# FY2016/2017 Massachusetts State Behavioral Health Assessment and Plan

**Community Mental Health Services Block Grant**

# 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](http://www.mass.gov/eohhs/gov/laws-regs/dmh/executive-order-no-244.html) 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](http://www.mass.gov/eohhs/gov/laws-regs/dmh/executive-order-no-422.html) 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 withDHCD 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 servedas 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.

**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.

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

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**](http://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.

1. **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.

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

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.

1. **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.

1. **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.

1. **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.

1. **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.

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

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

The SAMHSA definition of youth with serious emotional disturbance (SED) is individuals youngerthan 18 years who currently, or at any time during the pastyear, have had a diagnosable mental, behavioral, or emotionaldisorder resulting in functional impairment that substantiallyinterferes 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](https://email.state.ma.us/OWA/redir.aspx?C=TXwrc5tK_USNZV1ao_-k2iVEykJV3M9ItpW5hGWffPQVlp274aDrC7RjKPZlrWKKRi4PvCqyp_g.&URL=http%3a%2f%2fwww.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.

1. **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.

1. **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.

1. **Addressing the needs of specific populations, including:**
   * Cultural/linguistic minorities (see above)
   * GBLTQ (see above)
   * Deaf/HOH (see above)
   * Court involvement (see above)
2. **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](http://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.

Parents with Mental Illness

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

1. **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.

1. **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.

1. **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 |

**Table 1: Priorities for the SFY16-17 Block Grant**

|  |  |
| --- | --- |
| **Enhance service system to promote recovery, resiliency and positive outcomes** | |
| Goal | 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 | 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. |
| Performance Indicator | 1.   Increase the percentage of adult clients who report positively about treatment outcomes. Baseline: 66%; SFY16: 68%; SFY17: 70%  2.   Increase the percentage of family members of child/adolescent clients who report positively about treatment outcomes. Baseline: 47%; SFY16: 49%; SFY17: 51% |

|  |  |
| --- | --- |
| **Implement and promote use of best practices** | |
| Goals | 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 | 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. |
| Performance Indicator | Increase the percentage of adults served in Clubhouses who are competitively employed. Baseline: 12%; SFY16: 15%; SFY17: 17%  Increase the percentage of children and adolescents who maintain or improve school attendance. Baseline: 63%; SFY16: 65%; SFY17: 67% |

|  |  |
| --- | --- |
| **Increase access to treatment for early psychosis** | |
| Goals | 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 | 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 |
| Performance Indicator | Increase the number of young adults receiving evidence-based treatment for early psychosis. Baseline: 100 people; SFY16: 125; SFY17: 150 |

|  |  |
| --- | --- |
| **Ensure that all services are person and family centered** | |
| Goals | 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 | 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) |
| Performance Indicator | 1. Increase the percentage of adult clients who report positively about person-centered planning. Baseline: 76%; SFY16: 78%; SFY17: 80% 2. Increase the percentage of family members of child/adolescent clients who report positively family-centered planning. Baseline: 77%; SFY16: 79%; SFY17: 81% |

|  |  |
| --- | --- |
| **Promote community living** | |
| Goals | Align DMH inpatient and community systems to improve access and care coordination and promote community living. |
| Objectives | Increase the number of individuals maintaining community tenure |
| Strategies | 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. |
| Performance Indicator | Increase the number of people who are discharged from DMH inpatient continuing care to the community within 180 days of admission. Baseline: 60%; SFY16: 63%; SFY17:66% |

**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.”

**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.

**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.

**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.

**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
   1. 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.
   2. 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.
   1. PREP® East has a long tradition of providing educational forums for health care providers and educational institutions.
   2. 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
   3. 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.
4. 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.
5. 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

1. 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.

1. 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.
2. 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.

**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.

**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.

**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.

**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 evidence-based practices for early intervention | Implement second PREP® program (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. |
| #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. | Align DMH inpatient and community systems | % of adults who remain in community (without hospitalization or incarceration) | Monitor admission trends; ongoing 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 the delivery of care. | 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.  Continue monitoring rates of restraint and seclusion and refine intervention strategies as indicated. |
| Adolescents restrained per 100 patient days |
| #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. |

**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.

**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.

**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.

**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)

**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.

**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.

**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.

1. 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.

**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

**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 * 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 * Positive Behavioral Interventions and Supports in schools initiative * Money Follows the Person (MFP) Rebalancing Demonstration Grant * Children’s Behavioral Health Initiative; MYCHILD, SAMHSA Children’s System of Care grant | Step 1, Crisis Services  Step 2  Health Care System and Integration  Prevention for Serious Mental Illness  Community Living and the Implementation of the Olmstead Plan  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 * Expansion of Family Partners (within Caring Together Services) * Ongoing cross-training, DMH consultations to DCF regarding service planning and other planning activities | Step 1, Children and Adolescent Behavioral Health Services  Step 2, Children and Adolescent Behavioral Health Services  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 * Positive Behavioral Interventions and Supports in schools initiative | Step 1  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 * Joint sponsorship of the Massachusetts State Leadership Academy on Tobacco-free Recovery and ongoing subcommittee work; Massachusetts Coalition for Suicide Prevention * SAMHSA Project Launch grant * Elder Mental Health Planning Collaborative, Summit on Older Adults | Step 1  Step 2, Health Care System and Integration; Suicide Prevention  Prevention for Serious Mental Illness  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

# 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 substanceabuse, 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/](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](http://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.