Office of Behavioral Health Promotion and Prevention

Summary of Environmental Scan: Landscape Analysis, RFI, and Community Listening Sessions

August 2025

OBHPP Office of Behavioral Health Promotion & Prevention

MASS DMH HOPE • EQUITY • SERVICE Department of Mental Health

Background on the Office of Behavioral Health Promotion & Prevention

Establishment of the Office

OBHPP is a newly established Office within the Massachusetts Department of Mental Health (DMH) under the Executive Office of Health and Human Services (EOHHS). OBHPP works in partnership with the Community Behavioral Health Promotion and Prevention Commission and is dedicated to creating and supporting positive population-level impacts via upstream behavioral health promotion and prevention initiatives.

Legislative Mandate

OBHPP has been tasked with the coordination of all executive office, state agency, independent agency, and state commission activities that promote behavioral health and wellness.

Interagency Work

The office is responsible for setting internal goals for the promotion of services and programming for behavioral health and substance use conditions, integrating health equity principles, and applying a health equity framework to all its duties and obligations.

Evaluation and Reporting

The office is required to evaluate the effectiveness of initiatives and report annually on its progress and the Commonwealth's overall progress in 1) promoting behavioral health, 2) preventing substance use, 3) prevention of violence, and 4) using quantifiable measures and comparative benchmarks.

Mission, Vision & Health Equity Statement

Mission

Our mission is to promote behavioral health and wellness among the Commonwealth's residents. We are committed to statewide coordination and implementation of innovative, evidence-informed, data-driven, and trauma-informed strategies to advance the promotion of behavioral health and the prevention of mental health conditions, including substance use disorders; we aim to eliminate stigma, racial discrimination, and social inequities to strengthen the Commonwealth's residents' overall quality of life.

Vision

Our vision is a thriving and resilient Commonwealth where behavioral health promotion and prevention are fully integrated into every aspect of community well-being, fostering a culture of health equity and empowerment where all can engage fully in life.

Health Equity Statement

We are committed to ensuring fair and just pathways for behavioral health promotion and prevention initiatives for all, centering those with historically marginalized identities, including people who identify as Black, Indigenous, and people of color (BIPOC), people with disabilities, people who are incarcerated, veterans, LGBTQ+, and non-English speaking individuals. We prioritize accessibility, timeliness, affordability, cultural sensitivity, high-quality initiatives, and eliminating inequities through community engagement, trauma-informed initiatives, and data-driven approaches. We advocate for policies that support behavioral health equity for all.

Objectives for Social Impact

Core Values

Collaboration | Equity | Innovation | Competence | Resilience | Accountability

Mission Outcomes

- Resilient & Responsive Commonwealth
- Healthy and Safe Communities
- Improve Individual Well-Being

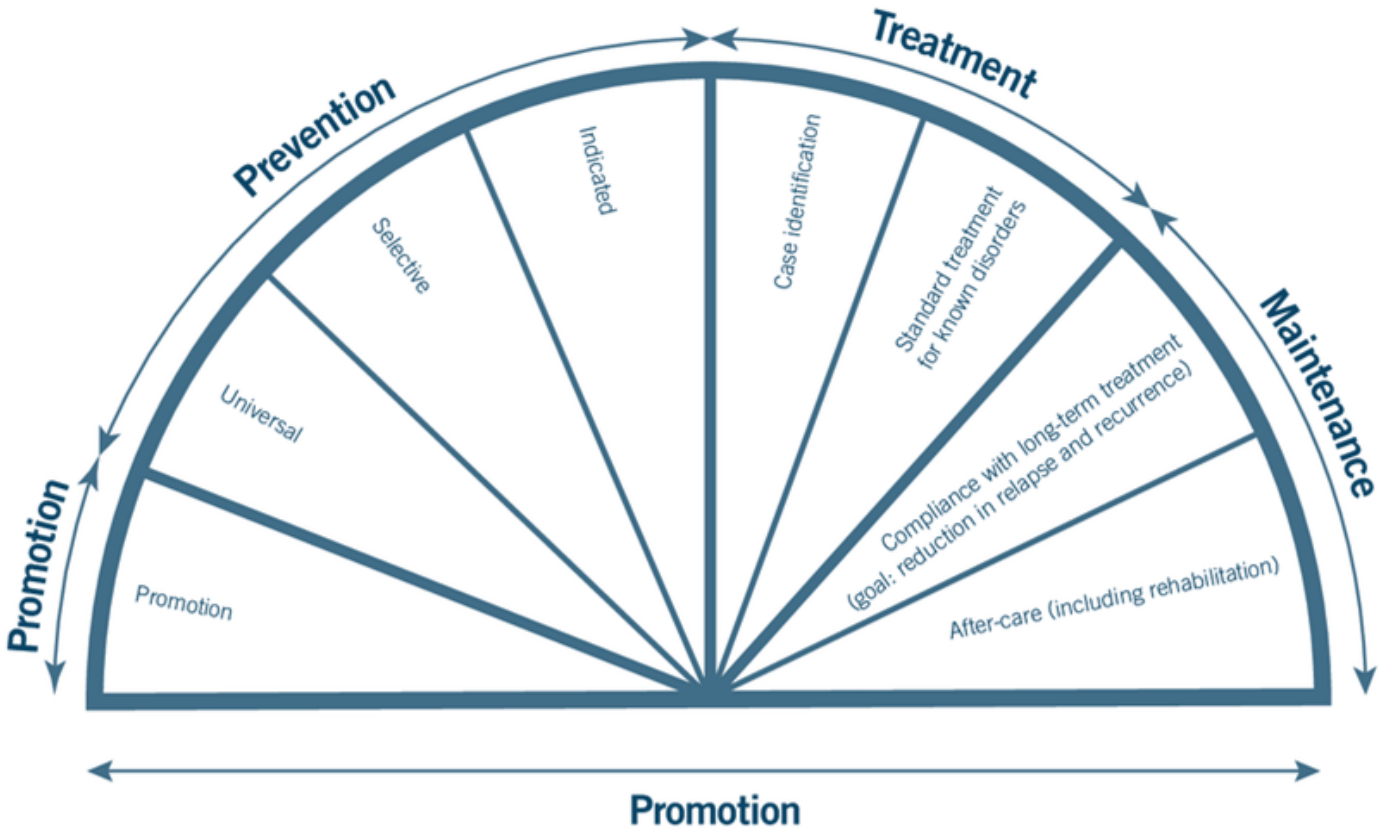
Objectives for Social Impact

- Improve Mental Health Wellbeing
- Reduce Stigma and Discrimination
- Advance Behavioral Health Equity
- Prevent Suicide
- Prevent Violence
- Prevent Substance Use Disorders
- Promote Positive Childhood & Youth Experiences

Defining Behavioral Health Promotion & Prevention

Promotion
Behavioral health promotion focuses on helping people acquire the knowledge and skills they need to promote and protect their mental well-being, while simultaneously working to create positive and equitable changes in our shared social environments and systems, where everyone can thrive.

Prevention
Behavioral health prevention is delivered prior to the onset of a condition; these interventions are intended to prevent or reduce the risk of developing a behavioral health problem.



Source: Adapted from Prevention United, “The Building Blocks of Mental Health Promotion,” https://preventionunited.org.au/how-prevention-works/what-is-mental-health-promotion/

Multi-Level Approach to Behavioral Health Prevention

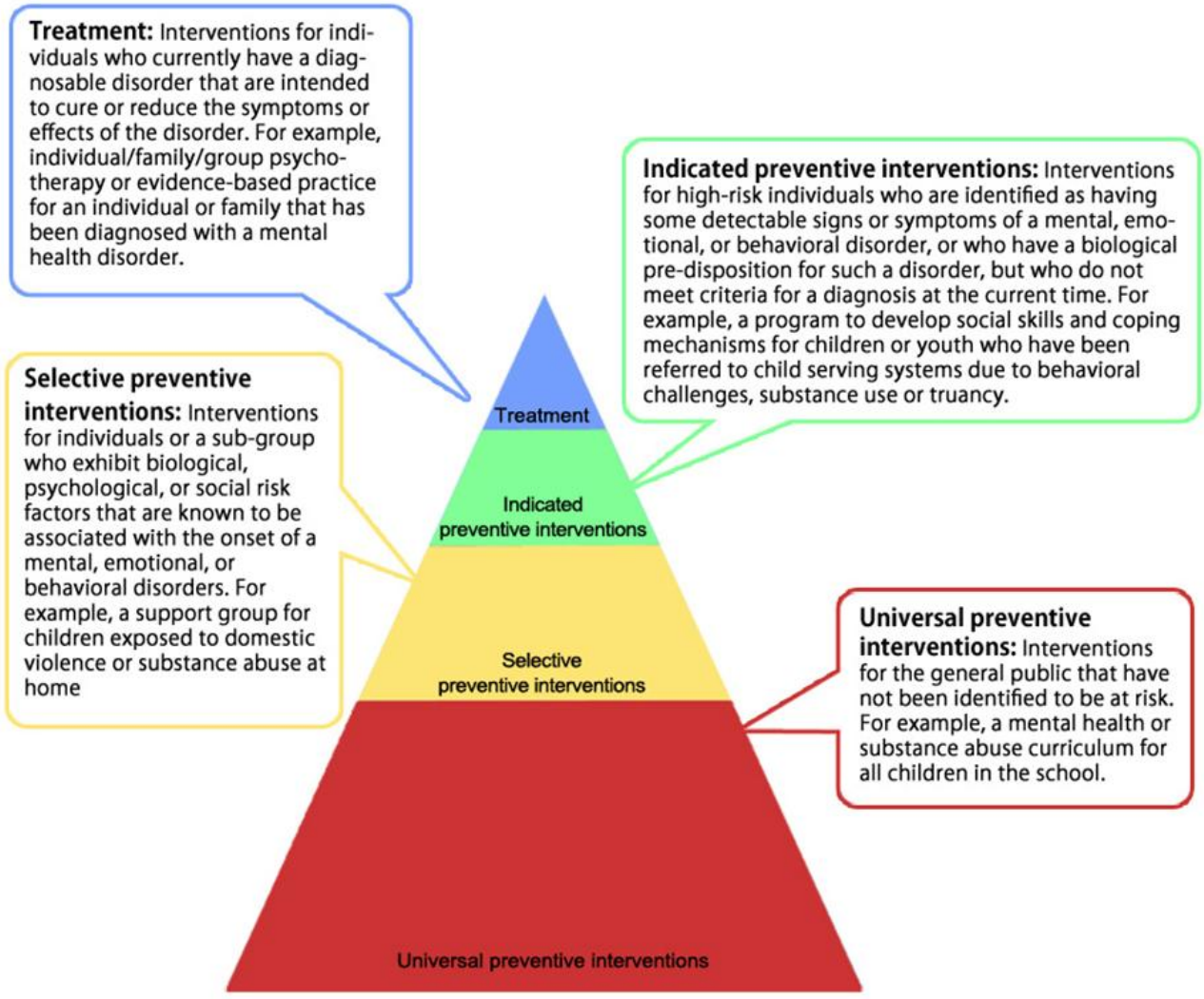
There are three tiers to prevention interventions:

- **Primary Prevention**: prevent the initial occurrence of a disorder or problem.
- **Secondary Prevention**: identify and address early signs of behavioral health issues before they develop into more severe problems.
- **Tertiary Prevention**: managing and mitigating the impact of established disorders to prevent further deterioration and improve quality of life.

OBHPP focuses on primary and secondary prevention interventions.

There are also multiple levels within prevention interventions (see figure).

OBHPP follows this tiered approach with a specific focus on promotion efforts as well as upstream prevention that targets universal, selective, and indicated prevention interventions.



Sources: Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), World Health Organization (WHO)

Social Ecological Model

Social Ecological Model (SEM)

The SEM recognizes how individual behaviors are influenced by multiple levels of social and environmental factors.

It helps guide the development of behavioral health promotion and prevention initiatives that target individual, interpersonal, community, organizational, and societal factors.

Sources: Prevention United; Centers for Disease Control and Prevention. (2015). *The social-ecological model: A framework for prevention.* Atlanta, GA: Author.

OBHPP Core Pillars & Strategic Approach

COORDINATE AND COLLABORATE WITH STATE AGENCIES ON BH AND WELLNESS PROMOTION

DISSEMINATE EVIDENCE-BASED & DATA-DRIVEN PRACTICES TO INFORM DECISION-MAKING WITHIN OBHPP

SUPPORT THE IMPLEMENTATION OF EVIDENCE-BASED PREVENTION AND PROMOTION PROGRAMS, CAMPAIGNS, AND INITIATIVES

STRENGTHEN & COORDINATE ACTIVITIES TO ADVANCE BH EQUITY

BUILD OPERATIONAL INFRASTRUCTURE FOR IMPLEMENTATION, EVALUATION, AND ONGOING REPORTING

Consult Commission of Community BH Promotion and Prevention
Leverage wide-ranging expertise to advise BH prevention and promotion practices

Overview of Environmental Scan

Overview of Environmental Scan

In FY25, OBHPP worked with DMA Health Strategies Inc. to lead a statewide assessment to explore current behavioral health promotion and prevention initiatives. This environmental scan used a three-pronged approach to identify gaps across activities and uncover opportunities for collaboration.

This included 3 data collection efforts:

Landscape Analysis

A comprehensive landscape analysis of current state agency programs, initiatives, and funding related to behavioral health promotion and prevention, highlighting gaps and duplication across state agencies.

Request for Information

An RFI to gather information from interested behavioral health providers, community-based organizations, peer networks, advocates, and individuals from across the Commonwealth. The RFI asked respondents to reflect on current prevention efforts, challenges in accessing public funding, strengths, evaluation needs, and collaboration opportunities.

Community Engagement Sessions

5 community listening sessions representing youth, parents and caregivers, immigrant community leaders, peer support workers, and grassroots organizations explored the same five thematic areas as the RFI.

Data Sources and Areas of Inquiry*

Landscape Analysis

- **Goal:** Completed to gain BHPP insights from the MA *state agency* and *department* perspective.
- **Timeframe:** December 2024
- **Activities:** Key informant interviews (KII) and/or surveys with 12 state agencies and departments
- **Areas of inquiry included:**
  - ✓Total spend per resident
  - ✓Trends in residents affected
  - ✓Morbidity or mortality
  - ✓Trend changes over time
  - ✓Evidence based practices
  - ✓Number of intervention programs

RFI Responses

- **Goal:** Completed to gain BHPP insights from the MA *provider* perspective.
- **Timeframe:** January 2025
- **Activities:** 51 RFI responses from MA public healthcare provider organizations
- **Areas of inquiry included:**
  - ✓Existing BHPP programming
  - ✓Health Equity
  - ✓Evidence based and informed practice and data collection
  - ✓Challenges and barriers to implementation
  - ✓Grant making

Listening Sessions

- **Goal:** Completed to gain BHPP insights from the MA *community* perspective.
- **Timeframe:** May 2025
- **Activities:** 5 sessions**, 189 session attendees
- **Areas of inquiry included:**
  - ✓Strengths and challenges of the current BHPP strategies
  - ✓Suggestions for public BH awareness campaigns
  - ✓Missing and underrepresented BHPP strategies

**While we requested that respondents and attendees focus their feedback on BH promotion and prevention efforts specifically, discussions about treatment and recovery efforts inevitable arose. Some of those responses are captured throughout the findings section and will be shared with the appropriate units for consideration.*

***One session was hosted by the DPH, BSAS Office of Community Health and Equity, another was hosted by the Office for Immigrants and Refugees, the remainder by OBHPP. Registrations flyers were shared in both English and Spanish.*

Landscape Analysis
Methods & Summary of Findings

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Landscape Analysis Overview

The landscape analysis included several key areas outlined below and detailed in the subsequent slides.

Alignment with Key Commonwealth Agencies and Departments

- Agency Description
- Agency Priority Areas
- Agency Promotion and Prevention Areas

Key Learning Domains

- -Loneliness and social isolation
- -Immigrant MH
- -SUD prevention
- -Suicide prevention
- -Infant and early childhood MH
- -Family stress
- -Health equity
- -Violence prevention
- -Maternal MH
- -School based MH

Evidence Based and Informed Practices

- Supporting programs with high evidence-based practices
- Bolstering programs with low evidence-based practices

Advancing Health Equity in Massachusetts (AHEM)

- Intent to prioritize the ten AHEM geographical locations in the state experiencing the largest health disparities across a variety of measures

Commonwealth Agencies and Departments Engaged

12 Agencies and Departments Engaged	Department of Mental Health
	DPH, Bureau of Substance Addiction Services
	DPH, Bureau of Community Health and Prevention
	DPH, Bureau of Family Health and Nutrition
	Department of Youth Services
	Department of Elementary and Secondary Education
	Office for Refugees and Immigrants
	Commission for the Deaf and Hard of Hearing
	Executive Office of Elder Affairs
	Executive Office of Veterans Services
	MassHealth
	Substance Abuse and Mental Health Services Administration

Key Learnings Across Priority Domains

1. **Key learning #1 Loneliness and Social Isolation:** At least 25% of young adults ages 18-24 report usually or always feeling isolated from others; the highest % of any age group. Very little public spending is directed at prevention of loneliness and social isolation.

2. **Key learning #2 Family Stress:** Between 2019 and 2023, the percent of parents of children aged 18 or less who reported high stress levels rose from 24% to 33% in a nationwide study by the American Psychological Association. Low-income and other disadvantaged families are more likely to experience depression & MH conditions.

3. **Key learning #3 Immigrant Mental Health:** In 2013 about 15.6% of residents were foreign-born, in 2023 that number rose to 18.1%. A 2015 survey showed that 5% of recent immigrants reported a high degree of psychological distress whereas in 2021 that same survey showed over 12% of respondents experienced a high degree of psychological distress, more than doubling over the 6-year period.

4. **Key learning #4 Health Equity:** Identifying and uplifting protective factors in communities that are underserved, leads to better promotion of behavioral health equity as opposed to only focusing on “risk-factors.” Advancing Health Equity in Massachusetts (AHEM) initiative has identified ten focus regions across the Commonwealth.

5. **Key learning #5 SUD Prevention:** Multiple agencies reported having workforce and staffing challenges with regards to both securing funding for positions as well as sourcing experienced candidates. The DPH Bureau of Substance Addiction Services identified alcohol misuse as a need area for increased prevention initiatives.

Key Learnings Across Priority Domains

6 **Key learning #6 Violence prevention:** The number of homicides related to intimate partner violence increased sharply between 2018 and 2022. Additionally, homicide by firearm for Black non-Hispanic individuals and for Hispanic/Latino/a individuals were 34 times and 12 times the rate of homicide by firearms for White individuals.

7 **Key learning #7 Suicide prevention:** DYS, EOVS, EOLD, DPH SPP (and others) have all adopted novel approaches to suicide prevention outreach. Between 2018 - 2022 the share of Hispanic residents in committing suicide nearly doubled, although during the same period overall suicides seems to have leveled off.

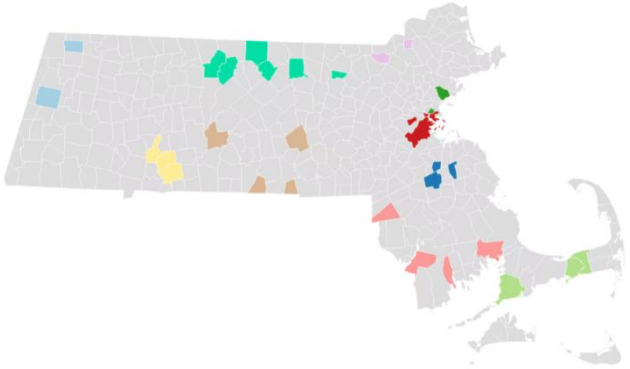
8 **Key learning #8 Maternal Mental Health:** Black, non-Hispanic, and Native Hawaiian / other Pacific Islander birthing people are more than twice as likely to have a stillbirth, and thus experience twice the rate of the psychological distress, low self-esteem, and elevated levels of anxiety and depression associated with perinatal loss.

9 **Key learning #9 Infant and Early Childhood Mental Health:** Individuals who experience early-life mental health challenges are more likely to develop chronic stress, attachment issues, cardiovascular disease, & weak immune & neuroendocrine systems.

10 **Key learning #10 School Based Mental Health:** Over the last ten years, high school student suicide attempts have increased from around ~5.5% in 2013 to ~ 7.6% in 2023. LGBTQA+ youth experience suicidal ideation at 3-4 times the rate of the rest of the high school population.

Largest Health Disparities Identified by Region

OBHPP learned about the AHEM initiative through the Landscape scan and intends to prioritize the ten geographies identified in its work.



Advancing Health Equity in Massachusetts (AHEM)

- As part of Governor Healey's ongoing commitment to regional and racial equity, and to alleviate health inequities, **the Healey-Driscoll Administration laid out a plan for Advancing Health Equity in Massachusetts (AHEM)**.
- AHEM's approach is focused on "place-based" solutions that recognize the unique strengths of each community. **Solutions should be tailored to fit the distinct needs of each community, municipality, and population.** Any health equity initiative must be community-driven and financially sustainable to ensure long-term success.
- Through data analysis across multiple health measures in Massachusetts communities, **AHEM identified ten focused geographies for targeted investments**. The ten geographies encompass 30 communities in Massachusetts experiencing the largest health inequities across a broad range of measures.

AREA	MUNICIPALITIES
Berkshire Area	North Adams, Pittsfield
Boston Area	Dorchester, Mattapan, Roxbury
Brockton Area	Brockton, Holbrook, Rockland
Chelsea-Lynn	Chelsea, Lynn
Fall River Area	Attleboro, Fall River, New Bedford, Wareham
Merrimack Valley	Lawrence, Lowell
Cape Area	Dennis, Falmouth, Yarmouth
North Central Area	Athol, Ayer, Fitchburg, Gardner, Orange, Winchendon
Greater Springfield	Chicopee, Holyoke, Springfield
Greater Worcester	Southbridge, Ware, Webster, Worcester

Source: Advancing Health Equity in MA, Advancing Health Equity in MA | Mass.gov

Request for Information(RFI)
Methods & Summary of Findings

RFI Analysis Overview

The RFI asked 24 questions of respondents that were categorized into the domains below for analysis purposes.

- **Populations of interest and focus areas**
- **Most effective BHPP modalities**
- **Equity**
  - Strategies in diverse communities
  - Organizational equity initiatives
  - Barriers to equitable BH access
  - Measures of equity in BH access
- **Implementation Challenges**
- **Resources Needed**
- **Data**
  - Use of data
  - Types of data collected
  - Defining successful outcomes
  - Data collection challenges
- **Grants and Funding Challenges**

RFI Respondent Organization Profile

OBHPP received 51 responses to the RFI. Responding organization *type* and *focus* are detailed below.

ORGANIZATION TYPE	NUMBER OF RESPONDENTS
Service Provider	24
Coalition	8
TA Provider	7
Other	3
Government Agency	3
Healthcare Provider	3
Advocacy Organization	1
Research	1
Educational Provider	1
TOTAL RESPONSES	**51**

ORGANIZATION FOCUS	NUMBER OF RESPONDENTS
Mental Health	15
Children/Students	9
Substance Use	7
General	7
General Health	6
Elders	3
Families/Parents	2
Immigrants/Refugees	1
Other	1
TOTAL RESPONSES	**51**

RFI Respondent Organization Intervention Profile

OBHPP collected 221 interventions across 51 RFI responses. Below, they are summarized by promotion/prevention level, OBHPP priority population, OBHPP priority area, population level, and population focus,.

Respondents Represented:
✓All BHPP levels
✓All population levels (universal, indicated, and selected)
✓A variety of populations and priority areas including: MH wellness, SUD prevention, stigma reduction, and suicide and violence prevention.

Promotion/Prevention Level	Count
Primary Prevention	54
Promotion	44
Secondary Prevention	30
Treatment	25
Tertiary Prevention	23
None	21
No Response	12
Maintenance	12
Grand Total	**221**

OBHPP Priority Population	Count
NA	116
Student Mental Health and Wellbeing	80
No Response	21
Veterans	3
Healthcare Workers	1
Grand Total	**221**

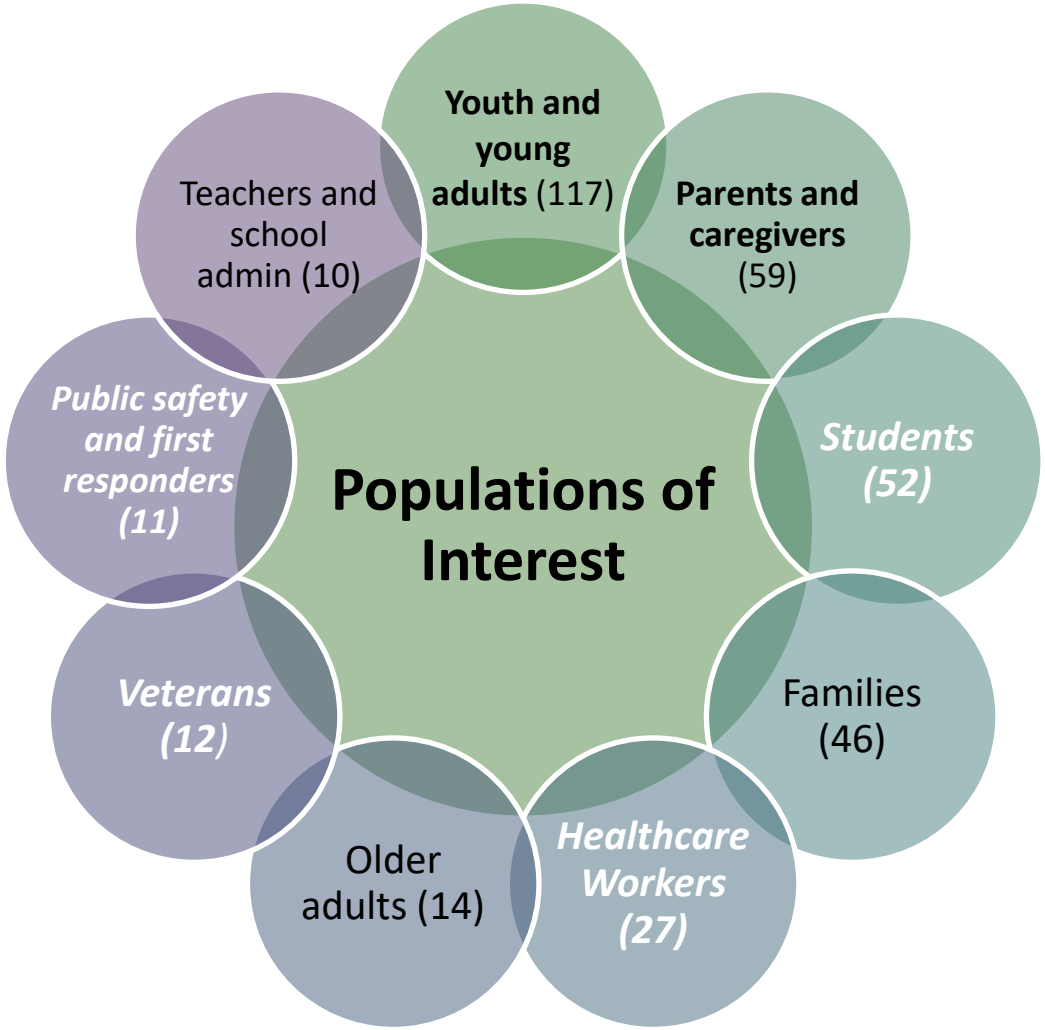
OBHPP Priority Area	Count
Other/NA	66
Mental health wellness	63
SUD Prevention	47
Stigma reduction	14
No Response	12
Suicide Prevention	11
Violence Prevention	8
Grand Total	**221**

Population Level	Count
Universal	123
Indicated	51
Selected	41
No Response	6
Grand Total	**221**

Population Focus	Count
Children/Students	95
General	42
Families/Parents	21
Mental Health	19
Elders	13
Other	9
Substance Use	7
General Health	4
Veterans	4
No Response	2
Homeless	2
Illness/Physical Health	2
Immigrants/Refugees	1
Grand Total	**221**

BHPP Populations Identified by RFI Respondents

Populations in bold, italics, and white font align with the OBHPP mandated special populations.



Youth/young adults and parents/caregivers were the most frequently mentioned.

Additional populations with fewer than 10 mentions included:

- Special populations (BIPOC, immigrants, justice involved people, and LGBTQ+ individuals)
- Behavioral health workers
- People struggling with complex conditions (SMI, co-occurring disorders, chronic illness, and IDD).

BHPP Initiative Focus Areas Identified by RFI Respondents

Focus areas in bold and italics align with the OBHPP mandate.

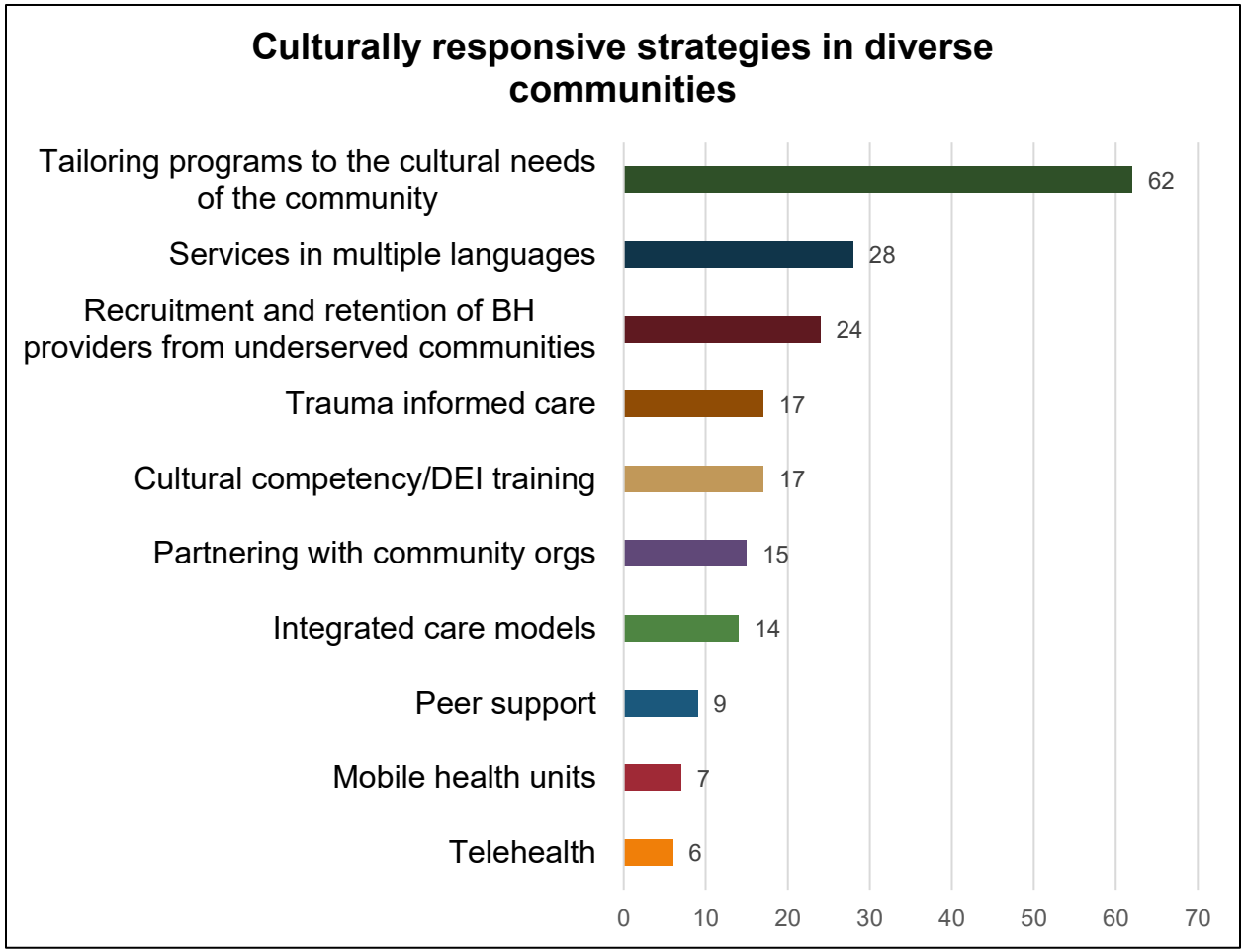
Focus Areas
Mental wellness and education (144)
SUD prevention, treatment, and recovery (132)
Training and technical assistance (57)
Family support (44)
Suicide prevention (44)
Peer recovery and mentoring (39)
Violence prevention (34)
Social emotional wellbeing (26)
Social determinants of health (13)
Linkage to care (12)
Stigma reduction (11)
Crisis support (11)

The areas listed here are the focus of previously described promotion and prevention modalities implemented by RFI respondents.

Additional focus areas were mentioned fewer times and included:

- Harm reduction
- Medical care
- Bullying prevention
- Eating disorder prevention

BHPP Strategies in Diverse Communities and Organizational Equity Initiatives Identified by RFI Respondents



- RFI respondents shared a variety of strategies related to BHPP strategies in diverse communities, summarized in the chart to the left.
- When asked about the equity initiatives of the organization for which they work, most respondents reported that related structures were in place, including:
  - ✓ Internal processes for centering health equity in program design (Yes, 41; No, 1)
  - ✓ DEI team (Yes, 34; No, 3)
  - ✓ Equity statement (Yes, 18; No, 7)
  - ✓ Equity included in organization's vision and mission (Yes, 38; No, 1)
  - ✓ Hiring staff that represent communities served (Yes, 39; No, 1)

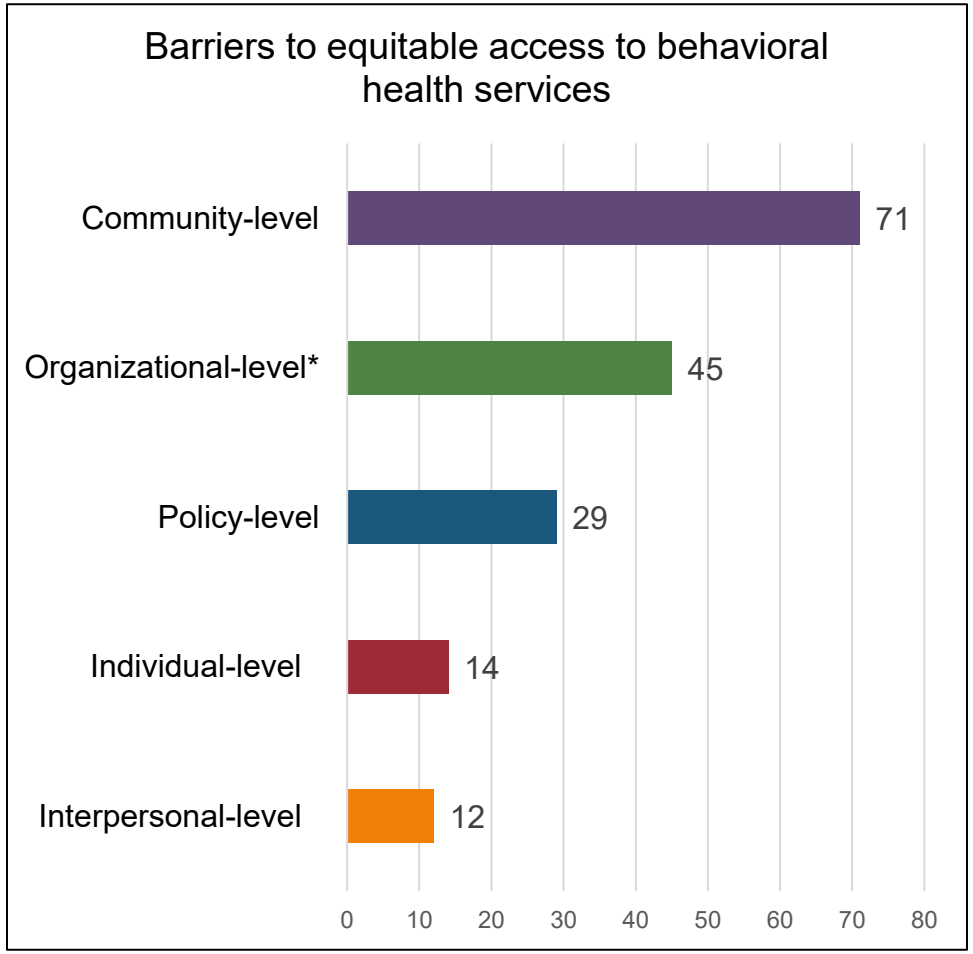
BHPP Strategies in Diverse Communities and Organizational Equity Initiatives Identified by RFI Respondents

"Culturally responsive strategies and programs have shown improved engagement and effectiveness in promoting mental health and preventing behavioral health conditions in diverse communities. The most impactful approach to developing culturally responsive strategies is to ensure that community members and/or investigators with lived experiences are involved in the development and adaptation of the strategies. By empowering professionals from diverse backgrounds to design, implement, and lead these programs, organizations can ensure interventions are genuinely grounded in cultural knowledge and lived experiences. Dedicated funding for diverse creators enhances cultural authenticity and relevance of programs, increases trust and engagement from target communities, promotes equity in the mental health field, and incorporates unique cultural perspectives and solutions."
–RFI Respondent

"Successful models of care emphasize culturally grounded, community-driven approaches, such as the implementation of prevention programs tailored to the specific needs of rural and NHPI populations. These interventions demonstrate that integrating cultural and familial influences with health promotion strategies can enhance access and outcomes. Evidence from rural settings underscores the importance of aligning interventions with cultural values and community dynamics to address behavioral health disparities effectively."
-RFI Respondent

"[Our organization] integrates health equity into every aspect of its operations through dedicated processes, organizational structures, and a strong focus on diversity and inclusion. We center health equity in program design by using a trauma-informed and culturally responsive framework that prioritizes the needs of underserved populations, including communities of color, immigrants, and LGBTQ+ individuals. Our Diversity, Equity, and Inclusion (DEI) team oversees initiatives to ensure equity is embedded in hiring practices, staff training, and service delivery."
-RFI Respondent

Barriers to equitable access to behavioral health services identified by RFI respondents



- The Social Ecological Model (SEM) was utilized to categorize responses to the question regarding barriers to equitable access to behavioral health services.
- The SEM is a framework for understanding the multiple levels of influence on individual behavior. It suggests that health and behavior are shaped by interactions across five levels:**
  - ✓ *Individual* – knowledge, attitudes, skills, behaviors
  - ✓ *Interpersonal* – friends, family, social networks
  - ✓ *Organizational* – workplaces, schools, faith-based organizations, healthcare systems
  - ✓ *Community* – cities, neighborhoods, resources, social norms
  - ✓ *Policy/societal* – federal, state, local legislation
- It emphasizes the importance of addressing factors at all levels to create sustainable change.
- RFI respondents identified *community*, *organizational*, and *policy level barriers* as having the most impact on equitable access to behavioral health services.

**Organizational includes N=27 workforce specific barriers*

***McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. Health Education Quarterly, 15(4), 351-377.*

Barriers to equitable access to behavioral health services as identified by RFI respondents

The quotes from RFI respondents below are organized by SEM level and pertain to barriers to equitable access to BH services.

Individual

- "Fear of discrimination further exacerbate these challenges, leading to delayed or missed care."
- "Families are often resistant to participating in mental health interventions being offered to them if they lack other basic needs because food and housing, for example, are more pressing concerns."
- "Stigma and lack of awareness: Fear of stigma and insufficient education about mental health issues prevent many from seeking help or recognizing symptoms."

Interpersonal

- "Challenges Unique to LGBTQI+ Populations: Among youth, there may be higher incidences of familial rejection and bullying."
- "When ensuring equitable access, it is vital to consider the time it may take to build rapport and trust with some of the most underserved populations who may be hesitant to engage."
- "The challenges underserved individuals experience, especially BIPOC populations, are typically a result of generational trauma as well as early family instability including foster care involvement, family homelessness, and/or a parent with a mental health condition and/or addiction."

Organizational

- "Additionally, the nationwide shortage of mental health professionals—particularly those trained in cultural competence— leaves many diverse populations without access to care that meets their unique needs and experiences."
- "The single greatest challenge for most of these initiatives is sustainability when current grant funding ends. We are exploring ways to condense and refine these models so that they are less costly, while also maximizing the benefits offered."

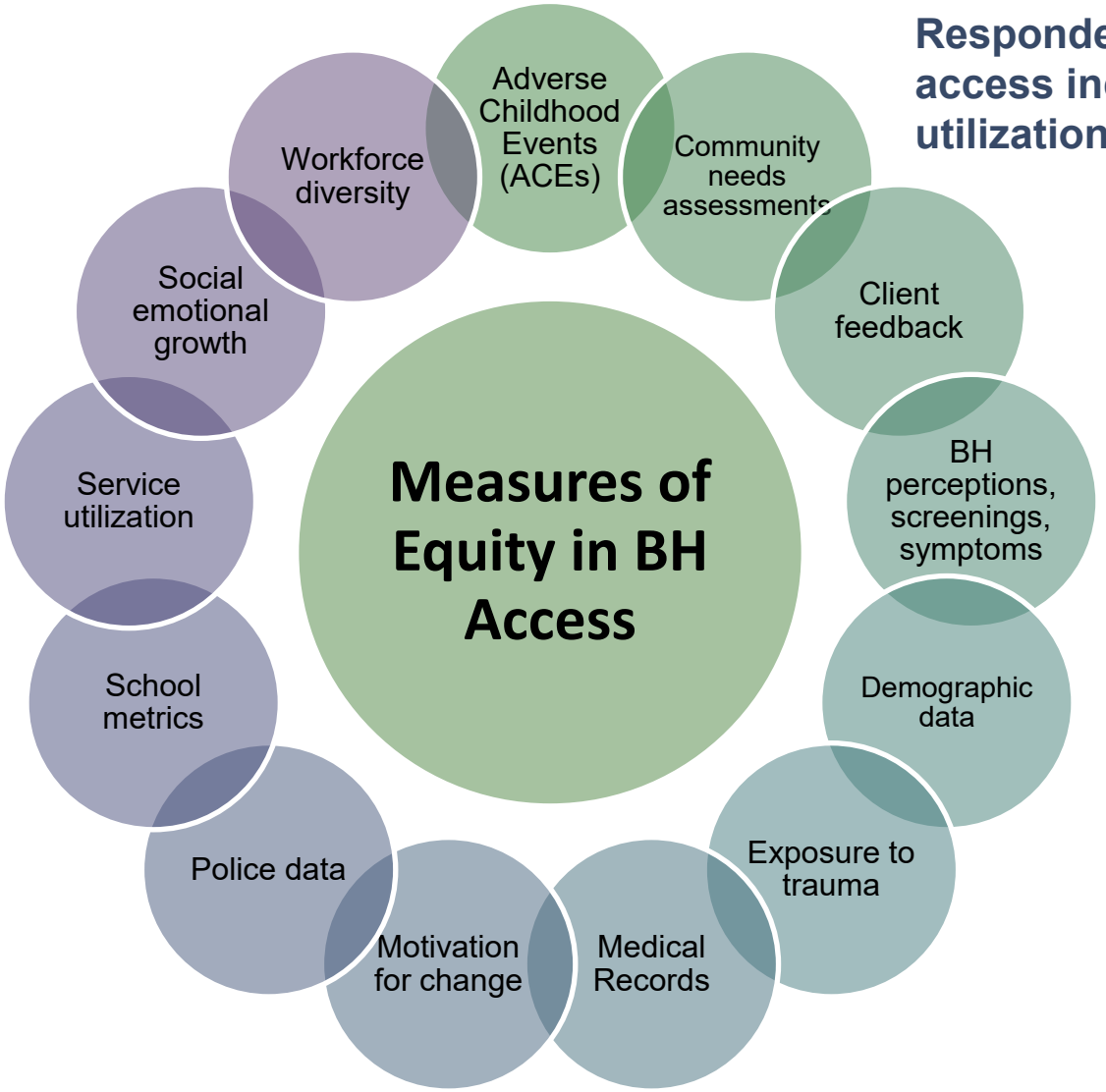
Community

- "Transportation is a large barrier for underserved people living in rural Western Massachusetts to access food, health care, [etc.] It often takes several hours and multiple bus changes to get to remote locations."
- "Housing costs are one of the single largest contributors to inadequate workforce capacity to prevent and reduce substance misuse and addiction; there is little the agencies can do to increase underlying salaries without a significant increase in reimbursables."
- "Some programs may lack culturally responsive or developmentally appropriate approaches. It is important for programs to partner with community members to fully understand needs and gaps and develop responsive programming and engagement strategies."

Policy

- "Systemic issues, including anti-immigration policies and the overall political climate, further complicate access for immigrants and refugees, as fear of deportation or discrimination can deter individuals from seeking care."
- "Complexities in insurance and coverage (for example, the different benefits and services covered between MassHealth ACOs versus MassHealth Limited) can make access to preventative behavioral health services difficult and discourage providers to engage with underserved populations."
- "Legislative and policy limitations may restrict the accessibility and range of services provided. Interacting with elected officials to create supportive legislative frameworks can enhance the accessibility and integration of behavioral health care."

How organizations measure equity in behavioral health access

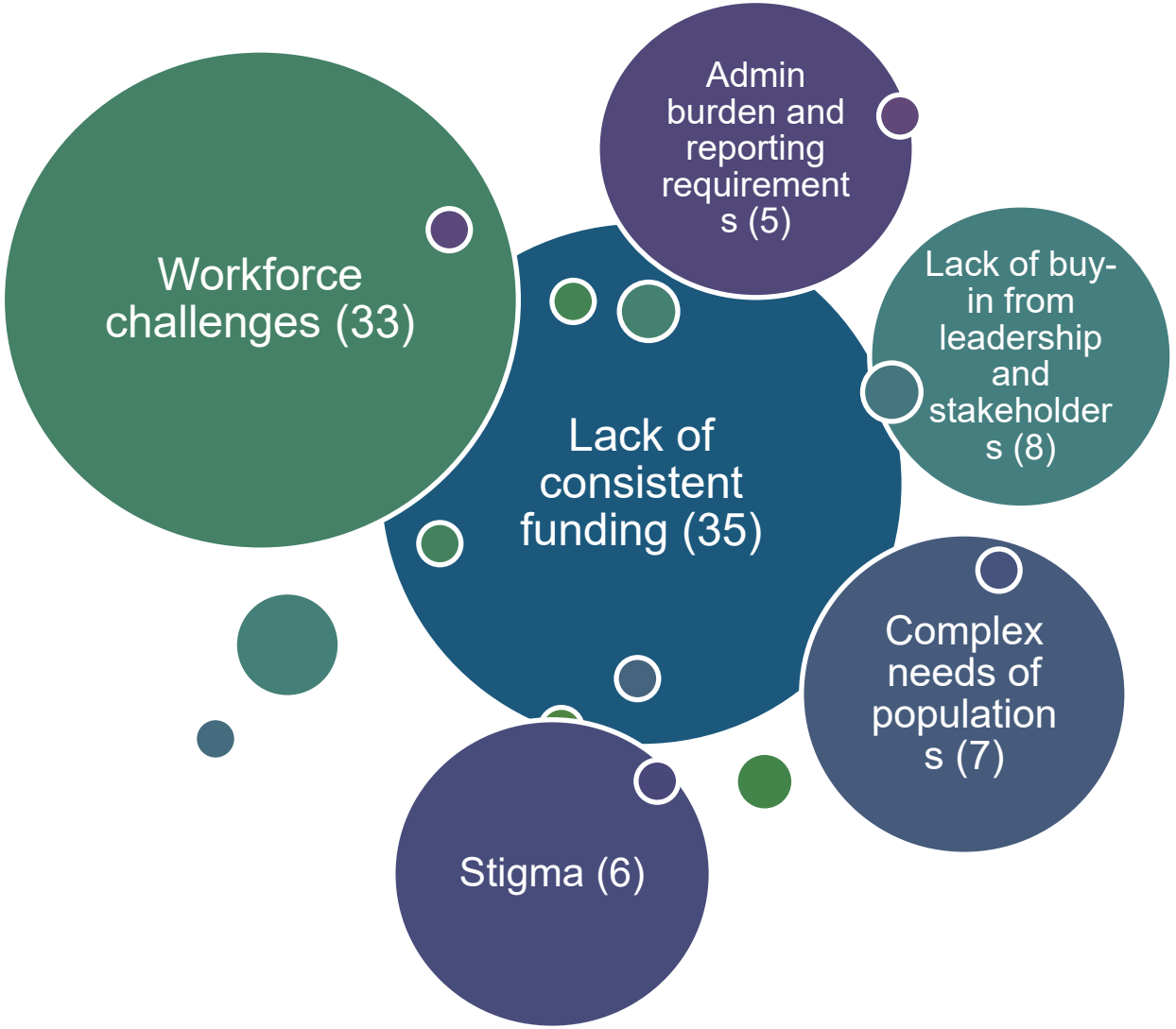


Respondents reported a variety of measures of equity in behavioral health access including metrics such as ACEs, BH screenings, service utilization, and policing data.

> **"**Currently, our efforts to assess health equity outcomes at the individual and population levels have focused on measuring differences or similarities in health outcomes (e.g., race or ethnicity, religion, age, gender and sexual identity, ability status, education, and income). We also have examined geographic variations in services (e.g., location of mental health providers) and other social determinants (e.g., average income levels) as related to behavioral health outcomes." – *RFI Respondent*

> "[Org name] measures health equity outcomes using a range of metrics, including demographic data, service utilization rates, client feedback, workforce diversity, and outcome disparity analysis. Demographic data, such as race, ethnicity, language, and socioeconomic status, helps us track whether services are reaching marginalized populations equitably. Service utilization metrics, including appointment attendance and program participation, identify barriers like stigma or transportation challenges. Client feedback, gathered through multilingual surveys and focus groups, provides insights into the cultural responsiveness and quality of care from the client's perspective. Workforce diversity is monitored to ensure our staff reflects the communities we serve, fostering trust and culturally competent care. Outcome disparity analysis compares program success rates across demographic groups, highlighting inequities that inform targeted interventions." – *RFI Respondent*

Challenges faced by organizations in Implementing BHPP Efforts



Respondents are facing a variety of BHPP implementation challenges.

- The most frequently cited are shown in the graphic to the left with *lack of consistent funding* and *workforce challenges* mentioned most often.
- The following challenges were shared four times or fewer:
  - ✓ Lack of standardization in EBPs (4)
  - ✓ Strict participant eligibility criteria (3)
  - ✓ Lack of time for BH/prevention efforts in schools (3)
  - ✓ Inadequate integration of BH services w/ primary care services (3)
  - ✓ Complex healthcare system (3)
  - ✓ Lack of transportation for clients (2)
  - ✓ COVID-19 pandemic (2)
  - ✓ Technology challenges (1)
  - ✓ Org visibility (1)
  - ✓ Lack of organizational knowledge about billing (1)

Challenges faced by organizations in Implementing BHPP Efforts

Respondents noted that current funding structures are mismatched for prevention and promotion work	Many organizations – particularly small, local agencies – lack the capacity to "prove" effectiveness of programs to funders, or to compete for contracts at all.	Organizations that provide technical assistance, particularly to schools, note resistance or inability by the recipient to participate in (or maintain) interventions.	General operational challenges
▸Most grant funding is rigid, unpredictable, and short-term – a bad mismatch for prevention and promotion work which is dynamic and long-term ▸Most school-based programming is funded through district-based grants, which are esp. vulnerable ▸Rigidity of eligibility criteria or program design discourages innovation and real-time responses to community needs ▸Existing funding requires separation of MH and Substance Use where there is a need for integrated funding	▸Requirements to document the effectiveness of models may bias responses in favor of larger institutions with capacity/expertise in this area ▸Data collection directly from persons receiving services has significant operational challenges ▸Many respondents (esp. agencies with direct service as a focus) note that data collection and documentation have a direct, negative impact on service delivery ▸Current EHRs are designed to capture treatment, not prevention	▸Interventions that require support or “buy in” from multiple parties (e.g. parents, students, teachers, staff, administrators) may be more vulnerable ▸Basic needs (at the personal or organizational level) must be met before training or EBP implementation can occur ▸Loss of champions can be destabilizing	▸Workforce shortages ▸Language access

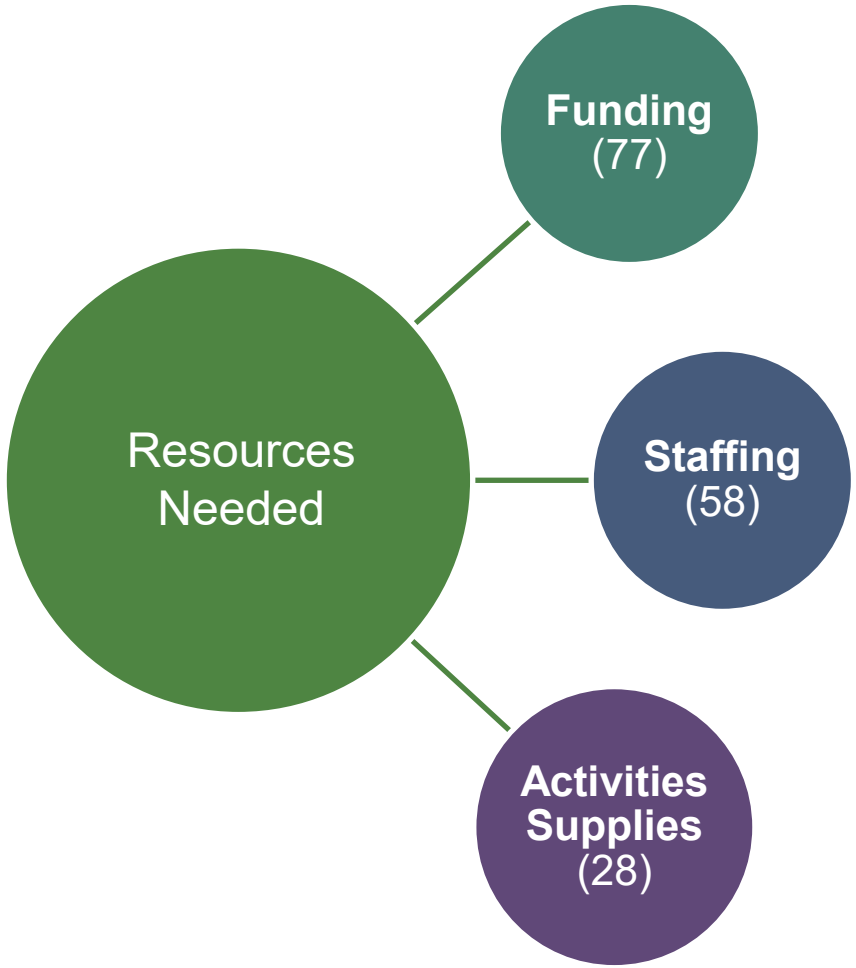
Challenges faced by organizations in Implementing BHPP Efforts

"A frequent barrier in the outer/systems setting is funding availability, specifically from external sources such as state and county level entities, grants, and foundation donations. While funding mechanisms are available for provider training, many are short-term (lasting 1 – 2 years), which limits long-term program sustainability in communities of focus."
– *RFI Respondent*

"Staffing services with trained personnel who reflect the diversity of the population served is a challenge, which intensified in the wake of the COVID pandemic, when workforce trends began to reflect a marked preference for "working at home" or "hybrid" models, which do not lend themselves well to service provision.. We continue to struggle with paying adequate salaries to staff and providing them with the support and benefits that will support retention." – *RFI Respondent*

"Workforce capacity is our most significant barrier towards implementation. Even when funding is available, unless there is enough funding with a long enough duration to create and maintain a full-time position, there is seldom time within working hours or even paid overtime for agencies to take on new services. Despite their desire to do so, it often feels like "one more coat to wear," contributing to fatigue and burnout that further compounds the capacity issue." – *RFI Respondent*

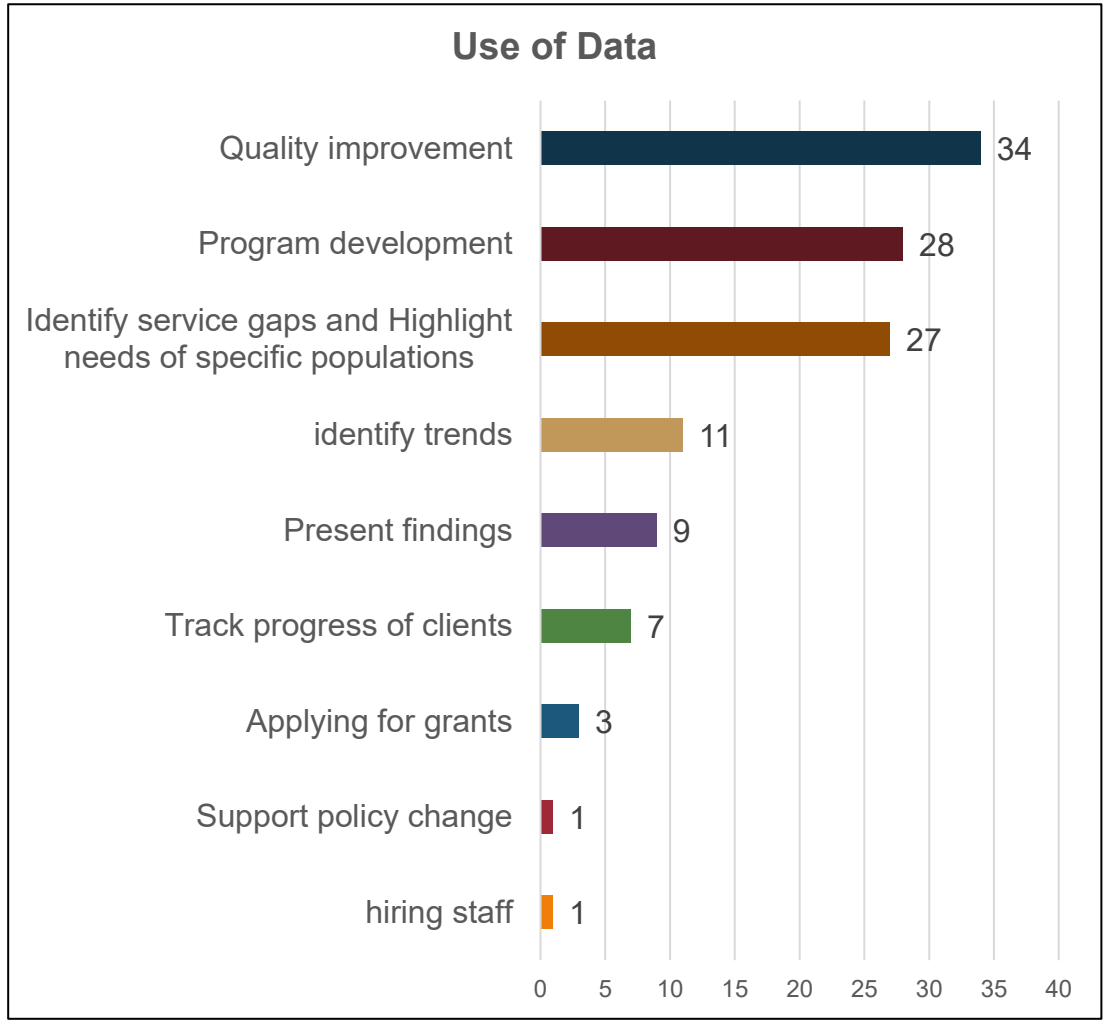
Resources Needed as Identified by RFI Respondent Organizations



"All of these programs take significant financial resources as well as staff for program operations, service delivery and community integration. Each program takes months of work in program design and recruitment, followed by a period to ramp up reach or build awareness of program offerings and build community partnerships... We have had several programs that have ended due to short funding terms or insufficient resources, which create gaps and impacts the whole community. Optimally, new program offerings or opportunities will integrate with and support existing community providers and coalitions to improve sustainability and cohesion." – *RFI Respondent*

- Asked about resources needed, respondents most frequently mentioned *funding*, *staffing*, and *supplies for activities*.
- They also reported needing:
  - ✓ Connections with schools, orgs, and communities (14)
  - ✓ Workforce capacity (13)
  - ✓ Training and technical assistance (12)
  - ✓ Technology (12)
  - ✓ Curriculum (9)
  - ✓ Staff buy'-'in at partner orgs/schools (3)
  - ✓ Publicity/external communications (3)
  - ✓ Participant transportation (3)
  - ✓ Childcare for participants (1)

RFI Analysis Findings: How organization use data to inform BHPP efforts



- Most respondents used data for *quality improvement*, *program development*, and to *identify service gaps and population specific needs*.
- Types of data collected included:
  - ✓ Assessments and screenings (intake, PHQ-9, GAD-7, CAFAS, Youth Mental Health Promoting Knowledge, etc.)
  - ✓ Recovery planning
  - ✓ Client satisfaction and follow-up surveys
  - ✓ Process and outcome data
  - ✓ Coalition survey data
  - ✓ Community-wide and regional data (overdose, suicide, and violence rates)
  - ✓ Population level BH surveillance data (BRFSS, etc.)
  - ✓ Pre/post training tests
  - ✓ Qualitative data

How organizations define success related to BHPP work

The tree map utilizes proportionality to illustrate the most frequently mentioned ways respondents indicated they define success.

- Other responses with fewer mentions included:
  - ✓ Improved stability and community integration (9)
  - ✓ Improved knowledge (4)
  - ✓ Successful resource and referral processes (4)
  - ✓ Number of people served (3)
  - ✓ Decrease in service utilization (2)
  - ✓ Positive childhood development (2)
  - ✓ Continuity of care (1)
  - ✓ Family preservation and reunification (1)
  - ✓ Improved organizational spending (1)
  - ✓ Staff retention (1)

"[We] define successful outcomes in behavioral health promotion and prevention as measurable improvements in the well-being of individuals and communities, along with increased access to equitable resources. We are able to determine if something has proven success through improved mental health outcomes, increased access and equity to underserved populations, steady or increased engagement and retention, and positive feedback and satisfied survey responses." – *RFI Respondent*

Challenges organizations face with data collection

Respondents are facing a variety of challenges with data collection.

- The most frequently cited are shown in the graphic to the left with *unreliable data* and *data integration from multiple sources* mentioned most often. *Mistrust from clients* was mentioned far fewer times but remains a prominent obstacle.
- The following challenges were shared three times or fewer:
  - ✓ Survey fatigue (3)
  - ✓ Lack of literacy/data acumen among clients (3)
  - ✓ Lack of clearly defined data collection process and outcomes (3)
  - ✓ Lack of buy-in from key stakeholders (3)
  - ✓ Varying levels of data literacy among partner, implementation orgs, and staff (2)
  - ✓ Population-level data not available (2)

Challenges organizations face with data collection

"Common data collection challenges in behavioral health promotion and prevention programs often include variability in data quality, inconsistent participation from stakeholders, and logistical barriers such as limited time or resources in school settings."
- *RFI Respondent*

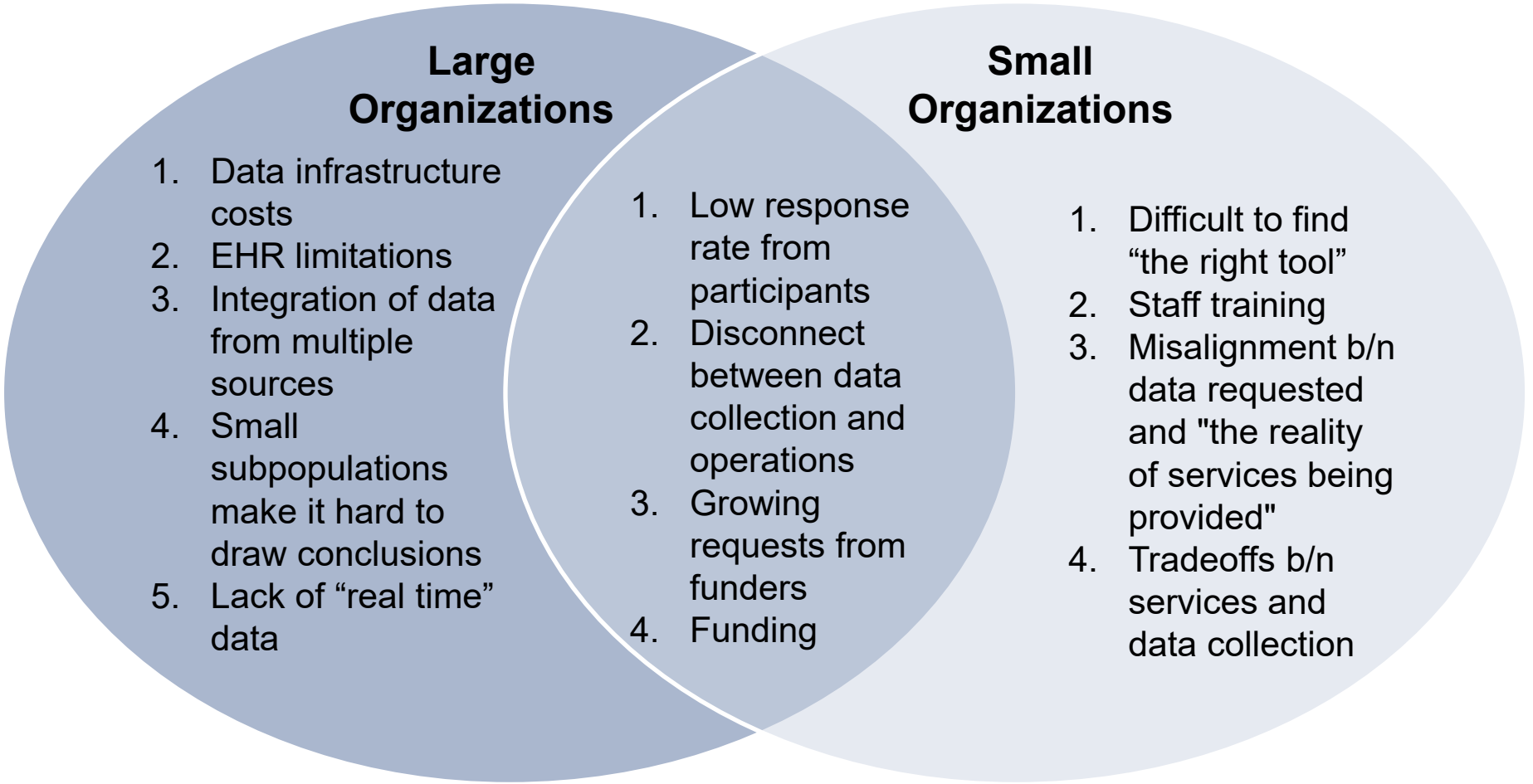
"Another challenge was integrating data from multiple sources, as disparate systems often made it difficult to consolidate information. Staff training was also a barrier, as inconsistent data entry and lack of familiarity with tools led to errors. "
– *RFI Respondent*

"Engaging clients to provide reliable feedback was a significant challenge, especially among marginalized populations such as immigrants and refugees, who may experience mistrust or survey fatigue."
– *RFI Respondent*

"While we gather data necessary for funders, we do not have internal capacity to collect or analyze data for promotion and prevention efforts."
– *RFI Respondent*

Challenges organizations face with data collection

Small and large organizations face many of the same challenges with data collection, but also grapple with many unique issues that may be size related.



Challenges with current funding models reported by RFI respondent organizations

- Many agencies, including almost all small agencies, **noted a strong preference or need for start-up funding; indicated a strong desire for partnerships between large and small agencies.**
  - Small orgs., and especially those providing direct services, also lack capacity to apply for funding

- **Structured payments are preferable** to cost-reimbursement models, esp. for smaller agencies
  - There is a mismatch between agencies that can accept a cost-reimbursement structure, and those with "cultural/linguistic capacity and community trust." (Haitian MH Network)

- Recommendation that **the competitive application process should be reversed**. The state should instead map out existing assets and resources, identify key gaps, then outreach potential agencies with offers." (Berkshire Reg. Planning Commission)

- One respondent (Trinity) **recommended a hybrid structure**, providing a lump sum setup and implementation, followed by structured payments for milestones/deliverables.

- Two respondents recommend **RFPs that incentivize partnership and coordination in lieu of competition.**

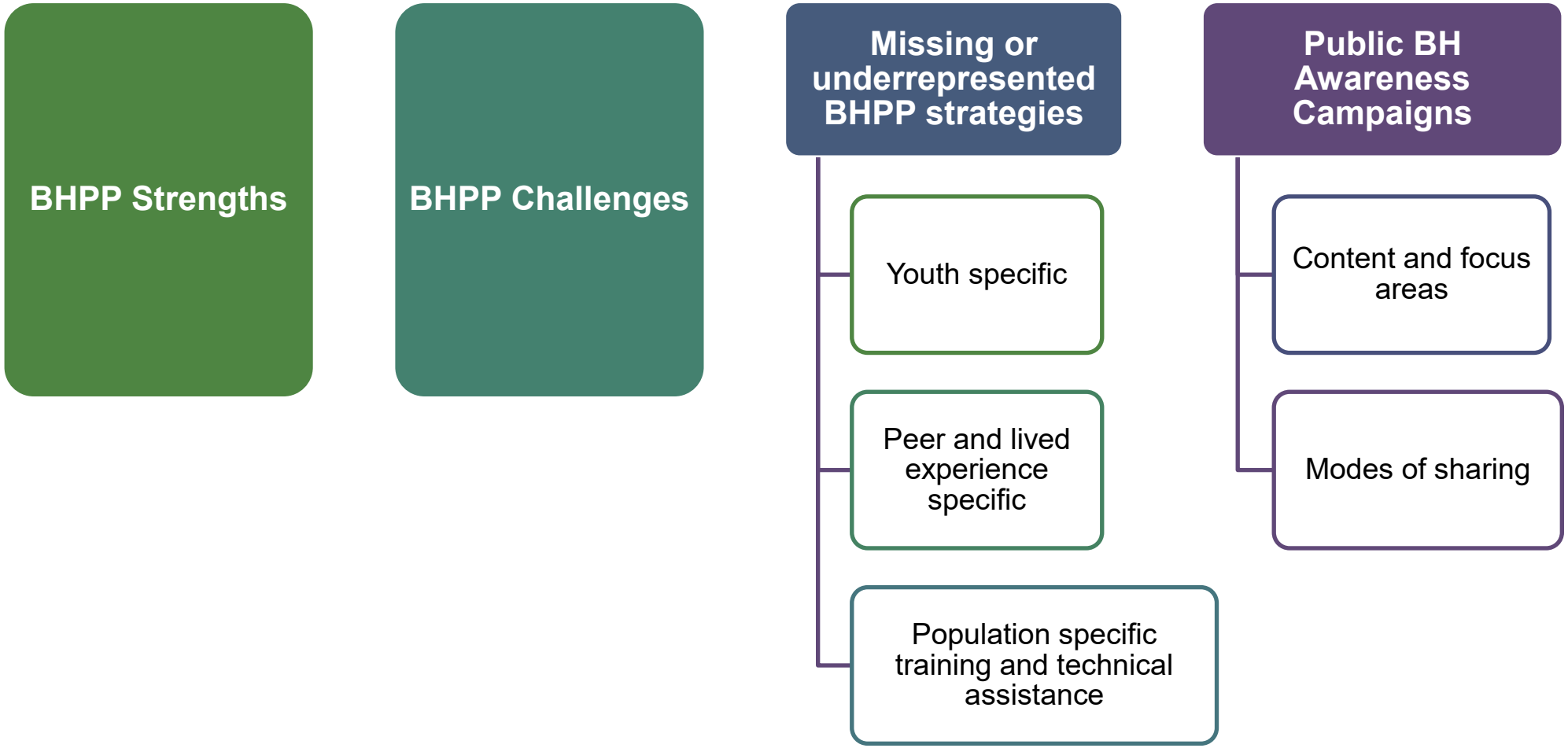
Community Listening Sessions
Methods & Summary of Findings

OBHPP Office of Behavioral Health Promotion & Prevention

MASS DMH HOPE • EQUITY • SERVICE Department of Mental Health

Listening Session Overview

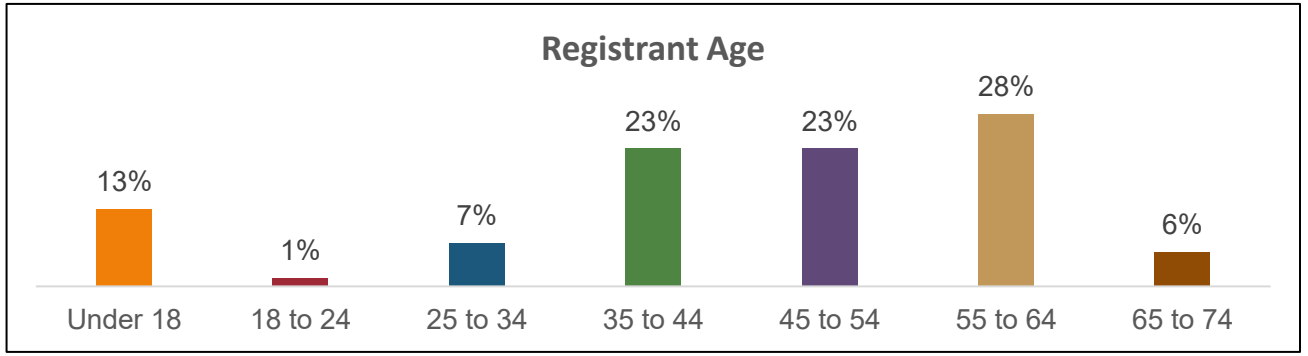
Listening Session attendees were asked to respond to several questions outlined in the diagram below.

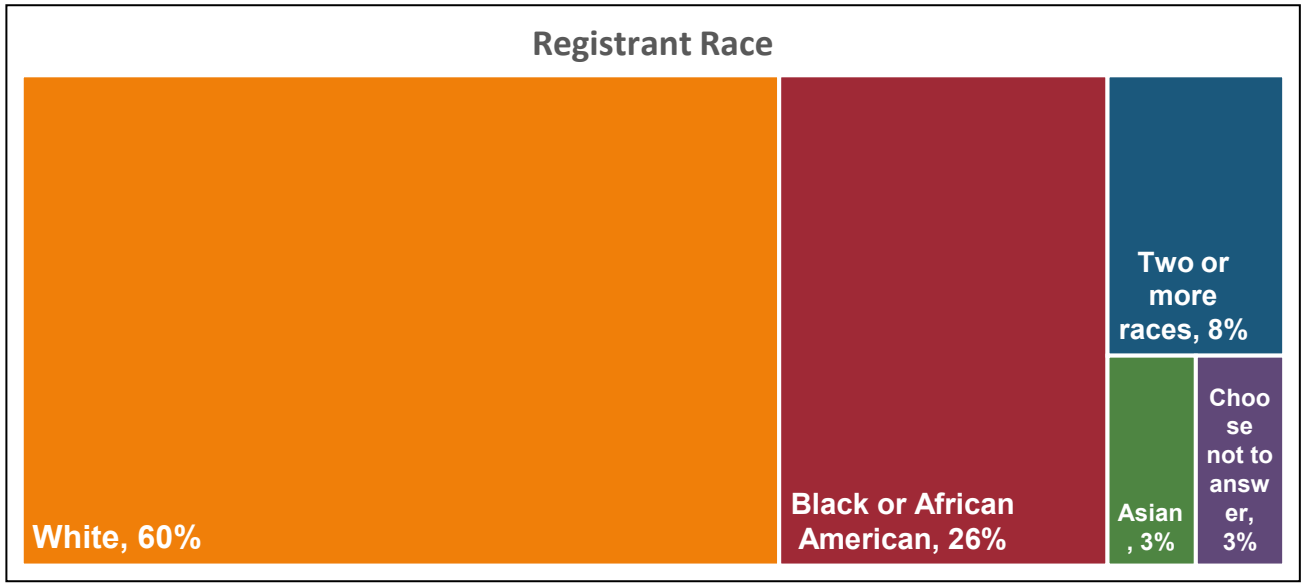


Listening Session Attendee demographics

189 people attended a listening session, with 119 completing a meeting registration form. Many attendees didn't complete a registration form, or only answered some of the questions.*

- Nearly three-quarters of registrants were between the ages of 35 and 64, and another 13% were under the age of 18.
- The majority of registrants identified as female (85%), another 11% as male, and 1 person as transgender.
- More than half of registrants were White, with another 26% identifying as Black or African American.
- 11% of registrants identified as Hispanic or Latino.
- 83% of registrants indicated that they represented a special population.**
- Zero registrants requested language interpretation or any other accessibility accommodation.

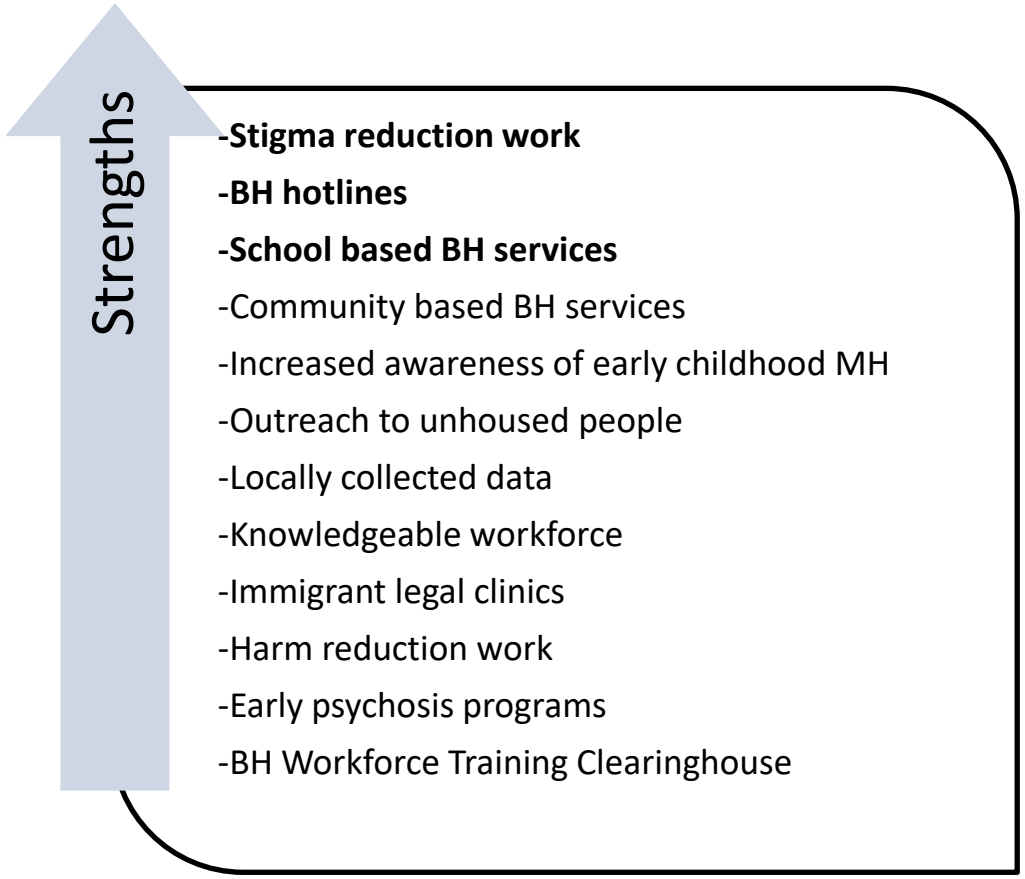




*One Listening Session comprised individuals representing or identifying as immigrants and/or refugees and were reluctant to register and share demographic data given current circumstances.
**Special populations included: BIPOC individuals, youth, LGBTQ+ residents, veterans, immigrants, people with disabilities, and/or rural populations.

Strengths of MA BHPP Strategies as Indicated by Session Attendees

Listening session attendees were asked to describe the strengths of behavioral health promotion and prevention in Massachusetts.



"Promotion of 988 is strong in the commonwealth. Folks know where to call to help when they are in crisis."
– *Listening Session Attendee*

The top three most mentioned items are bolded.

Challenges with MA BHPP Strategies as Indicated by Session Attendees

Listening session attendees were asked to describe the challenges of behavioral health promotion and prevention in Massachusetts.

"…from all the different community conversations and interactions with other providers for the past few months, there's been a lot of question and worry over funding, especially for a lot of Federal funded programs and projects, whether they'll be able to continue their work. It's been something a lot of organizations have been doing different things to prepare for the worst."
– *Listening Session Attendee*

Challenges

-Funding
-Current political climate and government processes
-Geographic isolation and accessibility
-Silos and lack of agency collaboration
-Workforce shortages
-Systemic discrimination
-Stigma
-Difficult to navigate BH system
-Effectively reaching the intended populations
-Language accessibility
-Regionally focusing efforts
-Evaluation
-Expanding and mobilizing the peer workforce
-Normalization of substance use
-Police involvement in BH response

The top three most mentioned items are bolded.

MA BHPP Strategies that Need to be Added or Enhanced According to Session Attendees

Educational Initiatives	• *Topics*: Psychoeducation and de-escalation tactics, gender, sexual orientation, and Serious Mental Illness • *Populations*: Students, families, communities, legislators, judges, and police officers
Peer and Lived Experience	• Promotion of peer and non-clinical support services such as peer grief support and respite • Design programs alongside those with lived experience
Youth Specific	• Upstream and developmentally appropriate approaches, interventions, and resources that are family centered and focus on early childhood MH, including safe social spaces • BH career exposure for BIPOC students
Other Strategies	• Focus on social determinants of health and culturally responsive strategies • Coordination among organizations • Readily available harm reduction resources

MA BHPP Strategies that Need to be Added or Enhanced According to Session Attendees

"It is critical that we get the work out that if we want to address the BH crisis we must begin as early as possible by doing dyadic/two generational work to support caregivers in the perinatal period and to support the developing child (during the critical birth through age three period)."– *Listening Session Attendee*

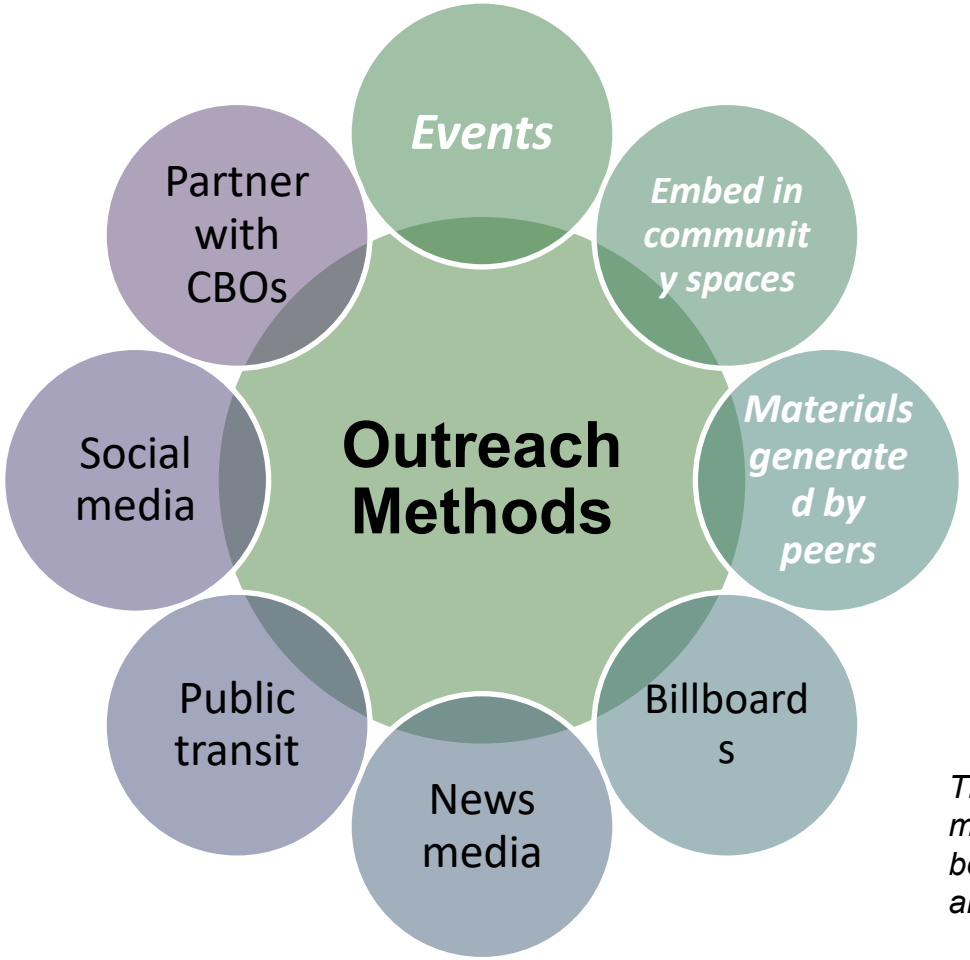
"So I think that some of the challenges that currently exist as someone with lived experience and someone who's, you know, helping family members through mental health challenges and what I see kind of out there. So we have 988. We have promotion of like going to therapy, which I think is great, but sometimes I think there could be more information on what we can do as people. Because sometimes community members feel helpless like, okay, I just need to call 988. But what are some of the tangible evidence-based, if you will, things that someone, just the everyday person can do?" -*Listening Session Attendee*

"…many community members have been so hurt by systems. And people say, going to the hospital, seeking treatment is not safe for them…particularly when we seek to reach out to immigrant populations. People who already marginalized in society, they're not thinking in terms of going to a place that has mental health on it or department of psychiatry. People said to me that they would rather go to say every Saturday morning at a certain coffee shop or the park and hang out…and just kind of get to know one another chit chatting, talking. And then by and by if people are feeling comfortable, then they'll say, "Oh, you know, I'm having problems with XYZ". Really kind of informal, but I think it would be so helpful to expand the peer workforce." -*Listening Session Attendee*

"And I think that when we think about individuals who can provide some of this education, you know we have no shortage of individuals who are…peer driven, that can actually be leveraged in a way that really makes a lot of sense. And I think that sometimes we have to kind of not be as concerned with the lettered individuals as those who have some real lived experience, and particularly those who have matriculated through systems in spite of challenges." -*Listening Session Attendee*

Public BH Awareness Campaigns – Effective Outreach Methods and Content Areas Shared by Attendees

Listening session attendees were asked to describe the most effective outreach methods for behavioral health awareness campaigns and to suggest content areas for potential OBHPP efforts.



The top three most mentioned items are bolded, italicized, and in white.

Content Areas
Cross-agency and community based
Culturally and linguistically relevant (attn to: BIPOC and immigrant populations)
Stigma reduction
LGBTQ+ populations (homelessness and bullying)
Rural communities
Veterans
Police departments
Schools
Justice involved populations
Support for family and friends of those struggling with BH challenges

Public BH Awareness Campaigns – Effective Outreach Methods and Focus Areas Shared by Attendees

"I will pass on something that we've heard from community, which in terms of messaging…the broad campaigns by design won't reach everyone. So, being purposeful about co-designing, messaging with the populations most disproportionately impacted." -*Listening Session Attendee*

"But in terms of delivery, we've heard that it's been successful in embedding this messaging in broader services that aren't specific. So where accessing mental health and substance use services are highly stigmatized, if there are events that are focused more on academic success or other things, and then embedding that messaging in those events or programming is going to make people feel more comfortable discussing, or even reviewing, the information so passing that along from community." -*Listening Session Attendee*

"…not just embedding it in like academic spaces, but also in recreational and theatrical spaces in which people are enjoying everyday life and activities. Basketball events, baseball events, soccer community gatherings, community meetings, community health centers. So it's just incorporating it and embedding the message in the everyday lifestyle of people, even restaurants." -*Listening Session Attendee*

Key Findings & Upcoming Initiatives

OBHPP
Office of Behavioral Health
Promotion & Prevention

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Key Findings: MA BHPP Challenges by SEM Level

Individual

- Youth and LGBTQ individuals, especially BIPOC youth, report high rates of social isolation, psychological distress, and suicidal ideation.
- Immigrant populations and birthing people of color face elevated risks of depression, anxiety, and trauma-related distress.
- Stigma and fear of discrimination remain a barrier to early help-seeking in public safety, veteran, BIPOC, and immigrant communities.

Interpersonal

- Family stress levels have sharply increased since 2019, especially among low-income, immigrant, and BIPOC households.
- High rates of ACEs and caregiver mental health challenges are negatively impacting intergenerational BH needs.
- Lack of social support and economic stability in families increases the risk for youth BH challenges.

Organizational

- Workforce shortages and limited cultural proficiency in many organizations limits capacity and reach.
- BHPP program evaluation and outcome measurement practices vary widely, negatively impacting tracking and improvement efforts.
- BIPOC serving and CBOs report inequitable access to sustainable funding and TTA.

Community

- Gaps in geographic access to BHPP services are most pronounced in AHEM regions, rural areas, and immigrant communities.
- Many BIPOC led organizations lack infrastructure and visibility to access grant opportunities, though they have deep knowledge of local need.
- Stigma, language barriers, and lack of engagement with trusted community members limit impact of BHPP efforts.

Policy

- Structural racism impacts disparities in housing, healthcare access, education, and safety, worsening outcomes for BIPOC communities.
- Short-term, siloed prevention funding negatively impacts long-term sustainability of BHPP strategies.
- Fragmented data systems and lack of equity benchmarks negatively impact coordination, transparency, and planning.

Key Findings: Priority Issue Areas and Focus Populations

Based on the findings from the Landscape Scan, RFI, and Listening Sessions, and in discussion with the OBHPP Team, the following seven priority issue areas and associated focus populations were identified.

	Priority Issue Area	Priority Populations	Source (Landscape, RFI, LS)	Mandate Alignment
1	**Maternal MH**	Birthing people, especially those that are of marginalized populations, including BIPOC	Landscape - Marginalized populations are more than twice as likely to experience sill birth and perinatal psychological distress, morbidity nearly doubled from 2011-2022. Low public spending on maternal mental health ($3.2/resident) RFI - Need for expanded culturally proficient supports during the perinatal period.	Perinatal and maternal MH, health equity.
2	**Family Stress and Caregiver Wellbeing**	Low-income families, caregivers of young children, immigrant families, single parents	Landscape - Increase from 24-33% of parents reporting high stress nationally vs. 20% of general population. MA lacks robust state level surveillance on adult caregiver stress. Relatively low public spending, few programs for whole family. RFI - Limited early support programs for caregivers, workforce challenges in delivering prevention services. LS - Call for two-generational support and more upstream family focused programming. Desire for community based programs that support the whole family.	Strengthening upstream prevention, violence prevention, child and family wellbeing, school based MH
3	**Infant and Early Childhood Mental Health**	Children 0-5, especially when exposed to ACEs, parents in the perinatal period	Landscape - 36% of children 0-17 experienced an ACE last year, increasing risk for lifelong behavioral and physical health challenges, substantial funding but gaps in workforce training and scale-up. RFI - Need for trauma responsive and culturally proficient care, especially in early childhood settings. LS - Emphasis on importance of healthy and positive early parent/child relationship.	Infant MH, perinatal and maternal MH, family-focused prevention
4	**School Based MH**	High school students, especially those in marginalized populations (LGBTQ+, BIPOC, etc.)	Landscape - LGBTQ+ youth are 3-4times more likely to report suicidal ideation, distress and suicide attempts are increasing even though there is existing programming. RFI - Youth and peer led models are noted as effective but under resourced, need for upstream and culturally relevant and proficient school strategies. LS - Youth are looking for tangible peer led/informed supports beyond crisis services.	Suicide prevention, school based programming, stigma reduction

Key Findings: Priority Issue Areas and Focus Populations

	Priority Issue Area	Priority Populations	Source (Landscape, RFI, LS)	Mandate Alignment
5	**Loneliness & Social Isolation**	Youth and young adults (especially ages 18-26), LGBTQ+ individuals, older adults, DHH individuals, rural residents, veterans, and immigrants	*Landscape* - High rates of reported isolation, low public spending ($0.40/resident). High % of youth and young adults report feeling isolated usually or always (15-25%). Isolation is associated with increased risk for many health concerns across the lifespan *RFI* - Comm members and small orgs note lack of informal, culturally grounded spaces for connection. *LS* - Repeated calls for informal, peer-driven, and community embedded strategies to reduce isolation.	Suicide prevention, stigma reduction, school-based MH, aging populations
6	**Immigrant Mental Health**	Newly arrived immigrants and refugees, undocumented individuals, immigrant youth	*Landscape* – Immigrant population in MA grew from 15.6% in 2013 to 18.1% in 2023. Psychological distress among immigrants more than doubled between 2015-21, with recent immigrants reporting the highest increases, low public spending. *RFI* - Culturally tailored, community based approaches are critical and effective but underfunded. *LS* - Fear and distrust of formal systems, preference for safe informal peer-led settings. Reports of rising distress among immigrant populations and a lack of tailored mental health promotion programs for this population.	Health equity, stigma reduction, culturally responsive BH promotion
7	**Veterans, Public Safety Personnel, and Healthcare Worker Mental Wellness**	Women veterans, veterans experiencing PTSD and/or MST, police, firefighters, EMS, healthcare workers	*Landscape* - SAVE and SERVE teams are primary efforts but under staffed and under funded, isolation especially for women vets, social determinants, need for better data collection, vicarious trauma and compassion fatigue, increased burnout and attrition in MA healthcare workers. *RFI* - stigma, need for trauma-informed supports, funding issues, sustainable funding for workforce MH and professional dev (especially in CBOs which can be high stress and underfunded). *LS* - peer driven, informal spaces, stigma reduction for those who are reluctant to seek help, workforce burnout.	Veterans and public safety personnel, healthcare workers

Applying Learnings Moving Forward

Identified Gaps

Many BHPP areas that are underfunded and/or underrepresented in state-wide initiatives. These included the following:

1. Reducing loneliness and social isolation;
2. Reducing family stress and supporting caregiver wellbeing;
3. Promoting infant, early childhood, and maternal mental health;
4. Reducing psychological distress in immigrant populations;
5. Promoting early intervention with youth and young adults;
6. Reducing family and intimate partner violence; and
7. Promoting population wellbeing through education, training, and skills development.

Many organizations, particularly small, community-based, and culturally specific providers, reported capacity challenges that limit their ability to collect data, evaluate programs, and meet traditional reporting requirements.

Recommendations for OBHPP FY26-28:

- Prioritize these areas in grant programs, funding new BHPP programs that fill existing gaps;
- Fund diverse initiatives across the lifespan - community, family, and school-based programs.
- Embed technical assistance into OBHPP grant programs by providing training, shared measurement tools, and evaluation planning support for grantees;

Conclusions

These findings will directly inform future OBHPP initiatives.

What was heard from communities and partners will guide grant priorities, design campaigns, and focus partnerships on where they can make the biggest impact. This work builds on what's already happening across the state and creates a foundation for community informed, data-driven behavioral health promotion and prevention initiatives for the future.

OBHPP is grateful for all who participated in these data-collection activities.