FY2027 MHBG Mini-Application: Narrative Sections Combined

Background: Every two years, DMH is required to submit a mini-application to Substance Abuse and Mental Health Services Administration for the Mental Health Block Grant (MHBG). The narrative sections discuss First Episode Psychosis/Early Serious Mental Illness, Crisis Services, and State Mental Health Planning Council (SMHPC) within the DMH system.

Next Steps: The bold text in this color are the current questions on this year's mini-application highlighted in Purple. These answers have been updated completed by DMH staff across various programs and are in the regular black font. Please review only the text in black.

Please complete review and provide feedback by end of day, July 30rd.

Please let Binah know if you have any questions or concerns.

Thank you in advance.

Section 2: **Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG**

Narrative Background Prompt:

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

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1. **Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.**

Model(s)/ EBP(s) for ESMI	Number of programs
NAVIGATE	6

2. **Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).**

FY2026	FY2027
1,934,172	1,970,380

3. **Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.**

Massachusetts Early Psychosis Coordinated Specialty Care (EP CSC) programs rely on fee for service billing for EP CSC. EP CSC programs may bill for Individual therapy, psychopharmacology, and family therapy. EP CSC programs rely on other sources of funding in order to be able to offer essential EP CSC treatment components including comprehensive assessments, peer support, employment/education services, family psychoeducation, and care coordination. Additionally, other sources of funding are needed for staff time spent on EPB training, supervision, and multi-disciplinary team meetings.

4. **Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.**

DMH utilizes MHBG funds to support 6 of the 8 Massachusetts Early Psychosis Coordinated Specialty Care (EP CSC) programs. Three of these programs are based in outpatient services of hospital systems. Three of these programs are operated by community mental health centers. All MA CSC programs utilize the NAVIGATE model of CSC. With MHBG funds, DMH established MAPNET, the early psychosis technical assistance center to provide on-going training in early psychosis evidence-based practices and to monitor fidelity to the chosen EBPs.

5. **Does the state monitor fidelity of the chosen EBP(s)? Please highlight Yes or No**
6. **Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? Please highlight Yes or No:**

7. **Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.**

Repeatedly, stakeholders have identified access to specialized EP services (e.g. comprehensive assessment and treatment) as an urgent need. The Massachusetts Psychosis Assessment and Triage Hub (M-PATH) at the Brookline Center for Community Mental Health (BCCMH) provides centralized screening, assessment, and admission for EP clinical programs.

DMH, MAPNET, and M-PATH work closely with the new Behavioral Health Helpline (BHHL) and the statewide network of Community Behavioral Health Centers (CBHC) to provide training in recognizing and responding to early signs and symptoms of psychosis and to establish workflows that facilitate warm handoffs and rapid access to specialized EP services. M-PATH also leverages BCCMH's BRYT programs, a network of embedded mental health services in over 150 school systems (representing 40% of youth in Massachusetts) to more expeditiously identify and direct youth experiencing early signs and symptoms of psychosis and their families to EP specialized services. Staffed by knowledgeable clinicians, care coordinators, and peer specialists, M-PATH centralizes referral and intake process for MA EP CSC programs, thereby eliminating duplicative screening and assessment processes at multiple EP CSCs and minimizing the burden on families and referring providers. M-PATH staff work closely with MAPNET to provide consultation, training, and support to behavioral health providers across the state so that treatment can be initiated immediately and relieve some of the pressure on the early psychosis programs that lack capacity to currently treat all who need specialized care.

8. **Please describe the planned activities in FY2027 for your state's ESMI programs.**

DMH has established an ongoing open contracting process to allow us to more flexibly support current EP CSC programs and invest in new EP CSC programs as funds allow. With this process, DMH has instituted a procedure for evaluating fidelity to the EP CSC model and has defined

criteria for what constitutes a fully operational EP CSC program. DMH completed fidelity reviews of all currently operational EP CSC programs in MA in early 2026 and is in the process of updating the list of Fully Qualified EP CSC programs. DMH will continue to work with community providers to expand the network of EP CSC programs across MA for all residents.

9. **Please list the diagnostic categories identified for each of your state's ESMI programs.**

Diagnostic categories include any psychosis including affective disorders with psychotic features. These may include mental health conditions such as schizophrenia, schizoaffective disorder, schizophreniform disorder, psychosis NOS, depression with psychotic features, and bipolar disorder with psychotic features. etc.

10. **What is the estimated incidence of individuals experiencing first episode psychosis in the state?**

1,266 individuals (based on 66 per 100,000 people between ages of 15-35).

11. **What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?**

There are a number of ways that DMH and MA work to raise awareness and to promote the use of EBPs for individuals with ESMI including most recently our strategic planning process. The findings of the Recovery After an Initial Schizophrenia Episode (RAISE) study galvanized interest in EP amongst policy makers, researchers, family members, advocates, and providers and in recent years MA DMH has been invited to support a number of federally sponsored research projects related to EP and EP EBPs. DMH decided to embark on a strategic planning process to assure that the influx of funding and other resources to Massachusetts will effectively address the needs and priorities of all people experiencing early psychosis and their families across the state.

DMH supports a number of strategies to raise awareness and to promote the use of EBPs for individuals with ESMI. M-PATH provides extensive training to area schools, colleges and universities, and to behavioral health and other health care providers to promote awareness of behavior associated with a psychotic episode and providing early and effective referral to services. All MA EP CSC providers are encouraged to engage in similar activities in their local communities as these presentations are important to build relationships with referral networks

that feed the EP CSC program with appropriate referrals as well as to engage community partners for services.

In addition to EP-specific training in EBPs for current BH workforce, DMH provides funding to ten psychology and psychiatry training programs to encourage the engagement of future behavioral health providers in working with people with SMI generally as well as ESMI specifically. Most of the Massachusetts EP CSC programs provide training to trainees of multiple behavioral health disciplines, psychiatry residents, psychology trainees across all stages (post-doctoral fellows, interns, practicum students, and college students), social work, nursing, and occupational therapy.

12. Please indicate area of technical assistance needs related to this section.

DMH is committed to the long-term sustainability of EP CSC programs across Massachusetts while recognizing that the cost of delivering adherent EP CSC exceeds what fee for service payment models provide. DMH is eager to identify sustainable payment models and is requesting technical assistance in this area.

FY2027 MHBG Mini-Application

Section 9: Crisis Services

Narrative Background Prompt:

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

.....to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" as well as an Advisory: Advisory: Peer Support Services in Crisis Care There is also the National Guidelines for Child and Youth Behavioral Health Crisis Care which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the

core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

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1. **Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.**

Someone to talk to:

The Massachusetts Behavioral Health Help Line (BHHL), available 24 hours a day and seven days a week, went live on January 3, 2023, and directly connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts. Anyone in Massachusetts can call, text, or chat at any time to receive individualized support, clinical assessment, and personalized treatment referrals. BHHL staff will remain on the line until callers are connected to their next step and offer follow up support after each call. Available 24/7/365, the call/text line and online chat service is completely free (no insurance needed) and available in over 200 languages through live interpretation. The BHHL supports callers with a wide range of needs and acuity levels and connects those in need of crisis services with the appropriate Mobile Crisis Intervention (MCI) teams, involving 911 only in emergency situations.

In July 2022, the 3-digit 988 code went live to support people experiencing behavioral health crises. 988 call takers are highly trained staff and volunteers with extensive experience in providing non-judgmental, compassionate support to people in emotional distress and suicide and crisis intervention. Like the BHHL, 988 can connect callers to crisis services at Community Behavioral Health Centers or to 911.

BHHL, 988, 211 (a call line that connects callers to information about critical health and human services available in their community), and other help lines collaborate to provide warm hand-offs between the lines to best serve the caller's needs—there is no wrong door for Massachusetts residents. Additionally, the BHHL is working on bi-directional warm hand-offs and support between the BHHL and 911. The BHHL engages 911 in emergency situations, while 911 may transfer behavioral health-related, non-emergency calls to the BHHL or conference the BHHL in to support the caller as they wait for an emergency

response. The state's public safety and mental health systems are working to strengthen collaboration and coordination to minimize the involvement of law enforcement in behavioral health crisis response, and provide residents with the least restrictive, most effective care.

Someone to respond:

Mobile Crisis Intervention (MCI) services are offered through a statewide 24/7/365 community-based crisis response system housed at Community Behavioral Health Centers (CBHCs) throughout the state. MCI services are available for anyone in Massachusetts experiencing a potential mental health or substance use crisis, regardless of insurance or ability to pay, and provided by trained professionals who provide triage, evaluation, intervention and de-escalation, and connection to next level of care for individuals who may be in crisis. Whether in the community, at a clinic, or via telehealth, no appointments are needed. Individuals may contact the BHHL to receive a warm handoff to the appropriate MCI team for their location, or they may call a central phone number that will route them to the MCI team based on their zip code.

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

Safe Place to be:

A network of **Community Behavioral Health Centers (CBHCs)** in communities across the state serve as local entry points to timely, high-quality, and accessible mental health and substance use treatment. As mentioned in the section above, CBHCs offer 24/7 mobile crisis intervention services for anyone experiencing a behavioral health crisis, whether in the community, at a clinic, or via telehealth. The CBHCs also provide a wide range of outpatient services including individual and group therapy, recovery coaching, and prescribing for mental health and addiction treatment medication under one roof. Experienced clinicians conduct thorough, confidential crisis assessments and work with individuals to develop individualized treatment plans that address immediate issues to seek to prevent future crises. After the initial crisis visit, the CBHC team will provide the appropriate follow-up support based on the individual's needs and treatment plan.

CBHCs also have the capacity to accept drop-offs by law enforcement, so police officers encountering individuals seeking help for their behavioral health needs can transport them to CBHCs instead of emergency departments when appropriate. CBHCs have the capacity to

provide medical screening with a goal of direct inpatient psychiatric admissions and can help individuals avoid emergency department visits even when needing a higher level of care.

Community Crisis Stabilization (CCS) is a less restrictive alternative to inpatient hospitalization for people in need of short-term, overnight crisis care. CBHCs offer both Adult (18+) and Youth (18 and under) CCS programs with services including individual, group, and family therapy; medication management; crisis intervention; and future crisis prevention planning.

Respite Services deliver temporary, short-term, community-based clinical and rehabilitative services to assist individuals to maintain, enter, or return to permanent living situations. The services are delivered at site-based (24/7) locations and as a mobile service. The availability of community respite capacity increases the psychiatric inpatient providers' ability to discharge patients to the next treatment level, provides alternatives to hospitalization, and provides additional settings for clinical assessments.

Behavioral Health Urgent Care (BHUC) locations (over 70 across the state) provide a range of mental health and substance use services for MassHealth (the state's Medicaid agency) members, including mental health assessments, substance use treatment, referrals, and much more. BHUCs are designed to provide MassHealth members with easier, timely access to mental health and substance use care, right in their communities.

2. **In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.**

    a. ***a) The Exploration stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.***
    b. ***b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on published guidance. This includes coordination, training and community outreach and education activities.***
    c. ***c) Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.***
    d. ***d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.***
    e. ***e) Program Sustainability stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.***

Check one box for each row indicating state's stage of implementation:

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						X
Someone to respond						X
Place to go						X

3. **Briefly explain your stages of implementation selections here.**

Full implementation and sustainment has been achieved; quality assurance mechanisms are in place to assess the quality of the crisis services, and continuous quality improvement processes are underway.

4. **Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.**

The state's development of its crisis system was guided by the National Guidelines and incorporated the essential elements of "Someone to Contact," "Someone to Respond," and "A Safe Place for Help" to create a seamless, comprehensive system that provides access to the "right care at the right time."

As noted throughout previous applications, the Behavioral Health Roadmap was the overarching strategic vision for the Massachusetts behavioral health system. The establishment of the 24/7 Behavioral Health Help Line (BHHL) was designed to help individuals access services with the hope of intervening early and averting emergencies while also connecting them with crisis services. The network of CBHCs was designed to be accountable for fully integrated mental health and substance use treatment that includes a coherent array of services that assures smooth, integrated services across levels of care including mobile crisis, new youth crisis stabilization beds, urgent behavioral health care, and ongoing substance use and mental health treatment. With the establishment of the CBHC network in January 2023, the Commonwealth

completely restructured 24/7 community-based crisis services to assure that all residents have immediate access to mobile crisis independent of insurance status.

5. **Other program implementation data that characterizes crisis services system development.**
    a. **Someone to contact: Crisis Contact Capacity:**
        i. **Number of locally based crisis call Centers in state**
            1. **In the 988 Suicide and Crisis lifeline network: 5**
            2. **Not in the suicide lifeline network: 1**
        ii. **Number of Crisis Call Centers with follow up protocols in place**
            1. **In the 988 Suicide and Crisis lifeline network: 5**
            2. **Not in the suicide lifeline network: 1**
        iii. **Estimated percent of 911 calls that are coded out as BH related: 11**
    b. **Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)**
        i. **Independent of public safety-first responder structures (police, paramedic, fire): 27**
        ii. **Integrated with public safety first responder structures (police, paramedic, fire): 170**
        iii. **Number that utilizes peer recovery services as a core component of the model: 1 model in which peer work is primary component, 5-6 models in which peer work is incorporated**
    c. **Safe place to be**
        i. **Number of Emergency Departments: 65**
        ii. **Number of Emergency Departments that operate a specialized behavioral health component: 0**
        iii. **Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 27**
6. **Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.**

    To provide more timely access to short term stabilization services, DMH expanded its Respite service capacity using the 5% set aside over the last three years to provide diversion points from emergency departments, inpatient units, and homeless shelters and

to facilitate safe transition plans for people with complex behavioral health needs. Respite services deliver temporary, short-term, community-based clinical and rehabilitative services to assist individuals to maintain, enter, or return to permanent living situations. The services are delivered at site-based (24/7) locations and as a mobile service. The availability of community respite capacity increases the psychiatric inpatient providers' ability to discharge patients to the next treatment level, provides alternatives to hospitalization, and provides additional settings for clinical assessments. In FY26, Respite services are provided in 47 programs across the state, with a capacity to serve over 1,600 people. Sixty-six percent (66%) of individuals accessing Respite Services enter into or return to a community living situation. Respite services continue to be a priority to help to expand "safe places to be" within communities.

7. **Please indicate areas of technical assistance needs related to this section.**

Please note that Massachusetts does not collect data on the number of Emergency Departments that operate a specialized behavioral health component. The percentage of 911 calls coded as BH-related is an estimate based on limited information.

FFY2027 MHBG Mini-Application

Section 14: State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Background Prompt:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. §300x-3 for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the State Behavioral Health Planning Councils: An Introductory Manual.

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

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1. **How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)**

The State Mental Health Planning Council (SMHPC) members are an integral part in the development and review of the state plan and report. The process for reviewing the Mental Health Block Grant application involves providing the Co-Chairs from each of the SMHPC's five subcommittees with a draft packet of the full application of the MHBG application for review (see attached sample packet). Each subcommittee provided a narrative which highlights their subcommittee's activities over the past two years, accomplishments and strengths, and unmet service needs and critical gaps. They were encouraged to update any information provided. Next, the full MHBG draft was emailed to all SMHPC members (see attached email) and made available on the SMHPC and DMH websites (see attached screenshots). SMHPC members were encouraged to read the draft and provide DMH with feedback. SMHPC subcommittees are encouraged to review the draft at their meetings.

The SMHPC are asked to review an early draft of the MHBG 'mini' application though a similar process as the review of the MHBG application. All SMHPC members receive an email of the MHBG 'mini' application for review, with a request to provide feedback to DMH. SMHPC Co-Chairs are also reminded to review and provide feedback during one of their Executive Committee

meetings. SMHPC subcommittees are also requested to review the 'mini' application during one of their meetings and provide feedback to DMH.

Further, the SMHPC and its subcommittees address certain DMH activities based on the meeting focus or their respective subcommittee's areas of focus. Feedback is provided directly to DMH representatives as the structure of each subcommittee includes at least one DMH staff member. DMH activities are usually curating the focal point of presentations and the Commissioner's report during the SMHPC meeting. Each meeting allows for SMHPC members to ask questions and provide feedback on the items discussed, which DMH brings back to staff responsible for the specific program. Similarly, the role of the DMH representative is to provide support for the committee and relay any concerns from the subcommittee to the appropriate DMH staff.

2. **Has the state received any recommendations on the State Plan or comments on the previous year's State Report?**
    a. **State Plan - Please highlight Yes or No**
    b. **State Report - Please highlight Yes or No**
    c. **Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).**
3. **What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?**

Massachusetts has separate departments that handle mental health and SUD services respectively. The Department of Public Health's Bureau of Substance Addiction Services (BSAS) is the Single State Authority that oversees the Commonwealth's addiction services as well as tobacco and gambling prevention and treatment services. DMH and BSAS collaborate on several initiatives related to the planning of services for people with co-occurring substance use and mental health conditions with current emphasis on implementing the Behavioral Health Roadmap. BSAS representatives also participate in the State Mental Health Planning Council. To further promote inter-agency collaboration, DMH's newly established Office of Behavioral Health Promotion and Prevention aims to promote statewide coordination and implementation through innovative, evidence-informed, data-driven strategies to advance the promotion of behavioral health and the prevention of mental health conditions, including substance use disorders. The SMHPC includes substance use condition stakeholders as members as well as a representative from BSAS as a member of the SMHPC. Also, BSAS staff presented specific topics related to substance misuse prevention, SUD treatment, and SUD recovery services during past meetings.

The SMHPC has also dedicated time to incorporate SUD in the specific topics. The April 2024 SMHPC meeting included a discussion of the work of the 39 Peer Recovery Support Centers and what is offered at the centers and information on recovery coach development through the Recovery Education Collaborative. Additionally, the April 2025 SMHPC meeting hosted a panel discussion on co-occurring conditions and dual recovery. This panel consisted of the Director of the DPH Bureau of Substance Addiction Services (BSAS), the Executive Director of the Massachusetts Organization for Addictions Recovery, the Clinical Director for DMH's Recovery from Addiction Program, the DMH Central Massachusetts Director of Recovery and Employment Services, and the Dual Recovery Coordinator from the Massachusetts Clubhouse Coalition. The panel discussed:

- treatment offerings in addressing substance use, barriers of integrative care, workforce development, peer support, and recovery coaching opportunities;
- MORE activities and highlighted various points such as the importance of becoming active in the community and encouraging folks in the mental health and substance use world to be intentional in working together
- work in inpatient settings such as relapse prevention, dual recovery and other programs,
- the work of the DMH Dual Recovery Collaborative; and
- information on the Massachusetts Clubhouse Coalition's Dual Recovery Anonymous (DRA) program, Benefits of DRA, information on DRA Certification Program, and where to find a meeting (e.g. http://www.massclubs.org/dra-overview

Recently, the April 2026 SMHPC meeting included a discussion of the Office of Behavioral Health Promotion and Prevention (OBHPP). The OBHPP Director discussed the Office's interagency work on the promotion of programing for behavioral health and substance use conditions and requirement to evaluate and report on its promotion of behavioral health and prevention of substance use. This included information on its outreach campaign and grants to community-based organizations to develop or expand existing programs in key focus areas

DMH staff also periodically provide focused discussions on the intersections of mental health and substance use service delivery. In July 2019, the DMH Commissioner discussed DMH becoming 'co-occurring competent' and issued licensing guidelines about expectations. In October 2019, the SMHPC meeting included another discussion with the DMH Commissioner on inpatient services and substance use disorder, namely adopting a co-occurring framework for DMH, to ensure comprehensive assessment of an individual's needs and co-occurring conditions to properly treat and protect individuals in inpatient facilities. Further, at the January and April 2022 SMPHC meetings, the Commissioner discussed the multi-channel 24/7 Behavioral Health Help Line (BHHL) and Behavioral Health Road Map. The Commissioner reviewed at the January

2025 meeting the progress related to the Behavioral Health Help Line (BHHL) since its inception in 2021. The October 2025 meeting included the Commissioner reporting on the Behavioral Health Treatment Referral Platform used to address Emergency Department boarding.

4. **Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? Please highlight Yes or No**
5. **Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) Please highlight Yes or No**
6. **Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.**

The State Mental Health Planning Council (SMHPC) is a standing committee of the Mental Health Advisory Council (MHAC) to the Department of Mental Health. The SMHPC includes individuals with lived experience, persons served, family members of adults and children, legal and program advocates, providers, other state agencies, mental health professionals and professional organizations. The Council's membership is reviewed regularly. Members who have not been active in the last year are contacted to confirm their commitment and new members are appointed. DMH provides staff to the Council.

The SMHPC's vision, updated along with its mission statement and guiding principles in FY24, is to ensure respect and dignity for all persons at risk for or living with behavioral health conditions. The SMHPC shall promote access to prevention, early intervention, holistic health engagement and activation, housing, employment, and recovery support services. The Council promotes services that encourage individuals of all ages and their families to develop resilience, fully recover and be productive members of their communities. The mission of the SMHPC is to provide informed advice and perspective to the Massachusetts Department of Mental Health (DMH) on key policy and program issues affecting individuals of all ages in Massachusetts who are at risk for, or have, behavioral health conditions and their families, and advocates for decision making and actions that protect and advance their health and well-being.

The SMHPC maintains a dedicated SMHPC website (https://www.mass-smhpc.org/) with sections for each subcommittee to facilitate committee communications and facilitate regular updates. The SMHPC adopted bylaws in 2022 to put in place rules and policies around its purpose and charge, vision and mission, membership, Council chairs, standing committees,

meetings, and amending and revising the bylaws. The bylaws were last amended in October of 2024 to reflect changes in its subcommittees. Documenting these processes helped improve the structure and work of the SMHPC.

The SMHPC meets four times a year with one meeting per quarter. Since March 2020, meetings have been held virtually to encourage maximum participation from across the Commonwealth. Similar to its in-person meetings, virtual meetings include individuals with lived experience, family members of those with lived experience, providers, advocates, and staff from various state agencies including DMH. Participation rates continue to be greater than in-person meetings with robust agendas and will continue hosting virtual meetings to maximize participation. This allows members from other parts of the state to attend meetings more frequently rather than travel to the DMH office in Boston, where meetings were held before the pandemic.

The SMHPC Co-Chairs solicit feedback on topics discussed at each of the meetings and plan future meeting agendas based on this feedback. Each fall, members are surveyed to gather information on topics for future meetings. One meeting each year highlights activities in a specific DMH Area of Massachusetts, with each Area having the opportunity to share its work on a rotating basis. The DMH Commissioner or designee such as the Deputy Commissioner for Mental Health Services or the Chief Medical Officer attends each quarterly meeting to provide updates to the SMHPC and to seek feedback.

The SMHPC has five subcommittees which consist of individuals with lived experience, family of those with lived experience, providers, advocates, and state agency staff. Stakeholders from the community at large and from DMH and other state agencies are represented on all subcommittees. Subcommittees meet either monthly or bi-monthly and regularly report back to the SMHPC at quarterly meetings. Also, the SMHPC highlights a subcommittee each fall, allowing it to provide more in-depth information about its activities during the SMHPC meeting. Subcommittees engage its members to provide feedback to DMH, based on the topic discussed, and work on specific projects. For example, the Housing Subcommittee created work groups on educational opportunities for housing stakeholders, housing advocacy, housing and peer support, revising the DMH housing plan and subcommittee membership. The Employment Subcommittee held focus groups of ACCS and CIES providers to learn about best practices and get feedback on the ACCS-CIES model. The State Young Adult Council held a meeting providing feedback on the DMH Transition Age Youth (TAY) social media.

These SMHPC subcommittees are a principal means of involving those with lived experience and families in DMH and provide a strong and ongoing voice of recovery and resilience by advocating for the needs of the individuals they represent, advising DMH on policy issues, and participating in the planning and implementation of new initiatives. The SMHPC makes important contributions in identifying domains needing change or improvement in the mental health system and subcommittees play an active role in planning and implementing many of these transformation efforts across Massachusetts.

7. **Please indicate areas of technical assistance needs related to this section.'**

SMHPC Co-Chairs regularly seek input and survey its members about topics of interest and potential areas of discussion for upcoming quarterly meetings. The Co-Chairs and DMH staff will work with the Block Grant Project Officer to request assistance if technical assistance is needed in soliciting further feedback from the SMHPC.