Step 2: Unmet Needs and Service Gaps

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

DMH continues to routinely engage multiple stakeholders in evaluating the strengths and needs of the current mental health system, including opportunities to respond to Requests for Information (RFIs) related to the redesign and re-procurements of adult and child community and child residential services; consumer and family involvement in procurement, policy development and quality improvement processes; work groups and task forces addressing issues such as behavioral health integration; and ongoing dialogue via established advisory and steering committees and workgroups. These groups, with diverse membership of consumers, family members, providers, advocates, state agency staff and others, are often the place where needs are first given voice as well as a place where information is exchanged, solutions are identified and successes are celebrated.

For DMH child, adolescent and family services, service planning is closely coordinated with MassHealth, which funds comprehensive community-based behavioral health services for children and youth under the age of 21, through its Children's Behavioral Health Initiative (CBHI). Family voice, choice, and engagement are overarching principles guiding this transformation and to that end, families and youth with SED are represented and active participants in these efforts.

Consistent through much of this feedback is the need for services that are individualized, flexible, person and family driven, and recovery and resiliency oriented. A related theme is also the need for integration with other behavioral, medical, and human services, as well as community resources and supports. The need for flexible and integrated services that focus on the strengths of the person and their family and result in positive outcomes is the common thread through the unmet needs and critical gaps identified below.

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

DMH has maintained its commitment to engage stakeholders in its business process review efforts. This section describes the processes through which needs and gaps are discussed and priority interventions identified.

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

As DMH continues to shift its services toward recovery-orientation, stakeholders, especially people with lived experience, have emphasized the need to provide services that result in positive outcomes for the people served, notably in health and wellness.

Health and Wellness

1) In partnership with the Massachusetts Department of Mental Health (DMH), the Massachusetts Department of Public Health (DPH) and its provider agency, the Institute for Health and Recovery (IHR), are now supporting the orientation and ongoing training of a Tobacco Education Coordinator (TEC) on each of the individual units of the psychiatric inpatient facilities of the Department of Mental Health. The model for the TEC role and its support is drawn from the work IHR has done over many years with facilities in the Massachusetts Bureau of Substance Addiction Services (BSAS). TECs are provided an initial orientation, followed by twice yearly support and update meetings, all conducted by IHR. The first DMH TEC orientation sessions occurred on 12/17/2018 and 1/28/2019, with the following results:
    - A total of 57 staff attended the orientation trainings
        - 26 staff from WRCH, Vibra, Corrigan, Pocasset, and Taunton attended at WRCH
        - 31 staff from Tewksbury, Shattuck, Fuller, and WRCH attended at Tewksbury Hospital
        - Almost all inpatient units in the state—29 out of 33 total—were represented by 1-2 staff who attended one of the orientation trainings
    - A total of 42 staff filled out the evaluations
        - 91% strongly agreed/agreed that the information provided in the training will be useful to their work
        - 88% strongly agreed/agreed that the skills provided in the training will be useful to their work
        - 90% had an excellent/good overall impression of the training

2) 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 been working to facilitate participation by BHCPs in the Cessation Implementation Group of the Massachusetts Tobacco Cessation and Prevention Program (MTCP) of DPH. The hope is to foster the development of a standard and robust tobacco screening, brief intervention and referral process within the restructured MassHealth system.

3) On 2/14/2019, the DMH psychiatric leadership group, comprised of Area Medical Directors and inpatient Facility Medical Directors, received a two-hour training by psychiatrist Eden Evins, MD of Massachusetts General Hospital on tobacco cessation treatment in individuals with mental illness. Dr. Evins is an internationally recognized expert and researcher in the field of tobacco treatment for the mentally ill.

4) Building on the Healthy Changes Task Force and working in partnership with the Massachusetts Department of Mental Health (DMH), the Massachusetts Department of Public Health (DPH) and its provider agency, the Institute for Health and Recovery (IHR), are now supporting the orientation and ongoing training of a Tobacco Education Coordinator (TEC) on each of the individual units of the psychiatric inpatient facilities of the Department of Mental Health. The model for the TEC role and its support is drawn from the work IHR has done over many years with facilities in the Massachusetts Bureau of Substance Abuse Services (BSAS). TECs are provided an initial orientation, followed by twice yearly support and update meetings, all conducted by IHR. The first DMH TEC orientation sessions occurred on 12/17/2018 and 1/28/2019, with the following results:
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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. 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, Adult Clinical Community Services, 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. MassHealth has implemented its five year Section 1115 Waiver that includes 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 continues via collaboration with MassHealth its commitment to assuring that DMH clients served by ACCS and/or BHCP receive quality services.

Needs: The capacity for data sharing continues to challenge service providers in care delivery and state agencies in contract monitoring, performance and quality management. DMH participates in the EOHHS Master Data Management system to identify MassHealth clients jointly served by DMH. Further, DMH is currently engaged in a multi-year process with the end goal of acquiring new technology supporting its community services by 2022. Challenged by state and federal regulation, DMH will persist in finding legally allowed data sharing approaches.

Behavioral Health Integration

Strengths: DMH, DPH and MassHealth all focus on improving integration among physical health, behavioral health, long-term services and supports, and health-related social services. MassHealth created three ACO models which cover DMH clients and invested in the Behavioral

Health Community Partners (BHCPs). The BHCPs are responsible for providing screening to identify current or unmet behavioral health needs; review of members' existing assessments and services; care planning, care management; care coordination; managing transitions of care; service navigation and health promotion. ACCS contractors, in planning and providing services with individuals, coordinate with the BHCPs and other MassHealth care coordinators.

Needs: Continuing efforts to integrate services across two new models of care, the BHCPs and ACCS providers will be necessary. Strengthening new approached to provider-client-family collaboration, compliant data sharing, and service planning that prioritize clients are areas for monitoring in this planning period.

Culturally Competent Services

The DMH Office of Race, Equity and Inclusion (REI), formerly the Office of Multicultural Affairs, 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 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 the many diverse racial, ethnic, and linguistic populations in Massachusetts.

Strengths: DMH is a leader in health care reform with the passage of health care reform legislation in 2006. Approximately 98% of Massachusetts residents are insured. 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. In all reform efforts, stakeholder outreach towards improved inclusion in service planning has been central.

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 to include all people who are accessing or seek to access behavioral health primary, and specialty care funded through each entity. DMH is actively engaged with MassHealth, BSAS and EOHHS which are described in detail in other sections of the Plan. A new partnership with DPH focuses on outreach and inclusion of Native American tribal nations indigenous to Massachusetts.

2. Addressing the needs of specific populations

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

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

However, DMH recognizes that the presence of these service standards does not in itself address the challenges and obstacles in providing services that competently address these needs. Furthermore, data also suggests that there are unique barriers for some population in accessing behavioral health care, including DMH services.

Cultural and Linguistic Minorities

DMH has standardized the collection of clients' race, ethnicity, and preferred language information in the agency's Mental Health Information System (MHIS) basing the manner of collection on the Institute of Medicine's recommendations and Office of Management and Budget guidelines. DMH's Office of Race, Equity and Inclusion (REI) regularly reviews population census data for DMH and also reviews service enrollment data and studies on prevalence rates of mental illness based on race and ethnicity. REI has worked closely with the DMH's two Centers of Excellence to identify social, cultural, environmental and economic determinants that have an effect on the prevalence of mental illness among racial, ethnic and culturally diverse populations. Further, DMH currently administers its adult client satisfaction survey in English and 6 additional languages: Spanish, Portuguese, Cape Verdean, Haitian Creole, Chinese, Vietnamese and Khmer.

Reviewing DMH data on the race and ethnicity of adults authorized to receive DMH services as compared Massachusetts census data reveal that that 65% of the adults (ages 19-64) served by DMH were White; 14% were Black/African American; 2% were Asian; 11% were Hispanic and 17% were non-Hispanic some other race. When compared to Massachusetts census, it is notable that while Blacks/African Americans (ages 19-64) represent 8.4% of the Massachusetts population, they represent 14% of the DMH population in this age group. Conversely, non-Hispanic, Whites (ages 19-64) represent 73.5% of the Massachusetts population, but 65% of the people served by DMH in this age group.

Elders

The Elder Mental Health Planning Collaborative, a subcommittee of the Planning Council, has been a strong advocate for the needs behavioral health needs of elders. The Collaborative is focused on identifying the behavioral health needs of older adults, identifying service gaps, and exploring best practices in order to improve service delivery, fill gaps and replicate and fund similar programs in MA. The Collaborative promotes prevention, outreach, wrap around peer and clinical supports and gatekeeping services; training and education; and partnerships on the local and state levels, as well as connection to the National Coalition on Aging and Mental Health.

Recent Accomplishments/priorities include working with the Executive Office of Elder Affairs (EOEA) to develop regional Aging and Mental Health chapters to network, build community capacity and share resources to better support older adults with behavioral health conditions in the community; helped support recruitment and training of COAPS (Certified Older Adult Peer Specialist); worked with Medicaid to get COAPS covered under the Home and Community Based Frail Elder Waiver; supported the development of EMHOT (Elder Mentlal Health Outreach Teams); hosted roundtable discussions to raise awareness and brainstorm solutions for unmet needs on topics relevant to aging and mental including, housing instability, hoarding, vocational rehabilitation; expanded membership to include representation from Mass Association of Mental Health; developed goals for upcoming year including, attention to topics such as older adults and opioids, supporting the EMHOT programs, expanding membership to include more diversity, and hosting a DMH and EOEA sponsored fall forum.

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

DMH has continued with its LGBTQI Initiative to improve services to lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI) populations. During the past year, the Work Group has conducted a Train-the-Trainer series to ensure that there is internal capacity to provide the necessary training to all DMH staff. That training has been initiated in stages – all managers/supervisors have been trained, and current training is focused on community staff. The last stage of training will be for inpatient staff.

Additionally, the agency is continuing to work on finalization of the Non-Discrimination Policy, and an Implementation Work Group has been established toward this goal. A Guidance for the Policy has also been developed to assist with implementation.

Deaf/Hard of Hearing (HOH) Population

DMH serves approximately 90 people who are deaf and use American Sign Language and approximately 150 people who are hard of hearing who may use ASL but also use English as a primary language. It is difficult to estimate how many people should be served but typically, deaf people are under-represented. The high frequency of trauma would predict that people who are deaf are at greater risk for mental health and substance abuse problems. Often people who

are Deaf are misdiagnosed and so not referred for services. Or, people who are deaf are not well served by the acute-care system due to cultural and linguistic barriers and so drop out of that system and never make it to continuing care services. There is also a lack of access to information to understand mental illness and fear and stigma around the issue in the Deaf community.

The DMH Worcester Recovery Center and Hospital provides Deaf services within one its units. Training efforts and other accommodations are being pursued to address the challenges of providing linguistic and cultural access and treatment within this setting.
The quality and dependability of interpreters is varied. Workforce development is a major obstacle, including the recruitment and training of Deaf staff to be skilled staff in the delivery of behavioral health services. Staff training for Deaf staff is usually done through interpreters and not on the same level as hearing staff and the same applies for supervision. During the past year, DMH conducted DHH peer specialist training.

Veterans

In 2008 Massachusetts revised its vision statement and focused its planning efforts on improving veteran-related data; outreach to veterans and their families; access to and utilization of care; and employment access and retention. In Massachusetts, towns on the Cape and in the West and Southeast have veterans' populations exceeding 10% of the total population. Further, the Veterans Administration (VA) facility in Bedford offers behavioral health services on its campus. Recently, DMH renewed its VA collaboration by initiating on campus visits to identify best approaches to serving MA veterans living with serious mental illness. DMH also collaborates with the MA Department of Veterans' Services and its liaison to the municipal Veterans Services Offices.

People with Court Involvement and Forensic Histories

Past research conducted in Massachusetts has shown that nearly three in ten individuals in a cohort of mental health services recipients experienced at least one arrest over a 10-year period and many experienced several (Fisher et al. 2007). Risks of arrest for misdemeanors and non-violent crimes were most significant, though many individuals also had histories of more serious offenses (Fisher et al. 2011). The risk factors for incarceration (unemployment, substance abuse, mental illness, poverty) are also risk factors for poor community outcomes. Individuals with mental health and substance abuse disorders have broad difficulties in the community leading to more specific problems including securing housing and appropriate healthcare, substance abuse, and subsequent criminality and related social costs post release (Baillargeon 2009).

At present there are several unique initiatives afoot in Massachusetts to "intercept" the multiple pathways to the criminal justice system for these individuals with co-occurring mental health and substance use disorders (CODs), based on the sequential intercept model (Munetz and Griffin 2006). DMH's grant program for behavioral health training and arrest diversion projects for law enforcement noted above is currently impacting over 140 communities in Massachusetts. Notably in the Boston Area, programs have been initiated with the Boston Police Department to train police in effective response to behavioral health crisis situations and support

clinician positions for co-response to enhance their arrest diversion capabilities. DMH also has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted adolescent residential units. The DMH Forensic Mental Health Services has assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court. Forensic specialists sited in the juvenile courts provide evaluation and consultation services for judges and probation officers on an as-needed basis, as well as treatment for children. Protocols between the Department of Youth Services (DYS - the juvenile justice service system) and DMH have been developed to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system. In a project jointly developed by DYS and DMH, the Capstone Project, a lead DMH clinician, based in Central Office, serves as the designated liaison to DYS regarding clinically challenging youth whose needs require sophisticated clinical and systems competencies.

3. Increased access to peer support and peer-run services.

The number of individuals with lived experience of mental illness who has been trained as Certified Peer Specialists (CPS) continues to increase. The Transformation Center, a peer-run organization in Massachusetts, has been providing CPS training and certification since 2008. Since the beginning of training, they have certified close to 1,000 Certified Peer Specialists. As part of re-contracting, DMH sponsored 3 Public Stakeholder Meetings to get input on the content of CPS training going forward, given the DMH's goal of fully integrating peer specialists into the healthcare system.

DMH and the peer and provider communities continue to expand the potential pool of CPS applicants and to provide culturally and linguistically competent peer services. The Transformation Center added an online application and interview scheduling process for the CPS training. This process includes a Self-Assessment and on-line preparation course.

DMH recently re-contracted our five Recovery Learning Communities (RLCs). These peer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state and continue to develop their capacity to support the growing peer workforce in Massachusetts. The RLCs have continued to offer peer bridging services for individuals leaving DMH-operated intermediate care facilities, as well as private acute-care psychiatric institutions, to help connect individuals with community resources beyond the tradition behavioral health services. Massachusetts is taking a national lead in furthering the discussion between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities. This project is a partnership between DMH, the Department of Public Health Bureau of Substance Abuse Services (BSAS), University of Massachusetts Medical School Department of Psychiatry, the Massachusetts Organization for Addiction Recovery (MOAR), the Transformation Center, and the MassHealth Office of Behavioral Health and the Massachusetts Association for Behavioral Healthcare.

Of special interest are the systemic barriers faced by people with co-occurring mental health and addictions disorders. Because mental illness and addictions have historically been seen as very different conditions, mental health and substance abuse support systems have developed under

separate state and provider agencies or divisions, each with its own funding mechanisms, job classifications, criteria for credentials, and treatment systems. Thus, people with co-occurring needs are often challenged with navigating these separate care systems.

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

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

The DMH Office of Recovery and Empowerment, currently led by Robert Walker, is expanding, and is seeking candidates for the Director position, formerly held by the late Russell Pierce. The Office has been active on the national scene, working to improve specific supports for persons receiving services who are parents, and furthering the national visibility of Certified Older Adult Peer Specialists.

Led by the Office of Recovery and Empowerment, DMH is using the TTI CT-R contract to expand in-state capacity for CT-R Trainers, and to roll it out to multiple settings in our continuum of services. We have created a CT-R Learning Collaborative with the teams involved. We have successfully trained teams from our First Episode Psychosis program, an acute care psychiatric inpatient unit, a PACT/ACT team, a homeless outreach PATH team, a Forensic PACT/ACT Team, and a unit from Tewksbury State Hospital.

4. Affordable housing and coordinated services for people who are homeless

Access to safe, affordable, high quality housing continues to be a key DMH objective in the delivery of mental health services. DMH works closely with the Department of Housing and Community Development (DHCD), the state's primary housing oversight agency, which is responsible for overseeing the Local Housing Authorities, managing federal and state rental assistance along with responsibility for policies and resources directed at homeless individuals and families. DMH clients who on average earn some $7,500 annually are at the very bottom of HUD's extremely low income category that targets those earning 30% of Area Median Income (AMI); DMH clients are at 15% of AMI).

DMH through its collaboration with DHCD has exclusive access to over 70 (ch. 689) developments, housing more than 650 clients. These units are owned and managed by the Local Housing Authorities. DHCD also manages the DMH-Rental Assistance program, currently funded at $7M housing that serves close to 1,300 clients. With respect to capital investment,

DHCD funds the Facilities Consolidation Fund (FCF) that supports development of independent, integrated housing for DMH and now has in excess of 800 units across the state. Virtually all of the units are owned by local Community Development Corps and other not for profit housing providers. The Department will continue to utilize FCF capital funds to expand integrated housing opportunities along with seeking to "re-purpose" state ch. 689 housing previously used by the Department of Developmental Disabilities.

HUD McKinney funds are critical to the mission of assisting those who are homeless and DMH is extremely active in all 20 HUD Continuums of Care across the state that in total manage some $65M in grant funds to house the homeless. DMH matches many of these grants that include Supportive Housing, Shelter Plus Care Safe Haven and Supportive Services Only.

DMH participated in the Interagency Supportive Housing Initiative, led by DHCD, to develop supportive housing, particularly for homeless persons and families, people with disabilities and elders. This groundbreaking initiative pulls together all the relevant housing and service agencies, 18 in all, to work toward securing the necessary housing funds along with their commitment to providing the clinical and service supports that would enable people to live in their own housing. This initiative was successful in creating 1,000 new units of Supportive Housing to serve homeless, disabled and elders exiting institutional care.

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

1. **Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system, and implementing evidence-based practices**

Workforce development has emerged as a major theme within the behavioral health system. As more is learned about effective engagement and treatment that promotes recovery and resiliency, there is a renewed urgency to ensure that staff are trained and demonstrate competencies in these practices. Providers frequently express frustration with high staff turnover rates that impede providers' ability to sustain best practices and a highly qualified workforce. The provision of training and ongoing supervision and support related to the practice is also resource intensive.

The Department of Mental Health's Person-Centered Planning Training initiative, which was initially funded by a SAMHSA Transformation Transfer Initiative (TTI) grant, occurred as a part of a Person-Centered Planning Implementation grant from the federal Centers for Medicare and Medicaid Services. DMH expanded on these efforts by developing its own curriculum. This overview training utilized a train the trainer model to provide training to all DMH staff. DMH launched a statewide effort to train all DMH workforce members in the philosophy of Person-Centered Approaches to Treatment Planning. 80 Trainers were trained to provide this training to the 3500 member workforce. In order to develop an infrastructure for full integration of these concepts into practice, DMH also retained the consultant to further develop the skills of PCA champions across the state as part of an effort to have subject matter experts working in most settings to mentor and coach other staff day-to-day. These individuals may also conduct quality improvement activities and will communicate with local leadership to address challenges to implementation and inform future training needs. The training strategy also includes an informational segment for persons served about their role in PCP and what to expect. Peer specialist staff has been trained to lead discussion groups with this material.

Another area in which DMH recognizes a significant need is in providing evidence-based trauma-informed care. Multiple studies have highlighted the prevalence of trauma within mental health settings. They include the findings that 90% of public mental health clients have been exposed to trauma and that most have had multiple experiences of trauma (Meuser et al., 2004; Meuser et al., 1998). Additionally, 34-53% of people in other studies reported childhood sexual or physical abuse and 43-81% report some type of victimization. (Kessler et al., 1995; MHA NY & NYOMH, 1995).

DMH continues to collaborate with The Transformation Center, a peer-run, DMH funded agency to further expand and adapt training opportunities for peer support workers and certified peer specialists. DMH has also piloted the Gathering Inspiring Future Talent (GIFT) training for young adults. This is an intensive training program that prepares young adults with "lived experience" for the role of Peer Mentors and young adult advisory board members within the Community Service Agencies (CSAs) under the STAY Together grant. The training was also opened to other young adults with lived experience who are exploring the field of peer support work.

DMH also provided a number of trainings and educational tools that focus on the correlation between employment and recovery. A website (www.reachhirema.org) was created as a resource for young adults and those who work with them, focused on resources for pursuing employment, education, and financial management. In addition, several benefits intensive trainings were

offered across the state to assist people in making informed decisions about employment options by better understanding their benefits.

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 instead of purchasing employment support as part of ACCS as was done in the previous service model, employment support would be leveraged from the existing employment service system, and primarily from the state vocational rehabilitation agency, MRC. Through this partnership, DMH now funds eighteen (18) specialized mental health counselor positions to provide outreach and engagement services to ACCS enrollees where previously enrollees could not have met with VR counselors prior to being determined eligible for MRC.

To further build capacity within ACCS while supporting the Peer Workforce, in August 2018 DMH partnered with the Boston University Center for Psychiatric Rehabilitation (BU-CPR) and the National Association of State Mental Health Program Directors (NASMHPD) to offer a six day training on Vocational Peer Support (VPS). The training was offered to thirty staff with lived experience, including peer specialists, peer mentors, and peer advocates, providing advanced training to members of the peer workforce on how to offer concrete, vocational support within the context of the Peer Role. Following the completion of the course, six months of monthly technical assistance calls were provided for participants to practice skills and discuss the real-world application of learning.

2. Developing and enhancing evidence-based Supported Employment programming for young adults experiencing a first episode of psychosis (FEP).

Massachusetts has been at the forefront of the nation in recognizing and addressing the needs of adolescents and young adults experiencing psychosis and their families. The recent RAISE studies have clearly established the value of multicomponent first episode psychosis (FEP) treatment programs as viable treatment models for improving symptoms, reducing relapse episodes, and promoting recovery among individuals experiencing psychotic illness.

Massachusetts is invested in developing a continuum of care available to young adults experiencing early psychosis and their families. DMH directly funds two PREP™ programs (in Boston and Holyoke) that offer the equivalent of an intensive outpatient program. In addition, through a competitive bid process,

DMH awarded outpatient clinics at Mass General Hospital (Boston), Advocates (Framingham), and Cambridge Health Alliance (Cambridge) funds to better align clinical services to existing best-practice models for serving youth experiencing a first episode of psychosis through the creation of Supported Employment and Education (SEE) positions. DMH provided training in Individual Placement and Support (IPS) and its adaptations for youth to FEP staff, and convenes a monthly group supervision of all available FEP staff from the five programs. Continuing to develop the capacity to offer high-fidelity, multi-disciplinary care for youth experiencing FEP is an ongoing priority.

5. Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system, and implementing evidence-based practices

Recruitment, promotion of learning through formal training programs and supervision are critical elements of workforce development across the service system. Expectations for contracted programs align with expectations of DMH operated services and are guided by the following:

- Clinical Staff are trained and demonstrate competency in the use of standardized screening and assessment tools, including the selection of tools and assessment approaches appropriate to Persons served.
- Clinical Staff are trained, demonstrate competency, and when relevant, certified in the following evidence-based practices: Motivational Interviewing, SBIRT, Harm Reduction, Stages of Change and Housing First and other evidence-based practices. Clinical staff provide supervision, mentoring and modeling of these interventions to ensure that all staff deliver these interventions consistent with best practice and in accordance with Treatment Plans.
- Clinical staff are knowledgeable and remain current about evidence-based treatment interventions (e.g. CBT, DBT), in order to support Persons receiving such interventions in other settings.
- DMH-operated facilities will focus on CBT, Motivational Interviewing, Illness Management and Recovery, Suicide Prevention (QPR, C-SSRS, and CAMS)
- Direct Care staff receive training and supervision consistent with their role and qualifications to support their participation in:
    - Screening and assessment activities.
    - Delivering treatment interventions, including strategies related to Motivational Interviewing, SBIRT, Harm Reduction, Stages of Change and Housing First and other evidence-based practices selected by a Contractor.
- Direct Care staff demonstrates competencies in these areas consistent with their roles and qualifications.
- Clinical and Direct Care staff providing direct services to Persons receive regularly scheduled and ongoing supervision and consultation by licensed clinicians with the appropriate credentials.
- DMH supports ongoing opportunities for people with lived experience to receive training to become Certified Peer Specialists. A specialized program geared toward transition age youth and young adults "Gathering Inspiring Future Talent (GIFT) is also offered several times per year to engage this age group to prepare them to be Peer Mentors or advisory board members for behavioral health organizations.
- DMH and its contracts employ Peer Specialists in key administrative and peer support roles across the service system.

Ongoing professional development opportunities help reinforce the skills of the workforce. DMH offers many learning events featuring subject matter sharing emerging and best practices. These events are announced via a centralized web-based calendar and are open to DMH and Provider staff as well as the general public when space allows.

As an aspiring learning organization, DMH has invested in its learning division and other learning champions and leaders by deeply training the staff in best practices for adult learning. As such the organization is apply the principles of Dialogue Education to both curriculum development and planning and execution of meetings. Both are meant to optimize these experiences by customizing them to the needs of the workforce, using intentional preparation frameworks, decision tools and a variety of modalities to facilitate the transfer of learning and achievements.

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

1. **Greater emphasis on services that directly impact on positive outcomes.**
   The SAMHSA definition of youth with serious emotional disturbance (SED) is individuals younger than 18 years who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities. Thus, these three primary life domains – home, school, and community - define the broad outcomes that DMH strives to impact through its Child, Youth, and Family Services. DMH Child, Youth, and Family services are also intricately tied to and aligned with the Commonwealth's interagency Children's Behavioral Health Interagency Initiative (CBHI). The goal of CBHI is to strengthen, expand and integrate Massachusetts state agency services into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success at home and in their schools and community. Underlying the CBHI system transformation activities is a commitment to shifting the child and family system of care to promote positive outcomes for children and families. DMH shares this commitment and to holding itself and its providers accountable to those outcomes. Through its procurements, DMH emphasizes outcomes relating to child success at school, in the home, and in the community, by establishing explicit expectations of DMH service providers to demonstrate progress in school, home and community participation for youth receiving these services. The DMH performance and contract management process provides mechanisms for DMH to monitor child outcomes and to work with providers to modify services when needed to better support youth and families in achieving greater success in these areas.

2. **Integration between adult and child systems for transition age youth and alignment between child service agencies for children and families with mental health issues, including parents of minor children.**

3. Children with SED frequently require and receive services from a complex array of public and private providers and payers. Families, particularly those who receive services from multiple providers, often find it difficult to understand how the system might help them and how to access

available services. When working with a family that is receiving services and supports from various parts of the system, service providers may also feel stymied by inefficient service planning, delivery, management, and financing processes. The result is less than optimal health, wellness, and life outcomes for the children, youth, and families receiving these services and inefficient use of system resources.

4. Parents and caregivers of youth with SED face a myriad of challenges associated with their children's care and may experience stigma relating to their children's behavioral health needs. Having a trusted ally who can provide structured and knowledgeable parent to parent support is often the critical link to successful access, engagement, and utilization of services. Parent to parent support, under a variety of titles, is currently offered in various places within the Massachusetts system of care: MassHealth Family Support and Training Service (FS&T, or "Family Partner"); MassHealth Mobile Crisis Service; Department of Mental Health Child, Youth, and Family Services (Family Support Specialists and Family Leaders); Department of Children and Families; Department of Youth Services; MassHealth Patient-Centered Medical Home Initiative; SAMHSA funded projects MYCHILD and Project LAUNCH; and individual providers, including residential schools.

The MassHealth FS&T (Family Partner) service is one of an array of Medicaid behavioral health benefits for eligible children with SED; and over 400 Family Partners currently provide support, education, coaching, and training to their parents and caregivers. Qualitative data collected in assessments of these services indicate that parents and caregivers highly value this service and it is integral to the success of the High Fidelity Wrap-around process that is the cornerstone of these MassHealth services. In focus group discussions with parents of children with SED, they consistently emphasize the importance of the Family Partner in helping them identify and access services, develop more effective strategies for advocating for appropriate services, managing their children's behaviors, and decreasing their own stress. A trusting relationship grounded in shared experience and mutual respect is key to the success of the service. It is one that requires time and nurturing to develop, particularly when a child moves from one part of the service system to another. The continuity of this unique relationship is often disrupted as the Family Partner service provided in one part of the system ends when a child stops receiving services in that part of the system. Yet, stress and uncertainty can be most pronounced during transitions from one service to another and the need for the support and guidance of a Family Partner is often at its highest. Parents frequently state that they wish their Family Partner could stay with them as their child moves across the service system, particularly between residential and community-based services.

Since 2013, DMH and DCF Child, Youth, and Family residential services have been re-procured as a single residential system: *Caring Together: Strengthening Children and Families Through Community-Connected Residential Treatment*. The goals of the new residential services are two-fold: to better support youth to remain in their homes/community and/or successfully return to their home/community setting from a residential placement; and to better coordinate and integrate residential services purchased by the two agencies, based on consistent service standards and reimbursement rates. To further these goals, a new Family Partner service will be available to parents/caregivers of children receiving residential services. Responding to the profound message from parents and caregivers about the importance of the continuity of the

Family Partner relationship as a child moves across service systems (see above), a key design element of this new service is to allow a Family Partner to continue working with a family as a child moves between the DMH/DCF residential system and the MassHealth community-based services. This will ensure the continuity of this important support and care for those youth who are publicly insured. As of June 2015, a pilot has been implemented in eight Community Service Agencies (CSAs) across the state.

Youth with behavioral health needs transitioning to adulthood require specific services to address the unique challenges they face as they move to greater independence from their family and from the child-serving to adult-serving service systems. Massachusetts has made great strides in developing services for Transition Age Youth (TAY) with diverse programming being offered across many areas of both the child and adult service systems.

5. Workforce development related to integrating peer workers and family partners into the service system and implementing evidence-based practices.

Parent to parent support, under a variety of titles, is currently offered in various places within the Massachusetts system of care: MassHealth Family Support and Training Service (FS&T, or "Family Partner"); MassHealth Mobile Crisis Service; Department of Mental Health Child, Youth, and Family Services (Family Support Specialists and Family Leaders); Department of Children and Families; Department of Youth Services; MassHealth Patient-Centered Medical Home Initiative; SAMHSA funded projects, MYCHILD and Project LAUNCH; and individual providers. The expansion of Family Partners through MassHealth and the DMH/DCF residential services poses opportunities and challenges regarding development of the Family Partner workforce across the Massachusetts system of care. These EOHHS agencies are working to develop consistent and cohesive training resources that respond to the needs of Family Partners across the system, including the potential development of a certification program.

DMH recognizes a significant need in providing evidence-based trauma-informed care across its service system. The child/adolescent and adult restraint and seclusion prevention and elimination initiatives have both highlighted the need for culture change that reduce and eliminate the use of coercive practices and promote trauma-informed care.

As DMH completes re-procurement of its Child Youth and Family community-based services over the next two years, it will require that providers of these DMH services provide them in ways that are trauma-informed and reflect current evidence–based practices. DMH will support and promote the training needs of the provider workforce in trauma-informed care.

As more is learned about effective engagement and treatment that promotes recovery and resiliency, there is a renewed urgency to ensure that staff are trained and demonstrate competencies in these practices. Providers frequently express frustration with staff turnover rates affecting the ability to sustain best practices and a highly qualified workforce. Recognizing the high turnover rate in mental health service agencies, training emphasis has expanded to the supervisory level, where turnover rates are lower. It is expected that this will better ensure consistency in the quality and delivery of the service, consistent service specifications, rates,

training, and quality management strategies are needed. DMH is working with MassHealth to align their respective services along these dimensions.

6. Improved linkages with schools

Children receiving community-based mental health services, including those living in residential programs, receive their educational services through their local educational authority, and are enrolled in public school programs or special education day programs either within or outside the school district. Children in hospitals or intensive residential treatment programs have their special education services delivered through the Department of Elementary and Secondary Education in accord with the local IEP. Most DMH clients receive special education services, while some receive Section 504 accommodations to address their mental health needs. In accordance with state law, the state Department of Elementary and Secondary Education (ESE), through its division of Special Education Services in Institutional Settings (SEIS), is responsible for delivery of educational services in DMH's inpatient and intensive residential programs, either directly or through provider contracts. DMH program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary.

Local school systems provide counseling within the school. Schools provide a variety of interventions, including but not limited to: aides; resource rooms; separate classrooms, within district or out of district, or operated by educational collaboratives; home tutoring; or placement in residential school. Depending on circumstances, DMH may pay for the residential component of such a placement while the school system pays for the education only component. If a child is enrolled in a DMH after-school treatment program, schools may provide transportation to the program. Data on the total number of DMH youth receiving special education services is not available.

DMH is firmly committed to supporting and strengthening linkages with schools and school-based services, and to developing a workforce knowledgeable about special education services, and student and parental rights under special education law. Each DMH Area funds community and school support contracts with providers to offer training and consultation to local schools and/or local school systems and thus support mainstreaming. The focus of training is usually to help school staff understand the needs of children with serious emotional disturbance, develop sensitive and effective classroom responses to children with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services.

Schools also provide an important opportunity to identify children and youth at risk for behavioral health conditions and to link them with needed services. DMH collaborated with the MA Child Psychiatry Access Project (MCPAP) in two pilot projects to provide child psychiatry consultations to school personnel in Western MA (2008) and in Southeastern MA (2014). The success of these projects provide a solid foundation for developing a model for statewide expansion, and DMH continues to work with MCPAP and other key stakeholders in seeking resources to support expansion of the MCPAP model into Massachusetts schools.

DMH provides training for case managers and other DMH staff on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and the DMH Family Support Specialists provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers may attend IEP meetings at school, or provide information to the team, as requested by the parent, and with parental approval school staff participates in Individual Service Planning meetings. The state director of special education participates on most interagency planning activities related to children's mental health, including the CBHI Advisory Committee and the Department of Elementary and Secondary Education (DESE) has been a payer in interagency blended funding initiatives.

Additionally, DMH and the Department of Early Education and Care are partnering to expand services and supports for young children with behavioral challenges. Of particular interest is to address suspension and expulsion practices within early childhood care settings, a key indicator of long-term academic and other life challenges. Most recently, in June 2017 DMH supported an Early Childhood Mental Health Summit where a diverse group of key stakeholders that included policy makers, academics, insurers, early childhood providers, and families convened to identify key action steps for advancing the early childhood system of care.

Unmet Needs and Critical Gaps in the DMH Community-Based System Spanning Child and Adult Systems

1. **Addressing the needs of specific populations, including:**

Transition Age Youth and Adults

The DMH Transition Age Youth (TAY) Initiative focuses on youth and young adults who; are 16-25 and entering the DMH adult service system, transitioning out of child/adolescent agency services into adult services or into the community, and those aging out of foster care or juvenile justice who have mental health challenges. The Department's framework for transition age approaches includes the following guiding principles:

- Diverse youth and young adult voices are incorporated into key decisions to ensure the Department is meeting the needs of young adults in the Commonwealth.
- Development of promising practices that focus on rehabilitation/recovery and life skills development.
- Access to health care, educational supports, young adult peer mentoring; rehabilitation and recovery programming; vocational; social skill development; housing and employment support.
- Engage and support parents/guardians and families of youth and young adults.
- Collaborate with other state agencies and key community resources.

Two Committees, the Youth Development Committee (YDC) and the Statewide Young Adult Council (SYAC) lead the initiative. The Youth Development Committee (YDC) was organized in 2002 to focus on transition age youth programming and to create a voice for youth and young adults. Membership includes young adults as co-chairs, parents, providers, advocates, university

representatives and interagency staff. This committee meets every month and effectively oversees the TAY Initiative. The Initiative has expanded its partnership through a concentrated focus on the development of young adult peer mentors and young adult peer leaders across the Commonwealth. The YDC represents and reports to the Planning Council on the various young adult activities occurring across the state and elicits feedback and input from the Area and Statewide Young Adult Councils. The two young adult co-chairs of the YDC are active members of the Planning Council and its steering committee. In 2018, the YDC has dedicated one meeting a quarter to be the SAMHSA System of Care Grant, Transition Age Youth and Young Adults System of Care Access Initiative (TSAI) Advisory Meeting, to ensure alignment and collaboration between the TAY Initiative's statewide efforts and those of the TSAI Grant.

An Education Subcommittee of the YDC was created and established in SFY14 with the focus of raising awareness of mental health needs in educational settings by outreaching and engaging with community education partners to join in membership; and providing input and reviewing the educational resources listed on ReachHire MA (www.reachhirema.org). In FY18 the Education Subcommittee was reintegrated into the work of the YDC because there was ReachHire MA is updated; and that the Education Subcommittee decided that the role of education should be continued and discussed at the YDC and Statewide Young Adult Council (SYAC) meetings.

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Starting in 2007, the Statewide Young Adult Council (SYAC) grew out of YDC because young adults wanted to create their own meeting to provide the young adult perspective and guidance on the TAY Initiative, share information on employment and educational opportunities, as well as provide feedback on policy and planning efforts ongoing in DMH. There are three young adult peer leaders co-chairing SYAC and the members comprised only of young adults and meets monthly in Westborough (Central MA). SYAC continued to provide feedback to Work Without Limits, BenePlan, the TSAI and YOUForward grants, and the UMass Transitions to Adulthood Center for Research;[1] and advise the Department on ReachHireMA (www.reachhirema.org) a young adult employment, education, and financial independence resource site, and Speaking of Hope (www.speakingofhope.org) a young adult recovery resource site. SYAC was honored with a citation from Governor Baker for 10 years of providing young adult voice and produced a video that highlighted SYAC's formation, history, accomplishes, and personal impact on its members (https://www.youtube.com/watch?v=54sprGpUjHM). In addition, SYAC has been instrumental in increasing youth voice into the mental health delivery system, and over the past year SYAC provided input into the Department's Reframe the Age Initiative, the development of the Core Elements of Young Adult Peer Mentoring, and the Massachusetts Rehabilitation Commission (the state's vocational rehabilitation agency) and DMH's efforts on providing employment services for persons served by ACCS. For SFY20-22 State Plan SYAC will continue to infuse youth voice into the various reprocurements the Department has planned to ensure services are age and developmentally appropriate for transition age youth and young adults; advised the Department into developing a weekly TAY email that highlights events and resources that young adults, providers, advocacy groups, and families will find useful. The purpose is to improve communication about available resources, and develop a greater sense of community across the Commonwealth for TAY.

[1] Formerly known as UMass Transitions Research & Training Center

These groups have identified several key needs related to employment, education, housing and provision of developmentally appropriate services, including peer mentoring. The needs for employment and education come together in two ways. The first is the need to provide pathways into the employment in the health and human service system by enlarging the young adult peer mentor workforce. The second opportunity to bridge education and employment is the need to engage in transition planning that occurs in special education and to continue to support transition to the Massachusetts Rehabilitation Commission and community colleges. The most important need within the delivery of developmentally appropriate services is to expand the peer mentor system so that young adults will have a support network as they move from the child to the adult service system. As described above, DMH is taking steps to provide additional training opportunities and career pathways for young adults.

In view of the changes that have been occurring in both the child and adult service systems, including the Children's Behavioral Health Initiative, ACCS, and the Reframe the Age; the TAY Initiative is looking to position itself to be strategically integrated into programming in the years ahead, and to ensure youth voice is included into every decision the Department makes that might impact youth and young adults. Identified ongoing needs in the areas of housing, employment, education, and developmentally appropriate services have emerged in this population with approximately 60% not completing high school and less than 5% employed full time. Housing and homelessness is also emerging as a need with 178 young adults or 26% of the young adults receiving case management identified as being at risk for homelessness in a housing assessment.

Young adults have participated on a number of advisory teams across the state and are continuously asked to join new boards and committees. These have included: the Children's Behavioral Health Advisory Council, Healthy Changes Task Force, DMH Safety Task Force, MBHP Consumer Council and EOHHS' Children, Youth & Families Advisory Council. In addition, young adults have been continuously included in procurements, such as DMH Flex Services, and other procurements in DMH.

Research continues to be one of the strong components of the Young Adult Initiative, with partnerships ongoing at Boston University's Psychiatric Rehabilitation Center, Beth Israel, Deaconess Hospital's Cedar Clinic and the Prevention and Recovery in Early Psychosis (PREP) program and the University of Massachusetts (UMass) Medical Center's Learning and Working grant.

<u>Parents with Mental Illness</u>

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

The State Mental Health Planning Council voted in 2009 to establish a Parent Support subcommittee. The Parent Support Sub-committee has made strides in increasing awareness among state agencies about the needs of parents living with SPMI. It has facilitated communication and collaboration among child and family-serving agencies to identify strategies for addressing parenting needs among adults with SPMI and the needs of children whose parents have SPMI. It is also working to identify existing promising practice models across the service system and promote broader adoption of these practices to improve supports for parents and children. DMH continues to provide the leadership in promoting these efforts with its sister health and human service agencies.

In 2015 the Parent Support Sub Committee merged with the PAC, the Child and Adolescent Subcommittee of the State Mental Health Planning Council. The PAC members believed that there was a significant need to understand and promote a Family Recovery Informed approach since recovery involved all family members.

This promotion of a family recovery- informed process was in part driven by the fact that, in spite of the high number of adults with mental illness and co existing conditions who are parents and members of a family, this dimension of a person's life is often not addressed when planning and providing recovery services. Most child and family mental health providers have no training or expertise in engaging parents with co-occurring conditions or understanding and addressing the process of recovery and the relevance of the parenting role in planning and providing services. There is also no systematic or structured cross-systems integration of services for the recovery needs of adults with mental illness and co-occurring conditions This lack of cross capacity to is also true in adult services including peer supports which are organized and delivered, for the most part, in separate categories such as health care services, mental health services, parent support services, and substance abuse services.

The Child and Adolescent Sub Committee of the State Mental Health Council, is working in partnership with the Department of Mental Health, to further promote a family- informed recovery process. The Department's long term understand and commitment to holistic care, aligns with the PAC's and the Department's vision of the importance of family informed intervention for individuals struggling with significant mental health and co occurring conditions.

6. Addressing research priorities of consumers and families

The Massachusetts Department of Mental Health provides funding to two Centers of Excellence (COEs) that engage in research related to mental illnesses and mental health services. Although much of this research is intended to lead to improvements in the care that individuals with mental illnesses receive, there has traditionally been little communication between the researchers and other stakeholders, such as consumers, Massachusetts-based mental health community service providers, and advocates for persons with psychiatric disabilities.

In 2008, legislation was passed mandating that a Children's Behavioral Health Knowledge Center be established within the Department of Mental Health, subject to appropriation. Its primary mission is "to ensure that the workforce of clinicians and direct care staff providing

children's behavioral health services are highly skilled and well trained, the services provided to children in the Commonwealth are cost-effective and evidence-based, and that the Commonwealth continues to develop and evaluate new methods of service delivery". DMH recognizes the research must inform practice improvement and that training supports diffusion of best and promising practices, and has solicited input from stakeholders across the CBHI service system to inform the development of an initial three-year strategic plan that outlines the Center's mission and goals, organizational structure, governance, and research agenda. The Center holds regular conferences and works collaboratively with MassHealth to provide trainings for direct care supervisors and staff.

The table below provides information on how the unmet need areas identified above are addressed by DMH priorities.

Identified Need	**Priority that Addresses Need**
Greater emphasis on services that directly impact on and result in positive outcomes	Enhance service system to promote recovery, resiliency and positive outcomes. Promote Evidence Based Practice use.
Addressing the needs of specific populations	Enhance service system to promote recovery, resiliency and positive outcomes. Promote Evidence Based Practice use.
Increased access to peer support and peer-run services.	Promote peer workers in all services to ensure that care is person and family centered. Continue Peer Specialist certification.
Affordable housing and coordinated services for people who are homeless	Enhance service system to promote recovery, resiliency and positive outcomes Promote community living and housing supports.
Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system, and implementing evidence-based practices	Expand and integrate a peer workforce Ensure that all services are person and family centered
Improve the safety of the service delivery system for people served and staff	Enhance service system to promote recovery, resiliency and positive outcomes Implement and promote use of evidence based best practices Ensure that all services are person and family centered.
Addressing research priorities of consumers and families	Implement and promote use of evidence based best practices Ensure that all services are person and family centered

Funding and coordination of prevention related activities with other state agencies, academic institutions, and other stakeholders.	Implement and promote use of evidence based best practices
Improved access and integration between primary care and behavioral health, mental health and substance abuse services, and between mental health and acute and continuing care services.	Monitor BHCP and ACCS coordinated care to assure improved care access. Implement and promote use of evidence based best practices