Massachusetts Department of Mental Health

Community Mental Health Block Grant
FY22/FY23

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Mass DMH
Department of Mental Health

Table of Contents

Land Acknowledgement

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

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

Overview of State's Mental Health System

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

Epidemiology

In 2020, the United States Census American Community Survey estimates the Massachusetts population over seven million. The Commonwealth is relatively small in land mass with a net area of 7,838 square miles, but populous with an average population density of 871 people per square mile. Among all states, MA ranks 45th in total land area and 3rd in population density. The state covers 190 miles, east to west, and 110 miles, north to south, at its widest parts.

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

Table 1: DMH Areas' Large Cities with 2019 Population

DMH Area/Population	Large Cities	2019 Population	% MA Total
Metro Boston	Boston	692,600	10.1%
1,041,232	Cambridge	118,927	1.7%
Northeast	Lowell	110,997	1.6%
1,772,842	Lynn	94,299	1.4%
Southeast	Brockton	95,708	1.4%
1,614,906	Quincy	94,470	1.4%
	Fall River	89,541	1.3%
Central	Worcester	185,428	2.7%
1,541,386	Newton	88,414	1.3%
Western MA	Springfield	153,606	2.3%
846,048			

The U.S. Census 2020 population estimates for Massachusetts further report that 80.6% of the population is White, 9.0% African-American, 0.5% Native American, 7.2% Asian, 2.6% identifies as multiracial with 12.4% identifying as Hispanic or Latino. Immigrants from Africa, Southeast Asia, Central America, the Caribbean Islands, and Eastern Europe continue with foreign-born persons representing 16.8% of the Commonwealth's population. While English remains the most commonly spoken language, Spanish and Portuguese are the non-English languages spoken by the largest group of non-English speakers. Other languages commonly spoken include Chinese dialects, French, French Creole, Italian, and Russian but a larger variety of languages spoken exists.

Table 2: Massachusetts (MA) Prevalence Estimates (2018-19)
Serious Mental Illness/Serious Emotional Disturbance

DMH Area	Ages ≤ 17	Ages 18-25	Ages 26-65	Ages ≥ 65
Metro Boston	15,777	6,801	13,876	2,959
Central MA	54,549	13,720	37,313	11,122
Northeast	59,044	16,318	43,450	13,094
Southeast	51,104	14,155	38,875	14,026
Western MA	27,330	9,740	19,450	6,855
Total MA	207,803	60,734	152,964	48,056

The prevalence estimates shown above were developed using the following methods. First, population estimates for Massachusetts were developed using the American Community Survey (ACS) (www.census.gov/programs-surveys/acs). The next step required the proportional estimate of the population living with a serious mental illness. SAMSHA provided these estimates from its National Survey on Drug Use and Health (NSDUH) (https://datafiles.samhsa.gov/study-series/national-survey-drug-use-and-health-nsduh-nid). In 2021, SAMHSA released state specific proportional prevalence estimates combining the information it collected in 2018-2019. Estimates were given for the population ages 18 and over (5.16%) and for two age sub-groups within that population: ages 18-25 (8.88%) and 26 and older (4.54%). Separately, SAMHSA released a national estimate of the prevalence of major depressive episode with functional impairment for children and adolescents ages 12-17 (15.61%). To arrive at the estimates displayed in the table above the proportional prevalence estimate was multiplied by the ACS numeric estimate. As no state-specific information was available for children and adolescents ages 12-17, the national prevalence estimate was used. The same proportional prevalence estimate (4.54%) was used for the age groups 26-65 and 66 and older.

COVID-19 Community Impact Survey

During 2020 DMH supported the Massachusetts Department of Public Health's (DPH) efforts to conduct a COVID-19 Community Impact Survey (CCIS). The survey, available in 11 languages, recruited participants via a large network of community-based organizations in order to reach populations who typically do not respond to surveys. Results were weighted to reflect the MA population. There were over 33,000 adult respondents in the final sample. It is notable that

compared to other surveillance survey respondents the sample represented a wide cross-section of the Commonwealth's residents including African Americans, Alaska Native/Native Americans, Hispanics, Asians, LGBTQ individuals, Deaf and Hard of Hearing people, and people who speak languages other than English.

Highlights from the COVID-19 Community Impact Survey include:

- Reports of poor mental health among survey respondents was 3x times higher than in 2019 (2019 BRFSS), with a third of adults currently reporting poor mental health (15+ days in the last 30 days)

- People experiencing persistent poor mental health were 2-3x more likely to experience significant barriers to accessing care, such as appointment delays or cancellations, concerns about contracting COVID-19, not having a private place for a telehealth appointment, cost/insurance coverage, and lack of safe transportation

- Assistance with telehealth barriers made up three of the top five resources requested by those reporting poor mental health

- Requests for suicide prevention and crisis management resources were as high as 11% among certain subpopulations, and highest among transgender people, non-binary people, and people questioning their gender identity

- People experiencing poor mental health were more likely to report having had a change in their work status because of childcare. Most people experiencing poor mental health indicated they are currently working

- People experiencing poor mental health were more likely to report being worried about basic needs like getting medication and paying bills. Nearly half of respondents worried about paying bills, and one in four worry specifically about paying housing-related bills. Some subpopulations were significantly less able to access essential things like food, masks, medication, and internet services

- While there has been an increase in people reporting poor mental health across all demographic groups, some populations were significantly more likely to report poor mental health: Transgender people; non-binary people and those questioning their gender identity; LGBTQ+ community; people with disabilities; American Indian/Alaska Natives; Hispanic/Latinx community; people who identify as multi-racial; people between the ages of 25-44; people with lower income; and caregivers of adults with special need

Massachusetts Department of Mental Health - The State Mental Health Authority

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

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

DMH directly provides and/or funds a range of services for more than 22,000 adult clients per year. These services include inpatient continuing care, case management, and other community clinical, rehabilitative, and recovery-based services. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some acute inpatient and outpatient services in the Southeast and Metro Boston Areas. The central aim of DMH service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for its clients.

MassHealth: Massachusetts' Medicaid Authority

Beginning with its initial 1996 Medicaid Section 1115 waiver, Massachusetts has led the United States in health reform, creatively expanding eligibility for Medicaid and implementing the nation's first healthcare marketplace to provide increased coverage and improved access. Massachusetts insures almost two million residents (over 25% of its population) through Medicaid, and was an early implementer of parity rules and mandates that expanded coverage for individuals with a substance use disorder. In Massachusetts, Medicaid and the Children's Health Insurance Program are together called MassHealth. DMH exercises its role as the State Mental Health Authority through partnership with MassHealth, including its Office of Behavioral Health Unit (OBH) to ensure compliance on an array of program standards, clinical criteria and protocols, policies, performance incentives, and quality improvement goals that ensure the MassHealth.

In SFY18, MassHealth, through the 1115 waiver, was authorized to receive $1.8 billion over five years for new Delivery System Reform Incentive Program (DSRIP) funding. DSRIP funds are supporting the restructuring of MassHealth's delivery system to promote integrated, coordinated care and hold providers accountable for quality and total cost of care. Specifically, DSRIP is supporting MassHealth's transition to Accountable Care Organizations, including funding for Community Partners to integrate behavioral health, long-term services and supports, health-related social needs, and funding to support statewide investments to efficiently scale up statewide infrastructure and workforce capacity, including behavioral healthcare capacity, in support of MassHealth restructuring.

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

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

Second, DMH aims to improve the integration of behavioral health, medical, and specialty services provided directly to people who receive services as DMH clients. Specifically, DMH developed its primary adult community service, Adult Clinical Community Services (ACCS) to align with the MassHealth Accountable Care Organizations Community Partners program, both implemented in 2019. The ACCS service model provides clinical treatment for adults with serious mental health conditions and is fully integrated with health care and employment delivery systems. DMH collaborated on the design of ACCS MassHealth's Behavioral Health Community Partner (BHCP) with the shared goal of improving integration, access to services and supports, and care coordination for members who are in ACCS and receiving BHCP supports. Approximately 4,400 DMH ACCS members are enrolled in the BHCP Program. Additionally, approximately 1,765 ACCS clients are enrolled in One Care. Across all DMH services, approximately 54% of DMH clients are enrolled in a MassHealth integrated care model.

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

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

Substance Abuse Authority

The Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) is the Single State Authority, overseeing the Commonwealth's addiction services as well as tobacco and gambling prevention and treatment services. BSAS' responsibilities include: licensing programs and counselors; funding and monitoring prevention, intervention, and treatment services; providing access to treatment for the indigent and uninsured; developing and implementing policies and programs; and tracking substance abuse trends in the state. DMH and BSAS collaborate on 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 the Behavioral Health Roadmap. In 2016 Governor Baker enacted Chapter 52 of the Acts of 2016, An Act Relative to Substance Use, Treatment, Education, and Prevention. Chapter 52 is most notably the first law in the nation to limit an opioid prescription to a 7-day supply for first time adult prescriptions and a 7-day limit on every opiate prescription for minors, with certain exceptions. Other provisions from the Governor's recommendations include a requirement that information on opiate-use and misuse be disseminated at annual head injury safety programs for high school athletes, requirements for doctors to check the Prescription Monitoring Program (PMP) database before writing a prescription for a Schedule 2 or Schedule 3 narcotic, and continuing education requirements for prescribers—ranging from training on effective pain management to the risks of abuse and addiction associated with opioid medications.

In January 2016, Governor Baker signed into law a bill to prohibit the civil commitment of women facing substance use disorders at MCI-Framingham and providing addiction treatment services at Lemuel Shattuck Hospital and Taunton State Hospital. This reform was a recommendation of the Governor's Opioid Working Group and ended the practice of sending women committed for treatment for a substance use disorder under section 35 of chapter 123 of the General Laws to MCI-Framingham. (For the prior 25 years, women committed under section 35 were sent to this correctional institution instead of a detox center—preventing proper treatment options for women.) Under this law, women can only be committed to a facility approved by DPH or DMH. Subsequently, in February, 2016, the DMH-operated 45-bed Women's Recovery from Addiction Program (WRAP) opened on the Taunton State Hospital Grounds.

In July 2021, WRAP became the Recovery from Addiction Program (RAP) with the addition of four men's units. This collaboration between DMH and DPH BSAS provides services related to substance use disorders as well as specialized mental health treatment for co-occurring disorders for individuals who are civilly committed by the courts for substance use treatment for up to 90 days (i.e. section 35 commitment). RAP provides administrative, medical, clinical, and non-clinical services via quality client-centered care and recovery-oriented treatment. The program provides acute detoxification and early clinical stabilization services as clients develop community-based linkages to outpatient supports and substance use disorder treatment providers. Individuals treated within RAP will be linked upon discharge to a range of services within the DMH and DPH continuum of care.

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

Organization of the Department of Mental Health

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

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

Each Area and Site has a citizen advisory board, appointed by the Commissioner and comprised of consumers, family members, professionals, interested citizens, and advocates. Board members assess needs and resources and participate in planning and developing programs and services in their geographic domain. Additionally, a Mental Health Advisory Council (MHAC), appointed by the Secretary of EOHHS and comprised of consumers, family members, professionals, interested citizens, and advocates, receives data pertaining to the entire system and advises the Commissioner on mental health policy and priorities. The State Mental Health

Planning Council (SMHPC) is established as a subcommittee of the MHAC. In addition, there is a statewide Human Rights Advisory Committee, and each hospital has a board of trustees appointed by the Governor and a trustee's seat on the Area board in the DMH Area where the hospital is located. Although not mandated by statute or regulation, there is also a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members, and state agency representatives.

All of the state hospitals, Community Mental Health Centers (CMHC), adolescent inpatient units, and child and adolescent intensive residential treatment programs are accredited by the Joint Commission and certified by the Center for Medicare and Medicaid Services (CMS). DMH has the statutory responsibility for licensing all non-state-operated general and private psychiatric inpatient units and adult residential programs in the state. Children's community residential programs are licensed by the Department of Early Education and Care (DEEC). As of July 2021, DMH licenses 2,871 inpatient beds located in 62 facilities statewide. These beds include 142 adolescent beds, 56 children's beds, 144 child/adolescent beds, and 441 geriatric beds. Children, adolescents, and most adults receive acute inpatient care in these private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions. Additionally, there are 32 DMH operated acute inpatient psychiatric beds at CMHCs in the Southeast Area.

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

Massachusetts Behavioral Health Roadmap

While Massachusetts has long provided an array of community-based outpatient, diversionary, and inpatient behavioral health treatment services, many of these services are not fully integrated, and the system often proves challenging for individuals and families to navigate. To address these challenges, DMH has worked in close collaboration with other Executive Office of Health and Human Services (EOHHS) agencies in the redesign of the behavioral health system

across Massachusetts. The multi-year plan – Roadmap for Behavioral Health Reform: Ensuing the right treatment when and where people need it – launched in February 2021 and was based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to more effective treatment and improved health equity.

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

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

The Roadmap also proposes to:

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

These reforms do not replace or disrupt existing services or provider relationships – rather they aim to help individuals and families more quickly and easily fully access the range of comprehensive services offered across the Commonwealth. The Roadmap provides more convenient community-based alternatives to the emergency department for urgent and crisis intervention services and more readily available outpatient services, including same-day evaluation and referral to treatment, and ensures residents can access integrated behavioral

health care which serves the entire person. In short, the Roadmap creates a no-wrong door approach to treatment by encouraging multiple points of entry with same-day access, integrating addiction and mental health services, and providing community-based crisis response while upholding evidence-based practices.

Mental health is envisioned as an essential component of health care that serves the entire person with same day access, providing community-based crisis response and upholding evidence-based care standards. The Baker-Polito Administration is investing $40 million in SFY21 to expand inpatient bed capacity, and the Governor's proposed SFY22 budget includes $84 million, plus $70 million from the SUD Trust, to support the public sector components of the Roadmap. Over the next three years, estimated new public expenditures will increase to over $200 million with commercial insurers being engaged to commit and engage in Roadmap reforms.

COVID-19 Supplemental Funds and American Rescue Plan Act Funds

Consistent with SAMHSA's guidance for strengthening behavioral health access, the DMH will use COVID-19 Supplemental funds and American Rescue Plan Act (ARPA) funds in service of the aforementioned Roadmap in order to augment existing services while planning for future system enhancements, including the development of the Roadmap's Front Door strategy. These cross-agency efforts involve coordinating the use of MHBG funds with funds awarded to DMH's sister EOHHS agencies including the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) and MassHealth, the Commonwealth's Medicaid agency. Along with its sister agencies, the Department is committed to serving the needs of persons living with a serious mental illness (SMI) or serious emotional disturbance (SMD), in particular those identified as disproportionally impacted by COVID-19 including Black, Indigenous, and People of Color (BIPOC) and/or Latinx individuals and individuals who identify as LGBTQ.

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

- Addressing the significant increase in behavioral health boarding episodes in Emergency Departments (EDs);

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

One hundred and eighty-two (182) responses were submitted from a variety of stakeholders and are undergoing a preliminary review, in advance of a more in-depth analysis. In addition to the priorities identified above, stakeholder feedback identified gaps and possible solutions across the crisis continuum of care including short-term residential stabilization beds, Mobile Respite, Emergency Respite, Peer Respite, and MassSupport/Mass 211 services. All of these service areas are described further throughout this MHBG application.

COVID-19 Supplemental funds will primarily be used to enhance MassSupport, an existing remote counseling program which is part of the Behavioral Health Redesign. MassSupport is an immediate and valuable resource for crisis services for adults, children, and families and is a key step toward reaching a centralized system as envisioned in the Roadmap. The goal is to eventually transform the program into a single call line where an individual can receive the right service and care at the right time. The centralized call center will provide individuals access to providers and real time clinical triage and service navigation accessible in multiple languages. Planning in collaboration with the EOHHS and its agencies will include technical assistance for the call center program, training call center staff, and evaluation of MassSupport and other DMH program enhancements. Additional funds from ARPA will expedite this work.

Additionally, DMH has utilized COVID-19 Supplemental funding to further enhance its Emergency Respite and Peer Respite capacity in order to provide more timely access to short-term stabilization services. These services are designed to function as diversion points from Emergency Departments and homeless shelters and facilitate safe transition plans for people with complex behavioral health needs. An expanded Respite is currently operational in the Northeast region. Additional enhancements will include services in Boston and the Southeastern region of the Commonwealth. ARPA funds will also further aid in the expansion of respite services.

The Department will further utilize ARPA funds to work with the EOHHS and MassHealth in the continued development of the Roadmap's Front Door strategy. Both short-term (i.e. immediate needs amplified by the pandemic and laying the groundwork for the Front Door) and long-term (i.e. Behavioral Health redesign through design, implementation, and enablement of the Front

Door) efforts will be funded. Further guidance toward specific uses of ARPA funds are evident in the clear themes identified in the RFI responses. These themes include workforce issues, technology, system collaboration and reaching communities, and expanding or enhancing services. Other areas touched upon from RFI feedback included school-based collaboration and integration of mental health services, ideas that address forensic populations, and disparity research that could lead to more recommendations.

DMH workforce related initiatives utilizing ARPA funds will complement Front Door efforts. The RFI process demonstrated widespread support for workforce development efforts which cut across programs, areas of need, and populations. These efforts include workforce training, technical assistance, and the development of a training curriculum to meet and address current and future workforce needs. Initial efforts may focus on specific communities to create pipelines between academic training programs and DMH-funded services. Further ideas include staff retention efforts, training specific segments of the workforce, peer training in crisis settings, alternatives to suicide training, the support of career pipelines, and the recruitment of BIPOC into the mental health field. First Episode Psychosis funds will also address workforce development as well as triage support. Finally, both MassHealth and BSAS have identified workforce development and capacity building as a primary gap too, and DMH will work collaboratively with its sister agencies to address the critical workforce needs essential for meeting the demand for services.

The DMH intends to address Information Technology Infrastructure (ITI) issues using ARPA funds in two phases to enhance provider reporting and promote greater health information. The primary concern in Phase 1 is managing clients' movement through the service system, in particular enabling them to easily access housing resources. Also, of immediate concern is the Department's capacity to monitor vendors' staff vacancies and to enable DMH Site office staff to electronically process service applications. Previous resource constraints lead to the combined use of databases and spreadsheets to collect data and manage business functions. In Phase 2, DMH will use ARPA funds to promote health information exchange (HIE) and engage technology vendor(s) for the Front Door system, including a decision support tool for triage, searchable database for Navigation to enhance access, and a clinical capacity transparency tool. DMH will also provide support for the Network of Care searchable database which is consistent with RFI responses calling for assistance with navigation within the system for housing, individuals in EDs, and navigators in community settings and colleges.

This commitment to ITI will help expand the current capacity and infrastructure for the Roadmap. Improvement in DMH's IT infrastructure will help providers share information to aid in care delivery. Enhancing the ability of providers to submit key encounter and utilization data to DMH will contribute to a more streamlined approach towards assuring persons receive the

appropriate services at the appropriate time. Furthermore, improving the HIE will ease provider burden in meeting data submission requirements of DMH and possibly MassHealth.

ARPA funds will also address critical issues regarding Emergency Department (ED) boarding, crisis services, and access. Funding from the ARPA will aid in the critical work underway in reducing the wait time individuals with SMI or SED. Work to address ED Boarding includes improved ITI enhancements that will help identify cases of those not placed in an inpatient psychiatric facility or program a timely manner. DMH will explore ideas received through the RFI process that seek alternatives to ED boarding and treatment within the ED that could help bridge to community-based programs and possible peer and other supports within the ED to aid in that connection. Such improvements will contribute to greater speed in accessing needed care outside of the ED and hopefully identify and implement alternatives to the ED.

Furthermore, system collaboration was a main emphasis of many responses to the RFI DMH published to seek external feedback. Collaboration ideas went beyond working within other departments or agencies within state government to include libraries, schools, high education institutions, hospitals, police, and courts. Working with these organizations will enhance or help expand services and aid in reaching underserved communities to increase capacity. As DMH further reviews responses received through the RFI, it is encouraged in the knowledge it will gain in potentially uncovering innovative ways to engage those with SMI and SED.

Regulations

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

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

Commonwealth. DMH regulations also support implementation of telemedicine under clinically safe and appropriate circumstances.

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

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

In January 2018, DMH implemented a new initiative designed to reduce the time patients waiting for inpatient psychiatric hospitalization wait ("board") in general hospital Emergency Departments (ED). Under the direction and with the support of the EOHHS Secretary, DMH chaired a 2016 Task Force charged with developing a strategies to intervene and shorten long waiting times. The resulting Expedited Psychiatric Inpatient Admission (EPIA) initiative requires the hospital to alert health insurers to start searching for a placement bed at 48 hours post emergency department admission initially, and now at 60 hours, and to go outside of the insurer's regular network of providers if necessary. If unsuccessful at 96 hours, the patient's case is referred to DMH, which engages in direct intervention with EDs, inpatient providers, and payers to find appropriate placements. Between January 1, 2018 and the onset of the pandemic, more than 600 individuals were placed through the EPIA. The onset of the pandemic brought a brief lull in the number of referrals to DMH. Beginning in August 2020, however, the number of referrals expanded dramatically rising to a total of 742 in October 2020 and then leveling at close to 600 monthly. This has been due in part to increased demand for psychiatric services, as well as to decreased supply in beds, as the result of infection control requirements. The increased demand is also likely the result of the strain the pandemic has imposed on outpatient community mental health services.

In addition to DMH regulations, DMH and its providers are subject to the regulations issued by the Commonwealth's Executive Office of Health and Human Services. These regulations include

requirements for conducting Criminal Offender Record Checks on potential employees, trainees, and volunteers.

Defining the Target Population

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

Human Rights

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

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

The Office for Human Rights has organized a REI (Race, Equity and Inclusion) in Human Rights work group. The work group has undertaken the issue of inadequate hair care products and

tools for clients of color in DMH facilities with the goal of ensuring clients of color have hair care products that are safe and appropriate for textured hair and culturally meets their hair care needs. In order to best advocate, the REI workgroup met with the DMH Commissioner, the Directors of Contract and Budget, and facility Chief Operating Officers to order these products and make them available to all clients. The REI in Human Rights work group collected and analyzed racial demographic data, and data on what hair care products and body care products each program had available. The data helped tell a story of the blind-spots DMH had related to hair care and total body care products for clients of color and advocated for changes in practices to ensure these products are readily available through statewide vendors, suppliers, and buyers.

Office of Race, Equity and Inclusion

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

- The OREI focuses on the following areas:
- System Transformation – Policies and practices that promote race equity and social justice in all DMH programs and services;
- Community Partnerships – Partner with mental health providers, community organizations, DMH area staff, and government agencies to raise multicultural communities' awareness of mental health issues and provide information on where to seek help. Continue to develop relationships with community organizations that have expertise in serving or outreaching to multicultural communities;
- Services – Strengthen culturally and linguistically competent services throughout the entire DMH service delivery system. Ensure DMH-operated programs are linguistically competent by providing a variety of language access resources that help DMH staff communicate with non-English speaking clients (such as in-person interpreting, phone interpreting, document translation, and bilingual flashcards);

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

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

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

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

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

Further, DMH amended the gender reporting fields within its Mental Health Information System (MHIS) to better reflect an individual's identification. Once implemented, DMH will be enabled to target services based on the needs of its persons served. The new fields include

gender identity, sexual orientation, and pronouns. Any new clients will have this information included in their medical record, and the goal is to update the records for all current clients by the end of the year.

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

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

- Trainings for hiring managers to promote diversity and address implicit bias;
- Professional development and retention strategies such as development of a pipeline into a career with DMH via internships for students of color from local colleges and universities;
- Development of trainings to promote respect and civility in the workplace and address microaggressions;
- Listening Sessions for staff of color following the murder of George Floyd and the shooting in Atlanta of the Asian women; and
- Recognition and promotion of staff via mini-presentations to support specific events (Black History Month and Deaf History Month 4-part series for each);
- Procurement of DMH services and the development and review of RFIs, RFRs, and RFPs for services;
- Working with Service Authorization to ensure that staff were accurately collecting race data for applicants; and
- Providing training for all Service Authorization staff which will extend to Case Management staff.

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

In a similar vein, OREI put together a series of mini-activities related to Black History Month, and also Deaf History Month. These were intended to be varied types of events, short (only one hour) to get as much participation as possible, and that supplement employee awareness and knowledge. While local offices have offered activities such as this in the past, this was the first time in recent history that DMH has offered agency-wide Black History Month and Deaf History Month events.

DMH has the oldest and largest interpreter service program of all state agencies (based on oral interpreting versus written translation). As such, DMH provides language access to clients at various points throughout their treatment, including both inpatient and outpatient services. Supplementing the provision of interpreter services is the provision of translated versions of key documents. Additionally, DMH provides interpreter services to the general public for any community events, as well as translations of educational materials that are for public consumption.

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

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

Finally, DMH conducts a Consumer Satisfaction Survey each year. As part of this effort, OREI facilitates the translation of the survey, and any responses, into multiple languages including Spanish, Portuguese, Cape Verdean, Haitian Creole, Chinese (Traditional and Simplified),

Vietnamese, and Khmer. This survey is conducted for both adult consumers as well as consumers in the Child, Youth, and Family division.

Training for Mental Health Providers

DMH offers a rich menu of ongoing professional development opportunities including mandatory training on critical, mission-driven topics supporting person-centered, trauma informed, and recovery-oriented care through core topics, evidence-base practices (i.e. Motivational Interviewing, Medication Assisted Recovery, First Episode Psychosis, Zero Suicide, C-SSRS, QPR, CAMS, Seeking Safety, the Social Resilience Model, and promoting resources for Family Talk) as well as conferences such as best practices for Mental Health in Law Enforcement, Deaf services, Dual Recovery, Mental Illness and Problematic Sexual Behavior, and other topics selected annually within regions to continuously develop staff skill sets.

The Learning and Development Division serves DMH's entire workforce in order to support the implementation of evidence-based programs and other Promising Practices. A Dialogic Educational model is utilized to engage learners in order to optimize the adult learning experience by continuously assessing learner needs and adjusting content and facilitation methods to best meet those needs. Although we continue to develop our expertise in this methodology, we have seen a positive impact in the learner experience from implementing this approach for the last several years and assessing program effectiveness.

The Learning and Development team is comprised of a diverse representation of the workforce including seasoned clinicians, staff with direct care experience, and a number of subject matter experts who bring their knowledge to bear in the development of curricula that reflect current best practices. The agency embraces recovery orientation and vets all presenters to ensure their content is aligned with our mission and values around trauma-informed, person-centered, and recovery-oriented care. When developing curricula, members of the Learning and Development Office apply these values into all courses, ensuring this is a thread that is woven into all learning experiences, reinforcing how all policies, procedures, and interactions should promote these guiding principles. Among the curricula developed in-house are Overview of Mental Health; Motivational Interviewing (a number of DMH staff are MINT level trainers); Safety, Hope, and Healing (a trauma-informed approach to maintaining a safe treatment and work environment required upon hire and annually thereafter); Compassionate Framework which emphasizes the mission and values of DMH as trauma-informed, person-centered, and recovery-oriented; and Substance Use Foundations.

DMH also designed a website specifically for Child, Youth, and Family providers, the Children's Behavioral Health Knowledge Center. This site shares numerous rich resources for providers

and families to readily access information related to evidence-based practices such as Family Talk, Parenting Well (toolkit), and In Home Therapy practice profile and webinars.

DMH researched and selected a new curriculum to optimally support safety in all care settings that relies heavily on violence prevention and trauma informed care. In preparation for implementation, a Steering Committee comprised of agency stakeholders began planning the roll-out which included corporate culture workshops for leaders to prepare the organization for implementation. This initiative was put on hold due to the pandemic as the training of trainers has an essential in-person component.

Furthermore, as part of an ongoing Zero Suicide initiative, multiple learning activities are ongoing including training of all workforce members in the Question, Persuade Refer (QPR) curriculum, implementation of the Columbia screening tool in multiple settings, and the implementation of CAMS and continuous assessment of care environments with regard to suicide prevention best practices. Two regions have supported practices to address First Episode Psychosis through educational opportunities for implementing this evidence-based practice. And all regions hosted training for the Agency's "Reframe the Age" initiative, designed to address the needs of Transition Age Young adults whose needs may be better met by providing a range of services across the Child, Youth, and Family system as well as the Adult service system. A regulatory change along with professional development to cross-train divisions and implement evidence-based practices for this age range of adults continues to promote a more smooth transition to adulthood with their unique developmental needs in mind.

Finally, DMH values continuous improvement of the learning agenda and resources and as such, uses ongoing evaluative processes to assess needs and improve offerings. A direct link to DMH's Learning Calendar is located on the desktop of all workforce members, and this link is accessible to provider staff and the community at large to readily view opportunities for ongoing professional development that support their work, particularly on topics that supplement clinical knowledge on evidence-based practices and topics that address ongoing systemic issues such as Understanding and Interrupting Racism.

Research

To carry out its statutory research mission, DMH has operated two Research Centers of Excellence for more than 20 years through contracts with Massachusetts' lead academic centers. These Centers have worked in close alignment with DMH to conduct research that furthers DMH's mission and service principles and advances the prevention, early identification, diagnoses, treatments, service programs, rehabilitation, and recovery of adults with serious

mental illness and children and adolescents with serious mental illness or severe emotional disturbance. DMH funds are used to support the infrastructure of each Center of Excellence. Other funding is sought from public and private agencies and organizations for its core research, and to allow the Centers to engage in activities that traditional external funders don't currently support, e.g. time necessary to develop mutual partnerships with communities

In 2018, DMH issued a procurement for the two current Centers of Excellence: Center of Excellence for Systemic and Psychosocial Research and Center of Excellence for Public Mental Health Services and Implementation Research. This procurement was exciting and different in several ways:

1. The substantial work in "services research" has created both the need and opportunity to invest more in implementation science, i.e., the study of methods to promote the adoption and integration of evidence-based practices, interventions, and policies into routine mental health care and mental health settings. Services research evidence is increasingly available but used inconsistently. Adaptations of evidence-based and research-informed services are generally not evaluated in a manner that continues to build the research base. DMH decided it is a priority to have a center focused on implementation science in order to support DMH and the larger Massachusetts behavioral health system in the implementation of evidence-based practices. Thus a hard decision was reached to change the focus of what had been the Research Center of Excellence for Clinical Neuroscience and Psychopharmacological Research into a new Center of Excellence for Public Mental Health Services and Implementation Research.

2. DMH wanted the work of both Centers to more directly and quickly respond to the needs and priorities of DMH and the people that utilize DMH services - consistent with the focus of federal research grants on "translational research" or research that is responsive to acute issues or needs, quickly disseminates findings, and works collaboratively with communities impacted and served.

3. DMH wanted the Centers to prioritize person-centered racial equity and inclusion both with actual research endeavors and with operations of each center, e.g. collaborate with communities who have not traditionally been engaged as partners in research and create a work environment and opportunities within the Centers to raise up staff who reflect the heterogeneity of MA residents.

The Center of Excellence for Systemic and Psychosocial Research was awarded to Massachusetts General Hospital (MGH) with Cori Cather, PhD as the Center Director. The mission of the Center of Excellence for Systemic and Psychosocial Research is to advance the

treatment, rehabilitation, and recovery of adults with serious mental illness and children and adolescents with serious mental illness or severe emotional disturbance through the conduct of psychosocial, forensic, and program/services research. The Center of Excellence for Systemic and Psychosocial Research is expected to provide broad leadership in conducting research that advances services for people at-risk for or experiencing serious mental illness or severe emotional disturbance, promote the rapid translation of research knowledge into practice, and inform health systems and policy.

With the FY18 procurement, MGH assumed the contract for the Center of Excellence (COE) for Systemic and Psychosocial Research with the renewed focus on person-centered outcomes research and racial equity and inclusion and a sub-specialty in early psychosis. MGH has worked to establish collaborative relationships with peer consultants who provide a critical link to diverse communities across the state and infuse their work with person-centered language, perspectives, and relevance. In the brief time since the contract was awarded they have developed several strong community partnerships and co-created with these communities four new projects, all of which are aligned with the goal of improving racial equity.

Their faculty and staff have received $150,000 in new research funding; published 42 articles; and delivered 57 presentations.

MGH COE Peer Consultants developed a video about parenting with mental health or substance use challenges designed to reduce stigma, decrease feelings of isolation, and foster hope and therapeutic optimism. MGH COE faculty partnered with DMH, MAPNET, and NAVIGATE trainers and provided training and consultation in the NAVIGATE model of Coordinated Specialty Care for first episode psychosis with the goal of improving capacity in this evidence-based practice in the community. MGH COE supported ten research and quality improvement projects that involved either a direct intervention for predominantly Black, Indigenous, and People of Color communities, or an analysis of the extent of racial inequity in systems of care or society.

Many of MGH Center staff provided tremendous leadership and direct service in response to the crisis associated with COVID-19, among these were the following:

- Dr. Derri Shtasel's leadership of the Division of Public and Community Psychiatry and relationship with Boston Health Care for the Homeless played a critical role in establishing and implementing a robust behavioral health framework for the 500 respite beds for homeless COVID-positive individuals as part of Boston Hope, a 1,000-bed facility created by Partners HealthCare to serve post-acute and homeless patients with COVID-19;

- Dr. Daphne Holt's MGH Resilience and Prevention team developed and made publicly available a 3-session video course to support frontline healthcare providers working tirelessly to care for those infected with COVID-19; and

- Dr. Oliver Freudenreich worked with DMH and international colleagues to delineate clinical guidance to assure continuity of care for patients with SMI, with emphasis on uninterrupted treatment with antipsychotics. Guidelines were established for clozapine and long-acting injectables, as a change in care delivery was necessitated due to the need for in-person contact associated with these treatments. An influential publication (Siskind D et al, 2020) with senior author Dr. Oliver Freudenreich, established a framework for using clozapine safely during COVID-19. This guidance is consistent with FDA guidance, was endorsed by DMH and other agencies across the state, as well as being adopted outside the United States.

The Center of Excellence for Public Mental Health Services and Implementation Research (iSPARC) was awarded to the University of Massachusetts Medical School (UMMS) with Maryann Davis, PhD as the Center Director. The mission of the Center of Excellence for Public Mental Health Services and Implementation Research is to conduct, disseminate, and support the use of research in the public mental health system to improve the lives of adults with serious mental illness and children and adolescents with serious mental illness or severe emotional disturbance. The public mental health system is defined as all the public, private, and voluntary entities that contribute to the delivery of essential mental health services in the Commonwealth. The Center conducts research and evaluates the needs, practices, programs, and service delivery models that comprise the public mental health system. As funding allows, it provides technical assistance on the use of research evidence, implementation of research findings and evidence-based practices, and continuous quality improvement efforts.

In FY20, UMMS faculty and staff of iSPARC, the new Center of Excellence, were able to maintain a high level of success as an academic research center that was evident throughout the previous 20 years when UMMS held the contract for the DMH Center of Excellence for Systemic and Psychosocial Research. These successes were maintained throughout a particularly challenging year for the Commonwealth and the nation—a year in which our lives were upended by a global health pandemic and a national uprising against the ongoing oppression of people of color.

Their faculty and staff received $8,224,124 in new research funding; submitted 24 grant applications; were awarded 14 new grants and contracts; submitted 41 peer-reviewed journal articles; and published 46 peer-reviewed journal articles.

In FY20, iSPARC leveraged DMH's investment to rapidly translate findings from mental health services and implementation research into best practices for individuals with lived experience,

their families, and the providers who serve them across the Commonwealth. With their Youth and Family Advisory Boards, iSPARC developed a series of brief products to provide guidance during the pandemic:

- Working from Home During the COVID-19 Pandemic: Tips and Strategies to Maintain Productivity & Connectedness
- Maintaining Your Emotional Wellness During COVID-19
- Finishing College Classes During COVID-19
- Coronavirus Economic Stimulus Payments: Who Gets It, How, and Impact on Other Benefits
- Parents Chime In: Our Self-Care Strategies While Supporting Loved Ones with Mental Health Conditions During a Pandemic
- How Young Adults Can Manage Loss of Income During the COVID-19 Pandemic
- Should I Attend College in the Fall? Questions for Students with Mental Health Conditions to Consider

Both Centers of Excellence are expected to:

- Leverage and enhance the impact of an Academic Center that has an active research portfolio focused on public mental health by funding research strategies and activities that are not supported by traditional basic research funding;
- Conduct research consistent with the DMH mission and service principles including person-centered outcomes research (https://www.pcori.org/) and implementation research;
- Facilitate the rapid translation and dissemination of research findings for providers, persons served, and the larger community;
- Shift the culture and operation of research by actively engaging potential research users and beneficiaries, including DMH staff, its operated and contracted programs, mental health service users, family members, service delivery partners, and stakeholders from across the state in order to produce research that is both relevant and rigorous;
- Conduct research in real-world settings and with the specific communities and populations served by DMH and other providers across the state in the public mental health system;

- Provide avenues for graduate students, postdoctoral researchers, and new investigators to develop independent research careers as principal investigators with their own funding; and

- Collaborate with each other and with the Children's Behavioral Health Knowledge Center (http://www.cbhknowledge.center/), DMH service delivery partners, community-based organizations, advocates, and stakeholders across the state in the public mental health system on both the conduct and dissemination of research.

In FY20, DMH worked with the two Centers to develop a Racial and Ethnic Equity Evaluation Plan for use across both Centers of Excellence. At the time of this report, iSPARC at UMMS and MGH have successfully collaborated to streamline measures to evaluate equitable continuous quality improvement (to be used during the planning phase of research), equitable research (to be used before, during, and upon completion of a research project), equitable stakeholder engagement, equitable center operations, and equitable workforce development.

Finally, as required by federal law and state regulation, DMH's Institutional Review Board (IRB) 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 approximately fifty research studies taking place within DMH facilities and around twenty new studies are reviewed and approved each year. The IRB Chair oversees the Research Centers of Excellence.

Addressing Early Serious Mental Illness

The Department of Mental Health recognizes the importance of addressing early serious mental illness and in conjunction with academic researchers at Beth Israel Deaconess (BIDMC), a Harvard Medical School hospital, developed the Prevention and Recovery for Early Psychosis treatment program, PREP East in 2004. With the Mental Health Block Grant (MHBG) First Episode Psychosis (FEP) Set-Aside funding, DMH established PREP West in 2015 in order to provide access to FEP Coordinated Specialty Care (CSC) and evidence-based practices to residents of Western Massachusetts. The Commonwealth has also benefited from other early leaders in FEP services who are affiliated with the Harvard and University of Massachusetts Medical Schools (e.g. Mass General Hospital, McLean, Cambridge Health Alliance, Children's Hospital, and Community Health Link). In 2017, FEP Set Aside funds were used to establish Massachusetts Psychosis Network for Early Treatment (MAPNET), a FEP evidence-based practices Technical Assistance Center. FEP Set Aside funds are also used to enhance existing FEP programs by supporting staff positions and/or responsibilities necessary for adherence to CSC (e.g. employment specialists and/or staff time for team meetings and EBP training and supervision) that are not third party reimbursable. More recently DMH has partnered with

NAVIGATE to establish FEP CSC programs in three community clinics in the Northeast region of Massachusetts where there have been no FEP specific services.

Beginning in 2019, MA began its FEP strategic planning process with active engagement of stakeholders from across the state. Repeatedly stakeholders have identified access to specialized services (e.g. comprehensive assessment and treatment) as an urgent need. DMH plans to address this in part by expanding the capacity of a current DMH-supported program which is affiliated with the CEDAR clinic at the Brookline Mental Health Center (BMHC). BMHC currently fields 40-50 calls per month from clinicians, consumers, and families who are seeking help with finding resources to evaluate or treat psychotic symptoms or signs of clinical high risk. BMHC will provide a dedicated, accessible, triage, and navigation hub (Hub) staffed by knowledgeable clinicians, care coordinators, and peer specialists who provide on-demand information, consultation, support, and care coordination including facilitated referrals to programs, thereby minimizing the burden on families and referring providers.

BMHC will also build upon BMHC's BRYT programs, a network of embedded mental health services in over 150 school systems (representing 40% of youth in Massachusetts) to more expeditiously identify and direct youth experiencing early signs and symptoms of psychosis and their families to the HUB for assistance. BMHC will use the BRYT network to rapidly promulgate information about early identification and to develop referral links between the school staff at these schools with the Hub. The BMHC Hub will work in close collaboration with the Massachusetts Behavioral Health Front Door initiative and other help line and community resources to ensure maximal coverage. Finally, as a way of expanding the capacity of the mental health system to recognize and treat individuals' early signs and symptoms of psychosis, the triage and navigation Hub will work closely with MAPNET to provide consultation, training, and support to behavioral health providers across the state so that treatment can be initiated immediately. This will also relieve some of the pressure on the early psychosis programs that lack capacity to currently treat all who need specialized care.

Recognizing the need for specialized early psychosis services for younger adolescents and inspired by the PREP program at the Massachusetts Mental Health Center, DMH has established a milieu treatment for youth 12 to 18 based upon the PREP model which is unique among early psychosis programs because it has had a social milieu – Life Skills: Learning And Readiness for Resilient Youth (LARRY) – utilizing CYF state funds and the CYF Lifeskills contract with Riverside Community Care. The CYF Lifeskills contract provides for a day treatment program for youth with a variety of mental health problems to receive intensive treatment planning, social connection, social skills training, and help with coping skills. Youth typically attend for three to six months. LARRY is a specialized Lifeskills program designed to serve youth at various stages in the development of psychotic illness. In 2020 the Lifeskills LARRY program

opened its doors virtually and also has a physical space awaiting its use in Somerville. The program employs two full-time social workers, one full-time licensed mental health counselor, a direct care worker, and a half-time peer counselor. MAPNET provides consultation and training to the staff in assessment and treatment of early psychosis with a focus on the NAVIGATE model of CSC as appropriate. Although the benefit of its milieu intervention has not been studied with objective methods, LARRY has been hugely popular among the people who have received treatment and their families.

DMH has also recognized the need to provide early psychosis services beyond the walls of traditional clinics in order to enhance access and engagement. With MHBG funds, PREP West has expanded staffing to deploy a clinician and certified peer specialist to meet with youth and their families in their homes or other community based settings as requested. This team provides information about the program, initiates the comprehensive psychodiagnostics assessment process, and has been able to engage people who were initially reluctant to obtain services. Building on this work, DMH is piloting the use of the CYF Flexible Support Services (FLEX) contracts to provide home and community based engagement and support services for youth experiencing early psychosis and their families. FLEX services are intended to strengthen the well-being of youth and their families, build family cohesion, and prevent the need for more intensive services. In concert with the investment in three FEP CSC programs for the Northeast Area, the Northeast Area contracted for a specialized FLEX team to serve the needs of youth experiencing psychosis and their families. The FLEX team is operated by JRI which is one of the three new clinic based FEP programs. Both services are overseen by the same masters level clinical team leader. FLEX Services are delivered to the youth, parent or caregiver, and/or siblings in their home and community primarily during after school, evening, and weekend hours. Transportation is arranged or provided, as needed, to support the youth and family in meeting their Community Service Plan goals. Flexible Support Services provide ongoing in-person, phone, and email support to the youth and family and link them to needed services, supports, community resources, and opportunities that the Flexible Support Service Provider is unable to provide. The JRI Early Psychosis FLEX program employs one full-time social worker, one-half time family partner, and two young adult peer mentors.

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

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

informed. DMH expects all individuals served to have all of their needs identified, assessed, and treated in all services and programs.

Under the direction of the Medical Director for the Office of Inpatient Management, DMH has implemented a multi-phased work plan that includes offering a range of professional development opportunities for staff across the organization. Topics included the neuropsychology of addiction, motivational interviewing for substance use, and harm reduction. Facilities have implemented standardized protocols for Medication Assisted Recovery and approximately 80 DMH clinicians across the continuum of care have participated in training on the ASAM criteria. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

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

To increase access and the quality of services, DMH has been an active member of an Interagency Work Group (IWG) established by the Department of Public Health in 2001 that meets monthly. Membership includes the Departments of Children and Families, Youth Services, Developmental Services and Transitional Assistance, the Massachusetts Behavioral Health Partnership, the Juvenile Court, the Parent Professional Advocacy League, and selected substance abuse providers as well as DMH. The IWG goals are to build common understanding and vision across state systems; design and implement a community-centered system of comprehensive care for youth with behavioral health disorders that incorporates evidence-based practice; coordinate service delivery across systems; and simplify administrative processes and purchasing strategies to maximize federal and state dollars.

DMH and the Massachusetts Department of Public Health’s Bureau of Substance Addiction Services (BSAS) collaborate on a number of initiatives related to the planning of services for people with co-occurring substance use and mental health conditions with current emphasis on implementing Governor Baker’s landmark legislation, Chapter 52 of the Acts of 2016 – An Act relative to substance use, treatment, education and prevention – including recommendations from the Governor’s Opioid Working Group. These initiatives and collaboration affect various DMH work related to co-occurring disorders.

The Massachusetts Department of Public Health (DPH) contracts with 26 community-based treatment providers across the Commonwealth to open new specialized residential rehabilitation treatment programs to serve individuals who experience substance use and mental health disorders. The programs, which include 398 treatment beds, represent a significant expansion of services to individuals who are at higher risk for a fatal opioid-related overdose and will increase their opportunity to access treatment for both diseases in a single program. Surveillance of the opioid crisis indicates that the risk of a fatal opioid-related overdose is six times higher for people diagnosed with a serious mental illness and three times higher for those diagnosed with depression. In addition, DPH data on patient enrollment in BSAS-funded treatment programs showed a high percentage of enrollees had prior psychiatric illness.

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

The Women's Recovery from Addictions Program (WRAP) at Taunton State Hospital continues its success in treating women civilly committed to care for a period of up to 90 days under MGL 123 Section 35 when it is determined that their substance use disorders are associated with a risk of harm to themselves or others. WRAP is licensed as an Opioid Treatment program delivering detoxification and clinical stabilization services with linkage to an aftercare component. Developed with close BSAS collaboration, the program delivers trauma-informed, person-centered, dual diagnosis treatment integrating the six ASAM dimensions of care with SAMHSA's eight dimensions of wellness. The program operates nine distinct group therapy sessions daily plus individual therapy. A bridge between the WRAP and community services helps to stabilize clients newly returned to the community.

Beginning in the summer of 2020, DMH developed a plan to expand its Recovery from Addictions Program (RAP), on the grounds of Taunton State Hospital, with four new units for

men. The new men's units will be operated in combination with the Women's Recovery from Addictions Program, and together they will make up the Recovery from Addictions Program (RAP). The men's units will add an additional 75 beds to the current 45 bed WRAP. Combined, the Recovery from Addictions Program will be 120 beds (45 women and 75 men) in seven units. As with the WRAP, the men's program has two levels of care: Enhanced/Acute Treatment Services(E/ATS) and Detoxification and Clinical Stabilization Services (CSS) in addition to Aftercare Services. RAP will provide an enhanced clinical treatment program for men who have been civilly committed for treatment by Massachusetts courts under MGL Ch.123, section 35, due to concerns about risk related to substance use, up to and not to exceed 90 days. The RAP provides withdrawal management services (Acute Treatment Services) as a medically monitored detoxification program along with a clinically managed detoxification program that will have extensive supportive recovery-oriented services. The clients will arrive to the facility from the courts under the Massachusetts civil commitment statute that mandates treatment of individuals with substance use disorders who have been determined to pose a danger to themselves or others (Mass General Laws c. 123, s. 35). It is anticipated the program will have a high proportion of clients with co-occurring mental health conditions. The enhanced program staffing will reflect the complexity of addressing both the substance use disorder challenges and other behavioral health and medical challenges the clients face. Construction on the new units should be completed by July 2021.

Suicide Prevention

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

Treat, Transition) as the framework to set expectations for contracted services, e.g. evidence based screening, assessment, safety planning, transitions support, and treatment planning.

Even with this strong commitment to better address suicidality, the needs are great and there is a gap between the aspirational goal and the ongoing challenge of assuring the delivery of effective suicide prevention services. DMH staff are brilliant multi-taskers and passionate about instituting exemplary suicide prevention practices. The multi-disciplinary members of the DMH statewide Zero Suicide committee bring both the wisdom of many years in their roles across the DMH system (CYF, adult, inpatient, outpatient, community, forensic, peer, human rights, racial equity and inclusion, data, training, etc.) and the reality of the multitude of demands they each manage and that the system as a whole manages. DMH has benefited from the opportunity to obtain SAMHSA Suicide Prevention grants to provide dedicated staffing on a short-term basis. DMH's efforts to instill effective suicide prevention strategies across the DMH and larger behavioral health system would be greatly advanced with additional resources, e.g. dedicated staff, to support the enormous amount of ongoing work to assure meaningful implementation of and fidelity to current best practices in suicide prevention.

Suicide prevention efforts in Massachusetts are funded largely through a separate line item in the state budget for the Massachusetts Suicide Prevention Program (MSPP) at the Department of Public Health. Each year both legislative bodies and the governor include more than five million dollars dedicated specifically to suicide prevention in the MA state budget. The MSPP funding supports suicide prevention services targeting veterans, older adults, college and university students, youth and young adults, mid-life adults, GLBT youth, and transgender people. MSPP also oversees the analysis and publication of annual data on suicide and self-inflicted injuries, and responds to requests for community/cohort specific data.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention (MCSP), working in close collaboration with the MSPP at DPH and DMH. The MCSP is a broad-based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, suicide survivors, mental health and public health consumers and providers, and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth. From its inception, the MCSP has been a public/private partnership, involving government agencies including DPH and DMH working in partnership with community-based agencies, academic researchers, and people with lived experience of suicide loss and suicide attempts working together across a network of regional and local suicide prevention coalitions. The initial State Plan was released in 2009, modified in 2015, and currently undergoing review and revision. It provides the framework for identifying priorities, organizing efforts, and contributing to a statewide focus on suicide prevention. DMH staff work closely with the MSPP staff to advance

the goals of State Plan, particularly around the importance of developing services informed by people with lived experience (e.g. survivors of suicide attempts, impacted friends and family, and suicide loss survivors); the implementation of Zero Suicide among MA healthcare provider organizations; and the dissemination of suicide prevention evidence-based practices.

Since 2012, the MSSP at DPH and DMH have forged a strong collaborative relationship, particularly around the dissemination of Zero Suicide to Massachusetts' health care systems. Massachusetts is proud to have been awarded the Garrett Lee Smith (GLS) grant four times, most recently in 2015. As an indication of the close collaborative work between MSPP and DMH, in 2017 DPH and DMH partnered to submit an application for the National Strategy for Suicide Prevention (NSSP) grant and were successful in garnering an NSSP grant for Massachusetts that is administered by DMH. Both the 2015 DPH GLS application and the 2017 DMH NSSP application reflect the state's continued commitment to adopt and promote Zero Suicide among Massachusetts' health care systems. Most recently MA suicide prevention efforts have benefited from several additional federal grants: 1) MSPP was awarded a grant to support the five state suicide prevention call centers to become credentialed call centers for the National Suicide Prevention Lifeline (NSPL) and to increase in-state response rates; 2) MSPP was awarded the first Comprehensive Suicide Prevention grant through the Centers for Disease Control (CDC) to reduce suicides among specific vulnerable populations, particularly males, Hispanic/Latinx, veterans, and specific occupations with high suicide rates; and 3) DMH was awarded a SAMHSA COVID-19 Emergency Response to Suicide Prevention (ERSP) grant to prevent suicide and suicide attempts among adults with particular emphasis for those populations (i.e. domestic violence victims) at increased risk during the pandemic because of social isolation.

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

The Massachusetts Zero Suicide Training Initiative: Massachusetts has developed in-state expertise on how to support effective dissemination and implementation of Zero Suicide in health and behavioral health care settings through efforts initially funded by the GLS grant and most recently work done under the NSSP grant. MSPP and DMH sponsored an initial 18 month Zero Suicide Learning Collaborative (ZSLCs) through the GLS grant for four hospital systems and six community mental health centers which wrapped up in late 2017. With the NSSP grant, DMH and MSPP completed a second 18 month ZSLC for providers representing the full continuum of care on the Cape and Islands. The third ZSLC, again a shared GLS grant and NSSP grant venture, focuses on Bristol County providers and community advocates across the lifespan and launched just before the COVID-19 restrictions on in-person gatherings were instituted. MSPP and DMH quickly pivoted to a virtual medium and redesigned the method for

providing training and implementation support for Zero Suicide and the associated suicide prevention evidence-based practices.

The Massachusetts' ZSLC initiative has benefited from the inclusion of the Massachusetts Medicaid behavioral health carve out entity, Beacon Health, that contracts with and monitors 1,200+ behavioral health providers, including many of the providers integral to effective suicide prevention and implementation of Zero Suicide. Beacon Health has been an early adopter of Zero Suicide as a payer. Additionally, the ZSLC effort was enriched by the participation of researchers at the University of Massachusetts Medical School (UMMS) who are engaged in supporting and evaluating the implementation of Zero Suicide in the UMMS associated healthcare system (UMass Memorial) through an NIMH grant. DMH, DPH, and Beacon Health are working with our statewide system of 24-hour psychiatric emergency service providers to standardize suicide risk screening and assessment and brief interventions, including safety planning and counseling on access to lethal means and to institute follow-up support following an ED or inpatient admission for suicide.

Massachusetts Annual Suicide Prevention Conference: DPH, DMH, and MCSP co-sponsor and organize the annual Massachusetts Suicide Prevention Conference. The conference attracts hundreds of participants each year from across Massachusetts and neighboring states. In addition to national leaders in suicide prevention, conference sessions target a range of audiences including individuals with lived experience of suicidality; family and friends who've experienced suicide loss and/or loved ones' suicide attempts; first responders and community advocates; and health care providers. With COVID-19 restrictions, the conference successfully shifted to a virtual medium for 2020 and 2021.

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

Regional Suicide Prevention Coalitions: In addition to the statewide coalition for suicide prevention, Massachusetts provides funding for ten 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.

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

Indian Health Services and Health and Human Services for the Mashpee Wampanoag Tribe: Beginning in 2017 under the NSSP grant, DMH and MSPP provided consultation and support to Indian Health Service to address suicide prevention efforts in the Southeast Area. DMH and MSSP staff also meet monthly with staff from Health and Human Services for the Mashpee Wampanoag Tribe to connect around suicide prevention, intervention, and postvention activities. This relationship is explored further in the next section of this document.

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

Governor's Challenge to Prevent Suicide Among SMVF: In May 2021, Governor Baker launched MA's participation in the Governor's Challenge for Suicide Prevention of Service Members, Veterans, and their Families (SMVF) and appointed DMH Commissioner Doyle as the co-agency lead with Secretary of Veteran Services, Cheryl Poppe. The Commonwealth's work under the auspices of the Governor's Challenge has blossomed into an inter-agency workgroup with over 35 individuals representing, MA National Guard, Department of Veterans Services (DVS), DPH, Riverside Trauma Center, HomeBase, Massachusetts Military Heroes, the School of Public Health at UMass (for evaluation support), the Veterans' Integrated Service Network (VISN 1), Jail Arrest Diversion Initiatives, Lowell VET Center, Air National Guard, Soldier On, New England Center for Veterans, MA House of Representatives Jerry Parisella, the Massachusetts Suicide Prevention Coalition, Trial Court, Bedford VA Medical Center, and DMH. Together they have provided additional impetus to Inter-Agency Suicide Prevention work among EOHHS agencies: MassHealth's Office of Behavioral Health, DPH Division of Sexual and Domestic Violence Prevention and Services (DVSDVPS), DPH BSAS, Department of Veteran Services, Massachusetts Rehabilitation Commission, and the Office of Elder Affairs. The Pre-Academy Virtual visit convened enthusiastic senior leaders and formed three work groups to complete a SWOT analysis on the following topics: 1) Screening and Identification; 2) Promoting Connectedness and Care Transitions and 3) Increase Lethal Means Safety and Increase Safety Planning.

DMH's internal suicide prevention efforts have been informed by the Zero Suicide method and has primarily targeted adults served in our inpatient facilities and in DMH adult community and outpatient services. DMH has incorporated the following strategies supportive of Zero Suicide:

DMH-wide: In FY17, then DMH Commissioner Mikula convened a DMH Suicide Prevention Steering Committee (DMH SPSC) to guide DMH's implementation of Zero Suicide across the continuum of DMH operated and DMH contracted services. The DMH SPSC is comprised of DMH staff from all five geographic services areas, child youth and family division, forensic services, inpatient, outpatient, and community services, recovery services, and quality management as well as community consultants with lived experience as attempt survivors. Informed by the recently updated Joint Commission standards, recent work has focused on the eight DMH inpatient facilities and implementing a standardized evidence-based approach to screening and assessing suicide risk, suicide specific treatment, discharge planning, and supporting transitions in care. The DMH Division of Clinical and Professional Services has responsibility for this task.

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

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

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

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

a. DMH instituted use of the Columbia Suicide Severity Rating Scale – Screener and an evidence based assessment process for mitigating suicide risk in all DMH inpatient programs.

b. The DMH Safety Plan workgroup has developed a comprehensive safety and wellness plan that incorporates elements from the Stanley Brown, the Copeland Wellness and Recovery Plan, and other person-centered coping and recovery strategies.

c. More than 80 staff across the DMH inpatient system have participated in CAMS training.

Adult Community/Outpatient: DMH piloted implementation of ZS EBPs across the DMH Southeast Area (SEA), primarily with DMH-operated adult services. DMH is now working to standardize suicide screening and assessment and suicide risk mitigation efforts across DMH-operated adult community and outpatient programs. DMH also instituted the requirement that vendor-operated programs that provide Adult Clinical Community Services (ACCS) must utilize the CSSRS-screener and an evidence based assessment process for mitigating suicide risk.

Child, Youth and Family (CYF): DMH began piloting the implementation of Zero Suicide evidence-based practices with the Southeast Area's division of Child, Youth, and Family Services. That area has established a CYF SEA Zero Suicide Steering Committee who have arranged numerous training opportunities for SEA CYF staff and DMH providers around suicide prevention and the voices of lived experience, an introduction to the ZS framework, and the implementation of CAMS. Staff from SEA CYF are also active participants in the Bristol County ZSLC.

Care Transitions for Suicidal Patients: In Massachusetts, through GLS, NSSP, and COVID-19 suicide prevention funding, DMH and MSPP are pursuing a number of pilot initiatives to improve care transitions for people who are being discharged from acute inpatient units or the emergency department following a suicide crisis. DPH and DMH have convened a workgroup with Beacon Health and representatives from both the Medicaid funded psychiatric emergency services programs (largely charged with assessing individuals for hospital level of care and marshalling resources to support hospital diversion when possible) and from the DPH funded suicide prevention crisis call centers to more seamlessly provide supportive resources for people experiencing a suicidal crisis. These pilots include:

- Under the GLS grant, two EDs hired dedicated staff to provide follow-up support to individuals discharged from the ED. Both EDs are exploring sustainability options at this time. One model emerging is the use of 'bridging groups' supported through the department of psychiatry;

- Under the NSSP grant, Massachusetts piloted a model utilizing volunteer staffed suicide prevention crisis call centers (several of which are NSPL centers) to partner with EDs and inpatient units to provide follow-up engagement and support. This model has since been featured at state and national suicide prevention conferences, and has begun to be replicated across Massachusetts and the U.S.;

- With COVID-19 suicide prevention funding, a pilot for enhanced staffing, e.g. Certified Peer Specialists for ESPs are providing engagement and follow-up support to individuals discharged from EDs and inpatient units following a suicidal crisis; and

- Other providers participating in the ZSLCs have been deploying social workers, utilizing bridging groups, and prioritizing individuals for expedited access to resources based on CSSRS-screener ratings.

Suicide Prevention with Tribal Communities

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

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

In 2018, IHS staff identified the importance of holding a community forum in response to recent suicides and overdose deaths. The forum – *It's Okay to Talk: Grief, Loss, and Suicide Prevention: How We Can Heal Ourselves and Each Other* – took place at the Mashpee Public Library with 35 people in attendance. Leading up to the forum, NSSP grant staff were asked to provide technical assistance around programming and best practices for suicide prevention safe messaging. NSSP staff also connected IHS staff to a colleague from the Executive Committee of the Massachusetts Coalition for Suicide Prevention who speaks publicly about her experience as an attempt survivor and the additional nuances being a person of color while navigating the

health and behavioral health care systems. NSSP staff connected IHS staff to the Samaritans on Cape Cod and the Islands (Cape Samaritans), and their staff members were invited to present at the community forum about upcoming grief support groups the agency could co-facilitate in partnership with IHS and HHS for Tribe members.

After seeking permission from HHS members, NSSP grant staff began inviting staff from the Cape Samaritans to the monthly meetings in order to continue supporting the Tribe's connections to the surrounding community and increase access to potential suicide prevention resources. This connection over the past three years has been invaluable, and has led to HHS staff receiving virtual QPR training and referrals of Tribe members into *A Caring Connection*, a successful engagement and follow-up program started under the NSSP grant.

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

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

Throughout 2021, meetings have resumed their monthly schedule. However, there continue to be frequent points of collaboration and connection in-between meetings and community events are taking shape again. DMH and NSPP staff were invited to take part in a community discussion on suicide prevention and the opioid crises in June. And HHS, NSSP, and DPH staff will be presenting at an upcoming Community of Practice meeting for the Suicide Prevention Resource Center focused on fostering and building strong partnerships with Tribal communities. However, it is the ongoing connection with HHS and genuine partnerships and friendships which have been created that represent a significant development within the region's suicide prevention efforts.

NSSP grant staff and MSPP leadership also serve together as DMH and SPP representatives to the Executive Office of Health and Human Services (EOHHS) Inter-Agency Tribal Work Group. In doing so, DMH staff stay informed about potential opportunities for training, technical

assistance, and grants available to Tribes and are able to more effectively coordinate collaborative efforts across state agencies.

Crisis Services

The Executive Office of Health and Human Services (EOHSS) through the MassHealth Program contracts with the Massachusetts Behavioral Health Partnership (MBHP) to maintain a 24/7/365 statewide system of Emergency Service Providers (ESPs). Begun more than 30 years ago, the current system was redesigned in 2009 with direction from DMH and the MassHealth Office of Behavioral Health. Every ESP provides behavioral health crisis assessment, intervention and stabilization services using four service components: Mobile Crisis Intervention for youth, Adult Mobile Crisis Intervention, ESP community- based locations, and Community Crisis Stabilization. ESPs are accessed via a central toll-free number with responses available in English and Spanish. Individual Service Plans, Referrals, and Linkages are outcomes expected for each person served.

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

DMH, in partnership with Riverside Trauma Center, also manages MassSupport, a Crisis Counseling Program funded by the Federal Emergency Management Administration (FEMA). MassSupport provides free community outreach and support services across the Commonwealth in response to the unprecedented public health crisis, COVID-19. Through the Crisis Services Set Aside from the COVID-19 MHBG supplemental funding, DMH intends to enhance MassSupport so that people may continue to access these much-needed services. MassSupport is also referenced within the Roadmap for Behavioral Health Reform, referenced throughout this document, as a key component that will contribute to the eventual evolution of a centralized call line. As the Roadmap is developed, DMH will continue to plan for evaluation efforts, identify additional crisis services enhancements, and evaluate the inclusion of further services for Crisis Services Set Aside activities while the “front door” is being built.

Finally, in an effort to provide more timely access to short term stabilization services, DMH expanded its emergency Respite and emergency Peer Respite capacity in late 2020 and early 2021. The stabilization services are designed to function as diversion points from emergency departments, inpatient units, and homeless shelters and to facilitate safe transition plans for people with complex behavioral health needs. An expanded emergency Respite is currently

operational in the Northeast region and other services are contracted to start in the Boston and Southeast regions. A statewide peer respite began operation in the Central Massachusetts region. Further expansion of respite services is a key DMH contribution to the Roadmap's Front Door and will include American Rescue Plan Act (ARPA) funds. Desire for this expansion was evident in the responses received from the ARPA RFI, solidifying DMH's focus on expanding these services, as well as Mobile Respite services mentioned above.

Inpatient Services and Emergency Department Boarding

DMH currently operates or contracts for 725 inpatient beds 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, including beds for forensic admissions, includes 663 adult continuing care beds, 32 adult acute admission beds, and 30 adolescent beds. In 2020, DMH served 1,255 adults and 47 children in its state operated and contracted psychiatric hospitals, a reduction from 2018 driven primarily by the impact of the COVID-19 pandemic and, in particular, infection control.

Children, adolescents, and most adults receive acute inpatient care in private or general hospitals. DMH has licensing authority over private inpatient psychiatric facilities, which provide acute care including short-term, intensive diagnostic, evaluation, treatment, and stabilization services to individuals experiencing an acute psychiatric episode. These services are provided almost entirely in private psychiatric facilities and general hospitals with psychiatric units. DMH licenses 2,850 acute psychiatric beds within 63 facilities. In 2019, licensed hospitals had 66,658 admissions. In 2020, admissions decreased to 59,775 due to COVID-19. In addition, DMH operates two acute care facilities in its Southeast Area. DMH is actively working to increase acute inpatient psychiatric beds and anticipates licensing 200 new beds within the coming year.

With the support of EOHHS, DMH has taken the lead in the Commonwealth's efforts to combat the crisis of emergency room boarding for individuals in need of psychiatric hospitalization. DMH, in partnership with MassHealth, DPH, and the Division of Insurance, convened a broad-based stakeholder group to develop an initiative with the goal of reducing the time individuals in psychiatric crisis wait for an appropriate discharge from emergency departments. In 2018, the Expedited Psychiatric Inpatient Admission Policy (EPIA) established clear steps for when placement has not been achieved in a reasonable period of time and a protocol for escalating cases to senior clinical leadership at insurance carriers, inpatient psychiatric units, and ultimately to DMH for the most difficult-to-place patients. During calendar year 2020, DMH

received 4,299 requests for assistance with patients who had waited for a behavioral health placement within an emergency department.

The COVID-19 pandemic has resulted in unprecedented demand for psychiatric inpatient treatment across all age groups with notable extended wait times for youth and adults with complex treatment needs. During the pandemic, DMH lowered the time for EDs, Emergency Service Providers, and Insurance Carriers to request help from DMH to more rapidly move patients out of EDs.

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

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

In addition, DMH contracts for a Peer-Run Respite service in the Western Massachusetts Area. This service provides temporary peer support to individuals in emotional distress and/or emergent crisis. The service utilizes self-help strategies, trauma-informed peer support, and mutual learning to address the needs of people experiencing emotional distress. The service is intended to be a community-based alternative to a hospital psychiatric setting or other clinical setting for managing emotional distress or emergent crisis. During the summer of 2020, there was an identified need to develop a plan to combat the significant increase in behavioral health boarding episodes in emergency departments. Additional DMH Respite capacity was identified as a need across the Commonwealth.

Comprehensive Community-Based Mental Health Services

DMH directly provides and/or funds a range of services for more than 22,000 adult clients per year. These services include inpatient continuing care, case management, and other community clinical and rehabilitative services, including Adult Community Clinical Services (ACCS), Program

for Assertive Community Treatment (PACT), Clubhouse, Respite, Homeless Services and Supports, and Recovery Learning Communities. Publicly funded acute-care services, including inpatient, emergency, and outpatient services are managed by MassHealth. However, DMH operates some acute-care inpatient and outpatient services in the Southeast and Metro Boston Areas.

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

In the early stages of the pandemic, DMH rapidly shifted its approach to utilize telehealth options to provide continuity of service delivery in the community. DMH also implemented a series of flexibility measures to reduce administrative activities and prioritize essential service delivery functions. All DMH community-based services continued to operate and provide in-person service delivery when clinically indicated with appropriate infection control precautions in place. DMH collaborated with providers and state-operated programs to respond to health and safety issues, including meeting basic needs for food, medication, access to healthcare, and use of technology for telehealth and social connections.

DMH worked extensively with EOHHS and sister agencies to develop and implement guidance addressing visitation, surveillance testing, and infection control practices in congregate care settings and re-opening of Clubhouse programs for in-person services. Specifically DMH partnered with DPH to offer COVID-19 vaccination clinics to all 35 clubhouses in Massachusetts. Given already high rates of vaccination among clubhouse members, six clubhouses opted to hold clinics, vaccinating approximately 28 additional members, close-contacts, members of the community, and other individuals served by the agency. Most recently, DMH provided technical assistance and support to congregate care providers to develop vaccination plans for all congregate care programs. All of these settings had completed first dose clinics and were on track to complete initial vaccination plans in March 2021. DMH will continue to provide support and education to providers, DMH employees and clients to promote vaccine acceptance.

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

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

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

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

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

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

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

- Homeless Outreach and Engagement: Comprehensive screening, engagement, stabilization, needs assessment, and referral services for adults living in shelters; and

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

Housing Services

The Department seeks to promote access to affordable integrated housing opportunities to support movement through the DMH service system, 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 municipal housing agencies and non-profit and for-profit housing organizations. Massachusetts is fortunate to have many affordable housing agencies and programs that directly and indirectly serve people with mental health conditions. Specific agencies include the Massachusetts Department of Housing and Community Development (DHCD), the MassHousing Finance Agency, and Community Economic Development Assistance Corp (CEDAC) in addition to the 200+ Local Housing Authorities.

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

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

Through its collaboration with DHCD, DMH 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 for DMH the DMH Rental Subsidy Program (DMHRSP) that enables clients to live in their own housing in communities throughout Massachusetts. The DMHRSP funding grew by $3M in FY21 the largest single increase in the history of the program that roughly translates to enough subsidies to house 180 – 225 individuals in their own apartments. These subsidies are expressly targeted to DMH clients and can pay up to 110% of the Fair Market Rent (FMR). Clients are able to lease quality units in the market and pay only 30% of their adjusted income for rent and the subsidy pays the balance. The DMHRSP program does not require CORIs or credit checks. The program represents a unique partnership between a state housing agency and state mental health agency rooted in

the recognition that people with mental health conditions are at a distinct disadvantage in accessing mainstream housing resources.

On the capital investment side, DHCD along with CEDAC helps DMH with building new housing, mostly integrated into multi-family developments, specifically dedicated to DMH clients. The Facilities Consolidation Fund (FCF) makes available loans or grants to non-profit and for-profit developers that covers up to 50% of the total development cost of the units dedicated to DMH. In a typical year, $11.5M is committed to projects funded through FCF. DHCD further assists in securing project-based subsidies for these units usually in the form of Sec. 8 or MA Rental Voucher Program that ensure long-term affordability. Units are high quality and 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.

Of particular note under State Public Housing is the Chapter 689/167 Special Needs Housing Program managed by the Local Housing Authorities providing Group Living Environments (GLEs) in communities across the state at rents well below market. DMH leases some 85 developments, housing more than 700 clients. These buildings are generally designed to house eight people in either shared or individual apartments; no CORIs or credit checks are required.

MassHousing is another critically important state housing partner of DMH with a portfolio of over 100,000 units of multi-family and elderly housing that provides a special set-aside of 3% of their affordable units for use by DMH and the Department of Developmental Disabilities (DDS). 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 and DDS have exclusive access to these units thereby avoiding the standard waitlist which in some cases can take years before a unit is available.

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

Given DMH's focus on housing and with so many housing resources in play across the state, DMH has specific housing staff assigned to each of its five Areas dedicated to managing and monitoring the various housing assets in their Area. The DMH housing staff also play an active role in promoting housing development working with Local Housing Authorities, Community

Development Corps, for-profit developers and others to expand DMH housing opportunities. They serve as the "boots on the ground" when it comes to local housing initiatives.

DMH Central Office helps to coordinate housing policy and programs across the five Areas, interfaces with State and Federal agencies, and links up the key state housing agencies with local needs and activities. Central Office brings together the Area housing staff on a regular basis to discuss issues and incorporates into that discussion those personnel from various state agencies who can assist DMH with its housing goals and objectives.

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

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

- Expand DMH Rental Subsidy Program funding annually to enable more individuals to move from Group Living Environments into their own housing with supports, promoting greater independence and recovery;

- Increase utilization of the DMHRSP Tenant-Based subsidy for ACCS enrolled individuals and other DMH programs who are ready to transition to their own lease;

- Expand the number of Safe Havens programs across the state and resources for Program Staffing Support contracts to support the Commonwealth's efforts to end homelessness, promote client movement within the DMH Homeless Support Services system, and address the reduction in shelter bed capacity due to COVID-19 crisis;

- Leverage increased access to both State and Federal affordable housing resources (capital and operating funds) to serve the housing needs of DMH clients;

- Secure technical and data systems to enhance management of DMH housing resources and support for contract monitoring that incorporates the tracking of client movement through the DMH system; and

- Identify and promote educational and learning opportunities specific to housing that are targeted to peers, service providers, and agency staff.

Finally, with MHBG Technical Assistance funds, DMH is supporting implementation of a set of recommendations specific to Peer Supporters in Housing intended to raise the profile of peers and bring them together with housing staff to support finding and keeping housing.

Outreach to Homeless

DMH has a long history of working to end homelessness through outreach and engagement as well as housing programs. DMH Central Office, in collaboration with each of the five Areas and specifically Area housing staff, participates in the thirteen Continuums of Care across the Commonwealth.

The DMH/SAMHSA funded Projects for Assistance in Transition from Homelessness (PATH) program outreaches on average to 2,100 individuals annually 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 $960,600 in 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. It serves persons with mental illness and co-occurring psychiatric and substance abuse disorders and renders assistance including direct care, housing search, benefits, advocacy, and referrals to health and behavioral health care services. Adults and older adolescents determined to have a serious and persistent mental illness are referred to DMH for service authorization. In the first seven months of FY21, they report enrolling over 1,100 individuals, made 1,300 referrals over half successful, and have housed 175 of those discharged from PATH. And Path has continued its collaboration with the Mass Library Association and Board of Library Commissioners to educate library staff around the state on issues of mental health and homelessness as libraries are challenged by the numbers of homeless coming to seek shelter during the day.

DMH also supports homeless outreach and engagement through its own state-operated program in Boston, the Mobile Homeless Outreach Team (HOT). Comprised of 12 staff, HOT provides 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 and further supports contracted homeless outreach services in Boston at the Pine Street Inn, Saint Francis House, and the Boston Public Health Commission. There is an additional contract serving Cape Cod that provides street outreach and support to local shelters and police. This past winter, DMH opened a Drop-In Center in Hyannis, working with a number of agencies to provide a daytime warming station with snacks and beverages. It is open three days a week from and averages 4-8 individuals on any given day.

During the pandemic, the PATH program teamed up with the State Emergency Management Agency to provide supports to individuals quarantining at four hotels across the state. PATH provided critical support by lending clinical staff expertise to the COVID-19 hotels established to serve anyone needing to isolate because of being COVID-19 positive. The program's supports proved immensely significant as the number of homeless individuals needing this service increased over the weeks and month of the pandemic. HOT and PATH also assisted with supporting a new temporary shelter in Boston for homeless women, established at a community college, due to overflow at existing shelters as a result of COVID-19 requirements.

Both of these programs have also assisted with increased outreach to an area of the City of Boston heavily populated by homeless and sheltering programs known as Melnea Cass. This area experiences overdoses daily, along with large crowds of people experiencing homelessness who have nowhere to go during the day. Due to violence there is now a police presence, and the outreach services have been well received.

DMH 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. (During the pandemic, the capacity has been reduced by 36 beds to 104.) 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.

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

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

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

extremely successful program either “saving” tenancies or providing for a “soft” landing in a more supported environment.

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

DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan. DMH’s Transition Age Youth Initiative representative was also appointed to the EOHHS Unaccompanied Homeless Youth Commission to study and make recommendations relative to services for unaccompanied homeless youth age 24 and younger with the goal of ensuring a comprehensive and effective response to the unique needs of this population. And DMH requires providers to deliver services that are age and developmentally appropriate, including services for elders.

Rehabilitation, Support, and Recovery-based Services

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

In addition, DMH offers services focused on recovery and client empowerment, such as Clubhouses. In a shift towards consumer-directed care, DMH funds and supports a variety of consumer initiatives, including peer and family support, peer mentoring, warm-lines and six Recovery Learning Communities (RLCs). These consumer-run RLCs initiate, sponsor, and provide technical assistance to a wide variety of supportive, educational, and advocacy activities spread

out across their respective regions and continue to develop their capacity to support the growing peer workforce in Massachusetts.

In January 2019, the Office of Recovery and Empowerment and DMH began the process of re-contracting DMH's Peer Specialist Training and Recertification program, and creating a new contract to focus on bringing the Voice of Lived Experience to all DMH activities. DMH hosted three public listening sessions to hear what was needed in these new contracts. Input gathered through these sessions and incorporated into the new Peer Specialist Training and Recertification program include emphasis on co-occurring disorders, documentation, institutional racism and trauma, and a streamlining of testing, notification, and application procedures. The Voice of Lived Experience contract seeks to increase voice, choice, access, and services for those who experience life-interrupting emotional distress and other challenges, and who've faced additional barriers due to marginalization due to race, ethnicity, sexual orientation, or religion.

DMH further promotes the development of the peer workforce by contracting with peer-operated organizations that train and certify persons with lived experience for the role of Peer Mentor and Young Adult Advisory Board Members within the Community Services Agencies (CSAs) under the STAY Together grant. DMH worked with three separate organizations over the last two years to specialize in training young adults. Gathering and Inspiring Future Talent (GIFT) is an intensive 15-week program that teaches young adults with lived experience to identify and understand their own core gifts, prepare for a role as a peer mentor, achieve personal and family stability, and develop career readiness. The training was also opened to other young adults with lived experience who are exploring the field of peer support work.

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

Since 2012 and in response to advocacy from the peer community, DMH sponsors a Peer-Run Respite in the Western MA division. This program, Afiya House, provides individuals experiencing emotional distress with short-term, overnight respite in a home-like environment. All staff members are peer supporters with intensive training in Intentional Peer Support and are employed by the Western Massachusetts Recovery Learning Community. Most are Certified Peer Specialists and many have additional intensive training in Hearing Voices and/or Alternatives to Suicide. Afiya House is located in a residential area and has separate bedrooms for up to three individuals.

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

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

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

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

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

DMH requires providers to offer Peer Support services in all of its community services. Depending on the population served, providers may hire Substance Use Recovery Coaches in those roles. Many of the Certified Peer Specialists in the workforce are also pursuing Recovery Coach certification. Most of the DMH-funded Recovery Learning Communities run groups around addiction. DMH Clubhouses continue to offer Dual Recovery Anonymous groups for members and others struggling with mental health and substance use disorders.

Massachusetts is taking a national lead in the discussion between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities, particularly the systemic barriers faced by people with co-occurring mental health and addiction disorders. This project is a partnership between DMH, the Department of Public Health Bureau of Substance Abuse Services (BSAS), University of Massachusetts Medical School Department of Psychiatry, the Massachusetts Interagency Council on Substance Abuse Treatment and Prevention, the Massachusetts Organization for Addiction Recovery (MOAR), the Transformation Center, and the MassHealth Office of Behavioral Health and the Massachusetts Association for Behavioral Healthcare.

Finally, Massachusetts has included Older Adult Peer Support as part of its Home and Community Based Frail Elder Waiver. DMH worked closely with the Executive Office of Elder Affairs (EOEA) and MassHealth to ensure its implementation. DMH, along with EOEA, is also exploring ways to dampen the workforce shortages in our older adult peer workforce by training home care aide workers who are aging out of heavy lifting duties to become older adult

peer specialists so they may continue their work with older adults and remain in the workforce. During the pandemic, a training was developed for older adult peer specialists to learn how to offer virtual peer support given the necessary isolation of older adults during the pandemic.

Employment Services

DMH provides employment services through 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, assisting members with housing, health and wellness, and above all providing a community within which members are “wanted, needed, and expected.” Clubhouses pursue a variety of jobs for members including integrated, independent employment. For the seventh consecutive year, DMH has determined competitive employment will be the principle outcome for clubhouses and has set a formal employment target (26%). The clubhouse employment target is then monitored through twice-a-year site visits, monthly reporting, and routine contract monitoring. Despite the COVID-19 pandemic and the ensuing economic effects, Clubhouses were able to maintain employment rates among members of over 24%.

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.

In 2018 DMH redesigned its principle community service to enhance the clinical focus and structurally integrate it in existing healthcare and employment delivery systems. As a result, it was decided that the new service, Adult Community Clinical Services (ACCS), instead of purchasing and integrating employment directly as was done in the previous service model, would leverage services from the existing employment service system. Using funding provided by DMH, the Massachusetts Rehabilitation Commission (MRC) employs specialized vocational counselors dedicated to serving each ACCS contract as well as offering employment-service providers with specific mental health expertise. The program has engaged 1,704 ACCS enrollees in its first two years. Of these enrollees, 330 individuals have been placed in employment and 272 remain employed, including 149 who have been successfully closed. The median hourly wage among those employed is $13.75 (minimum wage is $13.50) with an average hourly wage of $14.75. The median number of hours worked per week is 20; the average number of hours worked per week is 21.4. Finally, 75 individuals have been enrolled in education, career, or technical training programs. Given high demand for the service, MRC expanded the number of dedicated vocational counselors serving ACCS teams from 18 to 26 in 2020. This partnership with the state’s vocational rehabilitation agency seeks to leverage mainstream vocational

rehabilitation resources, and to create local partnerships between DMH, MRC, and ACCS so that those seeking employment will maximally benefit from the expertise of all parties.

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 MRC. Family Support Specialists have also been trained on these topics.

DMH continues to work with the MRC and its staff in supporting employment and higher educational opportunities. DMH's Director of Employment works closely with MRC to address employment needs for young adult and adult populations. DMH also continues to add Transition Age Youth Peer Mentor positions within the agency. And in 2019 DMH and MRC executed an unprecedented data-exchange agreement, providing for open communication of staff between agencies and the exchange of large-scale client-level data.

As part of DMH's ongoing initiative to increase the availability of high-fidelity Coordinated Specialty Care (CSC) to youth and families experiencing a first episode of psychosis, DMH currently funds SEE (Supported Employment and Education) Specialists in six FEP programs throughout the state. As part of this initiative, DMH provided training to state and vendor staff on conducting IPS fidelity assessments in August 2019, with additional training for new and existing staff in April 2021. DMH's Director of Employment convenes a monthly group supervision of SEE Specialists to collaboratively review difficult cases, share resources, and celebrate success.

DMH also continues to have a close relationship with UMASS Medical School's Work Without Limits program, and specifically the Work Without Limits Benefits Counseling Program (WWL). WWL provides training for staff and one-on-one counseling to DMH clients who are apprehensive about returning to work in light of the impact on their benefits. In 2021, WWL is scheduled to deliver and record a training focusing on the impact of work and benefits specifically tailored for staff working in DMH's inpatient facilities.

Forensic Mental Health Services

DMH provides forensic evaluation and treatment services to over 10,000 individuals each year who are referred to DMH by the Juvenile, District, Boston Municipal, and Superior Courts. In

FY20, DMH court clinicians completed 12,683 evaluations of which 11,276 were for adults and 1,407 for juveniles. Additionally, 760 adults (575 forensic eval, 185 forensic treatment) and 11 juveniles were admitted to DMH facilities for forensic evaluations. Furthermore, DMH provides step-down treatment in DMH facilities for individuals transferred from the Bridgewater State Hospital. DMH also provides community level re-entry supports for inmates with serious mental illness returning to the community.

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 (CIT) and clinician/police co-responder programs. The Department of Mental Health and its Jail Diversion Program supports law enforcement agencies across the Commonwealth with grant funds as well as direct support and technical assistance. Through an open application process, departments and behavioral health providers offering services to support law enforcement in community responses, can submit program proposals. Currently there are upwards of 70 programs funded.

Supported by DMH grants, the CIT and Co-Response Training and Technical Assistance Centers (TTAC's) provide behavioral health training for local law enforcement in Massachusetts. The pandemic's impact on in-person training, with strict gathering restrictions in the Commonwealth, also compelled TTAC's to facilitate training opportunities remotely. In FY19, there were a total of 80 trainings and 39,866 hours of training provided by all the TTAC's, resulting in over 700 officers receiving CIT training and 540 officers receiving Mental Health First Aid (MHFA). In FY20, with the impact of the COVID-19 pandemic, there were 61 Trainings and 22,002 hours of training provided by all the TTAC's, ensuring 430 police officers received CIT training and over 300 police officers had MHFA training for Public Safety. During FY21, there were fewer in-person trainings during the first half of the year, and more emphasis on remote trainings and providing technical assistance to departments. As the pandemic's conditions lessen this spring and more are vaccinated, the TTAC's plan to return to their regular scheduled in-person trainings.

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, and social workers, 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) and Care and Protection petitions. Court clinics used both videoconferencing and in-person evaluations during the pandemic. In 2020, there was a total of 6,478 adult court clinic evaluations and 416 juvenile court clinic evaluations.

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 coordinate with inpatient treatment teams and the courts. The inpatient evaluations ordered to DMH are conducted in DMH Continuing Care facility settings. 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 are set forth in DMH policy 10-01R.

Specialty Court Services: DMH Forensic Services partners with the Massachusetts Trial Court's Specialty Court initiative by providing clinicians in a total of seven Mental Health Courts, six veteran's treatment courts, 31 drug courts, and three other specialty courts in Massachusetts. A sexual exploitation session, with clinician, was added to the Dorchester court.

SAMSHA awarded a grant to the Court and Boston Medical Center for an outpatient assisted treatment program, available to all eight Boston area courts. This is an intensive court-supervised treatment program for individuals with serious mental illness.

These clinicians provide assessment services, care coordination, and referral services to participants and clinical consultation to court personnel and to the Specialty Court multi-disciplinary teams.

Justice-Involved Veterans: Forensic Services is involved with the administration and funding of programs and services for Justice Involved Veterans, including Veterans Treatment Courts, as an alternative to incarceration for veterans with co-occurring mental health and substance use challenges. DMH Forensic Services also provides a portion of funding to the Department of Veterans Services (SAVE Team) to assist with peer support services for veterans who are court-involved.

Forensic Transition Team (FTT): Established by DMH in 1998, the Forensic Transition Team is a statewide workforce of community care coordinators that ensures DMH-service authorized individuals have an effective community reentry plan from state prisons and county houses of

correction, as well as continuity of care when entering corrections from the community. The Forensic Transition team consists of over 11 personnel assigned to this work in Massachusetts.

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 to conduct audits. Audits ensure that inmates in those units receive appropriate medical, dental, and psychiatric care. Reports are generated for the Commissioner of Correction to review with occasional recommendations for corrective action. In addition, DMH provides annual reviews of specialized mental health units that operate in two of the county House of Corrections and coordinates care for persons served in the Bridgewater State Hospital (BSH), a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial.

As part of the process of "stepping down" BSH patients (strict security) to a DMH facility, some of these individuals may be identified as benefitting from an enhanced process. Before the COVID-19 pandemic, this enhanced process frequently consisted of clinical staff from a DMH facility meeting with BSH staff and the patient. One of the DOC's responses to the pandemic was to stop visitation at their facilities to decrease potential exposures. In response, Forensic Services worked with BSH senior staff to coordinate a video conferencing platform so that the DMH clinicians could meet with both the BSH clinicians and patients. No significant issues have arisen with this change in process.

Services for Special Forensic Populations: DMH Forensic Services provides a specialized program for persons with mental illness and problematic sexual behaviors (MI/PSB). It includes clinical and risk management assessments, consultations, and treatment to assist inpatient treatment teams and community providers working with persons with these specific difficulties, some of whom have also been charged and/or convicted of sexual offenses. The Independent Forensic Risk Assessment (IFRA) 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.

Prior to the pandemic, the IFRA process involved the IFRA consultant meeting in person with the patient's treatment team as well as with the patient at the inpatient facility (DMH or contracted unit). One of DMH's responses to the pandemic was to limit non-essential staff

access to inpatient facilities and limit or cease visitation to decrease potential exposures. As a result, the Forensic Service worked with its IFRA consultants and the facilities to provide a virtual platform that allowed DMH to continue to conduct these risk consultations, with our consultants conducting the evaluations remotely using a video conferencing system. Once the logistics were worked out, there have been no significant issues.

DMH has continued to provide technical assistance for the implementation of the systemic use of a structured risk assessment tool (HCR-20) for use in our inpatient facilities and community programs. Additionally, Forensic Services is the DMH liaison for the Sexual Offender Registry Board (SORB) and the Criminal Justice Information System, the state entity that maintains Massachusetts arrest and court adjudication records. In this capacity DMH accesses SORB and criminal history records for risk management purposes for DMH inpatient units, supports the completion of court-ordered forensic evaluations, and assists in resolving SORB registration obligations in individual cases when difficulties arise.

DMH has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted intensive residential treatment units for youth. The DMH Forensic Mental Health Services has assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court system. Forensic specialists sited in the juvenile courts provide evaluation and consultation services for judges, attorneys, and probation officers on an as-needed basis, as well as provide various other services including individual, group, and bridge treatment in some areas for court involved youth and case management services. Over the last 10 years, DMH Forensic MH Services has been a part of a statewide initiative, Juvenile Detention Alternative Initiative, focused on decreasing the number of youth being held in detention with clinicians participating on local committees and DMH representatives serving on the statewide Governance Committee. A Memorandum of Understanding (MOU) between the Department of Youth Services (DYS - the juvenile justice service system) and DMH has been developed to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system. DMH provides clinical and psychiatric consultation for DYS youth upon request.

Child, Youth, and Family Services

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

the unique needs of each youth and family, DMH purchases a wide array of services and supports. These include:

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

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

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

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

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

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

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

Massachusetts investment in a comprehensive array of community services has allowed our state the ability to successfully treat youth in their home environment and community settings. Since 1992, DMH has closed five state hospitals, including the state-operated children's center, transferring responsibility for acute care from the public to the private sector. Children and adolescents receive acute inpatient care in private or general hospitals. This has enabled DMH to focus its expertise on providing home and community-based treatment.

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

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

- DMH also supports the **Massachusetts Child Psychiatry Access Program (MCPAP)** which provides specialized psychiatric consultation to pediatricians and other primary care providers (PCPs) who serve children. The goal is to increase access to behavioral health treatment by making child psychiatry services available to PCPs across the Commonwealth. MCPAP is currently funded by DMH and through assessments on state regulated health insurance plans in Massachusetts;

- Through its Children's Behavioral Health Knowledge Center, the DMH Child, Youth, and Family (CYF) Division helps ensure that the workforce who provides services to youth and families are highly skilled and well-trained. The Center supports a range of training, workforce development and technical assistance opportunities. Highlights include:
    - Development of a skills-based curriculum based on Motivational Interviewing for parents of youth with mental illness or substance use disorders to help them learn how to engage in productive conversations with their children about difficult topics

  - Training for young adult peer mentors
  - Creation of technical assistance tools to support provider organizations, team members, and supervisors about the benefits of young adult peer mentoring and how to help peer mentors be successful in the workplace
  - Enhancing supervisor competency and organizational support for high-quality reflective supervision
  - Webinars on parental mental illness, racial identity development in young children, motivational interviewing, and strength-based approaches to working with children
  - Training for emergency shelter providers on early childhood mental health
  - Training for clinicians in family therapy and permanency practice

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

- Through DMH funds and three successive SAMHSA grants, the Department operates **Young Adult Access Centers** for youth and young adults in Framingham, Lawrence, Everett, Braintree, Springfield, and Worcester with recent additions in Gloucester and Lowell. Young Adult Access Centers are a key strategy for reaching underserved populations, especially young people of color, LGBTQ young adults, homeless teens, and youth aging out of foster care and provide a unique opportunity for young adults to receive trauma-informed, developmentally appropriate services that are young adult driven with an emphasis on peer support; and

- **LINK-KID** is a resource and referral hotline operated by the Child Trauma Training Center at the University of Massachusetts Medical School. It was designed to assist families, providers, and professionals looking to refer children to evidence-based trauma treatment throughout Massachusetts.

In March of 2020, DMH undertook a three-week research sprint that explored the question, *"How might DMH reach youth and their families earlier in their mental health journey?"* A series of focus groups and co-design sessions with over 40 stakeholders including families, DMH staff members, and staff from community-based organizations, resulted in important learnings that

highlighted several unmet service needs. These identified needs are explored further in Part 2 of this document.

DMH continues its implementation of "Reframe the Age" which extends service authorization criteria for Child, Youth, and Family Services from age 18 to 22 and brings together staff and resources of both Adult Mental Health and Child, Youth, and Family Services for the benefit of young adults. Now in the second year of implementation, we have seen a meaningful increase in the numbers of young adults ages 18-21 being approved for DMH services, approximately 11%. Additionally, we have seen a decrease in the numbers of young adults withdrawing their applications and dropping out of the process. In addition to delivering high quality mental health services for children and youth with significant mental health needs, DMH works with partners throughout state government to improve access to mental health services for all of the Commonwealth's children and youth, and to support clinical quality.

As part of DMH's Intensive Community Services procurement, DMH is purchasing services specifically designed for young adults that assist them in transitioning through different levels of service according to the young adult's developmental and treatment needs by providing different types of transitional housing with supportive services. Participation in work, school, or a job training program is required. Services are individualized so young adults may transition through the service levels as needed or use just one. The model includes both staffed and supported apartments.

DMH's Children's Behavioral Health Knowledge Center worked closely with researchers and experts in Motivational Interviewing to disseminate MI skills to parents. The MI for Parents (MI4P) project aims to develop and pilot test the feasibility and effectiveness of a motivational interviewing skills training course for parents and caregivers of youth (ages 14-24) with behavioral health concerns. Parents were asked to complete surveys and role play exercises pre- and post-training sessions. These surveys measured perceived stress, parenting confidence, family conflict, and expressed emotion (a term to describe over-involvement and resentment towards the child). The data suggests that parents who participated in the MI inspired training sessions reported less stress, less family conflict, less expressed emotion, and higher parenting confidence after the training sessions. These changes were maintained three months after the training session. Parents also demonstrated they learned and maintained the MI skills knowledge.

DMH continued its anti-stigma campaign with the promotion of Different Kinds of Hurt: Isaac's Story, a book and video developed by DMH, youth, and mental health experts which celebrated its one year anniversary in 2020. Isaac's Story has become a wonderful jumping off point for conversations about the power of friendship, the pain of stigma, and the importance of paying attention to and encouraging all youth to talk about mental health. 25,864 hard copies of the

book have been mailed. It is now available in English, Spanish, Haitian Creole, and Cape Verdean Criolo and will be available in additional languages in FY21. The social media campaign through Facebook generated a total of 95,527 clicks which directed users to the Isaacs Story website during FY20.

Working closely with partners in the Office of the Child Advocate and the Executive Office of Health and Human Service, DMH launched Handhold MA, an interactive, family-friendly website that seeks to provide parents and caretakers with highly accessible answers to the following questions:

- **Should I Worry?** Information they need to understand changes in their child's behavior and figure out when they might need help;
- **What Can I Do?** Curated resources for parents looking to help their child cope and heal from mental health challenges, promote healthy social and emotional development, de-escalate challenging situations, and connect to local supports and reports; and
- **Who Can Help?** A user-friendly "front door" to existing behavioral health system navigation and treatment locator tools, including guides on what to expect, how to find support, and how to prepare for a first visit.

Created by a team of mental health, child development, and human-centered design experts in partnership with parents who have navigated the mental health system for their own children, the HandholdMA site officially launched in the middle of October 2020 and has had more than 38,000 unique visitors.

Finally, more children and youth were served while living at home with a 20% decrease in use of out-of-home treatment services from FY19 to FY20. For youth served in our two continuing care hospital units and five Intensive Residential Treatment Programs, length of stay in these locked programs was substantially reduced, returning youth more quickly to the community and home. The two continuing care inpatient units, five Intensive Residential Treatment Programs, and one clinically intensive residential treatment program are striving to reduce both restraint use and length of stay. Half of the programs reduced their use of restraint.

Through the state's MassHealth (Medicaid) program, youth up to age 21 with serious emotional disturbance who meet medical necessity criteria are eligible for Intensive Care Coordination (ICC). Care planning is driven by the needs of the youth and developed through a Wraparound planning process consistent with Systems of Care philosophy. ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family and youth-driven, and ethnically, culturally, and linguistically relevant manner. ICC is designed to facilitate a collaborative relationship

among a youth with SED and their family, and involve child-serving systems to support the parent or caregiver in meeting their youth's needs. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child-serving systems to enable the youth to be served in their home community.

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

For youth experiencing a behavioral health crisis, Mobile Crisis Intervention is available to youth with MassHealth as well as for youth with state regulated commercial health insurance. It provides a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management and safety plan, if any. This service is provided 24 hours a day, 7 days a week and includes: crisis assessment; engagement in a crisis planning process that may result in the development or update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family; up to 7 days of crisis intervention and stabilization services including on-site face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

In order to best support youth and families with complex needs, DMH staff work closely with other child serving state agencies including child welfare, juvenile justice, substance addiction services, public health, developmental services, and the state's vocational rehabilitation agency. The agency engages in planning activities with state partners and other stakeholders to improve behavioral health care integration and outcomes of residents of the Commonwealth. DMH staff members sit on (or chair) a number of Commissions, boards, and workgroups that promote and support children's behavioral health across the state. Examples include the Grandparents Raising Grandchildren Commission; the Interagency Workgroup on Substance Use; Infant and Early Childhood Mental Health Interagency workgroup; the Childhood Trauma

Task Force; and the Unaccompanied Homeless Youth Commission. Finally, the DMH Commissioner also chairs a statewide Children's Behavioral Health Advisory Council which includes representatives from child-serving state agencies, providers, families, trade groups, and guilds. This group serves to inform the legislature and state leaders on critical issues and topics on children's behavioral health.

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

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

Finally, the CYF division of DMH provides ongoing training on Trauma Informed Care. The department has contracted with Janina Fisher, PhD, to provide trainings up to three times per year for all hospitals, child and adolescent treatment programs, community residential programs, and other programs as requested. Additionally, the department contracts with Dr. Laurie Leitch to provide trauma-responsive "SRM" (social resilience model) curriculum training monthly with supervision built in.

State Mental Health Planning Council

The State Mental Health Planning Council (SMHPC) is a standing committee of the Mental Health Advisory Council (MHAC) to the Department of Mental Health. 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, professional organizations, legislators, representation from state employee unions, and members of racial, cultural, and linguistic minority groups. The Council's

membership is reviewed regularly. Members who have not been active within the last year are contacted to confirm their commitment and new members are appointed to ensure a balanced and diverse membership. DMH provides staff to the Council.

The vision of the SMHPC is to promote respect, dignity and access to prevention, early intervention, health engagement and activation, housing, employment and other support services that encourage individuals of all ages and their families to develop resilience, fully recover, and be productive members of their communities. Its mission statement is to provide informed advice and perspective to DMH on key policy and program issues affecting individuals of all ages in the Commonwealth who are at risk for, or have, mental health conditions and their families, and advocates for decision making and actions that protect and advance their health and well-being. This advice and advocacy is aligned with the following guiding principles:

- Mental health is a key part of overall health;
- Integration of mental health, substance use, and primary care services produces the best outcomes and proves the most effective approach to caring for people of all ages with behavioral health conditions and multiple healthcare needs;
- Promotion of prevention, early intervention, resiliency, and recovery as well as fair and timely access to health care, income, education, employment, and housing are important for the protection and improvement of mental health and behavioral health;
- It is important to foster the strengths of individuals of all ages with lived experience, their families, communities, and the organizations serving them;
- Innovative evidence-based programs and best practices should be regularly examined for applicability to and replication in Massachusetts, and promising models should be identified and pursued for implementation;
- It is important to foster an understanding of social determinants of mental health and incorporate that understanding in policy and program planning; and
- Alignment of mental health policy across all state government agencies will promote better efficiency and effectiveness in providing individuals of all ages and their families with the mental health services and supports they need.

The Council has several subcommittees with membership that includes individuals on the SMHPC as well as other interested persons. These subcommittees are a principal means of involving consumers and families in DMH. 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.

The SMHPC and its subcommittees provide a strong and ongoing voice of recovery and resilience. The Council makes important contributions in identifying particular domains needing transformation in the mental health system and subcommittees have played an active role in planning and implementing many of these transformation efforts across the Commonwealth. Many members of the SMHPC are also involved in locally based participatory planning processes and with other advocacy groups. Each of the subcommittees are described below:

Professional Advocacy Committee (PAC) on Child, Adolescent, and Family Behavioral Health Subcommittee Overview

The mission of the Professional Advocacy Committee on Child, Adolescent and Family Behavioral Health is two-fold: To identify gaps in behavioral health services for children, youth, and families and to advocate for a family-based approach to service delivery.

In the past two years the PAC subcommittee has focused on a gap in services related to recovery-informed care needs for parents and young adults which we are essential elements to promote an individual's meaningful involvement in their chosen family activities, roles, and relationships. The PAC also identified a gap in competent services and supports that effectively focused on family members whose personal recovery needs, in terms of emotional and social functioning, had been compromised by behaviors of the family member with mental health and/or substance use conditions. Family members is broadly-defined to include partners, children, grandparents, kinship care, and siblings among others.

The PAC identified the need for the development of family-informed recovery care during collaborative learning experiences with representative from organizations including: Massachusetts Chapter of the National Alliance on Mental Illness; Massachusetts Chapter of the Federations of Families for Children's Mental Health's Massachusetts Chapter; Parent Parental Advocacy League; Institute for Health and Recovery; Central Massachusetts Recovery Learning Community; Massachusetts Organization for Addiction's Recovery; as well as representatives from Massachusetts' Departments of Mental Health, Public Health, Child Welfare, and the Division of Elementary and Secondary Education.

As noted earlier, Massachusetts has made a significant investment in the development of its peer workforce as a critical component in recovery care. In order to explore the peer workforce's perspective on the need for family-informed recovery services, the PAC collaborated with leadership in the Transcom Committee and the Young Adult Committee of the State Mental Health Planning Council, with peers who worked with Massachusetts General Hospital's Center for Excellence in Psychiatric Rehabilitation and Systemic Research, and other

state level peer leaders. In addition, the PAC reached out to the Substance Abuse and Mental Health Services Administration's Bring Recovery Supports to Scale Technical Assistance Center in an attempt to identify other national efforts to address the family recovery related needs of individuals with mental health and cooccurring disorders. The findings of these efforts both reinforced the gap in and the need for family recovery care in general and, specifically, peer training focus on promoting family related aspects in individuals' recovery planning and implementation. Peer training was identified to provide tools and resources related to an individual's family-related recovery needs and goals, and also to promote the emotional and social recovery needs of family members.

The PAC is proposing to the DMH that during the 2021 and 2022 years the capacity of the peer work force be expanded through the creation and dissemination of family recovery continuing education curriculum. The rational for this proposal includes:

- The expansion of the capacity of peer work force is timely as the Commonwealth is ready for further development of its peer workforce role and capacities;
- Care givers with mental health conditions and recovering individuals experience family relationships and roles are essential elements of recovery. Families and their members are experiencing significantly intensified stresses from the impact of COVID-19 in Massachusetts; and
- Continuing education skills and resources that enhance the ability of peers throughout the spectrum of workforce roles to identify family related strengths and provide resources that are sensitive to the health and economic disparities experienced by families are essential elements for wholistic recovery care.

Looking ahead to 2021 and 2022 the PAC's agenda includes:

- Advocating for the development and the dissemination of peer family recovery continuing education curriculum to the state peer workforce;
- Reviewing the current clinical providers work force's capacity and training to identify and respond to the family recovery needs of youth, young adults, and adults;
- Establishing a collaborative, inter-agency/inter-organizational family recovery learning collaborative to advance knowledge, training, and services to address a whole family response to mental health and substance use disorders; and
- Collaborate with statewide efforts to advocate for improvement of the quality of behavioral health care for children, youth and families.

Housing Subcommittee Overview

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

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

The Housing Subcommittee includes representatives from DMH provider agencies, family members, peers, state housing agencies, ACCS providers, advocacy agencies, and DMH staff from across the state. Membership of the Subcommittee has grown over the last two years with 35-45 active members and a mailing list just over 100 people. Members met 12 times since January 2020; 9 times in 2020 and 3 times in 2021. During the peak of the pandemic the subcommittee met virtually bi-weekly to support each through navigating the challenges of COVID-19.

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

- **DMHRSP Video:** The Housing Subcommittee created a YouTube video which explains how the DMH Rental Subsidy Program (DMHRSP) works. This video was finalized in January 2020 and is used to help ACCS participants, landlords, provider staff, DMH staff, and state legislatures understand the intricacies of the voucher;

- **DMHRSP Advocacy:** The Housing Subcommittee, along with the tireless efforts of MAMH, continuously advocated to increase the funding for the DMHRSP. In 2020, $3M was added to the state budget and the program has grown to house 1,750 people in the state;

- **Peer Support and Housing Workgroup:** Subcommittee members have led an effort to bring the voice of peer supporters into the work of housing. MAMH issued a report late last fall highlighting the valuable role peer supporters can play helping individuals find and keep their housing. The report outlined a series of recommendations including expanding the number of peers, increasing housing knowledge among peers, forming regional groups of peers focused on supporting clients in housing, and expanding

housing training opportunities for peers. MHBG technical assistance funds in the amount of $30,000 were committed to initiate implementation of the recommendations. This workgroup continues to meet and develop this plan;

- **Safe Haven Work Group:** Several subcommittee members formed a workgroup that encouraged the DMH Commissioner to seek state funding for three new Safe Haven programs in the Northeast, Western MA, and Southeast Areas. The group is also developing a set of program principles in addition to strategizing how to respond to the DMH Request for Information tied to new federal COVID-19 relief funds to address prevention, intervention, treatment, and recovery support services;

- **Statewide Provider Meeting:** In August 2020, the Housing Subcommittee hosted a Statewide Provider Meeting to address barriers, successes, and best practices to housing individuals within the ACCS Program. Providers have met for a total of five times to continue a dialogue around housing and supporting individuals receiving ACCS services;

- **Roommates Workgroup:** A small group of committee members met a couple of times to talk about ways to support individuals looking for roommate situations. The group plans to report back to the larger subcommittee during the next meeting; and

- **DMH Housing Plan:** This coming year the subcommittee will focus on the implementation of the Department's Housing Plan. The key objectives of the plan are to: 1) Expand DMH Rental Subsidy Program funding annually and improve fiscal management in conjunction with DHCD; 2) Increase utilization of the DMHRSP Tenant-Based subsidy; 3) Expand Safe Haven beds and resources for program staffing support contracts across the state; 4) Increase the use of both State and Federal affordable housing resources to serve DMH clients; and 5) Effectively manage housing resources and track movement through the DMH system.

Elder Mental Health Collaborative Subcommittee Overview

The Elder Mental Health Collaborative advocates for the behavioral health needs of elders. Its membership includes senior leaders from DMH, the Executive Office of Elder Affairs (EOEA), the Department of Public Health, representatives from local provider coalitions across the state, and statewide aging and mental health trade associations. The Collaborative advocacy efforts are of critical importance given the majority of the Massachusetts population in the next twenty years will be over 60 and over half of older adults receive their mental health care from primary care.

The subcommittee has been working with DMH, the Executive Office of 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 worked with the State Legislature to secure funding for six Elder Mental Health Outreach Teams across the state. Overseen by EOEA, these outreach teams work with older adults who are not connected with services to provide crisis intervention and connection with behavioral health services.

The Collaborative has been studying evidence-based practices and considering their potential application within Massachusetts. Several key models (IMPACT, PEARLS, Healthy IDEAS, In-SHAPE) appear to have great promise, and the Collaborative supports the development of new initiatives to replicate such models. Additional identified opportunities include addressing 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.

In addition to promoting evidence-based practices, the Collaborative has engaged in numerous additional projects over the last several years including 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.

Young Adult Subcommittee Overview

The Young Adult Subcommittee serves as an advisory board to the Massachusetts State Mental Health Planning Council (SMHPC), and influences the development of DMH's Transition Age Youth (TAY) Initiative. It enhances collaboration between youth and young adults with mental health challenges and their supporters to provide information about available supports, services, and resources. The subcommittee educate others about how mental health and recovery is perceived in the community, and advocates for change by shaping and improving policies and systems that are designed to support mental health for youth and young adults.

The vision of the subcommittee includes:

- Inspire hope and recovery, open possibilities, and facilitate youth and young adult voice within DMH;

- Empower every youth and young adult to realize their unique gifts, participate in self-advocacy, become part of systems change, and have access to supports and resources to help them in their recovery and transition toward independence;
- Work collaboratively with youth and young adults with lived mental health experiences, service providers, advocates, and policy makers to inspire hope and recovery; and
- Addresses mental health services and supports for specific life domains, such as employment, education, housing, and issues related to relationships, safety, health and well-being.

Membership of the subcommittee includes DMH Area representatives who report on progress related to supported employment, education, housing, training, and young adult activities (i.e. young adult councils, trainings). In addition, the Young Adult Subcommittee collaborates with other subcommittees of the SMHPC, in particular the Employment and Housing subcommittees.

Employment Subcommittee Overview

The mission of Employment Subcommittee is to promote timely and effective access to employment and career services that are integrated and coordinated with treatment and housing services, and to work collectively toward the common goals of promoting rehabilitation and recovery.

Employment is one of the basic essential elements of life in our culture. All members of this culture should be encouraged to participate without discrimination. This includes people in recovery with serious mental illness.

All public and private agencies that serve the needs of people in recovery with serious mental illness need to create opportunities to develop relationships and learn to work together, sharing experiences, and identifying barriers to employment and successful ways of overcoming these barriers.

The Employment Subcommittee gathers information on current vocational rehabilitation, employment, and education services and their integration across agency lines and with treatment and housing services, including statistical data. The group makes recommendations based on this information; monitors the implementation of these recommendations; and advocates for the resources to operationalize them.

Transcom Subcommittee Overview

The Transcom subcommittee is a broad-based coalition of diverse stakeholders from the mental health and substance use fields who are committed to building consensus and strengthening recovery supports throughout the Commonwealth which are person-driven and sustainable. It determined that establishing peer support roles and peer-operated programs as integrated and respected parts of the workforce is the most effective strategy for achieving these aims. The priority goals include:

- Support, safeguard, and expand Certified Peer Specialists, Recovery Coaches, peer workers, and peer-run programs;
- Promote information, education, and training on innovative recovery practices; and
- Advocate for funding for peer workers and innovative recovery oriented services.

The Transcom Subcommittee has been instrumental in supporting the implementation of much of the peer support workforce that exists today throughout Massachusetts. This rapidly expanding workforce is now integrated into both public and private service settings, including clinical and other community-based services, peer-run services, and inpatient care.

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

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

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

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

To address these challenges, as discussed in Part 1, the Baker-Polito Administration is proposing a Roadmap for Behavioral Health Reform to help people find the right treatment when and where they need it. Critical behavioral health system reforms through the Roadmap will include:

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

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

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

Incorporating Race, Equity, and Inclusion Practices

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

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

Culturally Responsive Services

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

Needs: All sectors of the service system are challenged by the ability to recruit and retain a qualified workforce, particularly for culturally and linguistically diverse populations. Access to services can be challenging, particularly for people for whom English is not their primary language. As DMH redesigns its service system, particular attention needs to be placed on ensuring that health care disparities among cultural and linguistic minorities are reduced and eliminated.

Furthermore, DMH serves approximately 109 people identified as Deaf or using American Sign Language as their preferred language and approximately 155 people who are Hard of Hearing. It is difficult to estimate how many people should be served but typically, Deaf people are under-represented. The high frequency of trauma would indicate that people who are Deaf are at greater risk for mental health and substance abuse problems. Often people 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 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. Training efforts and other accommodations are being pursued to address the challenges of providing linguistic and cultural access and treatment within this setting.

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

Infrastructure Support to Track and Monitor Process and Performance

Strengths: During the past two year period DMH has gained capacity for data-driven decision making. One key element is the expanded use of the Tableau data visualization software to promote a statewide approach to monitoring the Adult Community Clinical Services (ACCS), Clubhouses, and Children Youth and Families programs. DMH purchased 200 Tableau Viewer licenses and assigned them to DMH Site office staff. This facilitated their access to the ACCS contract monitoring and management dashboards, allowing staff members to both monitor clients' progress in recovery and vendors' contract compliance. Using an "impersonation" function, protected health information accessible through the visualizations is limited to a viewer based on their role-based access rights. Through this implementation the DMH Privacy Office worked with the DMH Assistant Commissioner for Quality, Utilization, and Analysis in developing a data governance framework, the Tableau Workforce Member Access Tables.

Needs: DMH currently has an IT infrastructure that does not easily support the collection, verification, and analysis of data for use in determining process and outcome performance. These are critical in determining program progress and success. Data and quality work are heavily dependent on technology. As the pandemic forced staff to work remotely, gaps in network infrastructure and aging hardware have challenged remote work efforts. This issue is not unique to DMH yet the nature of working with data as well as with office software has highlighted unmet technology service needs. DMH is currently working with EOHHS IT to identify needs and implement improvements that will benefit programs across DMH. Identified needs include data management, data warehouse improvements, creation of data marts, improved data access, and eventual use of advanced analytics to support program.

Telehealth

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

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

Implementation and Support for Evidence-Based and Emerging Practices

Strengths: DMH has engaged in significant efforts to implement evidence-based and emerging practices in a systemic manner, including the restraint and seclusion prevention/elimination initiatives in the child and adult systems, System of Care, trauma-informed care (child and adult systems), person-centered planning, supported employment, and Zero Suicide. DMH has partnered with providers, consumers, family members, academic institutions, and other experts to develop and implement these initiatives. During the 2016 Certification of Community Behavioral Health Clinics Planning Grant, DMH worked with members of the Association for Behavioral Health to identify evidence-based practices considered essential to recovery. EBPs identified are Motivational Interviewing (MI); Cognitive Behavioral Therapy (combined with medication, where appropriate); Wellness Recovery Action Plan; Medication Assisted Treatment; Screening, Brief Intervention, and Referral to Treatment; harm reduction; and an array of psychosocial rehabilitation models, including Supported Employment and Permanent Supportive Housing.

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

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

Community Services Standards and Outcomes

Strengths: The redesign of adult community-based services intended to further strengthen DMH's ability to carry out its commitment to addressing the needs of specific populations.

DMH is promoting a recovery system that is founded on the principles of person-centered care tailored to meet the individual needs of people served, including those whose needs are related to culture, language, sexual orientation, gender, age, and disability. Service standards in DMH contracts require that:

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

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

Behavioral Health Integration

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

Needs: DMH, BSAS, and MassHealth are each separate entities within EOHHS with distinct eligibility requirements, business process, and data systems. DMH administers continuing care community and inpatient services. Most public acute-care inpatient and outpatient services are funded and overseen by MassHealth and its managed care entities and more than half of DMH child and adolescent clients have at least part of their treatment paid for by their parent's

private insurance. This separation in funding can make it difficult to integrate the clinical and fiscal components of service delivery that need to be in place for individuals with complex service needs. It impedes care coordination and is a barrier to early identification and delivery of timely follow up care. The agencies continue to work together to identify strategies to better integrate services as well as obtain a complete picture of the people who are accessing behavioral health and specialty care funded through each entity.

Suicide Prevention Services

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

Needs: Even with this strong commitment to better address suicidality, the needs are great and there is a gap between the aspirational goal and the ongoing challenge of assuring the delivery of effective suicide prevention, intervention, and postvention services. DMH does not have a dedicated budget to staff suicide prevention specialists, and relies heavily on short-term SAMHSA grant funding for staffing and the promotion of evidence-based practices. DMH's efforts to instill safer suicide care practices across the DMH and the larger MA health and behavioral health care systems would be greatly advanced with additional resources, in particular dedicated staff, to support the enormous amount of ongoing work in partnership with the MSPP in order to assure meaningful implementation of and fidelity to current best practices with a goal toward reducing suicide attempts and deaths across the Commonwealth.

Affordable Housing and Coordinated Services for People Experiencing Homelessness

Strengths: The focus of DMH housing staff is to create independent, integrated housing in the community for DMH clients. The ability of staff to spend time and energy exclusively on managing housing resources has enabled DMH to grow its own rental assistance program and

create strong linkages with non-profit agencies, for-profit agencies, and municipalities who develop affordable housing. Furthermore, with our PATH grant we serve homeless individuals with mental health conditions and co-occurring mental health and addiction in shelters and on the streets. These situations make it extremely challenging to serve an individual in traditional settings. Without PATH it is difficult to comprehend how DMH would possibly care for these individuals. It is literally a life-saving service.

DMH is working with MassHealth and others to address the issue of discharges to shelter from private psychiatric hospitals. DMH Licensing established a tool for shelters to record and collect data on inappropriate discharges that come to their shelters. This data will inform the development and monitoring of policies and strategies addressing these discharges.

The State Mental Health Planning Council Housing Subcommittee led the effort to formulate the DMH Housing Plan with the goal to create movement through the DMH service system and support the Commonwealth's effort to end homelessness for individuals experiencing mental health and co-occurring conditions, including continued expansion of the DMH Rental Subsidy Program (DMHRSP). This recommendation was supported in the FY22 budget with an additional two million dollars in new funding , which brings the total DMHRSP budget to over $17 million. The DMH Rental Subsidy Program is currently serving over 1,700 clients. The plan further seeks expansion of Safe Havens programs and increased funding for Program Staffing Supports targeted to homeless support programs serving homeless individuals with SMI who are reluctant to enter traditional treatment settings. A smaller subgroup of the SMHPC Housing Subcommittee formed specifically on this topic of Safe Havens/Program Staffing Supports spearheaded by homeless providers and generated written guidance to those responding to the recent DMH COVID-19 Supplemental Funds Request for Information outlining the need to address discharge planning, expand homeless outreach services, and increase access to stable housing.

Needs: The quantitative demand for housing has not been fully measured. However, DMH providers, advocates, homeless shelters, and outreach programs continue to ask for more housing resources in the form of subsidies and capital investment. This demand is tied to the larger issue of the lack of affordable housing for low-income and working families, individuals with disabilities, those fleeing domestic violence, experiencing homelessness, and those with mental health and co-occurring conditions. In a recent state capital funding round for affordable housing over 500 units were awarded funds, yet only five of those units are dedicated to DMH clients. DMH has over 100 individuals currently on the DMH Rental Subsidy waitlist and counts an additional 2,300 as receiving assistance from the five DMH contracted and State-operated Homeless Outreach programs.

Peer and Family Member Involvement and Workforce

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

Needs: There continues to be a need to recruit and train additional peers and family members to assume paid roles in the system, particularly those from cultural and linguistic minority populations. There is also a need for ongoing continuing education and support to people engaged in this work as well as training and other efforts to shift organizational culture to support recovery and acceptance in workplace, including disclosure of mental health conditions and recovery experiences.

Increase Access to Peer Support and Peer-run Services

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

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

Expand Available Employment Services

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

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

Forensic Services

Strengths: Massachusetts is able to provide court ordered competency evaluations mostly in non-correctional settings in a speedy manner due to the robust DMH forensic mental health system in partnership with the Trial Court. Furthermore, the highest degree of excellence and professionalism is maintained via our rigorous Forensic Professional certification process and quality surveillance system.

Needs: Limited psychiatric facility capacity, housing, and access to certain specialty services and community supports for forensic patients and for releasing inmates continues to be a challenge for our system in the Commonwealth.

Connection with Schools

Strengths: DMH is firmly committed to supporting and strengthening linkages with schools and school-based services, and to developing a workforce knowledgeable about special education services, and student and parental rights under special education law. Each DMH Area funds community and school support contracts to offer support and consultation to parents on special education services and how to work with their local education authorities. DMH staff participate in a statewide special education advisory council to advise our state's single state education authority and also participate in IEP and school meetings at the local level for DMH-

served youth. DMH knows that schools provide an important opportunity to identify children and youth at-risk for behavioral health conditions and to link them with needed services.

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

Recognize the Early Signs of a Behavioral Health Challenge

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

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

Assist Families Navigating the System

Strengths: Massachusetts is in the midst of designing a new "front door" to treatment, a centralized service for people or their loved ones to call or text to get connected to mental health and addiction treatment. This front door will help families connect with a provider before there's a mental health emergency, for routine or urgent help in their community, or even right at home, allowing individuals and families to fully access the range of comprehensive services offered in the Commonwealth.

Needs: Families often struggle to know where to start or who to turn to when their child is in need of behavioral health treatment. The current system is designed to follow the logic and flow of funding and administration as opposed to the human experience. As such, families do not know where to turn, and some are experiencing long wait times to receive services or end up using an emergency department to meet an urgent need.

Provide Flexible Supports and Services for Young Adults

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

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

Coordinated Care for Older Adults

Strengths: DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan; and DMH requires providers to deliver services that are age and developmentally appropriate, including services for elders. Over the last seven years, DMH and the Executive Office of 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 has also been engaged as a key state partner and these agencies are working together to leverage resources to focus on suicide prevention in older adults.

Needs: DMH recognizes the need to coordinate care more closely for older adults with serious mental illness who need wrap around services from both home care agencies and behavioral health providers. The population of individuals with serious mental illness is getting older, and no one government agency is equipped to handle this need.