's existing curriculum which was designed primarily to reduce restraint and seclusion use in its inpatient facilities, teaching concepts from SAMHSA's Six Core Strategies. The workgroup extensively researched the existing literature in order to retool that curriculum to expand and integrate concepts of Trauma Informed Care and to include more opportunity for practicing primary prevention skills toward promoting a recovery oriented environment for persons served. Building upon that new training focus, the Personal Safety Workgroup simultaneously began development on a similar curriculum for community-based programs. This curriculum also promotes a collaborative recovery oriented focus while providing site specific information regarding safety for staff and persons served. Both curricula have been completed, Master Trainers have been trained and full roll-out across the agency is underway.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

Criminal and Juvenile Justice

DMH Forensic Services has a long history of providing mental health services at the intersection with the criminal justice system.

Courts

Forensic Services provides forensic evaluations and case consultations to the juvenile and adult criminal courts through a statewide system of court clinics. These include evaluations of individuals' competence to stand trial, criminal responsibility, aid in disposition, civil commitment for substance abuse, and other evaluations as requested by probation or ordered by the court. Services to juvenile courts also include assessments of children requiring assistance and care and protection proceedings as well as delinquency, Youthful Offender, and status offender cases.

In addition to the court clinics, DMH provides court-ordered statutory forensic evaluations (such as evaluations of competence to stand trial, criminal responsibility, aid in sentencing and need for care and treatment of inmates) its inpatient facilities. A specialized Child and Adolescent Forensic Team provides court-ordered evaluations for youth aged 17 and younger who have been committed by the courts for an inpatient forensic examination or forensic examination for youth ordered to one of our residential units.

Further, DMH funds a mental health court in the Plymouth District Court (Southeast Area) and in Springfield District Court (Western MA Area). Collaborations with the extant mental health courts in Boston continue. In addition, DMH is working very closely with the Massachusetts Trial Court and with the Department of Public Health to support new and existing specialty courts across the Commonwealth. In SFY14, DMH entered into a fiscal agreement with the Trial Court to fund additional specialty court clinicians for drug courts and a new mental health court in Quincy.

Also during SFY13 and SFY14, DMH assumed funding at the end of the SAMHSA funded Jail Diversion and Trauma Recovery Program to continue to provide MISSION services to court involved veterans. This includes DMH funding to the Department of Veterans Services for jail diversion peer specialists to assist veterans who are court involved.

Also during SFY13-14, DMH Forensic Services continued to collaborate with courts and probation providing cross-trainings on several occasions. These efforts will be ongoing.

During SFY13 and SFY14 DMH participated in policy academies through SAMHSA related to veterans and veterans in the justice system. In SFY14, Massachusetts was selected, with DMH as lead, as a Policy Academy/Action Network site as part of a SAMHSA/MacArthur Foundation Collaboration to develop strategies for diversion of youth with behavioral health challenges out of the juvenile justice system. Through this Policy Academy/Action Network, DMH is working with Probation to implement behavioral health screening and referral pathways from court, and developing family engagement strategies to enhance the services.

Corrections

Since 1998, DMH Forensic Services has maintained a statewide Forensic Transition Team (FTT) that provides community re-entry planning services to inmates with serious mental illnesses in preparation for discharge from county Houses of Correction and the Massachusetts Department of Correction (DOC). FTT now also provides re-entry planning for delinquent youth with significant psychiatric challenges who are transitioning from placement at secure treatment facilities operated by the Department of Youth Services (DYS). FTT coordinates its work with re-entering adults and juveniles with DMH Area-based case managers to provide continuity of care through psychosocial assessment, early engagement, consistent support and a well-monitored transition. During SFY14, DMH restructured the management of FTT and continued to assigned staff to locations that correspond to areas of high re-entry need.

In order to fulfill its statutory obligation with respect to supervising medical, dental and psychiatric services in the segregated units in DOC prisons, DMH coordinates a multi-disciplinary team that visits these units on a regular basis to help DOC 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 Houses of Corrections.

As part of the effort at improving collaboration with DOC, enhanced coordination of services has taken place, such as the establishment of a joint DMH/DOC committee to review issues that arise in the care and treatment of female inmates with mental illness at Massachusetts Correctional Institute in Framingham who may be sent to DMH for evaluation and treatment or may be re-entering the community. Similarly, a committee comprised of representatives from DMH and the Bridgewater State Hospital (BSH) continues to meet. BSH is a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial as well as individuals otherwise committed for mental health issues from DOC prisons.

Since 2004, the Massachusetts Department of Correction (DOC) and MassHealth have operated a program that aims to achieve a seamless transition to Medicaid coverage for state prisoners leaving DOC custody. Of those eligible for Medicaid in a pilot program across 18 DOC facilities, 91% of released inmates had MassHealth coverage re-instated within a year post-release. In addition, DMH continues to work with court clinic staff and court personnel to better understand MassHealth services for court involved youth. As part of the Juvenile Justice Policy Academy and Action Network, there is increased interest in reviewing and tightening linkages to MassHealth providers as part of a strategy to divert youth with behavioral health needs from the juvenile justice system.

Forensic Services has provided psychiatric Performance Improvement/Quality Assurance mortality reviews of DOC suicides and specialized case conference type consultation on cases involving management of inmates whose mental illnesses present challenges to DOC clinicians.

In SFY13, DMH also received a grant from the Department of Justice Second

Chance Act. The Second Chance Act grant aims to provide re-entry services for medium- and high- risk male and female offenders with co-occurring disorders and trauma histories. Through this initiative, which is managed in partnership with DOC, and UMass Medical School, with UMass Boston evaluation support, clinical staff and forensic peer support has been utilized. A SFY13 Bureau of Justice Assistance JMHCP planning grant offered the Commonwealth an opportunity to reflect upon jail diversion and re-entry activities that focus on individuals with mental health and substance use issues.

A weekly interagency telephone conference call is held to discuss issues of mutual concern and to coordinate grant application activities between DPH, DMH, DOC, DYS and court representatives along with input from academia (via UMass Medical School).

Police

In SFY07, the legislature awarded DMH funding for "start up" grants to support implementation of five pre-arrest jail diversion programs. A system of consultation and technical support to assist planning, implementation and program evaluation has been put into place. These grants have enabled the generation of data that will inform models of jail diversion in operation in Massachusetts. DMH finalized a report demonstrating the effectiveness of these programs and presented it at a meeting of legislative representatives and their staff. During SFY11 and SFY12 funding was spread across 19 programs, and between SFY13 and SFY14, these programs have spread further to enhance and establish Crisis Intervention Team (CIT) training in numerous cities and towns throughout the Commonwealth. With the push to establish CIT, DMH supported an increase in the skills and knowledge of countless officers. This has expanded toward funding CIT-Training and Technical Assistance Centers, which are aimed to serve as the CIT-Training hub for neighboring cities and towns. In addition to focusing on the actions of the CIT officers, DMH is examining diversion strategies and opportunities to help divert veterans and youth in addition to persons with serious mental illness.

During SFY12, Forensic Services was asked by several police departments to present training for line police officers. In SFY14 DMH worked with NAMI-Massachusetts and the Municipal Police Training Committee to develop two major trainings - one for new police recruits and a second for in-service officers focused on trauma-informed responses and working with individuals with mental health conditions who may be in crisis. These have been given to hundreds of officers across the state.

For the last approximately five years, DMH, sponsored a "Mental Health and Law Enforcement" conference in collaboration with law enforcement and emergency services, and advocacy groups and other agencies. Typically these conferences have had between 250-400 attendees. This day-long event brings together law enforcement, clinicians, and human services managers to discuss issues of common concern.

Juvenile Justice

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. In SFY99, the DMH Forensic Mental Health Service 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.

Veterans

DMH Forensic Services has been working with partner agencies, including state Veteran Services and the state medical school, to provide diversion activities focused on veterans based on a federal grant from SAMHSA. In the fall of 2008, DMH and the University of Massachusetts Medical School was awarded $2.1 million in funding over five years to create a jail diversion and treatment model for male and female veterans of Operation Enduring Freedom/Operation Iraqi Freedom who are arrested for non-violent or low-level crime and who have PTSD or other trauma-related disorder and co-occurring substance abuse as one of the programs funded via the SAMHSA Jail Diversion and Trauma Recovery programs. At least one in five veterans returning from Iraq and Afghanistan will develop PTSD, other trauma-related disorders and addiction. Left untreated these disorders may result in behaviors leading to involvement with the criminal justice system. This grant was piloted in Worcester, in partnership with the Veteran's Administration and numerous state agencies, and was then disseminated to two other communities. Over the course of the grant period, the programming was added into the DMH Western Massachusetts Division. The program provides an opportunity for veterans facing incarceration to opt for an alternative community-based treatment model (MISSION services) that emphasizes the role of peer support and case management. With the ending of the grant, DMH Forensic Services has continued to support the program operations and additional peer support staff in partnership with the Department of Veterans Services.

Other Special Populations

DMH Forensic Services provides the Independent Forensic Risk Assessment (IFRA) program. This program 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 DFMH 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.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

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

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

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

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

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

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

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

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

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

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

Footnotes:

State Parity Efforts

The passage of Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Cost Through Increased Transparency, Efficiency and Innovation", reaffirms Massachusetts' commitment to implementation of federal and state parity laws and to the integration of physical and behavioral health care. The Division of Insurance (DOI) is the primary agency charged with monitoring and enforcing parity requirements in Massachusetts. It has promulgated regulations requiring that payers they regulate conform to federal parity, and has engaged in various studies and other public information forums to gauge compliance. MassHealth has also promulgated its own regulations on parity. DMH is participating in both the DOI and MassHealth parity activities.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

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

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

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

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

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

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

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

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

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

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

Footnotes:
Not Applicable - for SABG only.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

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

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

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

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

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

Crisis Prevention and Early Intervention:

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

Crisis Intervention/Stabilization:

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

Post Crisis Intervention/Support:

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

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

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

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

Footnotes:

Crisis Services

Massachusetts provides a statewide network of Emergency Service Programs (ESPs) that provide a comprehensive, integrated program of crisis behavioral health services. ESPs are jointly funded by DMH and MassHealth. The Massachusetts Behavioral Health Partnership (MBHP) manages the ESP network as a component of the behavioral health carve-out program. 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.

Since SFY07, 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.

DMH-Western Mass 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. During SFY14, 97 people, ranging in age from 18 to more than 60 years old, stayed at Afiya for a total of 142 stays. Most stays (111) were for 7 days or less, with only one stay exceeding 12 days in length.

Afiya team members had more than 800 phone or in-person contacts with people in the community. The reasons for these contacts varied, but the most common reason was that people wanted to stay at the program and were calling for information and availability. In 440 of these cases, people were not able to be admitted because there was no space available. The vast majority of stays (77%) concluded with the person returning to their own home. An additional 15% concluded with the person staying with a friend or family. Less than 4% of stays ended with a person entering a medical or psychiatric hospital. People staying at the program are also asked to complete a survey at the end of their stay to assist in tracking outcomes, including hospital diversion rates. Of the 53 people who completed the survey in FY14, 84% reported having at least one prior hospitalization and 58% said they would have gone to the hospital if Afiya was not available.

Please refer to the following sections for additional information regarding comprehensive crisis services within Massachusetts:

- Criminal and Juvenile Justice (Jail Diversion, Mental Health Courts, Crisis Intervention Teams)
- Step 1 (Child) and Children and Adolescent Behavioral Health Services (Family Engagement, Family Partners)
- Recovery (Recovery Learning Communities, Peer Support, Whole Health Action Management)

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

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

Footnotes:

Recovery

DMH has taken significant steps to develop, support and sustain a peer and parent workforce in the Commonwealth. A DMH-convened workgroup created definitions and job descriptions of peer and family support workers to be utilized in advancing policy development, funding opportunities and implementation. In SFY11, the workgroup established a three-level job series for Certified Peer Specialists (CPSs) and Family Support Workers in DMH. There are approximately 50 Certified Peer Specialists and Family Support Specialists employed by DMH. In addition there are five Central Office and regional peer leadership positions.

Employment of peer workers and/or Certified Peer Specialists is contractually required in Community Based Flexible Supports, Programs for Assertive Community Treatment and in Emergency Services Programs. In addition, two federal grants along with the Western Massachusetts Recovery Learning Community provide for forensic peer specialists to assist with court-based diversion and/or reentry programs. As a result of the positive experience with the forensic peer in the federally-funded DMH re-entry program, the Department of Correction adopted an inmate-peer model in the women's correctional facility to assist with female offenders with trauma histories.

DMH funds six Recovery Learning Communities (RLCs), two in each DMH Area. 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. In SFY12 and 13, DMH utilized increases in Block Grant funds to expand the scope and supports provided by the RLCs. RLCs utilized these funds to increase hours of operation, offer new and expanded supports, and provide supports to a larger geographic area, including "satellite" offices. Since RLCs are grounded in the community, it is ongoing challenge for them to reach out and provide resources in all communities. The funds were also used to build additional capacity for peer support worker supervision and to implement a Peer Community Bridging program. This program is modeled after a successful pilot implemented in the Northeast division of the state in which individuals transitioning from Tewksbury State Hospital were matched with a peer bridger from the local RLC to support transitions into the community. Although the pilot was limited to six people over a four-month period, it demonstrated that there is a need for community bridging services and that individuals transitioning from the hospital found the support to be beneficial.

In addition, DMH procured a new service, Peer-Run Respite in SFY12 in the Western MA division. This program, Afiya House, provides individuals experiencing emotional distress with short-term, overnight respite in a home-like environment. This program is described in Crisis Services.

DMH contracts with the Transformation Center, Massachusetts' statewide consumer technical assistance center, to provide leadership, support and training within the peer community. The Transformation Center has taken a lead role in the state in training consumers for leadership roles. The Transformation Center conducts annual peer specialist (CPS) trainings. There are currently over 500 people who have graduated from these trainings and received certification. In SFY15, DMH provided funding to the Transformation Center to provide CPS training to 180 individuals with a goal of

achieving at least an 80% certification rate. To meet the growing demand for peer specialists, DMH also funded additional peer specialist training offered by Recovery Innovations of Arizona in SFY13 and 14. In addition, the Transformation Center offers a Massachusetts Leadership Academy and participates on training teams with DMH and several leading national consultants to provide training on person centered planning and trauma informed care.

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. In SFY15, DMH utilized Block Grant technical assistance funds to sponsor a Deaf Certified Peer Support Specialist Training session. This intensive 40-hour training focused on providing Deaf, Hard of Hearing, and DeafBlind individuals who are recovering from mental health challenges with the tools necessary to mentor others who are experiencing similar life challenges. Eleven people participated in the training session and passed the exams.

Many supervisors of CPSs are also in a process of learning about mental health recovery and the CPS role, and are not themselves a CPS. The Transformation Center produced and published an on-line training with written and video components to orient supervisors to the CPS role and to the nationally recognized role competencies around which job descriptions and supervision is organized. This training was viewed on-line over 3200 times. In addition, two federal grants along with the Western Massachusetts Recovery Learning Community provide for forensic peer specialists to assist with court-based diversion and/or reentry programs. As a result of the positive experience with the forensic peer in the federally-funded DMH re-entry program, the Department of Correction adopted an inmate-peer model in the women's correctional facility to assist with female offenders with trauma histories.

DMH has also piloted 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. Five sections were offered across the state for a total of 43 participants.

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.

In SFY15, DMH invited Dr. Cynthia Zubritsky from the University of Pennsylvania to teach Pennsylvania's Certified Older Adult Peer Specialist training program, and consult with state leaders. The class and subsequent consulting was

sponsored by a number of partners, including the Substance Abuse and Mental Health Services Administration (SAMHSA), BayPath Elder Services, Community Counseling of Bristol County, Mass Association of Councils on Aging, and the Mass Association for Mental Health. Eighteen Certified Peer Specialists or Recovery Coaches, age 55+, attended the three day workshop which covered topics such as: demographics, normal aging, culture, depression, anxiety, substance use, trauma, and suicide as they relate to older adults. The final afternoon of the class was spent on local resources funded by the Executive Office of Elder Affairs, and Councils on Aging in local cities and towns.

In line with the goal of including peers to support health and wellness, DMH has supported the training of 70 peers to become facilitators for Whole Health Action Management (WHAM). WHAM is an emerging best practice that provides CPSs with the skills needed to help consumers develop, implement and sustain a whole health goal. Three classes in Boston and Western MA were conducted through a collaboration led by DMH, and including the Massachusetts Behavioral Health Partnership (MBHP) and the Transformation Center. These trainings were led by Larry Fricks, Deputy Director of the SAMHSA/HRSA Center for Integrated Health Solutions; and Ike Powell, of Appalachian Consulting Group. DMH utilized Block Grant Funds to sponsor a three-day WHAM Master Trainer class to develop an internal capacity to train additional facilitators. DMH Area offices currently coordinate regional WHAM trainings offered to peers served by any behavioral health provider in the region. Massachusetts was also chosen to pilot WHAM for Asian American and Pacific Islander Peers and bi-lingual Community Health Workers, in conjunction with the National Asian American and Pacific Islander Mental Health Association and the National Asian American and Pacific Islanders Empowerment Network. The Transformation Center also provided WRAP facilitator trainings. At least 76 of the total 135 WRAP facilitators were trained by Massachusetts Advanced Level WRAP facilitators (ALFs) between the Fall of 2013 and the Summer of 2014.

In 2004, TransCom (the Transformation Committee) was established to guide the work of the Mental Health System Transformation Grant funded by the Centers for Medicare and Medicaid Services (CMS). TransCom then became a sub-committee of the Planning Council in SFY07. This committee brings together a diverse group of individuals and organizations to advocate for a flexible, peer-driven and recovery-oriented infrastructure; model collaboration and cultural/linguistic inclusion; and to support the development, promotion and coordination of innovative recovery-oriented practices. In 2008, Transcom created a vision statement for the integration of peer workers as a part of creating a "road map" for this integration to occur.

> *We envision a system where people in recovery have guaranteed access to certified peer specialists and peer support workers throughout Massachusetts, whether through an agency where they receive services, from a Recovery Learning Community or from another peer operated program. Peer Specialists and Peer Support Workers will serve as critical role models for their peers and colleagues that recovery is possible and achievable. Their unique roles and job functions will be understood and valued by their peers, their colleagues and supervisors. They will be equitably reimbursed and supported in their primary focus of advocating for the consumers they work with.*

In SFY14, Transcom released and disseminated two documents developed in monthly stakeholder meetings with associated subcommittee work. The first, 2013 Revision-Promoting a Culture of Respect: Trancom's Position Statement on Employee Self-Disclosure in Health and Social Service Workplaces, is an update of a document providing guidance to the field regarding personal disclosure. Personal disclosure of mental health recovery is encouraged as communities and human service professionals gain understanding of peer support roles. The second document, April 2014: Massachusetts Peer Professional Workforce Development Guidelines was developed by invitation of DMH after a State Mental Health Planning Council discussion identified confusion about the emergence of peer roles in healthcare. Based on collaborative work by diverse stakeholders, Trancom summarized the unique contribution of peer support roles in the field, outlined essential practices regarding the effective use of peer professionals, and developed a chart showing the various stages of peer professional development. The document includes examples of job titles, roles, competencies, prerequisites and available trainings associated with professional development stages.

Between May and July of 2014, the Transformation Center coordinated six regional community gathering events in which an estimated 296 community members participated. Information was shared about the status of peer professionals in the state and included dissemination of the Trancom Peer Professional Guidelines. In addition, these forums generated discussions about three topics: access to peer support and CPS training, the use of person-driven wellness tools, including Wellness Recovery Action Plan (WRAP) and WHAM training, and access to culturally diverse peer support.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

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

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

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

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

Footnotes:

Community Living and the Implementation of Olmstead Plan

The Executive Office of Health and Human Service (EOHHS) Community First Olmstead Plan, created in 2008, provides a roadmap and action plan reflecting the Commonwealth's commitment to ensuring that people with disabilities and elders have access to community-living opportunities and supports that address each individual's diverse needs, abilities and backgrounds. The fundamental goals of the Olmstead Plan are to help individuals transition from institutional care; expand access to community-based long-term supports; improve the capacity and quality of community-based long-term supports; expand access to affordable and accessible housing with supports; promote employment of persons with disabilities and elders; and promote awareness of long-term supports. As a result of this plan, DMH created its Community First Initiative to champion people's right to live as independently as possible in the community through facility closures and enhancing the community-based system.

In February 2011, Massachusetts was awarded a five-year Money Follows the Person (MFP) Rebalancing Demonstration Grant from the Federal Centers for Medicare and Medicaid Services. MFP is overseen by the Executive Office of Health and Human Services (EOHHS) in collaboration with MassHealth, the Mass Rehabilitation Commission, the Executive Office of Elder Affairs, the Department of Developmental Services, the Department of Mental Health, partnerships with Aging Services Access Points (ASAPs), Independent Living Centers (ILCs) and Aging and Disability Resource Consortia (ADRCs), and other community-based organizations throughout Massachusetts. Through this alliance, EOHHS seeks to assist more than 2,000 qualified MassHealth members needing long-term care and supports and who prefer to receive them in community based settings.

MFP Program goals are as follows:

- Increase the use of home and community-based services (HCBS) and reduce the use of facility-based services.
- Eliminate barriers that restrict the use of Medicaid funds for people receiving long-term care in the settings of their choice.
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions

In addition, DMH completed the Community Expansion Initiative in SFY15. DMH discharged 135 patients from inpatient continuing care facilities and created new community placements. To support the discharged patients, DMH designated a Staff Liaison for each one, and developed Internal Protocols to provide crisis planning and emergency services via a multi-disciplinary team as needed.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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

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

Footnotes:

Children and Adolescents Behavioral Health Services

Please refer to Step 1, Comprehensive Community-Based Mental Health Services – Child for a description of the DMH Child/Adolescent service system and Health Care System and Integration for additional efforts related to behavioral health integration for children, youth and families. This section focuses on how DMH Child and Adolescent division integrates with other child and family serving systems.

The Executive Office of Health and Human Services (EOHHS) which encompasses MassHealth, is the responsible secretariat for the coordination of all children's services in Massachusetts. The agencies within EOHHS serving children exclusively are the Departments of Children and Families (DCF), and Youth Services (DYS). The Departments of Public Health (DPH), Mental Health (DMH), Developmental Services (DDS), and Transitional Assistance (DTA) and the Commissions for the Blind, and Deaf and Hard-of-Hearing, serve children and adults. The Departments of Elementary and Secondary Education (DESE) and Early Education and Care (DEEC) are not within EOHHS. DMH has primary responsibility for delivery of non-acute continuing care mental health services for those children with serious emotional disturbance (SED) who are not able to receive appropriate mental health services through other entities or through insurers. The five DMH Areas, 27 Local Service Sites and Central Office Division of Child/Adolescent Services are responsible for procuring, contracting for and monitoring all children's services. On interagency issues, EOHHS has taken the responsibility for coordinating, planning, and holding its constituent agencies accountable for results. DESE and DEEC are often asked to participate in interagency planning efforts, and these agencies similarly invite DMH to participate when their activities relate to mental health.

Having a well-funded system of integrated services remains the highest priority for parents and advocates as well as for the state itself. Major planning for service system development and integration occurs within the Children's Behavioral Health Initiative (CBHI). Originally established to coordinate and monitor implementation of new MassHealth children's behavioral health services mandated by the Rosie D decision, CBHI is an on-going EOHHS effort to develop an integrated public system of services to support children, youth, and young adults with SED and other behavioral health needs. The original CBHI Advisory Group has been reorganized, but most of its members are now also members of the Children's Behavioral Health Advisory Council mandated under An Act Improving and Expanding Behavioral Health Services for Children in the Commonwealth. The Council is continuing to advise on implementation of the remedy for the Rosie D lawsuit and, in addition, has the responsibility to review the following: reports from the Secretary on the status of children awaiting clinically-appropriate behavioral health services; behavioral health indicator reports from Department of Early Education and Care; research reports from the Children's Behavioral Health Knowledge Center; and Legislative proposals and statutory and regulatory policies impacting children's behavioral health services. In addition, the Council prepares an annual report that includes legislative and regulatory recommendations related to: best practices for behavioral health care of children, including practices that promote wellness and the prevention of behavioral health problems and support development of evidence-based interventions with children and their parents; implementing interagency children's

behavioral health initiatives that promote a comprehensive, coordinated, high-quality, safe, effective, timely, efficient, equitable, family centered, culturally competent, and a linguistically and clinically appropriate continuum of behavioral health services for children; the extent to which children with behavioral health needs are involved with the juvenile justice and child welfare systems; licensing standards relevant to the provision of behavioral health services for programs serving children (including those licensed by non-EOHHS entities); continuity of care for children across payers, including private insurance; and racial and ethnic disparities in the provision of behavioral health care to children.

There are numerous activities to promote the mental health of young children. DMH has been an active participant in DPH's Project LAUNCH grant program funded by the Substance Abuse and Mental Health Services Administration for promoting the wellness of young children from birth to 8 years of age by addressing the physical, emotional, social, cognitive and behavioral aspects of their development. Massachusetts was one of 12 states awarded this grant for up to $850,000 each year for 5 years. DMH is also actively engaged in MYCHILD, SAMHSA Children's System of Care grant which seeks to identify children through age five who have or are at high risk for SED, providing them with family-directed, individualized, coordinated and comprehensive services. Target areas include: 1) Early identification and linkage to effective services and supports of children showing warning signs of SED and/or exposed to "toxic stress"; 2) Culturally and linguistically competent support and linkage of children and families to accessible, affordable, coordinated services; 3) Expansion of service capacity to provide community based mental health clinical and consultation services in children's natural environments; 4) Cross-training of early childhood and family support workforces to recognize and respond to infant and early childhood mental health issues using evidence-based, developmentally-appropriate, relationship-based tools and practices; and 5) Evaluation of outcomes for continuous improvement, and identification of the return on investment of early intervention and treatment.

In SFY12, DMH entered into an Interagency Service Agreement with the Massachusetts Department of Early Education and Care (DEEC) to participate in Massachusetts' Race To The Top award. Massachusetts was one of 12 winning states in the national Race to the Top competition, funded by the U.S Department of Education to promote reform in four areas: standards and assessments, great teachers and leaders, school turnaround, and data systems. DMH is charged with increasing awareness, capacity, and access for the mental health care for young children, 0 – 5, and their families through training, professional development, and consultation. Targeted populations within the health and mental health fields include pediatricians, Massachusetts Child Psychiatry Access Project (MCPAP) clinicians, CBHI service teams, early childhood mental health consultants, and other clinical staff. Other populations include early childhood educators and staff within state agencies who work closely with young children (e.g., DCF, DHCD). DEEC (which licenses all childcare programs in the state) and MassHealth have jointly funded clinical positions, based in community clinics selected by childcare programs, to provide consultation, training and triage for children with behavioral problems. Many of these children exhibit symptoms of Post Traumatic Stress Disorder or other early traumas. DEEC also funds clinical

consultation to day care programs, inviting DMH to participate in its provider selection process.

DMH and DCF have collaborated to change daily practice in both agencies to better address the needs of service provision for parents with mental illness and improve outcomes for children. DMH changed its practice to offer short term services to adult applicants who were DCF involved, cross-training has been provided so that workers in each system better understand the resources and also the regulatory environment in which each works, and DMH consults to DCF regarding service planning for children with mental health problems and for those whose parents have mental illness. DMH continues to assess how its services can be improved for those children who have a parent or primary caregiver living with mental illness and collaborate with DCF to improve identification and supports for parents with mental illness. Based on the recommendations of participants in an October 2011 interagency forum, DMH is expanding its efforts to collaborate with other EOHHS agencies to improve services and supports for parents living with mental illness.

In regard to education, DMH is a co-funder and Steering Committee member of an EOHHS pilot project involving state agencies and 13 school districts and educational collaboratives to improve linkages between schools and mental health and social services. DMH and members of PAL, the statewide organization that supports parents and families of children with behavioral health needs, are members of the Statewide Advisory Committee on Special Education. DMH also works closely with advocacy organizations such as Massachusetts Advocates for Children and the Federation for Children with Special Needs to promote understanding of the mental health system and help insure trainings and materials are helpful to parents and to providers working with children with mental and behavioral health needs.

Between 2008 and 2011, DMH served on the Task Force on Behavioral Health and the Public Schools, established by Chapter 321, the Children's Mental Health Law. In August 2011, the Task Force released its final report, "Creating Safe, Healthy, and Supportive Learning Environments to Increase the Success of All Students", which details recommendations for statewide use of a framework for public schools to increase the capacity of schools to collaborate with behavioral health providers, provide supportive school environments that improve educational outcomes for children with behavioral health needs, and utilize an assessment tool to measure schools' capacities to address these needs.
(http://www.doe.mass.edu/research/reports/0811behavioralhealth.pdf).

DMH sits on the DESE Statewide Advisory Committee on Special Education, and continues to provide leadership to efforts to improve behavioral health supports in school settings as a member of the Governor's Child and Youth Readiness Cabinet's Partnership for Youth Success Initiative. The Cabinet is a state leadership team focused on improving children's readiness for school so they are better prepared to learn and benefit from supports in the school environment that foster their healthy development and their family's well-being. Established in 2008, the Readiness Cabinet provides for the consistent, efficient and effective coordination of efforts between government agencies whose services and programs collectively address the needs of the whole child and his or her family. It is jointly chaired by the Secretary of Education and Secretary of Health and Human Services and includes the state secretaries of Administration and Finance,

Housing and Economic Development, Labor and Workforce Development, Public Safety and the Child Advocate, as well as the Commissioners of the state child serving agencies. Additionally, DMH sits on an adhoc work group of special education and state agency administrators committed to fostering on-going communication and collaboration to improve the integration of school-based and public services for children and their families.

DMH has a long standing commitment 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 Residential Services contracts. In addition, training requirements for managing individuals with co-occurring disorders are included in DMH's Psychiatry Residency and Psychology Internship Training Program contract.

At a systems level, DMH works closely with the Massachusetts Chapter of the American Academy of Pediatrics, particularly with its children's mental health task force which includes DMH, DCF, DPH, and DESE as members, as well as child psychiatrists, pediatricians, nurses, and parents. Recent successes of the Academy include securing agreement from the state's major HMOs to reimburse for mental health screening and implementation of post-partum depression screening. The group is now focusing on several key areas: mental health services in schools, including support for school nurses; better integration of primary care and behavioral health; and the implications of national health care reform efforts on the Massachusetts behavioral health service system for children and adolescents, such as implementation of medical homes and Accountable Care Organizations (ACO).

DMH also funds the Massachusetts Child Psychiatry Access Project (MCPAP), administered by MBHP with DMH funding, that makes psychiatric consultation available to pediatric practices to improve primary care as it relates to mental health, to address 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. Supported by funding from two federal grants, significant enhancements and expansions to the MCPAP service have occurred:

1. Through a CMS State Innovation Model grant, MCPAP 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.
2. Through a U.S. Department of Education Race To The Top grant, DMH and MCPAP are implementing an innovative, evidence-based early childhood parent support intervention in primary care settings.

The DMH Child and Adolescent Division is committed to the principles of family voice, choice, and engagement at all levels of service delivery and policy development, and continues to promote inclusion of parent professionals at all levels of the DMH service system. DMH and DCF, as part of their joint procurement of residential services (see below), is currently designing a new Family Partner service that will be available to parents/caregivers of youth receiving residential services from the two agencies. Family Partners are currently available in various parts of the Massachusetts service system, including the MassHealth *Rosie D* remedy services. To maximize the positive impact that this unique parent-to-parent relationship can have on both child and family outcomes, the new DMH-DCF service is being aligned with the MassHealth service to ensure continuity of the relationship across service systems. Parents/caregivers, and providers alike have lauded the agencies' vision for such a system. The design effort is also addressing the workforce development needs relating to this expansion, including the development of consistent training curricula, and recruitment and training of parent partners from cultural and linguistic minority communities.

As a majority of children in the state have some of their mental health treatment covered by private insurance, that population must be considered as well when talking about an integrated system providing comprehensive services. Massachusetts passed mental health parity legislation in 2000 mandating coverage for both acute and intermediate care and created an ombudsman resource at DPH to oversee managed care implementation. In 2008, the law was amended to broaden its scope to include substance abuse disorders, post-traumatic stress disorders, eating disorders and autism for both adults and children. In 2009, DMH, the Division of Insurance, and DPH issued guidance clarifying what is covered under intermediate care As the state achieves full implementation of the *Rosie D* court order, one of the challenges will be to create a provider network that can serve both the publicly and privately insured to afford continuity of care as children move on and off of MassHealth.

As a result of the *Rosie D* remedy, several interagency projects that served as templates for the remedy and that targeted Medicaid enrolled youth are no longer being funded as separate pilot projects, but are continuing in another form. All of the agencies that were hosts for MBHP's Coordinated Family Focused Care pilots were selected to be Community Services Agencies (CSA's) to provide Intensive Care Coordination (ICC) as mandated by the remedy. In addition, the Mental Health Service Program for Youth (MHSPY), a Robert Wood Johnson Foundation system of care replication project based in a Health Maintenance Organization, served children at risk of out-of-home placement from 1998 to 2009 at which time services to these clients population became available through two local CSAs. The Collaborative Assessment Program (CAP) a ten-year old statewide DMH-Department of Children and Families project, administered by the latter, ended in June 2009. For Medicaid enrollees, services previously available through CAP are offered through the CSA's, Intensive Care Coordination and Family Partner, and the new Medicaid services created as part of the remedy.

To further advance the CBHI vision and evolution of the system, in FY13, EOHHS, DMH and DCF jointly procured residential services for youth served by the two agencies. Although over the last decade these agencies have systematically procured residential services with a System of Care lens, they have done so separately. Through

this joint initiative, “Caring Together”, the goal is to achieve better and more sustainable positive outcomes for children and families by:

1. Procuring program models that provide trauma-sensitive environments and are focused on strengthening connections to family and community;
2. Embedding evidence-based clinical practices in those programs that are responsive to the complex social, emotional, educational and psychological needs of children and families;
3. Unifying the Agencies’ administrative and management structures and processes in order to improve efficiencies;
4. Supporting stronger integration and continuity of out-of-home behavioral health services with those that are delivered in the home;
5. Providing a fair rate of reimbursement for these services; and
6. Rewarding providers that consistently deliver positive outcomes.

These services were implemented in SFY13.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

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

Footnotes:
Not Applicable - for SABG only.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

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

Footnotes:

MASSACHUSETTS STRATEGIC PLAN FOR SUICIDE PREVENTION

"It is the hope that the plan will bring attention to the public health problem of suicide and the reality that there is a great deal that we can do to prevent it."

Timothy P. Murray,
Lieutenant Governor
September, 2009

"Suicide remains the sorrow that still struggles to speak its name."

Eileen McNamara
Boston Globe
December, 2007

MASSACHUSETTS COALITION FOR SUICIDE PREVENTION
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

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

.

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

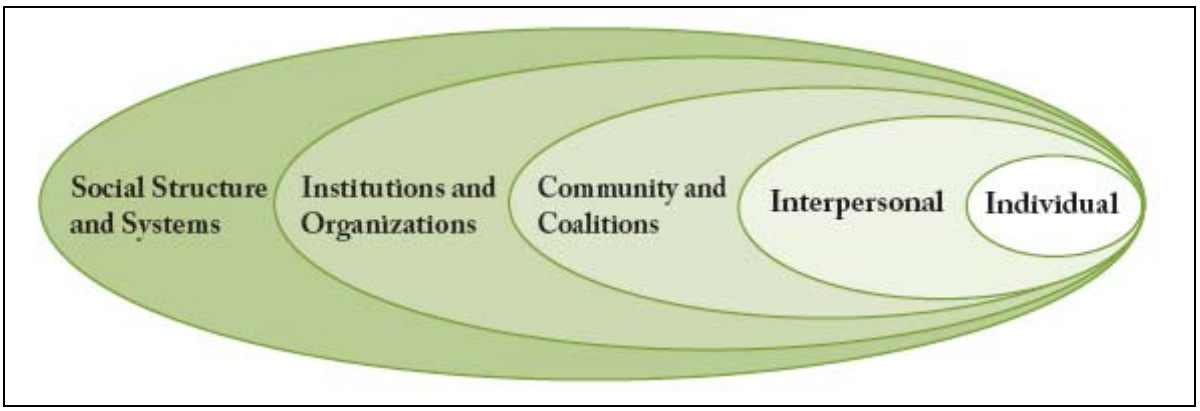
The Massachusetts Strategic Plan for Suicide Prevention recognizes the complex interplay between the various stakeholders (individuals, groups, communities, government, organizations, and institutions) in society that are involved with and, indeed, required for successful suicide prevention efforts. 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.

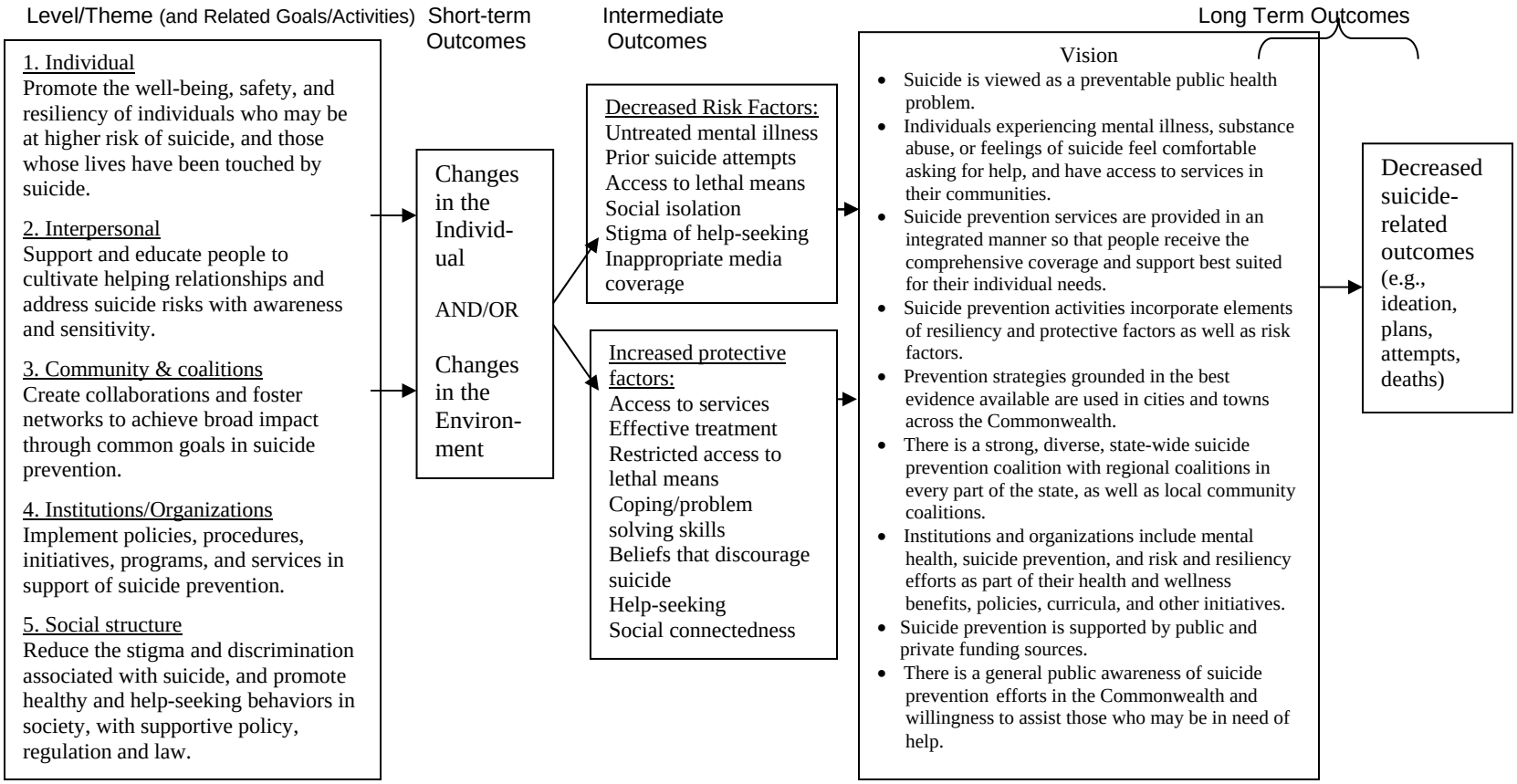
B.) There are logic models for each of the five Levels of the framework—individual, interpersonal, community and coalitions, institutions and organizations, and social structures and systems. These illustrate how implementation of Possible Actions will result in the realization of each Level/Theme.

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.

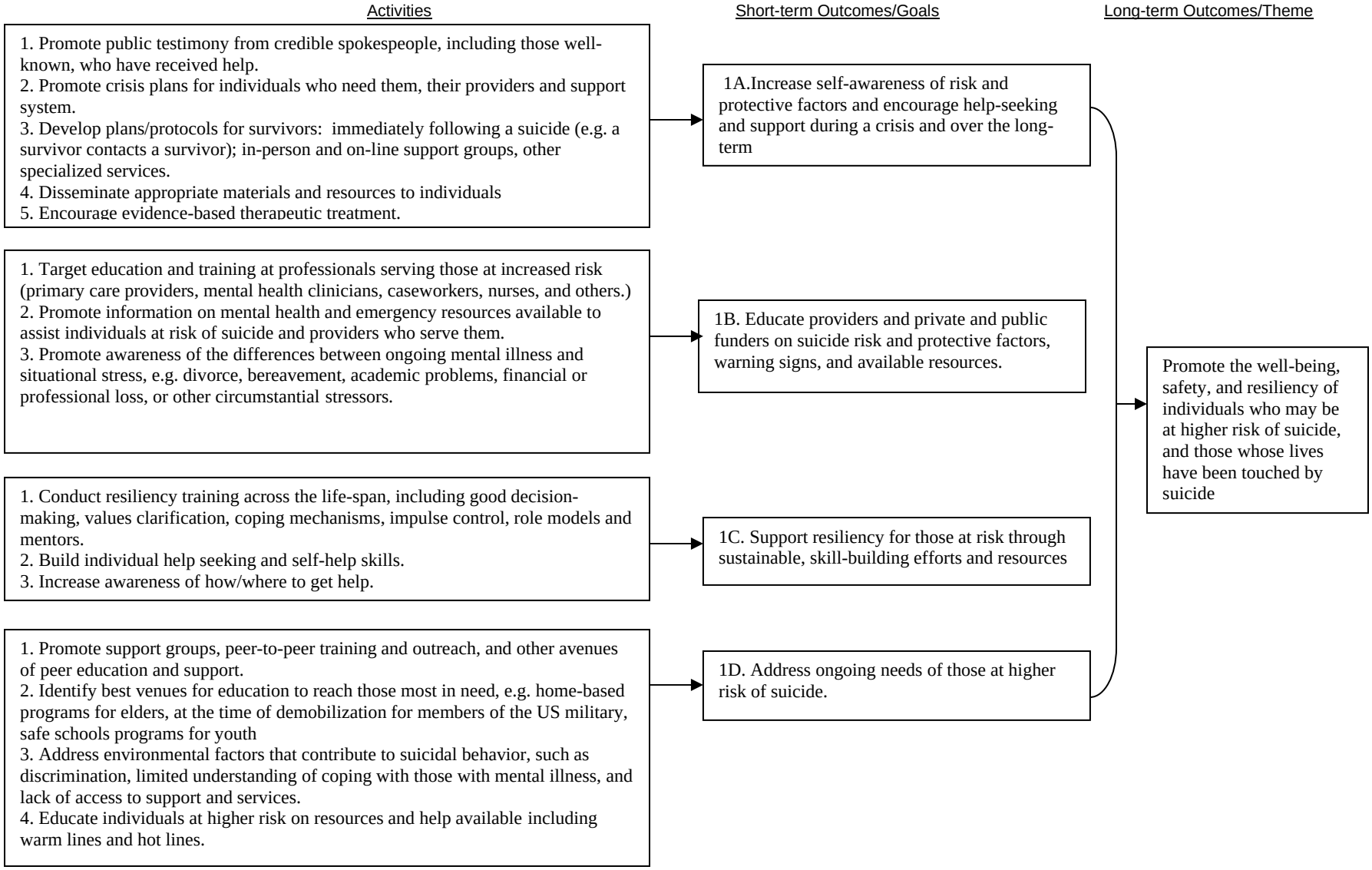
A. Logic Model for Overall Plan



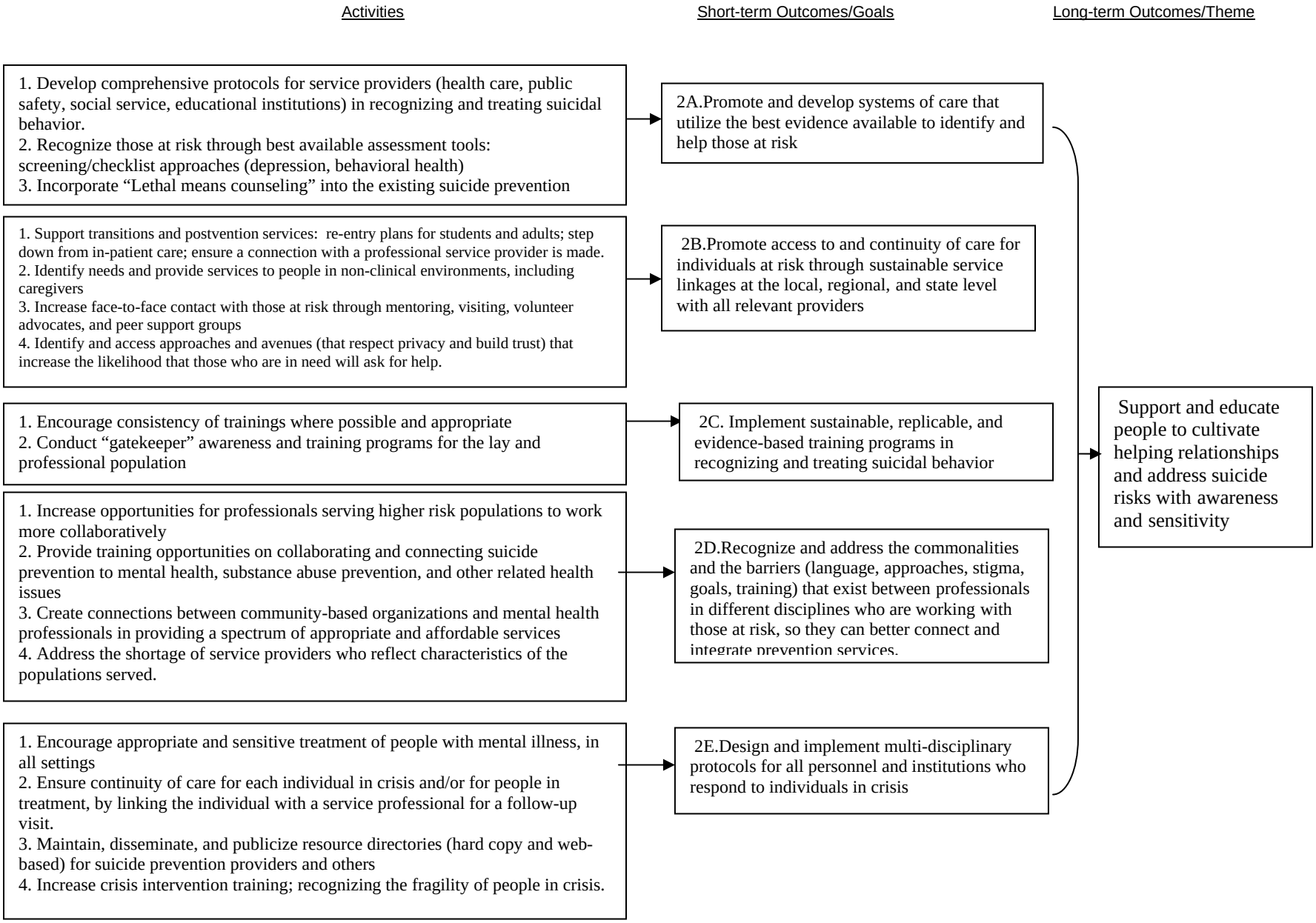
Guiding Principles:

- 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

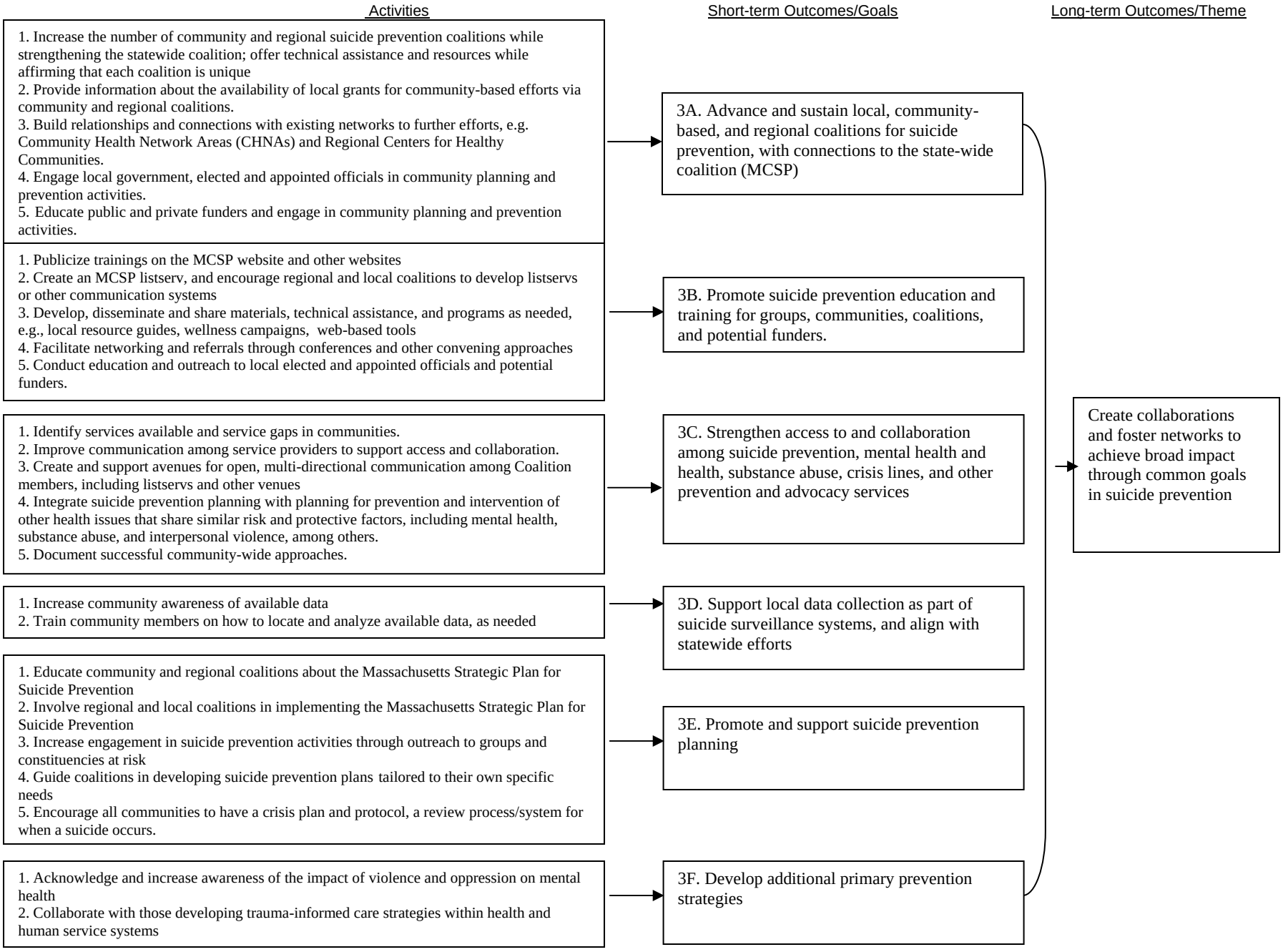
B. Level I-Individual



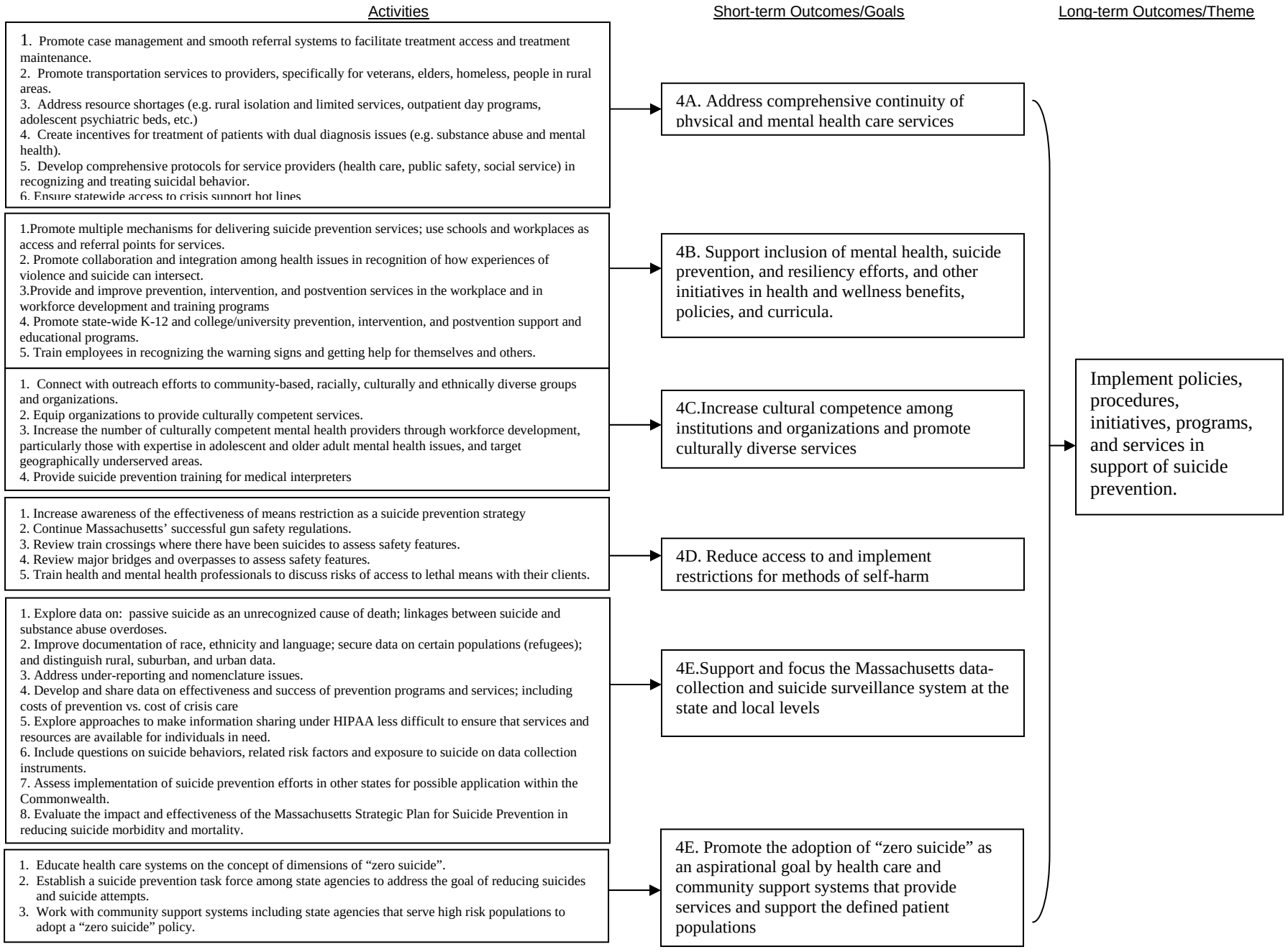
B. Level II-Interpersonal



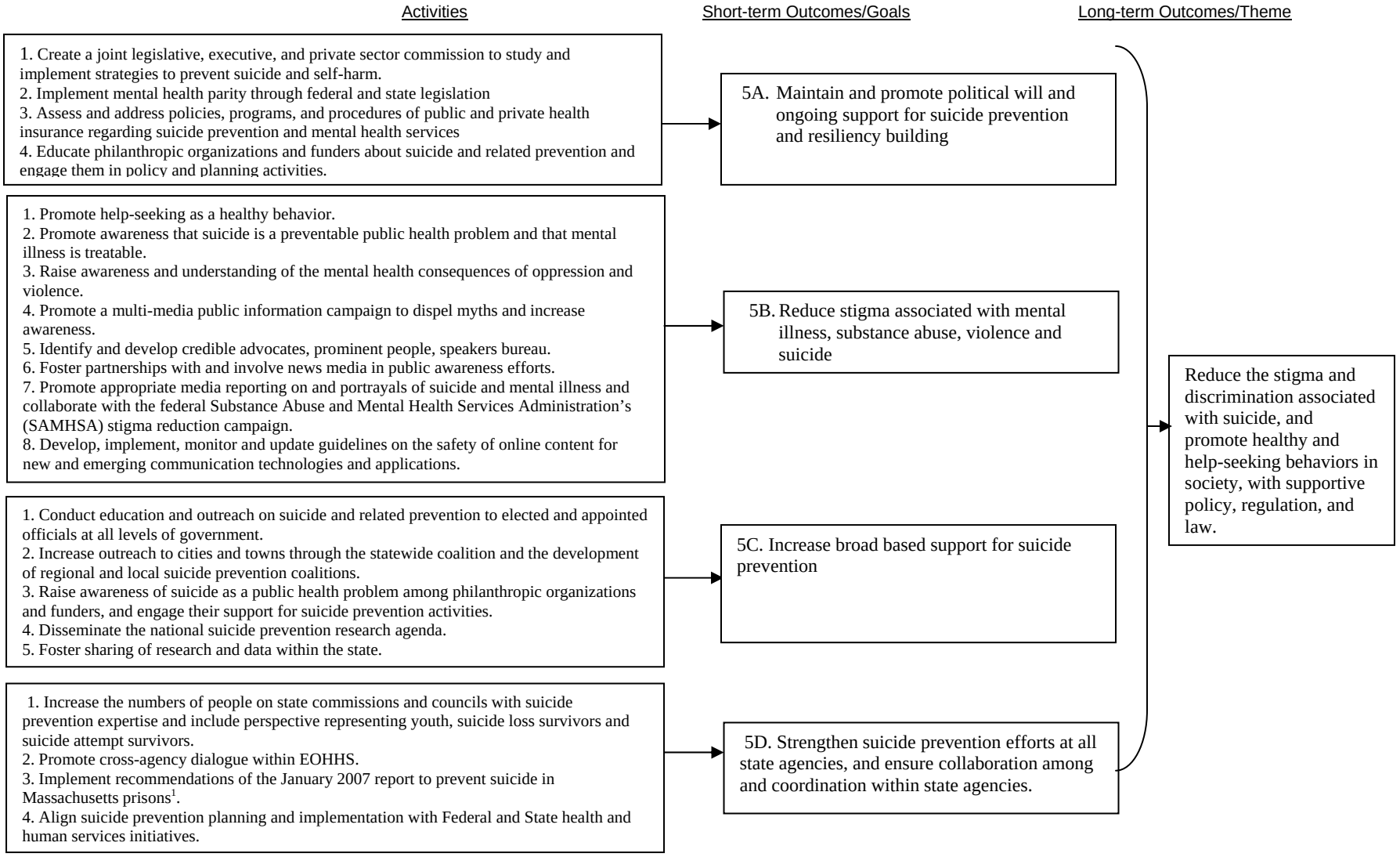
B. Level III-Community and Coalitions



B. Level IV-Institutions and Organizations



B. Level V-Social Structure and Systems

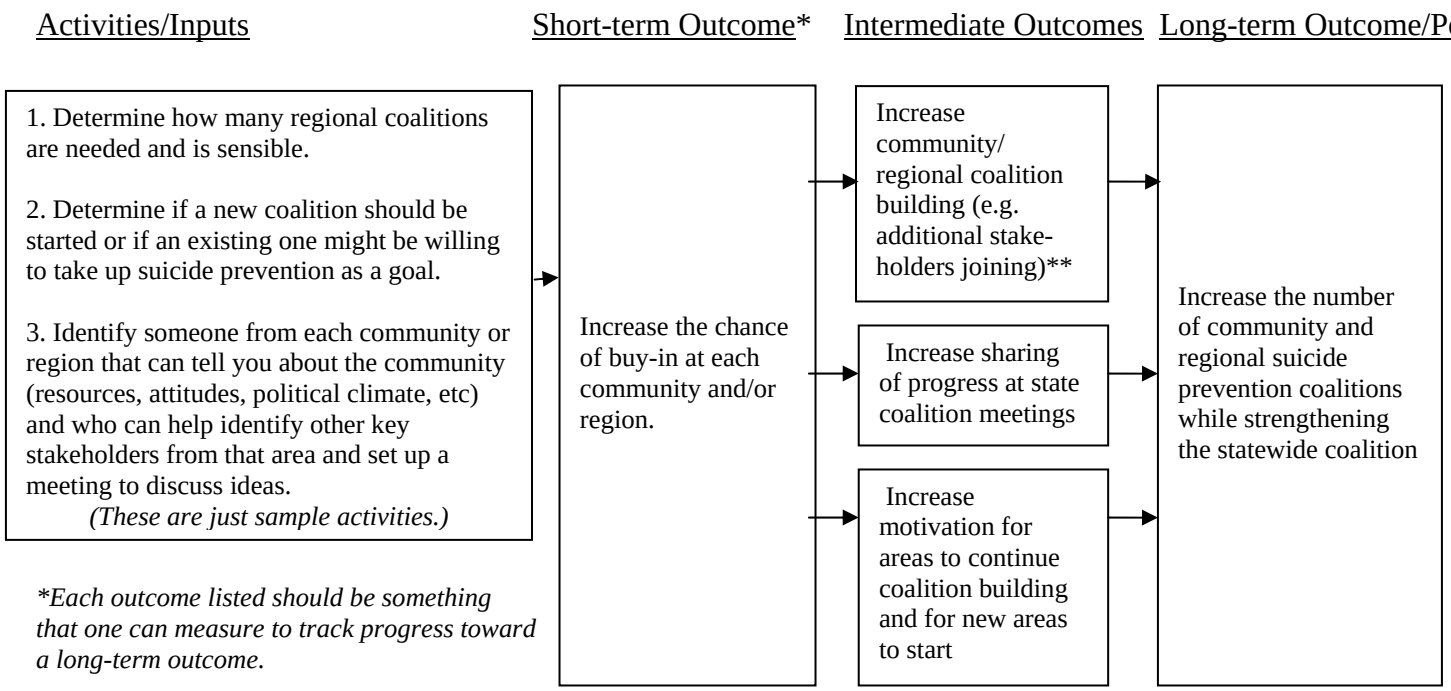


C. Example of a Logic Model for a Possible Action found in Level III, Goal A.

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

Suicide Prevention

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, provides a 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 2015 modifications reflect the state's commitment to adopt and promote Zero Suicide as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

DPH, DMH and the Coalition collaborate on a number of the initiatives outlined in the plan, including:

- The convening of 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.
- The recent expansion from six regional coalitions to 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 launching of a 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 individualized suicide prevention services targeting veterans, older adults, college and university students, youth and young adults, mid-life adults, GLBTQ youth, and transgender people.
- DPH publications of annual data on suicide and self-inflicted injuries, and provision of targeted data to communities

- Training efforts including clinical and gatekeeper training for nearly 8,000 advocates, teachers, clinicians, substance abuse staff, elder advocates, human resource and youth service organizations.
- Collaboration between DPH, DMH and the Coalition to co-sponsor annual Massachusetts Suicide Prevention Conferences, attracting hundreds of participants each year.
- Coalition sponsored annual State House Suicide Prevention Awareness Events, honoring over 60 legislators, individuals and organizations with its 'Leadership in Suicide Prevention Award'
- DMH partnership with DPH in the submission of a proposal for what would be the fourth round of federal funding through the Garrett Lee Smith grant for youth suicide prevention from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant would create Suicide-Safe Centers of Care based on a Zero Suicide approach to enhance effective treatment and care management of youth at-risk; develop Suicide-Safe Communities in which prevention and early identification are priorities and treatment and support are available; and ensure suicide prevention is integrated into state systems to create a Suicide-Safe Commonwealth.
- Provision of education and training for Recovery Learning Centers and promotion of suicide prevention through Trauma Informed Care education

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

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

Footnotes:

Support of State Partners

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, lists the activities and provides the Plan section(s) in which the description of the activity can be found.

State Agency	Activities	Plan Section
Executive Office of Health and Human Services (EOHHS)/ MassHealth	• Joint management of the Massachusetts Behavioral Health Partnership (MBHP) contract	Step 1, Crisis Services Step 2
	• Coordination of the One Care Implementation Council; expansion of Family Partners; SAMHA STAY grant addressing transition age youth services in MassHealth Community Service Agencies; Safety Administrators meeting	
	• Primary Care Payment Reform; Dual Eligibles Demonstration/One Care; Health Homes	Health Care System and Integration
	• Positive Behavioral Interventions and Supports in schools initiative	Prevention for Serious Mental Illness
	• Money Follows the Person (MFP) Rebalancing Demonstration Grant	Community Living and the Implementation of the Olmstead Plan
	• Children's Behavioral Health Initiative; MYCHILD, SAMHSA Children's System of Care grant	Children and Adolescent Behavioral Health Services
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	Step 1, Step 2

MassHousing	• Set-Aside of affordable units for use by DHM	Step 1
Department of Children and Families	• DMH/DCF Caring Together Services	Step 1, Children and Adolescent Behavioral Health Services
	• Expansion of Family Partners (within Caring Together Services)	Step 2, Children and Adolescent Behavioral Health Services
	• Ongoing cross-training, DMH consultations to DCF regarding service planning and other planning activities	Children and Adolescent Behavioral Health Services
Massachusetts Rehabilitation Commission	• Memorandum of Understanding, including designation of local liaisons and MOU Implementation Committee	Step 1, Step 2
Department of Elementary and Secondary Education (DESE)	• Educational services in inpatient and intensive residential settings	Step 1
	• Positive Behavioral Interventions and Supports in schools initiative	Prevention for Serious Mental Illness
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	Step 1
	• Joint sponsorship of the Massachusetts State Leadership Academy on Tobacco-free Recovery and ongoing subcommittee work; Massachusetts Coalition for Suicide Prevention	Step 2, Health Care System and Integration; Suicide Prevention
	• SAMHSA Project Launch grant	Prevention for Serious Mental Illness
	• Elder Mental Health Planning Collaborative, Summit on Older Adults	State Mental Health Planning Council

Courts	• Court Clinics, Mental Health Courts, Tenancy Prevention Program (TPP)	Step 1, Criminal and Juvenile Justice
Police Department	• Jail Diversion Programs	Step 1, Criminal and Juvenile Justice
Department of Veterans Services	• MISSION Implementation Services, Peer Support	Step 1, Criminal and Juvenile Justice
Prisons and Houses of Correction	• Forensic Transition Team	Step 1, Criminal and Juvenile Justice
Department of Correction	• Joint committees on care and treatment of female inmates at MA Correctional Institute in Framingham and persons served at Bridgewater State Hospital • Department of Justice, Second Chance Act	Step 1, Criminal and Juvenile Justice Criminal and Juvenile Justice
Executive Office of Elder Affairs	• Elder Mental Health Planning Collaborative, Summit on Older Adults; participation on the Elder Mental Health Planning Collaborative	Step 1, Step 2, State Mental Health Planning Council
Department of Developmental Services	• Co-funding of two Regional Employment Collaboratives	Step 2
Department of Youth Services	• Interagency protocols addressing information sharing and transition planning	Step 2, Criminal and Juvenile Justice
Department of Early Education and Care (DEEC)	• Race to the Top award from the U.S. Department of Education; DESE Statewide Advisory Committee on Special Education	Prevention for Serious Mental Illness, Children and Adolescent Behavioral Health Services

In addition to the activities identified above, DMH participates on numerous interagency committees, commissions and workgroup, including:

- EOHHS Housing Committee – Step 1
- Interagency Council on Housing and Homeless – Step 1
- Task Force on Behavioral Health and Schools (2008-2011) – Step 1
- Massachusetts Commission on Gay, Lesbian, Bisexual and Transgender Youth – Step 2
- 18 agency Memorandu m of Agreement to continue activities of the SAMHSA funded grant – Jail Diversion and Trauma Recovery: Priority to Veterans – Step 2

- Interagency Supported Housing Initiative – Step 2
- Health Planning Council (2012-2014) – Step 2
- Behavioral Health Task Force, chaired by DMH Commissioner (2012-2013) – Step 2
- Task Force on Behavioral Health Data Policies and Long Term Stays (2014-2015) – Health Care System and Integration
- Interagency Restraint and Seclusion Prevention Initiative – Use of Evidence in Purchasing Decisions, Trauma
- Mental Health Task Force of the Massachusetts Chapter of the American Academy of Pediatrics
- Governor's Child and Youth Readiness Cabinet

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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

Footnotes:

The State Mental Health Planning Council

The State Mental Health Planning Council is a standing committee of the Mental Health Advisory Council (MHAC) to the Massachusetts Department of Mental Health. The MHAC, established by statute (MGL c.19, section 11) and regulation (104 CMR 26.04 [4]) consists of 15 individuals appointed by the Secretary of the Executive Office of Health and Human Services to "advise the commissioner on policy, program development and the priorities of need in the Commonwealth for comprehensive programs in mental health." The Council does not have its own set of bylaws. All members of the Planning Council are nominated and appointed by the MHAC and include consumers, family members of adults and children, legal and program advocates, providers, other state agencies, mental health professionals and professional organizations, legislators, representation from state employee unions and members of racial, cultural and linguistic minority groups. The membership of the Council is reviewed regularly. Members who have not been active within the last year are contacted to confirm their commitment and new members are appointed to ensure a balanced and diverse membership. DMH provides staff to the Council.

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.

Elder Mental Health Issues

The Elder Mental Health Planning Collaborative is a partnership between the Massachusetts Aging and Mental Health Coalition (MAMHC), a statewide membership organization dedicated to improving awareness of the critical problems elders face when experiencing mental illness, dementia or substance abuse, and three state departments: Department of Mental Health, the Executive Office of Elder Affairs (EOEA) and the Department of Public Health (DPH). The local Coalition was formed in Massachusetts in 1999 from the national efforts of SAMSHA and the AARP Foundation which went on to form the National Coalition on Mental Health and Aging. Membership in the Massachusetts Coalition includes representatives from local private agencies, the Massachusetts Association of Older Americans (MAOA), Massachusetts Councils on Aging, Mass Home Care, The Massachusetts Partnership on Substance Use in Older Adults, Boston University Institute of Geriatric Social Work and the Association for Behavioral Health, formerly the Mental Health and Substance Abuse Corporation of Massachusetts. The Coalition and the Planning Collaborative are focused on the needs and concerns around serving elders and has a history of success in completing projects directed at systems improvement. These projects include publishing a guide on 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 of those with a history of mental illness and revising 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 of aging.

Past examples of the Collaborative's work include engaging the three dual Special Needs Plan (SNP) providers, known as Senior Care Organizations (SCOs) with the values of a medical home to support their growing mental health network and promote evidence-based practices, particularly in the area of screening for and treating depression and anxiety, and engaging DMH leadership in the Areas and Sites to hear about their work with older adult clients and how the Collaborative may be able to help.

The Coalition has held twelve annual conferences drawing ever increasing numbers and highlighting best practices across the state. Featured speakers have included leading practitioners in aging and mental health, top state administrators, and clinicians from a promising demonstration project. In addition, the Boston University Institute of Geriatric Social Work and MAOA, created a blended model of online and face to face training on mental illness for elder network staff. It sought out leaders in aging, mental health and emergency responders to contribute. One of the local coalitions, The Greater Lowell Elder Mental Health Collaborative, has also created a web site- http://www.eldermentalhealth.org/ for elders and their caregivers. It is an easily accessible tool for understanding issues, learning about existing services and finding out the work of the local and statewide coalitions.

In 2012, members of the Elder Collaborative attended a SAMHSA Policy Academy on the behavioral health needs of older adults. At the request of SAMHSA, senior leaders from Elder Affairs, MassHealth, DMH and DPH Bureau of Substance Abuse Services (BSAS) attended a Northeast regional meeting at SAMHSA headquarters, which also included senior leaders from SAMHSA, CMS and ACL (formerly the Administration on Aging). As part the action plan, the group committed to doing a summit related to this topic. The Summit on Older Adults: Behavioral Health Issues and the Coming Wave, was held on October 30, 2014. It was a joint effort of three state agencies, Department of Mental Health, Department of Public Health and the Executive Office for Elder Affairs, as well as the Massachusetts Association of Older Americans. This invitation only event was attended by over 100 health policy, health care delivery and aging services leaders. The speakers included Dr. Stephen Bartels, a researcher on aging and behavioral health issues from Dartmouth, Dr, Thomas McGuire, a Harvard health economist, and A. Kathryn Power, the North East SAMHSA Regional Administrator. The meeting was well received and most feedback emphasized the timeliness and urgency of the topic and the planning committee will produce a report.

The focus of the group in SFY12-14 was to take a more in-depth look into the opportunities offered by the Affordable Care Act of a Medical Home model for elders that fit both the Massachusetts state initiative and federal health care reform. These include becoming more involved in a number of initiatives in Massachusetts to integrate primary and behavioral health through the Primary Care Medical Home Initiative, the Dual Eligibles Initiative, Health Homes, Money Follows the Person and the Balancing Incentive Program.

Child/Adolescent Issues

Although there are now several children's mental health advocacy groups, the Professional Advisory Committee on Children's Mental Health (PAC) continues to be unique in its broad approach to children's mental health. It priorities include continued review of the implementation of the 2008 "An Act Improving and Expanding Behavioral Health Services for Children in the Commonwealth", comprehensive legislation that addresses issues ranging from insurance parity to pre-school mental health services. It also continues to pay active attention to the Children's Behavioral Health Initiative by meeting with the commissioners of the Departments of Children and Families and Mental Health regarding departmental goals and priorities; the impact of the broad implementation of the first phase of the Children's Behavioral Health Initiative, the Rosie D remedy; and the opportunities for promoting integrated service delivery across child and family serving agencies.

In SFY14 and 15, the PAC has focused its efforts on making infant and early childhood mental health a statewide priority. The PAC organized a panel presentation at the April 2014 Planning Council meeting on "Meeting the Mental Health Needs of Young Adults and their Families". The PAC is advocating for DMH to assume an essential cross- systems leadership role in Infant-Early childhood Mental Health (IECMH) and has noted multiple accomplishments, including trainings in infant and toddler mental health, enhanced capacity of pediatric practices, implementation of the Top of the Pyramid Skills (TOPS) curriculum, creation of the early Childhood Learning Collaborative Initiative and the completion of an early childhood mental health guide for early childhood educators. The PAC will continue to advocate and engage with state agencies and other partners on the following priorities areas in IECMH: addressing its cross-cutting nature, encouraging greater attention to early identification and response, increasing access to IECMH services and financing, building capacity and competency to IECMH practice and promoting public awareness.

Youth Development Committee

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.

Two young adult peer leaders co-chair the Statewide Young Adult Council (SYAC). The SYAC Council 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. The SYAC provided feedback to Work Without Limits, BenePlan, the Success for Transition Age Youth (STAY) grant and the UMass Transitions Research & Training Center. Specifically, the SYAC informed the design, development and beta-test for the ReachHire MA website (www.reachhirema.org) with Work Without Limits and MORE Advertising and provided feedback on the development and creation of Work Without Limit's Massachusetts Job Board. The SYAC was recognized for their contributions with the 2014 Leadership Award from Work Without Limits at the Annual Raise the Bar HIRE conference.

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, Young Children's Council, DMH Council on Recovery and Empowerment (CORE), MBHP Consumer Council and EOHHS' Children, Youth & Families Advisory Council. In addition, the YDC formed an Education Subcommittee, which is developing a work plan and inviting various post-secondary programs who assist with re-entry into college to present their program models at upcoming meetings. YDC members are also active on the Housing and Employment Subcommittees of the Planning Council.

In SFY14, DMH was awarded a SAMHSA/CMHS System of Care Expansion Implementation Grant. The "Success for Transition Age Youth" (STAY) grant and the Northeast DMH Area was awarded a SAMHSA Now is the Time (NITT) Healthy Transitions grant. Both grants are working to reach into communities across the state and engage young adults of diverse populations with mental health services and supports. The YDC continues to collaborate on the planning and implementation of grant activities. The YDC and the STAY grant hosted the 4th annual Young Adult Peer Leadership Appreciation Day in May 2015 to celebrate the work and service of young adult peer leaders/peer support workers.

In preparation for the SFY16-17 State Plan, the YDC identified a series of unmet needs and service gaps and proposed a number of recommendations. These include:

- Improving service continuity and availability by re-establishing Young Adult Case Managers and providing training to case managers and young adults;
- Increasing outreach and engagement through implementation of STAY youth engagement strategies, social media presence and youth leadership development;
- Promoting employment though collaboration with the Employment subcommittee, providing employment preparing and readiness trainings (such as GIFT training) and increasing support for the Reach Hire website;
- Increasing high school graduation rates and post-secondary education enrollment with support from the Education Subcommittee by promoting model education support programs and developing Mental Health 101 trainings for educators; and
- Improving access to housing resources through collaboration with the Housing Subcommittee and the Special Commission for Unaccompanied Youth.

Employment Issues

The employment subcommittee (ESC) was created in 2006 because a significant number of Council members believed that an effort should be made to make employment, including self-employment and volunteer opportunities, a central part of the fabric of the DMH delivery of care system. The subcommittee is currently working on the following priorities:

- Advocate for DMH to focus on the employment of individuals served as an important component of recovery and to see employment as a priority. Largely through the subcommittee's advocacy, DMH created the position of Director of Employment in SFY14, to monitor, evaluate, and coordinate the Department's various employment services and staff. In SFY15, the subcommittee convened a statewide forum of CBFS providers and employment service subcontractors to develop a series of recommendations addressing employment outcomes, IPS fidelity and the role of DMH. The ESC intends to submit these recommendations to DMH for consideration in CBFS re-contracting. The ESC has identified variation in the emphasis and expertise of CBFS providers as a current gap in the system. In addition the subcommittee met with the DMH Area Employment Coordinators to learn about their diverse roles.
- Support the development of common employment measures and data collection methods to ensure an unduplicated count of all individuals who are working based on the efforts of DMH-funded employment services (CBFS, Clubhouses, PACT, and RLCs). The subcommittee is beginning to review and analyze employment data for PACT and identifies the lack of employment data for Clubhouse as a current gap that DMH is addressing.
- Advocate with government agencies, legislators and private entities to preserve and enhance the availability of employment services for individuals with mental illness. The ESC is partnering with Alexis Henry from Work Without Limits at the University of Massachusetts as she researches and publishes on the positive impact employment can have on mental health recovery.
- Advocate for greater collaboration amongst state agencies, providers and private entities in supporting integrated/coordinated employment services and employment opportunities for individuals with mental illness. The ESC has three members on the DMH/MRC Memorandum of Understanding Steering Committee. The subcommittee will continue to advice DMH and MRC on the implementation of the MOU, including its impact on interactions between DMH service providers and MRC.
- Support DMH in its focus on employment for young adults aged 18-25 as an important component of recovery. Members of the subcommittee have been meeting jointly with the YDC to advance this goal. The ESC identified current gaps to include a lack of funding to maintain the Reach Hire website and a lack of employment services and supports for young adults.
- Explore ways to increase membership of the ESC. One strategy is to recruit one or more young adults through the YDC and STAY grant.

Multicultural Advisory Committee

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. For SFY 2014-15, MAC's goals included:

- 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.

The goals were accomplished by holding regular, ongoing MAC meetings. MAC's areas of focus for SFY14 were on 1) anti-stigma practices towards mental illness and the promotion of prevention and treatment, 2) recovery, empowerment and peer support, 3) children's mental health services, 4) integrated health and behavioral health care, and 5) reduction of barriers to care. For SFY15, the areas of focus were based on the DMH Cultural and Linguistic Competence Action Plan. MAC members were also connected to DMH staff who participate in the Department's Cultural Competence Action Team (CCAT). CCAT promotes and assists DMH's mission to provide culturally and linguistically competent care that is person-centered and trauma-informed. The CCAT consists of DMH staff from each DMH service area and from DMH's Mental Health Services, Clinical and Professional Services, and the Commissioner's Office. MAC members played a crucial role in organizing the Many Faces of Mental Health: Sharing Our Stories event held in 2013. The Many Faces of Mental Health event was held for the second time during September 2014 and MAC has plans to grow the event into an annual tradition. The role of MAC is anticipated to increase because membership roles and expectations were developed through consensus in SFY15 and twelve members are committed to serving on the committee until SFY18.

TransCom

TransCom (the Transformation Committee) was established in 2004 to guide the work of the Mental Health System Transformation Grant funded by the Centers for Medicare and Medicaid Services (CMS). TransCom became a sub-committee of the

Planning Council in SFY07. This committee brings together a diverse group of individuals and organizations to advocate for a flexible, peer-driven and recovery-oriented infrastructure; model collaboration and cultural/linguistic inclusion; and to support the development, promotion and coordination of innovative recovery-oriented practices. Lead organizations are DMH, the Transformation Center – a statewide technical assistance center for the consumer/survivor movement, MassHealth, the Association for Behavioral Healthcare (ABH), and the University of Massachusetts Center for Health Policy and Research (CHPR). In SFY10, Transcom completed a strategic planning process identifying three priority goals for the committee:

- Support, safeguard, and expand peer specialists, peer workers, and peer-run programs;
- Provide information, education and training on innovative recovery practices (for providers, hospitals, peer communities, DMH, legislators, and cultural/ linguistic communities); and
- Advocate for funding for peer workers and innovative recovery oriented services (with an emphasis on Medicaid).

Transcom members committed themselves to continue to work as a group on system transformation following the end of federal funding.

In recent years, Transcom released and disseminated two documents developed in monthly stakeholder meetings with associated subcommittee work. The first, 2013 Revision-Promoting a Culture of Respect: Trancom's Position Statement on Employee Self-Disclosure in Health and Social Service Workplaces, is an update of a document providing guidance to the field regarding personal disclosure. Personal disclosure of mental health recovery is encouraged as communities and human service professionals gain understanding of peer support roles. The second document, April 2014: Massachusetts Peer Professional Workforce Development Guidelines was developed by invitation of DMH after a State Mental Health Planning Council discussion identified confusion about the emergence of peer roles in healthcare. Based on collaborative work by diverse stakeholders, Trancom summarized the unique contribution of peer support roles in the field, outlined essential practices regarding the effective use of peer professionals, and developed a chart showing the various stages of peer professional development. The document includes examples of job titles, roles, competencies, prerequisites and available trainings associated with professional development stages.

In June 2015, TransCom hosted an "Invitational Summit" with peer leaders from the mental health and substance abuse communities. The purpose was to identify common themes supporting peer support in both systems and to share lessons learned. Additional goals of TransCom are to: host an event that promotes understanding by insurers, policy and practice leaders; support reimbursement of the Certified Peer Specialist and Recovery Coach roles; and to expand opportunities for certification and continuing education.

Restraint/Seclusion Elimination

In November 2008, the Planning Council voted to create a subcommittee on restraint/seclusion elimination. The subcommittee had previously been established as an advisory committee to the SAMHSA-funded State Incentive Grant (SIG) on restraint and seclusion elimination. While reduction of restraint and seclusion in the state-operated

system continues as a core mission, the subcommittee expanded its focus to include trauma-informed care activities. The subcommittee provides ongoing review of DMH restraint and seclusion data; makes recommendations on accurate and meaningful data reporting; and provides oversight of restraint/seclusion elimination activities at state facilities. The subcommittee membership was expanded to include the DMH Director of Human Rights and Director of Child/Adolescent Statewide Programs.

The subcommittee continues to review restraint and seclusion data from DMH state-operated facilities and discuss trends with DMH leadership. The subcommittee membership now includes a DMH Area Medical Director, facility Director of Nursing and Chief Operating Officer, leading to improved communication between the subcommittee and facility and Area leadership. In SFY15, the subcommittee completed facility site visits and is preparing recommendations to include a process for sharing information and best practices between DMH inpatient facilities. In addition, the subcommittee supported DMH's acquisition of analytic software for the purposes of analyzing restraint and seclusion data.

Parent Support

In March 2009, the Planning Council voted to establish a Parent Support subcommittee. The subcommittee began monthly meetings in May 2009. It is composed of a broad cross-systems representation of parents, peer organizations, providers, academic researchers, and representatives from DMH, the Department of Children and Families, Department of Public Health, Bureau of Substance Abuse Services, and Department of Transitional Assistance. The need for this subcommittee is based on the fact that nationally adults with psychiatric disorders were as likely, or more likely, to be parents than adults without psychiatric disorders. In Massachusetts 11% of DMH eligible adults are parents of one or more children. In addition, rehabilitative and treatment services for adults consistently fail to recognize the role of parent as a significant life domain.

In October of 2011 the Parent Support Subcommittee, with the sponsorship of the Department of Mental Health, convened an inter-agency forum entitled *Mental Health Is Family Health.* The forum was attended by over 85 people including consumers, providers, advocacy groups, and representatives from six state agencies. The forum generated a statement of priorities for the state agencies to better respond to the needs of parents with mental health conditions and their children. These priorities included: the importance of a public health approach; identifying opportunities to support parents and children across agencies and within service categories; mobilizing resources within Clubhouses and Recovery Learning Communities; maximizing use of existing peer support opportunities to make them "parent-informed" and "family-friendly"; capitalizing on emerging interest in and resources for this population and their children; identifying opportunities in existing adult mental health services to support consumers who are parents and their families and creating guiding principles and core curriculum that can be drawn upon in varied training venues and activities.

Recent activities of the Parent Subcommittee include:

- Collaboration with the Worcester Recovery Center and Hospital (WRCH) to develop family-oriented services in the inpatient setting to support patients and their families as well as in the future to offer family support services to

the larger community. A staff from WRCH is now a member of the subcommittee.

- Representatives of the subcommittee were trained to facilitate the *Parenting Journey* and collaboratively implement the 12-week program supporting parents in recovery to focus on self-care, factors that influence parenting style and building on strengths of the family.
- The Parent Subcommittee planned a Regional Educational Forum in October 2014 for the Planning Council, bringing together stakeholders and Evan Kaplan from Children Family Connections in Philadelphia, who has been successful in developing direct services for families in mental health recovery.
- Several members of the subcommittee contributed to a manual designed to assist providers in adapting existing services to foster service growth within the mental health system. This manual, *Creating Options for Family Recovery: A Provider's Guide to Promoting Parental Mental Health* was authored by Dr. Joanne Nicholson with contributions by Kate Biebel, Chip Wilder and Toni Wolf.

The subcommittee made several recommendations, including: data collection of the number of parent enrolled in DMH services; identifying existing programs for families with parental illness for the purposes of resource sharing; workforce development to include training/consultation, implementation of an evidence-based model, "Let's Talk" and enhancing peer support to develop a parent peer training curriculum; and promoting collaboration between state partners, including DMH and DCF, and with the Medical Home Model and Homelessness Prevention programs and shelters.

Housing Committee

In May 2013, the Planning Council voted to establish a Housing Committee following a presentation to the Council on an overview of housing resources and agencies and the personal experience of a young adult with accessing housing resources and supports. The committee held its first meeting in September 2013, and identified three broad policy areas: resource advocacy, policy advocacy and external educational outreach. In SFY15, the Committee has engaged in the following activities related to these priorities:

- Resource Advocacy: The committee worked with the Massachusetts Association for Mental Health, DMH and other stakeholders in advocating for additional state appropriations for special rental assistance account for DMH clients which is within the budget for the Executive Office of Housing and Community Development (EOHCD) and is administered jointly be EOHCD and DMH. The goal of increasing the account by $1 million to $5,125,000 was achieved.
- Policy Advocacy: The committee met with DMH contracted service providers, housing agencies, housing programs and other stakeholders to identify policy or regulation changes that would make the rental assistance program more effective. The committee identified two specific policy areas to advocate for policy changes: multiple inspections of premises approved for

the special rental assistance account for DMH clients and the limitation that rental assistance is only available to CBFS clients.

- External Educational Outreach: The committee developed and presented a Housing Workshop, "Home is Where Recovery Lives", at the October 2014 NAMI Annual Convention. The session was well attended and attendees were provided with a handout on housing programs and resources as well as practical tips on helping a loved one prepare for a housing search and related matters.

Planning Council Steering Committee

In March 2009, the Planning Council voted to establish a steering committee in response to feedback received in 2008 during the block grant monitoring visit. Specifically, the feedback provided in the written report identified that the large size of the Planning Council did not facilitate addressing the business of the Council during its quarterly meetings. The Planning Council endorsed a charter document for the steering committee and the first meeting was held in November 2009. The membership of the subcommittee includes the co-chairs of the Council, a chair or designee from each subcommittee and two members-at-large. The membership also includes at least two consumers and two family members of a person with a mental illness. The steering committee meets before each full Planning Council meeting to review the status of subcommittee activities, discuss block grant related activities, inform the agenda for Planning Council meetings, and address any other business that does need to go before the full Council membership. The Planning Council membership felt it was important to address in the charter document that the role of committee is not to exercise the powers or authority of the Council.

Planning Council Meeting Summary

The Planning Council reviews the Department's State Plan, monitors its implementation and advocates regarding mental health system issues. The Council met on July 13, 2014, to review DMH strategic priorities and progress, receive a presentation on the peer and family workforce and provide subcommittee reports and updates. The peer and family workforce panel included a presentation by TransCom on the Peer Professional Workforce Development Guidelines and by the Urban College on the Children's Behavioral Health Certification Program. The Planning Council meeting on October 23, 2014 was devoted to a panel presentation organized by the Parent Support subcommittee on "Families Living with Parental Mental Illness" and subcommittee updates. The Council met again on January 29, 2015. The subcommittees presented recent activities and identified unmet needs to inform the development of the SFY16-17 State Plan. The Council meeting on April 23, 2015 included discussion of MassHealth priorities and updates, including the Health Connector, payment reform, health care integration, long-term supports, transition age youth and early childhood. Several subcommittees also reported on recent activities including TransCom and the Professional Advisory Committee. In addition to feedback providing in the meeting, the subcommittees also produced written recommendations for inclusion in this section of the document. The Council met on July 28, 2015 to review the draft of the Plan and prepare the Planning Council letter. The meeting also included a presentation on the Tobacco

Summit and Leadership Academy and subcommittee reports. 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.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
Mental Health Advisory Council

State Mental Health Planning Council

August 18, 2015

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 10, 2015 to review the State 2015-16 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 transparent and effective planning process that engages a wide stakeholder group to address service needs and policy recommendations.

The Council engaged in active planning within subcommittees and open discussion during Council meetings as the Plan was developed and presented. 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. It was a thoughtful, well-organized and well written document, with a strong recovery focus and a strong shift in incorporating individuals with lived experience in many aspects of service delivery. Although all members of the Council received the document in advance of the meeting, the Council did request that in the future, an executive summary be created to better ensure all stakeholders are engaged in reviewing the document. The Council was particularly pleased to see information in the plan regarding

the development of effective working relationships with educational and cultural resources to assist and support people served in accessing educational services.

Recent data from Massachusetts and other states 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). There has been some effort to address tobacco use among people served by the Department, but it has not been very far reaching. Therefore, Council members would like to see more action steps and outcome targets in the Plan going forward.

Specific Comments from Subcommittees and Stakeholders

The Youth Development Subcommittee appreciated the foresight of the Department in their involvement to better address homeless youth. The newly developed Housing Subcommittee also echoed the importance of Youth interface ensuring a comprehensive and effective response to the unique housing needs of young adults. The Youth Development Committee requested that the Plan also include their special initiative, an interactive website; Speaking of Hope which provides "a canvas for expression and a toolbox of valuable resources."

The Employment Subcommittee of the Council has been a strong advocate for increasing access to employment services and improving employment outcomes. They acknowledged the important step that was taken last year identifying a statewide DMH Employment Specialist fostering employment services throughout the adult system. The Subcommittee expressed its eagerness in working with the Department to establish dashboard indicators and employment targets and improve employment outcomes statewide.

The Parent Subcommittee acknowledged that the plan better reflects this year, the work of the Department in the integration between adult and child systems for parents and families affected by mental illness yet 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 identified the need to improve understanding of trauma in the inpatient setting, increased collaboration and communication at all levels of the system, provide training and ongoing workforce

development, and offer alternatives to restraint and seclusion. The Subcommittee acknowledged the Department's continuing efforts to redesign the system to a trauma informed recovery centered system of care. The Subcommittee chair stated that it will be important in the near future to reconvene key stakeholders as many of the change agents have left due to restructuring and retirement. This will be essential to continue best practices and training new personnel ensuring the reduction of restraint prevention.

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.

Lastly, we wish to formally express our gratitude and appreciation for the dedication and professionalism of two people who have embarked on a new life stage journey. We are very grateful to Bernard Carey and Timothy O'Leary from the Massachusetts Association for Mental Health (MAMH), who listened and engaged stakeholders over the years, and successfully led the process that we will continue to follow; establishing a cooperative culture, while passionately caring about the mental health issues of the residents of the Commonwealth. It is thanks to them and others that we come together as a State Mental Health Planning Council; a diverse group of passionate change makers, nurturing a culture of both advocacy and collaboration.

Yours truly,

Anne Whitman	Jonathan Bowen-Leopold	Danna Mauch
Co-Chair	Co-Chair	Incoming Co-Chair

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

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
Brenda Correia	State Employees	Executive Office of Elder Affairs	One Ashburton Place, 5th Floor Boston, MA 02108 PH: 617-222-7482	
Rep. F.D. Antonio Cabral	State Employees	Massachusetts House of Representatives	State House, Room 22 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, #818 Boston, MA 02116 PH: 617-424-9665	
Scott Taberner	State Employees	Medicaid	600 Washington Street Boston, MA 02111 PH: 617-573-1715	
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	
Elena Eisman, Ed.D	Others (Not State employees or providers)	Massachusetts Psychological Association	195 Worcester Street, #303 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	
Phil Hadley	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI-Mass	400 West Cummings Park, #6650 Woburn, MA 01810 PH: 781-938-4048	
Marjorie Harvey	Others (Not State employees or providers)	Statewide Advisory Committee	80 Park Street, #23 Brookline, MA 02446 PH: 617-735-9477	

Don Hughes	Providers	Riverside Community Care	450 Washington Street Dedham, MA 02026 PH: 781-329-0909
Lisa Lambert	Parents of children with SED	Parent/Professional Advocacy League	59 Temple Place, #664 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, Suite 6650 Woburn, MA 01801 PH: 781-938-4048
David Matteodo	Others (Not State employees or providers)	Massachusetts Association of Behavioral Health Systems	115 Mill Street Belmont, MA 02478 PH: 617-855-3520
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
Adelaide Osborne	State Employees	Vocational Rehabilitation	600 Washington Street Boston, MA 02111 PH: 617-204-3620
Vic DiGravio	Others (Not State employees or providers)	Mental Health & Substance Abuse Corporations of Massachusetts, Inc.	251 West Central Street, Suite 21 Natick, MA 01760 PH: 508-647-8385
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
Chrystal Kornegay	State Employees	Housing	Department of Housing and Community Development, One Cambridge Street #300 Boston, MA 02114 PH: 617-573-1101
Kate Nemens	Others (Not State employees or providers)	Mental Health Legal Advisors Committee	399 Washington Street, 4th Floor Boston, MA 02108 PH: 617-338-2345
Linda Spears	State Employees	Social Services	Department of Children and Families, 24 Farnsworth Street Boston, MA 02210 PH: 617-748-2325
Stephanie Ward	Others (Not State employees or providers)	Massachusetts Council of Human Service Providers, Inc.	JRI Meadowridge, 664 Stevens Road Swansea, MA 02777

			PH: 508-207-8504
Carol Trust	Others (Not State employees or providers)	Massachusetts Association of Social Workers	14 Beacon Street, #409 Boston, MA 02105 PH: 617-227-9635
Ruth Rose-Jacobs	Parents of children with SED	Boston University School of Medicine & Boston Medical Center	91 East Concord Street, Room 5106 Boston, MA 02118 PH: 617-414-5480
Beverly Sheehan	Others (Not State employees or providers)	Massachusetts Psychiatric Society	40 Washington Street Wellesley, MA 02181 PH: 781-237-8100
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, DMH Suite 516 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, Suite 300 Worcester, MA 01609 PH: 508-756-6676
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, Apt. C Pepperell, MA 01463 PH: 978-858-4462
Sarah Ruiz	State Employees	Other	Department of Public Health, 250 Washington Street Boston, MA 02108 PH: 617-624-5136
Lisa Gurland	State Employees	Other	Department of Public Health, 250 Washington Street Boston, MA 02108 PH: 617-624-5294
Tom Brigham	Others (Not State employees or providers)	Massachusetts Housing & Shelter Alliance	PO Box 120070 Boston, MA 02112 PH: 617-367-6447
Toni Wolf	Providers	Employment Options	82 Brigham Street Marlboro, MA 01752 PH: 508-485-5051
Reva Stein	Others (Not State employees or providers)	Massachusetts Clubhouse Coalition	15 Vernon Street Waltham, MA 02453 PH: 781-788-8803
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
Chantell Albert	Parents of children with SED		45 Bromfield Street, 10th Floor Boston, MA 02108 PH: 617-542-7860
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
Darcy Rubino	Parents of children with SED		47 Harold Street North Andover, MA 01845 PH: 978-201-1196
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
Danna Mauch	Others (Not State employees or providers)	Massachusetts Association for Mental Health	130 Bowdoin Street Boston, MA 02108 PH: 617-680-8200

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	55	
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)	17	
Total Individuals in Recovery, Family Members & Others	38	69.09%
State Employees	10	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
Total State Employees & Providers	17	30.91%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* 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 letter and State Mental Health Planning Council section describe the Planning Council's involvement in the development of the State Plan, including recommendations.

The current membership database does not include information the following information:
- Individuals/Family Members from Diverse Racial, Ethnic and LGBTQ Populations
- Providers from Diverse, Racial, Ethnic and LGBTQ Populations
- Persons in recovery from or providing treatment for or advocating for substance abuse services

Therefore, we have indicated '0' for each of these categories. DMH will work with the Planning Council to update the membership database to include this information.

The Criminal Justice state agency representative position is vacant.

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 7 2015

Ms. Joan Mikula
Massachusetts Department of
Mental Health
25 Staniford Street
Boston, MA 02114-2503

Dear Ms. Mikula:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Terri Anderson
Christina Fluet
Anne Whitman

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory