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

Overview of State's Mental Health System

The Department of Mental Health (DMH) envisions mental health as an essential component of health care. Over the past years DMH has actively engaged in the design of a behavioral health system for Massachusetts working to ensure that residents of the Commonwealth can access integrated behavioral health care that serves the entire person. To begin this overview the section below describes Massachusetts and its people.

Criterion 2: Epidemiology

Massachusetts Demographics

Massachusetts traces its origins to the 1620 arrival of the Mayflower. One of the 13 original colonies and the 6 New England States, Massachusetts is relatively small in land mass with a net area of 7,838 square miles, but populous with an average population density of 880.6 people per square mile. Among all states, MA ranks 44th in total land area and 15th in population density. The state covers 190 miles, east to west, and 110 miles, north to south, at its widest parts.

This section describes the Massachusetts population and identifies prevalence estimates. In 2018, the United States Census American Community Survey estimates the Massachusetts population at 6.8 million. Further, the Census notes an annual population growth of less than 1% (.75%). The Department of Mental Health divides the Commonwealth into 5 Areas each containing at least one of the ten most populous cities. The MA population distributes across these Areas as shown in Tables 1 & 2. The three 3 Massachusetts largest cities are Boston, Worcester and Springfield located in Eastern (Metro Boston), Central and Western Massachusetts respectively. The Table 1 below displays the 5 DMH Service Areas with the distribution of the 10 largest Massachusetts cities and their population.

Table 1: DMH Areas' Large Cities with 2018 Population

DMH Area/Population	Large City(ies)	2018 Population	% MA Total
Metro Boston	Boston	667,137	9.6%
1,037,084	Cambridge	110,602	1.6%
Northeast	Lowell	110,699	1.6%
1,535,245	Lynn	92,457	1.3%
Southeast	Brockton	95,316	1.4%
1,7656,779	Quincy	93,618	1.3%
	Fall River	88,756	1.3%
Central	Worcester	184,815	2.7%
1,608,472	Newton	88,817	1.3%
Western MA	Springfield	154,341	2.2%
842,677			

The U.S. Census 2018 population estimates for Massachusetts further report that 81.3% of the population is White, 8.8% African-American, 0.5% Native American, 6.9% Asian, 2.2% identifies as multiracial with 11.9% identifying as Hispanic or Latino. The trend in arrivals from Africa, Southeast Asia, Central America, the Caribbean Islands and Eastern Europe continues with foreign born persons now representing 16.2% 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, Arabic, Vietnamese dialects and French but a larger variety of languages spoken exists. For example, in 2018 the Boston Public Schools report its students speaking 74 different languages.

Table 2: Massachusetts (MA) Prevalence Estimates
Serious Mental Illness/Serious Emotional Disturbance
Displayed by select Age Group in total and by DMH Area

DMH Area	Ages 17 and Under	Ages 18-25	Ages 26-65	Ages over 65
Metro Boston	13,861	5,691	13,060	2,451
Central MA	47,927	11,480	35,118	9,211
Northeast	51,877	13,654	40,894	10,843
Southeast	44,901	11,845	36,588	11,615
Western MA	24,012	8,151	18,306	5,677
Total MA	182,578	50,821	143,966	39,797

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 2018, SAMHSA released state specific proportional prevalence estimates combining the information it collected in 2016-2017. Estimates were given for the population ages 18 and over (4.76%) and for two age sub-groups within that population: ages 18-25 (7.46%) and 26 and older (4.29%). Separately, SAMHSA released a national estimate of the prevalence of major depressive episode with functional impairment for children and adolescents ages 12-17 (13.77%). 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 (4.29%) was used for the age groups 26-65 and 66 and older. The NSDUH noted that as compared to the 2008 state estimates the 2018 prevalence had almost doubled (3.8% to 7.46%) among youth and young adults aged 18-25.

In its 2019 report, "The State of Mental Health in America" (www.mentalhealthamerica.net) Mental Health America ranks Massachusetts as 3rd among states noting this high ranking reflects a lower prevalence rate of mental illness as compared with access to care. Examining this ranking for adults, the Commonwealth ranks 7th, while for youth the ranking is 4th.

DMH - The State Mental Health Authority

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

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

In this two year planning period, DMH is engaged in a significant effort to redesign the Commonwealth's ambulatory behavioral health care delivery system. In collaboration with sister state agencies and the EOHHS DMH is working to align payments and policies governing licensing, credentialing and regulations. 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 upholds evidence-based care standards.

Organization of the Department of Mental Health

Currently, DMH is organized into a Central Office and five geographic Areas; Central, Western, Northeast, Boston and Southeast Areas. The Central Office in Boston is organized into five divisions in addition to the Commissioner's office - Mental Health Services, Child and Adolescent Services, Clinical and Professional Services,

Management and Budget, and Legal. All Area Directors report to the Deputy Commissioner for Mental Health Services. The Central Office coordinates planning, sets and monitors attainment of broad policy and standards, and performs certain generally applicable fiscal, personnel and legal functions. Additionally, the Central Office provides liaison to the Executive Office of Health and Human Services, which maintains consolidated human resources, information technology and revenue functions. Central Office manages some specialized programs, such as forensic mental health services, adolescent extended stay inpatient units, and child and adolescent intensive residential treatment programs. Within Central Office, there are offices of Human Rights, Recovery and Empowerment and Multicultural Affairs. Quality improvement activities, data analytics and liaison to the Executive Office of Health and Human Services (EOHHS) Information Technology Services (EHS-IT) are also coordinated through the Central Office Division of Clinical and Professional Services, which has primary responsibility for the Mental Health State Plan.

Each DMH Areas is managed by an Area Director and Area leadership teams, including medical directors, senior psychiatrists, child/adolescent psychiatrists, directors of community services, directors of child/adolescent services, and quality managers. Further, Child and Adolescent services are managed by six Child/Adolescent Directors aligned with an earlier six area structure. The DMH Areas are subdivided into 27 local Service Site Offices located in 25 places across the Commonwealth. Each Service Site Office is overseen by a Site Director or a Case Management Supervisor who may also serve the Site Director role. The Sites authorize services for individuals, provide case management and oversee an integrated system of state and vendor-operated adult and child/adolescent mental health services. Most service planning, service and contract performance management, quality improvement and citizen monitoring services emanate from Site and Area offices, with Central Office oversight and co-ordination.

Each Area and Site has a citizen advisory board, appointed by the Commissioner and comprised of consumers, family members, professionals, interested citizens and advocates. Board members assess needs and resources and participate in planning and developing programs and services in their geographic domain. Additionally, a Mental Health Advisory Council (MHAC), appointed by the Secretary of EOHHS and comprised of consumers, family members, professionals, interested citizens and advocates, receives data pertaining to the entire system and advises the Commissioner on mental health policy and priorities. The State Mental Health Planning Council is established as a subcommittee of the MHAC. In addition, there is a statewide Human Rights Advisory Committee, and each hospital has a board of trustees appointed by the Governor and a trustee's seat on the Area board in the DMH Area where the hospital is located. Although not mandated by statute or regulation, there also is a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members and state agency representatives and two advisory groups to the Office of Multicultural Affairs.

All of the state hospitals, Community Mental Health Centers (CMHC), adolescent inpatient units, and child and adolescent intensive residential treatment programs are

accredited by the Joint Commission and certified by the CMS (Center for Medicare and Medicaid Services). DMH has the statutory responsibility for licensing all non-state-operated general and private psychiatric inpatient units and adult residential programs in the state. Children's community residential programs are licensed by the Department of Early Education and Care. DMH currently licenses a total of 2,945 inpatient beds located in 67 facilities statewide with approximately 70,000 admissions annually.These beds include 142 adolescent beds, 37 children's beds, 144 child/adolescent beds and 469 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 Community Mental Health Centers in the Southeast Area.

Each of the 5 DMH Service Areas includes a major population center, and each local service site has at least one town or incorporated city with a population greater than 15,000 that is considered the site's center of economic activity. None of the local service sites' catchment area has a population density below 100 people per square mile. Hence, DMH has not designated sites as 'rural' or developed a separate division or special policies for adults, children or adolescents who reside in the less densely populated areas of the state. However, access to services in these areas continues to pose a challenge to Area planners and providers. Thus DMH has collaborated with the State Office of Rural Health in its planning efforts.

Historical Perspective on Shift from Inpatient to Community Services

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

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

In 1984, Executive Order 244 prohibited children under 19 from being treated on adult inpatient wards of state hospitals and led to the creation of new residential programs and a contracted vendor network for most services for children and their families. Executive Order 422 of June 2000 continues this prohibition but permits placement of certain

forensically involved 17- or 18-year-olds on adult inpatient units in DMH facilities and permits youths under 19 to be admitted to certain specialty units in DMH facilities.

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

Recognizing some individuals' continuing need for inpatient psychiatric care and after a seven-year planning, design and construction process, the Commonwealth invested $302 million to build and open in August, 2012 a new public psychiatric hospital, the Worcester Recovery Center and Hospital (WRCH). DMH currently operates or contracts for 671 continuing care beds in six facilities, including 260 beds at the WRCH. In 2018, MA served 1,579 adults and 56 children in its state operated and contracted psychiatric hospitals.

Defining the Target Population

The DMH policy defining "priority clients" was developed in response to a legislative mandate narrowing the DMH service mission to adults with serious mental illness and children with serious emotional disturbance. 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.

Regulations

The Department's enabling statute is M.G.L. Chapter 19 and its operating statute is M.G.L. Chapter 123. DMH is also governed by Regulations (104 CMR). These regulations outline the Department's authority, mission and organizational structure, citizen participation, licensing and operational standards for service planning, fiscal administration, research, investigation procedures and designation and appointment of professionals to perform certain statutorily authorized activities. Licensing and operational standards apply to all inpatient facilities (DMH-operated and other licensed inpatient facilities) as well as community programs.

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

services it provides, contracts for or licenses, while also seeking to streamline administrative processes and to reduce the regulatory burden for providers.

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

DMH directly provides and/or funds a range of services for approximately 25,000 adult clients per year. These services include inpatient continuing care, emergency services, case management and other community and rehabilitative services, such as Adult Community Clinical Services (ACCS), Program for Assertive Community Treatment (PACT), Clubhouse and Respite. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some inpatient, emergency and outpatient services in the Southeast and Metro Boston Areas.

Beginning in 2014, Massachusetts has made it a priority to strengthen and reform the behavioral health system in the Commonwealth. Policy changes across DMH, MassHealth and 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 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. ACCS enhanced and transformed service components by combining into one service type the delivery of residential and community rehabilitative services that were previously provided via separate funding and through a more fragmented system.

Also in January 2018 DMH implemented new regulation governing the time Emergency Departments (ED) may 'board' or hold for long time periods those patients admitted with a mental health disorder. Initiated with Secretary Sudders' 2016 Task Force examining these long wait times, the 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 and to go outside of the insurer's regular network of providers if necessary. If unsuccessful at 96 hours, the patient's case goes to the DMH. DMH negotiates patient placement. Since 1/1/2018 more than 600 individuals have been placed.

In addition to DMH regulations, DMH and its providers are subject to the regulations issued by the Commonwealth's Executive Office of Health and Human Services. These regulations include requirements for conducting Criminal Offender Record Checks on potential employees, trainees and volunteers.

Research

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

In FY '18 bids will open to applicants for a new 10 year contract period. For this period, DMH seeks a Research Center of Excellence for Systemic and Psychosocial Research as well as a Research Center of Excellence for Clinical Neuroscience and Psychopharmacological Research. To be eligible, bidders must be either (1) a department of psychiatry of a medical school, or (2) an academic clinical health care system affiliated with a medical school having a distinct department of psychiatry and providing inpatient and outpatient services to adults with serious mental illness and children/adolescents with serious mental illness or severe emotional disturbance. Each Center has its distinct research focus: the Center of Excellence for Systemic and Psychosocial Research will focus on services research, including racial and ethnic disparities in healthcare utilization, forensic services and issues specific to child, adolescents, transition age youth and families while the Center of Excellence for Clinical Neuroscience and Psychopharmacological Research will focus on such areas as clinical neurobiological studies of brain functioning, efficacy of psychopharmacological treatments as well as genetics research. Since DMH recognizes the value of collaboration in research efforts, it expects that the Research Centers will collaborate with each other, as well as with other research facilities and with consumer/family groups.

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 about 50 research studies taking place within DMH facilities, and about 20 new studies are reviewed and approved each year. The IRB Chair oversees the Research Centers of Excellence.

Human Rights

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

DMH is both a monitor and promoter of the use of the legal processes that exist pursuant to DMH regulation, state law and federal law to protect the rights of service recipients. DMH has developed a human rights handbook, human rights brochure for parents and children, and human rights videos for children and adolescents and for the Deaf and hard of hearing. DMH sponsors Area-based Human Rights training with an emphasis on skill building for Human Rights Officers, Coordinators, and Committee members. Collaboration between the Office of Human Rights and DMH Staff Development has produced an annual Human Rights review course, mandated for DMH personnel.

Forensic Mental Health Services

DMH provides forensic evaluation and treatment services to nearly 12,000 individuals each year who are referred to DMH by the Juvenile, District, Boston Municipal and Superior Courts. In FY 19 DMH court clinicians completed 18,249 evaluations of which 16, 290 were for adults and 1,959 for juveniles. Additionally, 759 adults and 12 juveniles were admitted to DMH facilities for forensic evaluations. Further, 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 and clinician/police co-responder programs.

- **Court Clinics:** Court Clinics are responsible for providing all court-ordered forensic and clinical evaluations in the Juvenile, District, and Superior Courts in Massachusetts. Comprised mainly of psychologists, psychiatrists, 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.
- **Inpatient Forensic Evaluations:** DMH Forensic Services Designated Forensic Professionals (DFP) and Certified Juvenile Court Clinicians II (CJCC II) conduct inpatient examinations of defendants on issues primarily pertaining to CST and CR or aid-in-sentencing and coordinates with inpatient treatment teams and the courts. These inpatient evaluations 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 provides funding for clinical services at a total of seven Mental Health Courts in Massachusetts. Four are in District Courts (Plymouth, Quincy, Lowell and Springfield), and three are in Boston Municipal Courts (Central, Roxbury, West Roxbury). DMH supports the special sessions by providing a clinician to each team.
- **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 currently provides support funding for clinical services at six Veterans Treatment Courts in Massachusetts (Framingham, Dedham, Lawrence, Brockton, Holyoke and the Central Division of the Boston Municipal Court). DMH Forensic Services also provides a portion of funding ~~to~~ for 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 [deleted boundary spanning] statewide community care coordination service that ensures DMH-service authorized individuals have an effective community reentry plan from state prisons and county houses of correction.
- **Certification and Training:** DMH Forensic Services oversees, through its regulations, the certification and training of Designated Forensic Professionals, Qualified Social Workers, and Certified Juvenile Court Clinicians.

- **Corrections:** In order to fulfill its statutory obligation to supervise medical, dental and psychiatric services in the segregated Department of Correction (DOC) prison units, a DMH coordinated multi-disciplinary team visits these DOC units on a regular basis 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, a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial.
- **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 ~~help~~ assist inpatient treatment teams and community providers in working with persons with these specific difficulties, some of whom have also been charged and/or convicted of sexual offenses. The Independent Forensic Risk Assessment (IFRA) program 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. Recently, DMH has provided 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.

<u>Office of Race, Equity and Inclusion</u>

The DMH Office of Race, Equity and Inclusion (REI), 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. REI works collaboratively with DMH area leadership and staff including area diversity committees, divisions within DMH, and a group of mental health external stakeholders that comprise the State Mental Health Planning Council's Multicultural Advisory Committee to deliver culturally and linguistically appropriate services in DMH-operated and DMH-funded programs. The purpose of culturally and linguistically appropriate services is to promote recovery, improve access to quality mental health care, and reduce mental health disparities among diverse racial, ethnic, and linguistic populations in Massachusetts.

REI focuses on the following areas:

- 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/retention of diverse DMH workforce.
- 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.

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

Training for Mental Health Providers

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

MassHealth: Massachusetts' Medicaid Authority

Since 1992, the Commonwealth has operated its Medicaid program under a Section 1115 Demonstration waiver. The 1992 waiver authorized a behavioral health care carve-out program for MassHealth recipients, a group including about 4,000 DMH clients, enrolled in the Primary Care Clinician Program (PCCP). The Massachusetts Behavioral Health Partnership (MBHP) manages the network of the Primary Care Clinician Program, including a full array of Mental Health/Substance services. Together, MBHP, DMH,

exercising its role as the State Mental Health Authority and MassHealth have ensured compliance on an array of program standards, clinical criteria and protocols, policies, performance incentives, and quality improvement goals that ensure the MassHealth Office of Behavioral Health Unit (OBH) and the vendor maintain a high quality of care. DMH provides funding to manage the Massachusetts Child Psychiatry Access Progam (MC-PAP), a pediatric psychiatry consultation service.

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

Beginning with its initial 1996 Medicaid Section 1115 waiver MA has led the U.S. in health reform, creatively expanding eligibility for Medicaid and implementing the nation's first healthcare marketplace to provide increased coverage and improved access. Massachusetts insures almost 2 million residents, or over 25% of its population through Medicaid, and was an early implementer of parity rules, and mandates that expanded coverage for individuals with a substance use disorder. In Massachusetts Medicaid and the Children's Health Insurance Program are together called MassHealth.

On November 4, 2016, EOHHS received approval from the Centers for Medicare and Medicaid Services (CMS) to amend and extend its MassHealth Section 1115 Demonstration (Waiver) beginning July 1, 2017 (SFY'18). This extended waiver supports over a 5 year period the restructuring of the MassHealth program to provide integrated, outcomes-based care. The Waiver authorizes $1.8 billion in spending for the 5 year period to implement major new demonstration components to support a value-based restructuring of MassHealth's health care delivery and payment system, including a new Accountable Care Organization (ACO) initiative and Delivery System Reform Incentive Program (DSRIP) to transition the Massachusetts delivery system into accountable care models. The Wavier also authorizes and sustains nearly $6 billion of additional safety net care payments over 5 years to hospitals and the health safety net for the uninsured and underinsured, and for subsidies to assist consumers in obtaining coverage on the Massachusetts Health Connector.

During the new extension period approved for state fiscal year (SFY) 2018-2022, the goals of the demonstration are:

(1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
(2) Improve integration of physical, behavioral and long term services;

(3) Maintain near-universal coverage;
(4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and
(5) Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services; and,
(6) Increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

This new Waiver invests in Community Partners for behavioral health (BHCPs) and long-term services and supports, and allows for innovative ways of addressing the social determinants of health. This year DMH transferred $14 million to MassHealth to continue consumer access for care coordination services through the BHCP program.

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 Governor Baker's landmark legislation, Chapter 52 of the Acts of 2016, An Act relative to substance use, treatment, education and prevention, including recommendations from the Governor's Opioid Working Group.

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

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

options for women. Under this law, women can only be committed to a facility approved by the Department of Public Health (DPH) or the Department of Mental Health (DMH). Subsequently, in February, 2016, the DMH operated 45 bed Women's Recovery from Addiction Program (WRAP) opened on the Taunton State Hospital Grounds. More information concerning WRAP appears below.

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

Comprehensive Community-Based Mental Health Services - Adult

Available Services Narrative

DMH directly provides and/or funds a range of services for approximately 28,000 adult clients per year. These services include inpatient continuing care, emergency services, case management and other community and rehabilitative services. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some inpatient, outpatient and community services in the Southeast and Metro Boston Areas.

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

DMH continued its redesign of the adult community mental health system with the re-procurement of respite services in SFY10. Subsequently, in SFY12, DMH procured a new service, Peer-Run Respite in the Western MA division. This service provides temporary peer support to individuals in emotional distress and/or emergent crisis. The service is described in further detail in the Crisis Services and Recovery sections. In SFY13, DMH issued Requests for Responses (RFRs) for Clubhouse services. The service model was enhanced to address unmet needs in the current community-based service system and focus on goals of employment and community integration. During SFY15, DMH worked with the Massachusetts Behavioral Health Partnership (MBHP), MassHealth's behavioral health coverage carve out, to expand peer resources for emergency services in two regions (Western Mass Area and Northeast Area). During state fiscal 2018, DMH re-procured its community services programs. New contracts are currently in place for ACCS, PACT, Homeless Support Services, Child/Adolescent Day Services, as well as adult and juvenile court clinics.

Housing Services

The Department seeks to promote access to affordable integrated housing opportunities that foster independence, provide choices, offer the rights and responsibilities of tenancy, and help individuals to receive services tailored to their specific needs. DMH

accomplishes its housing mission through a close working relationship with state and 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 MA Department of Housing and Community Development (DHCD); the MassHousing Finance Agency; Community Economic Development Assistance Corp (CEDAC); in addition to the 200+ Local Housing Authorities.

DHCD is DMH's primary partner in providing affordable housing given the number and size of programs they administer In their role they oversee state and federal housing resources including both federal and state rental assistance, public housing programs, Local Housing Authorities, state capital financing, tax credits (federal & state) and homeless programs.

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 required.

DHCD also manages for DMH the DMH Rental Subsidy Program (DMHRSP) that enables more than 1,300 clients to live in their own housing in communities throughout Massachusetts. Funding for DMHRSP was increased in FY19 by $2M raising the total budget to $10.5M. 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, 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. These funds will support 175 newly leased units, crucial for supporting recovery and client flow through the system.

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/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.

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 Dept. 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/DDS has 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 homeless persons, DMH has been very involved in accessing housing resources through participation in all15 of Massachusetts HUD Continuums of Care (CoC) that manage HUD homeless funds.. The five DMH Areas all provide matching funds or leveraged services to CoC local grants that deliver rental assistance and leased housing. These programs are vital to the Department's ability to serve those who because of their illness have difficulty accepting more traditional housing.

Given the Department'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 they plan an active role in promoting housing development working with Local Housing Authorities, Community Development Corps, for profit developers and others to expand DMH housing opportunities. They 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 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 (EOHHS). 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 develop activities with CEDAC and DHCD.

DMH established a housing plan to give direction and support to the housing effort. The plan adopted the following goal and objects: To create movement of clients through the DMH system by securing a predictable flow of State and Federal housing resources that enable individuals to move into safe, affordable community based housing. The plan addresses following key objectives

1. Expand DMH Rental Subsidy Program (DMH-RSP) by $1M for three consecutive years FY19-21 and improve fiscal management of the resource.
2. Create a Tenant-Based program within the existing DMH-RSP to enable individuals to retain their housing subsidy after ACCS and create opportunities for "other housing planning populations" within the Department.

3. Expand access to existing State and Federal housing resources through use of capital investments FCF, c689 Special Needs Housing and 811 subsidies.
4. Manage housing resources and track movement through the DMH system by implementing a statewide contract monitoring system.
5. Gain access to safe affordable community based housing by expanding training opportunities.
6. Secure qualified outside expertise to assist the Department in identifying additional housing opportunities and in the implementation of the plan.
   DMH is actively working to implement the plan in cooperation with service providers, State housing agencies and other partners.

Recently DMH began a review of its housing services business process. The goal of this review is to align practices across the 5 DMH areas and adopt a common data system supporting system wide vacancy and housing placement management. Further, new housing unit development in the DMH Northeast and Southeast Areas are planned for development with Housing Trust Funds.

Rehabilitative, Support and Recovery-based Services

As DMH is the primary provider/contractor of continuing care community-based services, rehabilitation, support and recovery are at the core of its programs. The primary community-based service providing rehabilitation and support in the community is ACCS, serving approximately three quarters of the people receiving a DMH community-based service. Other DMH state-operated and contracted services providing rehabilitation and support include case management and Program of Assertive Community Treatment (PACT). In addition, DMH offers services focused on recovery and client empowerment, including Clubhouse services. In a shift towards consumer-directed care, DMH funds and supports a variety of consumer initiatives, including peer and family support, peer mentoring, warm-lines and Recovery Learning Communities (RLCs).

Employment Services

DMH continues to provide employment services through Clubhouses, which provide members with a range of career counseling, job search, training, support, and placement services for obtaining and maintaining permanent, supported, and transitional employment. Clubhouses also serve as multi-service centers for DMH clients and other persons with serious mental illness living in the community. Clubhouses pursue a variety of jobs for members including integrated, independent employment.

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

In July 2018, the Department of Mental Health (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. In light of this ACCS providers were allowed to offer "bridging" services for the first year, such that individuals who were receiving specialized employment support directly from the previous service (ACCS) would not suffer an immediate break in service. During this "bridge year," DMH and MRC, the state vocational rehabilitation agency, agreed on a new service model to provide similar supports to ACCS enrollees (partially described in Step 2) beginning July 1, 2019.

Employment activities are further described in Step 2.

Educational Services

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

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

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. DMH incorporated program standards for the care and treatment of individuals with co-occurring disorders into its community service contracts. These requirements include the capacity to provide or arrange for interventions addressing engagement, relapse prevention, use of self-help groups and peer counseling.

The Massachusetts Department of Public Health (DPH) will contract 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 recently announced 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 will also 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.

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 delivers trauma informed , person-centered dual diagnosis treatment integrating the 6 ASAM dimensions of care with SAMHSA's 8 dimensions of wellness. The program operates 9 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.

Health and Mental Health Services Medical and Dental Services

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

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

Within DMH community-based adult services, contracted providers are required to provide rehabilitative and support services that enhance the physical health and well-being of people served through: wellness promotion and support of the management of medical conditions; assistance and support in accessing psychiatric and medical services as needed; and development of linkages and working relationships with community providers, including health providers. DMH's contract management activities emphasize quality care, using measures related to health and wellness as a priority and encourage providers to develop innovative strategies to engage people served in wellness promotion activities.

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

Massachusetts behavioral health facilities have been addressing nicotine dependence with increasing emphasis over the last 20 years. Certain clinical staff at each of the large facilities are trained as Tobacco Treatment Specialists in order to provide both group and individual smoking cessation treatment, and carbon monoxide were purchased for their use. Peer specialists in state mental health facilities have served as champions of wellness issues including physical activity, healthy eating and tobacco cessation.

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

Reducing the Rate of Hospitalization

DMH has continued efforts to shift its focus to community-based care as responsibility for acute care inpatient services was transferred from the public to the private sector. In addition to reducing the number of beds in the DMH system to 725, this private sector emphasis also has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community. The expansion of diversionary services and other community supports, and the entrance of behavioral managed care have substantially reduced the rate of hospitalization.

DMH currently operates or contracts for a total 725 inpatient beds. These are spread among two DMH-operated state psychiatric hospitals, two community mental health centers (CMHCs), two contracted adolescent units housed in a state psychiatric hospital, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total inpatient capacity, which includes beds for forensic admissions, includes 663 adult continuing care beds, 32 adult acute admission beds and 30 adolescent beds. Children, adolescents and most adults receive acute inpatient care in private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions.

Since FY 2012 DMH has procured a Peer-Run Respite service in the Western MA Area. This service provides temporary peer support to individuals in emotional distress and/or

emergent crisis. The service utilizes self-help strategies, trauma-informed peer support, and mutual learning to address the needs of people experiencing emotional distress. The service is intended to be a community-based alternative to a hospital psychiatric setting or other clinical setting for managing emotional distress or emergent crisis. Over time, DMH also expects that Peer-Run Respite Services will be an effective early intervention to prevent hospitalization and dependency on public mental health services through its focus on recovery and wellness values.

DMH Community-Based Services

Adult Community Clinical Services (ACCS)

DMH directly provides and/or funds a range of services for approximately 25,000 adult clients per year. These services include inpatient continuing care, emergency services, case management and other community and rehabilitative services, such as Adult Community Clinical Services (ACCS), Program for Assertive Community Treatment (PACT), Clubhouse and Respite. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some inpatient, emergency and outpatient services in the Southeast and Metro Boston Areas.

Beginning in 2014, Massachusetts has made it a priority to strengthen and reform the behavioral health system in the Commonwealth. Policy changes across DMH, MassHealth and 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 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. ACCS enhanced and transformed service components by combining into one service type the delivery of residential and community rehabilitative services that were previously provided via separate funding and through a more fragmented system. The goal is to offer active and assertive engagement to improve health and behavioral health outcomes. ACCS offers clinical and rehabilitation serves 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. Both ACCS and the Behavioral Health Community Partners contracts initiated on July 1, 2018. To date, 92% ACCS clients maintained community tenure.

An delivery system design of ACCS includes continuity of clinical teams across living arrangements thus clients moving into a subsidized apartment keep the clinical team which supported them during their stay in group living. Further, integration of addiction treatment specialists within the clinical teams provide assertive care for those living with

co-occurring mental health and substance use disorders. The specialists include addiction treatment counselors, recovery coaches and certified peer specialists.

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

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

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

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

The Recovery Learning Community (RLC): The RLC provides peer-to-peer support to individuals with serious mental illness. It is expected to serve as a "hub" in its respective DMH Area. The RLC Program is a resource and referral center that provides general information on topics of concern to peers. The information focuses on

community resources and programs. Services may be offered in a variety of settings; at the RLC Program site, community mental health centers, inpatient hospitals, generic community settings, town hall, fairs, shopping mall, etc. Services include: providing and/or referring to a wide range of peer to peer support services; supporting the providers of peer-to-peer support through training, continuing education, and consultation; and linking together peer-operated services and supports for the purpose of creating a network. This network improves communication, facilitates the delivery of services, coordinates advocacy, and assists in responding to a person's needs, aspirations and goals as they evolve over time. The main goal of every RLC Program is to help persons achieve full community integration. Participation is not an end unto itself, but an additional step toward recovery. The services of a RLC Program are delivered primarily by Peers.

Comprehensive Community-Based Mental Health Services - Child

Reframe the Age

DMH launched an ambitious effort to formally modify its service system statewide in order to align with best practice and research evidence for working with young adults. This effort, known as Reframe the Age, is informed by several former and current initiatives supporting young adults. DMH's sister agencies, including DCF, DYS, MRC and the Special Commission on Homeless Unaccompanied Youth are likewise focused on better serving this age group. The goal is to develop a service system that will support the unique needs of young adults who are at high risk for mental health and co-occurring substance use challenges. Our data analysis showed that a significant number of young adults who submitted a DMH application for services did not complete the service authorization process. Reframe the Age will ultimately create a smooth process to bridge the gap between child and adult services. By allowing young adults (18-22) to receive services in both the Children Youth and Families as well as the Mental Health Services (Adult services) Divisions the Department is creating more permeability between service divisions in order to provide more developmentally appropriate services to meet clients needs. It's anticipated that more young adults will be able to achieve independence without needing formal state services and fewer young adults will transition to adult services at age 22 than currently do at age 18.

Transition Age Youth

Needs: The successful transition of young adults from the child system to the adult system and into the community continues to be a challenge. Since implementation of the Children's' Behavioral Health Initiative (CBHI) behavioral health services available to adolescent MassHealth members under 20 in 2008, the disengagement of young adults from treatment has been highlighted. The award of a SAMHSA/CMHS grant, Success for Transition Age Youth (STAY), led to developing supports for enhanced outreach, service planning and engagement services for transition age youth. Building on that, DMH received an award in 2017 resulting in the Transition Age Youth and Young Adults System of Care Access Initiative Grant (TSAI). This grant will help develop an

accessible gateway to Systems of Care (SOC) for Transition Age Youth and Young Adults (TAYA) with mental health and co-occurring substance use disorders. The TSAI will build on the MassHealth CBHI, the previous Success for Transition Age Youth (STAY) grant, and the Now Is The Time-Health Transitions Grant (YOUForward) in the Northeast region to develop Access Centers, located in Worcester and Springfield, that will be staffed by trained peers, recovery coaches, provide drop-in spaces, assertively outreach to TAYA disconnected from services, teach life skills, and assist TAYA in accessing substance use treatment, housing, education and employment.

Health and Mental Health Services Medical and Dental Services

DMH is seeking to improve the integration of the health care system in two broad areas. First, DMH aims to improve the integration of behavioral health, medical and specialty services provided directly to people who receive services as DMH clients. Second, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with state partners and other stakeholders to improve health care integration and outcomes of residents of the Commonwealth. Most notable are the ACCS and BHCP implementation. DMH recognizes that adults with chronic mental health conditions have a life expectancy of just 53 years and for those with co-occurring substance use disorders the life expectancy drops by 10 years. In partnership with sister agencies, DMH has designed services to promote early intervention, primary prevention and linkages to medical care for all clients served.

While the majority of health and mental health outpatient services for DMH clients are provided through MassHealth, DMH supports the health and wellness of individuals in a number of ways. Since the MassHealth system restructuring (Waiver) has identified health education and health and wellness coaching activities as responsibilities of the newly created Behavioral Health Community Partners (BHCPs), DMH has actively encouraged this approach. Throughout its community services DMH seeks to better coordinate community medical and dental care for its clients across the life span, and coordinate services with child welfare, transitional assistance, housing, education, day care, long term supports, employment and criminal justice agencies.

Within DMH community-based adult services, contracted providers are required to provide rehabilitative and support services that enhance the physical health and well-being of people served through: wellness promotion and support of the management of medical conditions; assistance and support in accessing psychiatric and medical services as needed; and development of linkages and working relationships with community providers, including health providers. DMH's contract management activities emphasize quality care, using measures related to health and wellness as a priority and encourage providers to develop innovative strategies to engage people served in wellness promotion activities.

Health, acute-care mental health services, and some intermediate care services for youth who are DMH clients are provided through public and/or private insurance, with virtually all children in the state having access to some primary care coverage. Part of the responsibility of case managers and program staff is to work with parents and youth to

help them get connected and stay connected to appropriate mental health and other health services. Eligibility staff work with DMH applicants to assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage.

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

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

Rehabilitation Services

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

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

For children with severe needs, DMH provides a range of intensive services to meet these needs, including a residential level of care that can be provided in a child's home if clinically appropriate. These include the DMH/DCF Caring Together (CT) services, a unique collaboration between DMH and DCF, the Commonwealth's Child Welfare Agency. Caring Together, through a single procurement, creates standardization in

services, rate structure, administrative processes, quality oversight, and evaluation for all youth in need or at risk of out-of-home services, through a variety of different service models. Full implementation of Caring Together Services include:

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

In addition to community based services, DMH also contracts for continuing care inpatient services for adolescents, and for secure intensive residential treatment programs. Emergency services, available to the community at large, are provided through the MassHealth contracted behavioral health vendor (MBHP). Funded by DMH in collaboration with the Juvenile Court Department of the Trial Court, juvenile court clinics operate across the state to provide assessments and referrals for children who come before the court, and that thereby promote diversion into treatment.

Each person receiving DMH funded direct services has an Individualized Action Plan (IAP) specifying the range of services and supports that will be provided to the child and or family by DMH service providers, and the outcomes these services are expected to achieve. If a youth is receiving DMH case management services, then s/he will also have an Individual Service Plan (ISP). Developed by the DMH Case Manager, the ISP is individualized, identifying the client's goals, strengths, and needs, the DMH services and programs that address those needs, as well as the program specific treatment plans prepared by the service providers.

Support Services

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

DMH funds parent support coordinators in every DMH Area. These coordinators, or "Family Support Specialists", assist other parents to navigate the system, access entitlements, and develop the skills that allow them to effectively advocate for the services and supports they and their child need. Family Support Specialists also

facilitate parent support groups that are open to all parents or caregivers of a child with emotional or behavioral needs. In addition, DMH provides funding to the Parent Professional Advocacy League (PPAL), the statewide organization that supports and advocates on behalf of parents and families of children with behavioral health needs. This organization works to promote parent participation in policy and program development so that behavioral health services are family-driven and reflect family voice and choice.

Employment Services

The focus on transition age youth and young adults, ages 16-25, has increased the attention given to pre-vocational skill development and supported work and supported education activities. Residential providers and those providing intensive in-home interventions focus on arranging and supporting part-time work opportunities for youth that they can manage while still in school and during the summer. DMH training for case managers in understanding the requirements of IDEA in regard to transition have focused on helping them learn to use the IEP to promote vocational preparation, and also about services available through the Massachusetts Rehabilitation Commission (MRC). Family Support Specialists have also been trained on these topics.

DMH continues to work with the Massachusetts Rehabilitation Commission (MRC), the state's vocational rehabilitation agency, and its staff in supporting employment and higher educational opportunities. DMH also continues to add Transition Age Youth Peer Mentor positions within the agency.

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

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

In partnership with the DMH's SAMHSA funded Success for Transition Age Youth (STAY) grant, the Children's Behavioral Health Knowledge Center, MassHealth's Children's Behavioral Health Initiative co-developed the Young Adult Peer Mentor (YAPM) Practice Profile. (http://www.cbhknowledge.center/young-adult-peer-mentoring-overview). The development of the Practice Profile took place in work groups that reflected the voice and expertise of many talented young adult peer mentors from across Massachusetts. In fact, 64% of work group participants were young adults with lived experience. Upon the completion of the Practice Profile, DMH developed the Core Elements of Young Adult Peer Mentoring training, which consists of a 3-day core that covers all six core elements detailed in the Practice Profile. This training replaces the

"Gathering & Inspiring Future Talent (GIFT) Training" as the training for YAPM because the need for the training to be condensed and highlighting the core element of their work.

Housing Services

Virtually all youth under the age of 18 served by DMH who are not in a residential treatment program live in the home of a family member or foster home, as do most youth who are age 18. DMH focuses on supports to youth and their families or caregivers in order to facilitate that kind of living arrangement, as is normative in our society as well as economically realistic. Most youth, however, aim to eventually live independently. DMH supports this goal in several ways. Adolescent residential providers are required to use a formal curriculum to teach independent living skills, and teaching these skills can also be a focus of intervention for those receiving Community-Based Flexible Supports (ACCS). DMH currently funds a few supported housing slots specifically for older youth. As an agency, DMH has sponsored aggressive efforts to increase supported housing opportunities for its clients. DMH maintains housing staff which works with DMH providers and state and local housing agencies to promote housing supply development efforts in support of DMH's locally administered discharge planning process and to achieve other DMH agency-wide housing and community-based treatment goals. DMH Central Office housing staff works with Area Housing Coordinators in each of DMH's five Area offices.

A few members of the Youth Development Committee (YDC) have joined the State Mental Health Planning Council's Housing Subcommittee to represent and ensure the housing needs and concerns of young adults are addressed. Staff from the DMH TAY initiative and STAY grant is partnering with the Housing Subcommittee and young adult peers to begin a focused discussion on the housing needs of young adults and reviewing existing models for young adult housing. DMH's Transition Age Youth Initiative has also been appointed to the EOHHS Unaccompanied Homeless Youth Commission to study and make recommendations relative to services for unaccompanied homeless youth age 24 and younger with the goal of ensuring a comprehensive and effective response to the unique needs of this population.

Educational Services

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

program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary.

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

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

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

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

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

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

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. DMH incorporated program standards for the care and treatment of

individuals with co-occurring disorders into its ACCS contracts. These requirements include the capacity to provide or arrange for interventions addressing engagement, relapse prevention, use of self-help groups and peer counseling. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

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

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

Case Management Services

DMH remains committed to providing case management and its case management workforce, and currently serves approximately 1,000 children and youth annually. Principally, clients in need of service coordination amongst various providers are assigned to case management.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. Since 1992, DMH has closed five state hospitals, including the state-operated children's center, transferring responsibility for acute care from the public to the private sector. Children and adolescents receive acute inpatient care in private or general hospitals. This has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community.

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

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

Outreach to Homeless – Adult and Child

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

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

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

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

Of particular note is a long-standing permanent housing program for homeless co-funded by DMH and the Department of Public Health (DPH) that operates statewide referred to as the Aggressive Treatment and Relapse Prevention program (ATARP). ATARP provides a "housing first" approach with necessary support services to a minimum of 60 clients (55 single adults and 5 families) diagnosed with co-occurring psychiatric and substance abuse disorders.
DMH is an active partner is the Commonwealth's Tenancy Prevention Program (TPP) a court centered program operating across the state with mental health providers serving as the contracted clinical support. TPP operates in all five housing courts in Massachusetts and some District Courts, intervening with people who are about to be evicted from their housing. Four of the six providers serving TPP are mental health providers and bring critically important clinical and mediation skills to help avoid eviction or secure alterative housing. It has proven over the years to be an extremely successful program either "saving" tenancies or providing for a "soft" landing in a more supported environment.

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

DMH's Transition Age Youth Initiative was also appointed to the EOHHS Unaccompanied Homeless Youth Commission to study and make recommendations relative to services for unaccompanied homeless youth age 24 and younger with the goal of ensuring a comprehensive and effective response to the unique needs of this population.

Older Adults

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

Over the last seven years, DMH and the Executive Office of Elder Affairs (EOEA), the Massachusetts' State Unit on Aging, have taken on a number of initiatives to improve services to older adults. The Department of Public Health (DPH) has also been engaged as a key state partner and these agencies are working together to leverage resources to focus on suicide prevention in older adults.

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

Rural Area Services – Adult and Child

DMH does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. Each of DMH's 27 Sites has at least one town or incorporated city with a population greater than 15,000 that is considered the center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.

The primary goal of DMH's local planning process is to address the issue of access to services for all DMH clients. Each Site plan identifies target population, needs, available services and resources, gaps in services and resources, and barriers to implementation of a local service delivery system. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. A particular focus relevant to rural populations continues to be access to transportation. At the Area level, many clients have identified this as a challenge. In child and adolescent service contracts, for example, transportation is one of the flexible supports often provided.

Service System's Strengths and Needs

Massachusetts demonstrates a number of strengths which, woven together, represent the promise of a service delivery system organized around principles of recovery oriented, consumer and family-directed care. At the heart of these strengths is a commitment to

fostering partnerships with other state agencies, advocates, consumers, family members and other key stakeholders.

Peer and Family Member Involvement and Workforce

Strengths: Massachusetts benefits from a strong network of consumers and family organizations that engage with DMH and other partners in a wide range of policy, program, advocacy, and other system-level efforts. Having built strong relationships statewide, these organizations effectively identify emerging consumer and family member leaders and provide training and mentoring to support their development as leaders. Further, Massachusetts is also building a strong workforce of peers and family members. The State Mental Health Planning Council has adopted the TransCom's Workforce Development Guidelines. Additionally, Massachusetts has an adult peer specialist training and certification program and is developing peer and family curricula specific to family support, transition age youth and the Deaf and hard of Hearing. Peer and family support positions are now required in multiple services.

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

Service System Planning for Transition Age Youth (TAY)

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

Needs: The successful transition of young adults from the child system to the adult system and into the community continues to be a challenge. Since implementation of the Children's Behavioral Health Initiative (CBHI) behavioral health services available to

adolescent MassHealth members under 21 in 2008, the disengagement of young adults from treatment has been highlighted. Inaugurated with 2012 SAMHSA funding, each DMH Area now has active TAY teams, including a workgroup focused specifically on substance abuse service guidelines.

Interagency Collaboration

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

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

Implementation and Support for Evidence-Based and Emerging Practices

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

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

Community Services Redesign

Strengths: DMH engaged multiple partners over the course of several years to identify the strengths and weaknesses of the community service system. During SFY 17, MassHealth renegotiated a five year Section 1115 Waiver to implement an Accountable Care Organization (ACO) model with Delivery System Reform Incentive Payments (DSRIP) funding Behavioral Health Community Partners (BHCPs). The BHCP role focuses on care coordination for MassHealth members enrolled in an ACO. DMH has worked closely with MassHealth towards implementing its Adult Community Clinical Services (ACCS) model which aligns, but does not supplant funded services for MassHealth member DMH clients. Extensive collaboration

Within DMH Children Youth and Family Services' system, a re-procurement of Individual and Family Flexible Supports is underway. Redesign includes changes that enhance system flexibility, recovery- and resiliency-orientation and family- and consumer- direction that result in positive outcomes for consumers, youth and families. Feedback obtained from youth and families served by DMH have also informed the implementation of the Children's Behavioral Health Initiative (CBHI).

Needs: As this system change continues to occur, it is essential for DMH to measure and monitor the effectiveness of these services, including demonstrating that consumers, youth and families are experiencing positive outcomes.

Behavioral Health Integration

Strengths: DMH is a leader in health care reform with 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 is working 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 primary, and specialty care funded through each entity. DMH has always actively engaged with MassHealth, BSAS and EOHHS as is described in detail in other sections of the Plan.

Culturally Competent Services

Strengths: State mental health authorities are poised to address issues in serving culturally and linguistically diverse populations. There are only a limited number of dedicated offices across the country that have taken a series of steps and strategies to implement cultural and linguistic competence with the goal of reducing mental health disparities in status and care. The Office of Race, Equity and Inclusion (REI) recently completed a review of interpreters in its 5 Areas, and is working to use technology to effectively and efficiently increase access and provide more culturally competent services.

DMH has placed a significant focus on planning and monitoring efforts for underserved populations. REI, DMH's Statewide Cultural Competence Action Team and the Multicultural Advisory Committee continue their focus on the goals outlined in the multi-year Cultural Competence Action Plans. Further, DMH is reviewing the completeness of its data systems in reliably recording clients' race and ethnicity data.

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.