ACCESS TO BEHAVIORAL HEALTH CARE IN MASSACHUSETTS: THE BASICS

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Abt ASSOCIATES

Prepared for the Blue Cross Blue Shield of Massachusetts Foundation by Abt Associates:

Alicia Sparks, PhD
Amy Berninger, MPH
Meaghan Hunt
Jenna Sirkin, PhD
Katharine Witgert
Melanie Whitter

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Design: Madolyn Allison
Line Editing: Barbara Wallraff

EXECUTIVE SUMMARY

The Commonwealth of Massachusetts, a national leader among states in the delivery of behavioral health care, continues to make important improvements to its behavioral health care system. In recent years, access to behavioral health care has improved, but barriers remain. These barriers result in considerable unmet needs that often disproportionately affect low-income residents, racial and ethnic minorities, people with disabilities, and other vulnerable groups. Many factors contribute to access issues, including lack of insurance coverage, service availability, timeliness of care, and workforce capacity.[1] Improving access to behavioral health care services is critical to improving health outcomes, achieving health equity, ensuring quality of life, and reducing costs to society.

In 2014, based on responses to the *National Survey on Drug Use and Health*, 1,056,000 adults in Massachusetts reported living with a mental health disorder, and 471,000 adults reported a substance use disorder (SUD)—specifically, alcohol or drug dependence or abuse.[2] Many individuals need, but may not be receiving, behavioral health care services necessary to prevent, treat, and support recovery. For example, based on responses to a separate survey question, 346,000 adults in Massachusetts indicated that they needed but were not receiving treatment for their alcohol use.[2]

Access to Behavioral Health Care in Massachusetts: The Basics is a primer designed for health care providers, policymakers, advocates, and other stakeholders to increase their understanding of the behavioral health care system and the issues affecting access to care for individuals with mental health and substance use disorders.

The primer offers a brief background on the Commonwealth's behavioral health system. It provides a historical context for access to behavioral health care and the problems and factors affecting access to services in the state. To highlight the extent of and trends in behavioral health conditions, the primer presents data on the prevalence of mental health and substance use disorders. The following sections provide available data on the behavioral health workforce, system capacity, affordability of services, and consistency of measurement and reporting of data on quality; these are systemic factors affecting access to care. These sections present data specific to the Commonwealth, comparing state statistics with national data when appropriate and available. It merits noting here, and is discussed in greater detail in the final section of the primer, that there is a dearth of available data on these topics and behavioral health care generally, which limits the ability to provide a comprehensive understanding of the behavioral health system and client access.



BACKGROUND

DEFINING BEHAVIORAL HEALTH

Behavioral health: Mental and emotional well-being and/or wellness.[3] "Behavioral health" also designates delivery models of health care that are designed to provide both physical health and mental and/or substance use health services to the client in a coordinated, integrated, and holistic manner.

Behavioral health conditions: A range of conditions, from unhealthy stress or subclinical conditions to preventable, diagnosable, and treatable diseases and acute episodes (sometimes referred to as illnesses or disorders). Throughout this primer, the term "behavioral health" includes both mental health and substance use disorders.

Mental health disorders: Syndromes characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental health disorders are usually associated with significant distress in social, occupational, or other important role functioning activities.[4]

Substance use disorders: Illnesses that are characterized by cognitive, behavioral, and physiological symptoms and that impair control over substance use despite significant substance-related problems. SUDs typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing reward, stress, and executive functions like decision-making and self-control.[4]

Other terms commonly used in behavioral health care can be found in Appendix A.

REGULATION AND FUNDING OF BEHAVIORAL HEALTH SERVICES

- There are three major entities responsible for regulation and public funding of behavioral health services in Massachusetts: the Department of Mental Health (DMH), the Bureau of Substance Abuse Services (BSAS) within the Department of Public Health (DPH), and the Office of Medicaid. These organizations are overseen by the Massachusetts Executive Office of Health and Human Services (EOHHS).
- In addition, it is important to note that public spending associated with behavioral health services is disbursed by a wide range of state entities, including, among others, the departments of children and families, correction, elementary and secondary education, housing and community development, trial courts, and youth services.

The budgets in Table 2 represent state budget allocations. Agencies may also acquire additional funding from federal or other grants. For MassHealth, the amounts include the full spending by both the state and the federal governments, who jointly share in financing of the program. Not all of the MassHealth funding is dedicated directly to behavioral health services or programs, except where noted.

TABLE 1: ROLES AND RESPONSIBILITIES OF DEPARTMENT OF MENTAL HEALTH, BUREAU OF SUBSTANCE ABUSE SERVICES, AND OFFICE OF MEDICAID

	Department of Mental Health (DMH)	Bureau of Substance Abuse Services (BSAS)	Office of Medicaid (MassHealth)
Authority	DMH oversees services and supports for individuals with mental health disorders. Responsibilities include: funding and monitoring mental health services and supports; licensing private and general hospitals with psychiatric units and residential treatment programs; providing access to contracted and state-operated programs, services, and supports for those with mental health needs; establishing standards to ensure effective and culturally competent care; setting policies to promote self-determination and protect human rights; and supporting mental health training and research.	BSAS oversees SUD prevention, intervention, treatment, and recovery services. Responsibilities include: funding and monitoring prevention and treatment services; licensing outpatient, detoxification, and residential treatment programs and counselors; providing access to contracted and state-operated treatment for low- and moderate-income individuals and the uninsured; developing and implementing policies and programs; and tracking SUD trends in the state.	The Office of Medicaid oversees the MassHealth program, which encompasses both Medicaid and the Children's Health Insurance Program (CHIP). Responsibilities include: providing health insurance coverage for a broad range of physical and behavioral health services, including certain behavioral health care services and long-term services and supports not covered by commercial insurance for children, adults, and seniors.
Number of People Served	Approximately 30,000 individuals with severe and persistent mental health disorders—including children and adolescents with severe and persistent mental health disorders as well as individuals referred from the courts for evaluation and aid in sentencing—are served by DMH or its contracted programs.[5]	More than 150,000 individuals were served by BSAS contracted providers in fiscal year (FY) 2014.[6]	More than 1.89 million individuals are currently enrolled in the MassHealth program.[7] More than one in five MassHealth members has used a mental health service and one in 20 has used a SUD service.[8]

TABLE 2: DEPARTMENT OF MENTAL HEALTH, BUREAU OF SUBSTANCE ABUSE SERVICES, AND MASSHEALTH BUDGETS[9,10,11]

		FY2014	FY2015	FY2016 (projected)	FY2017 (appropriated)
Department of Mental Health (DMH)		$682,881,000	$696,122,000	$731,035,000	$761,125,000
Bureau of Substance Abuse Services (BSAS)		$82,634,000	$91,509,000	$108,541,000	$125,692,987
MassHealth		$12,071,481,000	$13,713,854,000	$14,896,877,000	$15,296,957,000
*Spending on Behavioral Health Services**		$1,273,298,194	$1,414,123,536	$1,447,351,788	Not Available
Spending on Behavioral Health Services by Category:	Percent Mental Health	63.0%	60.8%	62.3%	Not Available
	Percent Substance Use Disorder	12.5%	13.1%	13.8%	Not Available
	Percent Prescription Drugs	24.5%	26.1%	23.9%	Not Available

*This represents total spending on behavioral health services and behavioral health-related prescription drugs for all MassHealth members. This does not include administrative costs.

HISTORICAL CONTEXT

Over the last 70 years, many initiatives at the state and federal levels have been designed to use less institutional treatment and more community-based services for individuals with mental health and substance use disorders, ensure parity in coverage for behavioral health services with physical health services, implement payment reforms through vehicles such as accountable care organizations (ACOs), and integrate behavioral health care into physical health care. Highlighted below are a few key initiatives extracted from the more comprehensive historical summary.

- The Commonwealth instituted some of the nation's first state-level policies to address behavioral health: the 1966 *Comprehensive Mental Health and Retardation Services Act* increased the number of mental health community facilities and services, and the 1978 *Brewster Consent Decree* required treatment in the least restrictive settings, promoting wider access to a broader spectrum of mental health services.[5]
- In 2000, Massachusetts passed Chapter 80 of the Acts of 2000, *An Act Relative to Mental Health Benefits,* the first mental health parity law in the Commonwealth. This law required applicable health plans to cover treatment for certain biologically based conditions in the same way it treated coverage for physical health conditions. In addition, the law precluded annual or lifetime dollar or number-of-visit limits for services associated with these conditions. This law was amended in 2008, through Chapter 256, expanding the list of biologically based conditions that insurers are required to cover at parity with physical health conditions.[12]
- Intensive home- and community-based services covered through the Children's Behavioral Health Initiative (CBHI), overseen by EOHHS, became available to MassHealth-eligible youth in 2009. CBHI was developed in response to a class action lawsuit (often referred to as *Rosie D.*) and was intended to strengthen, expand, and integrate state children's mental health services into a comprehensive community-based system of care.[13]
- In 2014, Massachusetts passed *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.* The law requires MassHealth plans, state employee plans, and commercial insurance plans to cover a minimum number of days of acute treatment services (detox) and clinical stabilization services without prior authorization.[14,15]
- The MassHealth Section 1115 waiver was extended and includes support for the implementation of ACOs, which will include behavioral health care services in the total cost of care for members as well as a specific role for behavioral health community partners (CPs) in improving integration, coordination, and access to care for approximately 1.2 million members who are eligible to be served by an ACO.[16,17]
- In 2016, the national *Comprehensive Addiction and Recovery Act* was passed. The evidence-based strategies to mitigate the national opioid epidemic authorized by the act include expanded prescribing eligibility for buprenorphine-based drugs and access to opioid overdose-reversal drugs.[18]

Figure 1 provides a historical timeline of major state and national policy changes that have affected access to behavioral health care.

FIGURE 1: TIMELINE OF STATE AND NATIONAL POLICY CHANGES AFFECTING ACCESS TO BEHAVIORAL HEALTH CARE

STATE ACTIONS AND EVENTS

1966

The *Comprehensive Mental Health and Retardation Services Act* is enacted, establishing a network of community-based mental health facilities to deliver services and support to clients close to their homes. The act mandated movement toward deinstitutionalization and development of community mental health centers.[5,9,21]

1973

Massachusetts begins closing state psychiatric hospitals. By 2017 Taunton State Hospital and the Worcester Recovery Center and Hospital are the only hospitals solely dedicated to state psychiatric services in operation.[19,24]

1978–1992

The *Brewster Consent Decree* asserts the rights of individuals to receive care in the least restrictive settings possible. Over a five-year period, this consent decree resulted in a 10-fold increase in state expenditures for community mental health services and a 15 percent decline in state hospital admissions.[19,25]

1984

Executive Order 244 is passed, prohibiting children from being treated in adult inpatient wards of state hospitals and leading to the creation of several new residential programs in the state.[27]

1990

Chapter 150 is passed, diminishing state regulation of mental health services in an effort to reduce reliance on state mental health hospitals and to build community-care systems with an aim toward increasing access to additional types of services across the spectrum of care.[19,28]

2006

A class action lawsuit, known as *Rosie D.*, results in a plan (referred to as CBHI) to restructure the children's mental health system in the Commonwealth by incorporating access to intensive home-based services, including behavioral health screenings, assessments, case management, crisis intervention, and in-home therapeutic supports.[19,31]

2006

Massachusetts enacts Chapter 58 of the Acts of 2006 to increase access to affordable, quality health care by providing near-universal coverage for residents of the Commonwealth. This law creates the Commonwealth Care program, includes a provision requiring certain employers to contribute to health insurance coverage for their employees, and establishes a requirement that individuals have health insurance that meets minimum credible coverage (MCC) requirements. MCC requirements specify the level of coverage and scope of benefits a plan must have for an individual to meet the state mandate requirement. Included in these requirements is that an individual's insurance plan must provide coverage for—at a minimum—a core set of health services, including those for mental health and substance use disorders.[32,33]

2008

The *Massachusetts Mental Health Parity Law* is enacted through Chapter 256, requiring insurers to cover the diagnosis and treatment of select biologically based mental health conditions at parity with physical health conditions, cover a full range of mental health services, and provide treatment in the least restrictive clinically appropriate setting.[34,35]

2009

Intensive home- and community-based services covered through CBHI, overseen by EOHHS, becomes available to MassHealth-eligible youth.[13]

2012

DMH opens a state-of-the-art 320-bed hospital, the Worcester Recovery Center and Hospital.[5]

2012

Chapter 224 of the Acts of 2012, *An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*, is signed into law to control health care cost growth through a number of mechanisms,[38] including investments in developing the behavioral health workforce.[39]

2014

An Act to Increase Opportunities for Long-Term Substance Abuse Recovery is signed, requiring MassHealth and state employee and commercial insurance plans to cover a minimum number of days of acute treatment services (detox) and clinical stabilization services without prior authorization.[15]

2016

The MassHealth Section 1115 waiver is extended and provides support for the implementation of ACOs, which will include behavioral health care services in the total cost of care for members as well as a specific role for behavioral health community partners (CPs) in improving integration, coordination, and access to care for approximately 1.2 million members who are eligible to be served by an ACO.[16,17]

FEDERAL ACTIONS AND EVENTS

1949

The National Institute of Mental Health is established by the *National Mental Health Act* to transform the understanding and treatment of mental illness through basic and clinical research, paving the way for prevention, recovery, and cure.[19]

1963

The *Community Mental Health Act* is passed, providing federal funding for community mental health centers to provide community-based care as an alternative to institutionalization. The law led to deinstitutionalization in some states, although only half of the mandated community mental health centers were built and none were fully funded.[19,20]

1970

The *Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act* ("the Hughes Act") is passed, authorizing a comprehensive federal program to support the development and funding of alcoholism treatment and prevention services and also encouraging hospitals to admit those with alcoholism.[22,23]

1981

The *Community Mental Health Act* of 1963 is repealed, discontinuing federal funding for community mental health centers and diminishing the direct role of the federal government in providing services for individuals with mental health disorders.[19,26]

1999

The *Olmstead Act* is passed, requiring states to treat people with disabilities, including those with serious mental illness, in integrated, community settings as opposed to institutions.[29]

2000

The *Children's Health Act* is passed, reauthorizing federal funds for programs that work to improve treatment services for children and adolescents with mental and substance use disorders.[30]

2008

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* is passed, requiring insurers and group health plans to guarantee that financial benefits and limitations on treatment benefits for mental health or substance use disorders are no more restrictive than the insurer's or plan's requirements and restrictions for medical and surgical benefits.[36]

2010

The *Patient Protection and Affordable Care Act* (also known as the Affordable Care Act) is enacted, putting in place comprehensive health insurance reforms and expanding coverage for behavioral health care services by requiring that most individual and small employer health insurance plans cover services for mental health and substance use disorders, including preventive services.[37]

2016

The *Comprehensive Addiction and Recovery Act* is signed into law to address the growing number of opioid use disorders nationally through expanded access to prevention and treatment efforts.[18]

ACCESS TO BEHAVIORAL HEALTH CARE

Understanding who is accessing care and the barriers they confront is challenging, requiring analysis of factors including geographic location of populations and services, availability of transportation, health insurance coverage, the cost of care, hours of service, consumer knowledge, cultural norms, and trust in the health care system.[40,41] Healthy People 2020 notes the following barriers that impede access nationally: 1) insufficient workforce capacity, 2) lack of services available in a timely fashion, and 3) lack of insurance coverage and high cost of care.[1] Studies have found that similar barriers exist in the Commonwealth.[42]

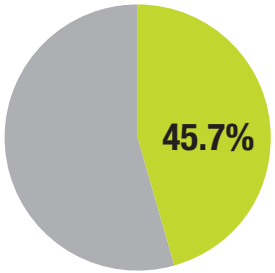
Many Massachusetts residents report unmet behavioral health needs, suggesting that individuals may not be able to access needed care.

- Almost half (45.7%) of adults with any mental health disorder reported not receiving care in 2013. Although this percentage is lower than the national average (56.5%), it represents 466,000 adults in Massachusetts with a mental health disorder who did not receive care.[43]
- Approximately 59 percent of Massachusetts youth who experienced a major depressive episode received no mental health services.[44]

Individuals with illicit drug use disorders in Massachusetts report unmet need for care slightly more frequently than do individuals with illicit drug use disorders nationwide. Adults with alcohol use disorders in Massachusetts report unmet need for care more frequently than adults with alcohol use disorders nationally, as well as more frequently than individuals with illicit drug use disorders both in Massachusetts and nationwide.

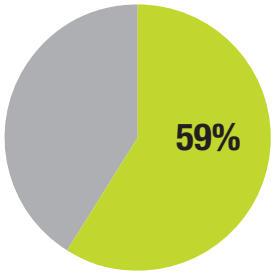
- In the 2014 National Survey on Drug Use and Health, 2.6 percent of Massachusetts residents surveyed indicated that they needed, but were not currently receiving, treatment for their illicit drug use. This was slightly higher than the national average of 2.1 percent of respondents across all states.[2]
- In the same survey, 6.6 percent of Massachusetts residents surveyed indicated that they needed, but were not currently receiving, treatment for alcohol use. Nationwide, 4.0 percent of individuals reported alcohol use disorders for which they were not receiving treatment.[2] It is important to note that many individuals with SUDs may not identify that they have a need for treatment, which may result in an undercount of unmet need for treatment.[45,46]

FIGURE 2: UNMET TREATMENT NEED FOR ADULTS IN MASSACHUSETTS WITH MENTAL HEALTH DISORDERS



Almost half (45.7%) of adults in Massachusetts with any mental health disorder reported not receiving any care.

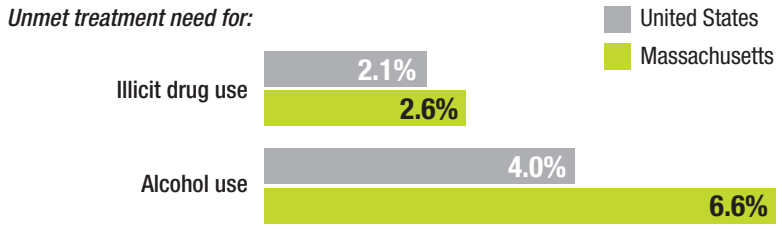
FIGURE 3: UNMET TREATMENT NEED FOR YOUTH IN MASSACHUSETTS WHO EXPERIENCED A MAJOR DEPRESSIVE EPISODE



Approximately 59% of Massachusetts youth who experienced a major depressive episode received no mental health services.

Source: Mental Health America, 2014.

FIGURE 4: UNMET TREATMENT NEED FOR ALCOHOL AND ILLICIT DRUG USE DISORDERS, IN MASSACHUSETTS AND NATIONALLY



Source: SAMHSA, 2015.

After a review of prevalence data pertaining to behavioral health conditions, this primer will focus on four primary factors affecting access to behavioral health care in the Commonwealth:

- workforce capacity
- system capacity
- affordability
- quality

PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS

PREVALENCE OF MENTAL HEALTH DISORDERS

In 2014, more than one million adults 18 or older in Massachusetts reported they were living with a mental health disorder.[2]

In a national survey, about one in five adults in Massachusetts reported they were living with a mental health disorder in 2014; this number has been rising in Massachusetts, while leveling off nationally.

- In 2010–2011, the percentages of individuals with a self-reported mental health disorder in Massachusetts and the United States were about the same (17.8% and 17.9%, respectively).[47]
- From 2011 to 2014, the national percentages increased slightly and then leveled off at 18.5 percent.[47] During the same period, however, the percentage of Massachusetts residents who reported living with a mental health disorder continued to rise, increasing from 17.4 percent to above 20 percent.[2,47]

Rates of self-reported serious mental illness (SMI) among adults in Massachusetts have fluctuated modestly, while generally remaining below marginally rising national rates.[48]

- During 2010–2011, the proportion of adults who reported living with an SMI in the past year were the same in Massachusetts and in the United States, at 3.9 percent.[49]
- Nationally, prevalence rates continued to rise from 3.9 percent in 2010–2011 to 4.2 percent in 2013–2014.[49]
- Prevalence in the Commonwealth fluctuated from 2010 to 2014, with a slight decrease to 3.7 percent in 2011–2012 but an increase to 4.2 percent in 2012–2013 and 2013–2014.[49]

FIGURE 5: ADULTS 18 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES REPORTING LIVING WITH ANY MENTAL HEALTH DISORDER, 2010–2014

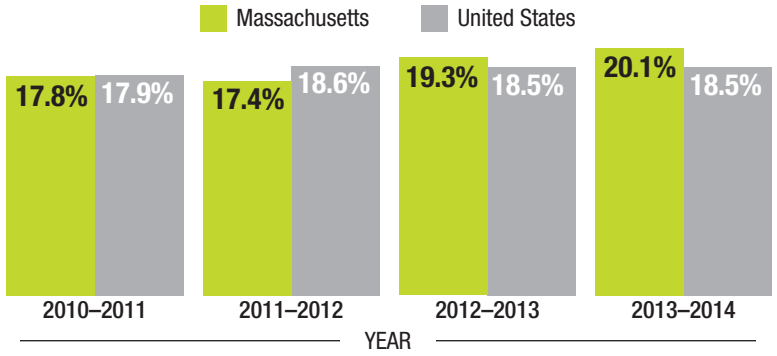
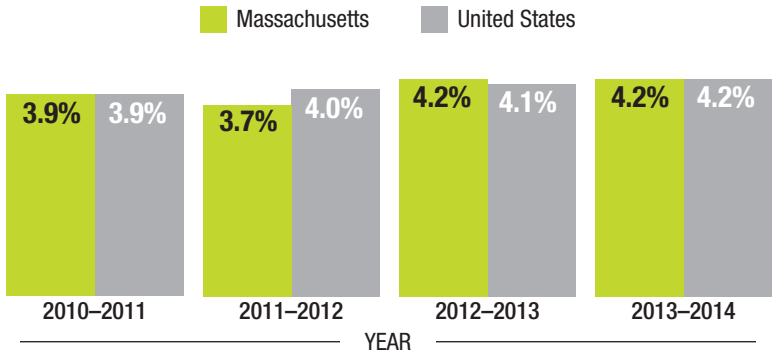


FIGURE 6: ADULTS 18 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES REPORTING LIVING WITH AN SMI IN THE PAST YEAR, 2010–2014



Source: SAMHSA, 2010–2014.

Rates of self-reported major depressive episodes among adults in Massachusetts fluctuated from 2010–2014, most recently rising above national rates.

- In 2010–2011, the percentage of Massachusetts adults who reported having experienced a major depressive episode in the past year was slightly higher than the national percentage (6.9% and 6.7%, respectively).[47]
- Nationally, the percentage of adults who reported having experienced a major depressive episode in the past year remained constant at 6.7 percent from 2010–2014.[2,47]
- In Massachusetts, the percentage of adults who reported having experienced a major depressive episode in the past year fluctuated during the same five-year period but ended in an overall increase in 2013–2014 to 7.5 percent, nearly 1 percentage point higher than the national rate.[2,47]

Rates of self-reported major depressive episodes among adolescents ages 12 to 17 have been rising nationally and increased 2.5 percentage points in Massachusetts in 2013–2014.

- In 2010–2011, the percentage of Massachusetts adolescents who reported having experienced a major depressive episode in the past year was somewhat higher than the national percentage (8.8% and 8.1%, respectively).[49]
- Nationally, the proportion of adolescents who reported having experienced a major depressive episode in the past year gradually rose from a low of 8.1 percent in 2010–2011 to a high of 11 percent in 2013–2014.[49]
- In Massachusetts, the percentage of adolescents who reported having experienced a major depressive episode in the past year based on 2013–2014 data remained fairly close to the national percentage.[49]

FIGURE 7: ADULTS 18 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES REPORTING HAVING EXPERIENCED A MAJOR DEPRESSIVE EPISODE IN THE PAST YEAR, 2010–2014

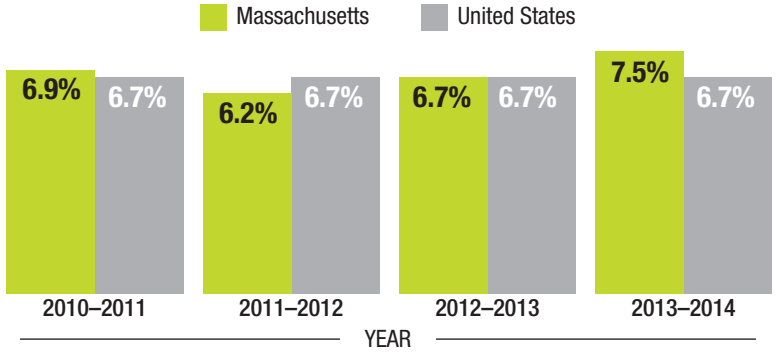
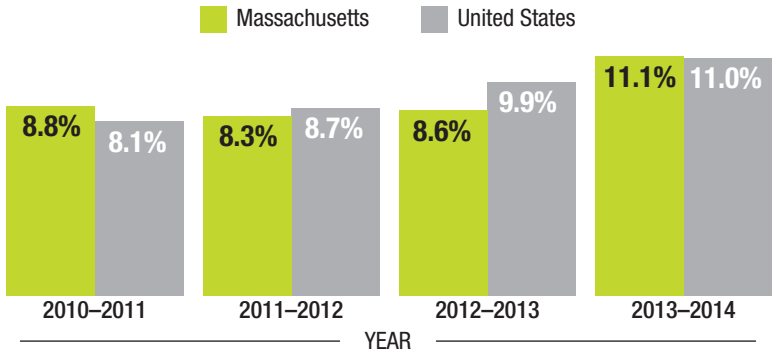


FIGURE 8: ADOLESCENTS AGES 12 TO 17 IN MASSACHUSETTS AND THE UNITED STATES REPORTING HAVING EXPERIENCED A MAJOR DEPRESSIVE EPISODE IN THE PAST YEAR, 2010–2014



Source: SAMHSA, 2010–2014.

PREVALENCE OF SUBSTANCE USE DISORDERS

In 2014, nearly 500,000 residents aged 12 or older reported having an SUD, specifically alcohol or drug dependence or abuse.[2]

Rates of self-reported alcohol or illicit drug misuse or use disorder among adults have often been slightly higher in Massachusetts than nationally.

- In 2010–2011, the proportion of Massachusetts adults who reported an alcohol or illicit drug misuse or use disorder was 8.7 percent, slightly higher than the national percentage of 8.5 percent.[47]
- After a shift in 2011–2012, when the national percentage exceeded the state percentage, the percentage of Massachusetts adults who reported an alcohol or illicit drug misuse or use disorder again rose above the national percentage.[47]

Self-reported alcohol or illicit drug misuse or use disorder among adolescents ages 12 to 17 has decreased both in Massachusetts and nationally.

- In 2010–2011, 9.0 percent of adolescents in Massachusetts reported alcohol or illicit drug misuse or use disorders, while the rate for adolescents in the United States was 7.3 percent.[47]
- Between 2010–2011 and 2011–2012, self-reported alcohol or illicit drug misuse or use disorders among adolescents decreased by 2.0 percentage points in Massachusetts, to 7.0 percent, and by 0.4 percentage points in the United States, to 6.9 percent.[47]
- Rates continued to decrease from 2012 to 2014 to 5.1 percent for both Massachusetts and the United States.[2,47]

FIGURE 9: ADULTS 18 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES WITH A SELF-REPORTED ALCOHOL OR ILLICIT DRUG MISUSE OR USE DISORDER IN THE PAST YEAR, 2010–2014

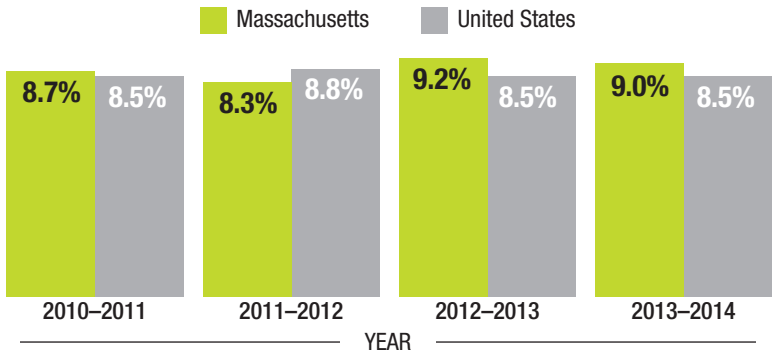
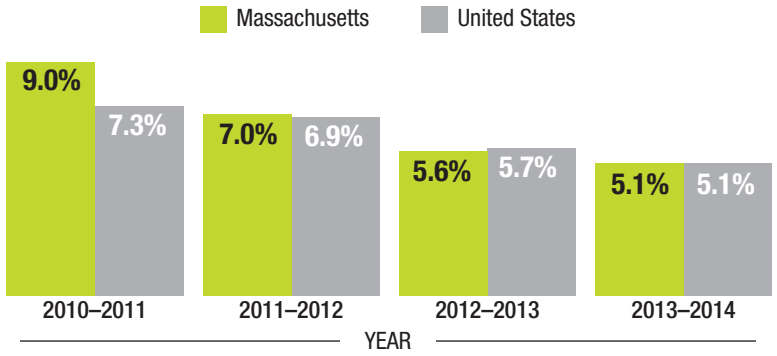


FIGURE 10: ADOLESCENTS AGES 12 TO 17 IN MASSACHUSETTS AND THE UNITED STATES WITH A SELF-REPORTED ALCOHOL OR ILLICIT DRUG MISUSE OR USE DISORDER IN THE PAST YEAR, 2010–2014



Source: SAMHSA, 2010–2014.

Rates of self-reported alcohol misuse or use disorders among those ages 12 or older have been slightly higher in Massachusetts than in the United States but have been decreasing over time.

- In 2010–2011, the percentage of individuals ages 12 or older who reported an alcohol misuse or use disorder in Massachusetts was 1.6 percentage points higher than in the United States (8.4% and 6.8%, respectively).[49]
- The national percentage remained fairly level from 2010–2014, ranging from 6.8 percent to 6.5 percent.[49]
- During this same five-year period, the percentage of Massachusetts residents ages 12 or older who reported an alcohol misuse or use disorder decreased from 8.4 percent to 6.7 percent, slightly above the U.S. percentage.[49]

Rates of self-reported illicit drug misuse or use disorders among individuals ages 12 or older have been slightly higher in Massachusetts than in the United States, and they have been increasing.

- In 2010–2011, the percentage of individuals ages 12 or older who reported an illicit drug misuse or use disorder was 2.8 percent in Massachusetts and 2.7 percent in the United States.[49]
- The national percentage remained fairly consistent from 2010 to 2014, varying between 2.7 percent and 2.6 percent.[49]
- In Massachusetts, the percentage decreased to 2.5 percent in 2011–2012 and then increased to 3.0 percent in 2013–2014, exceeding the national percentage.[47,49]

FIGURE 11: INDIVIDUALS AGES 12 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES WITH A SELF-REPORTED ALCOHOL MISUSE OR USE DISORDER IN THE PAST YEAR, 2010–2014

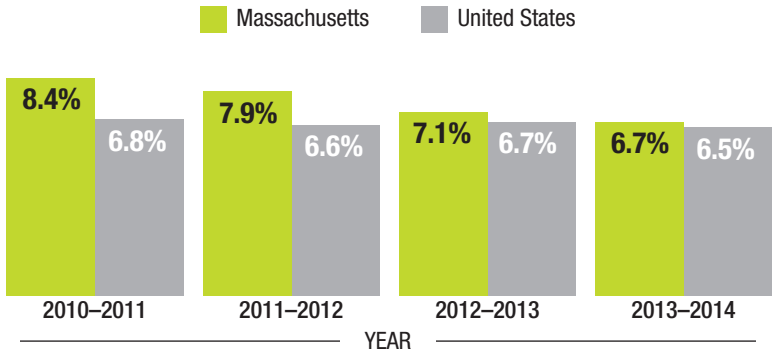
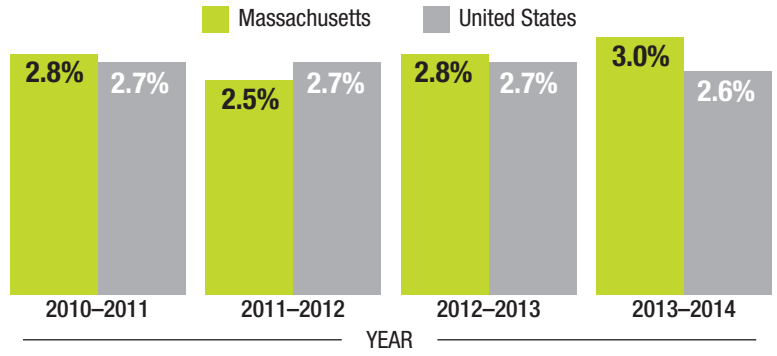


FIGURE 12: INDIVIDUALS AGES 12 OR OLDER IN MASSACHUSETTS AND THE UNITED STATES REPORTING ILLICIT DRUG MISUSE OR USE DISORDERS IN THE PAST YEAR, 2010–2014



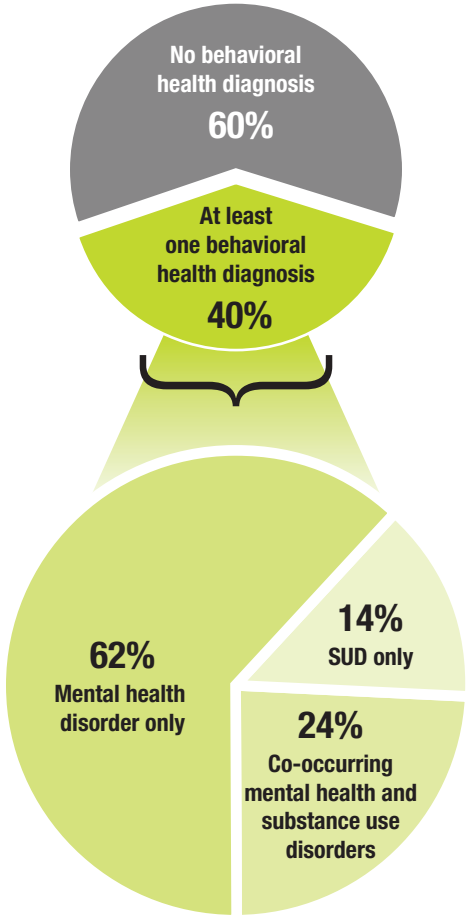
Source: SAMHSA, 2010–2014.

CO-OCCURRING DISORDERS

A significant percentage of adults in Massachusetts acute care hospitals have comorbid behavioral health conditions.

- In 2013 and 2014, 40 percent of patients admitted to Massachusetts acute care hospitals had at least one comorbid behavioral health condition (any mention of a diagnosis of a mental health disorder, SUD, or co-occurring diagnoses of mental health and substance use disorders).[50]
- Of these patients, 62 percent had a diagnosis of mental health disorder only, 14 percent had a diagnosis of SUD only, and 24 percent had both a mental health disorder and a SUD.[50]

FIGURE 13: INDIVIDUALS AGES 18 OR OLDER ADMITTED TO MASSACHUSETTS ACUTE CARE HOSPITALS WITH COMORBID BEHAVIORAL HEALTH CONDITIONS



Source: CHIA, 2016.

BEHAVIORAL HEALTH WORKFORCE CAPACITY

UNDERSTANDING THE BEHAVIORAL HEALTH WORKFORCE

The behavioral health workforce is composed of an array of mental health and substance use providers.

- Health care professionals who provide behavioral health services include primary care physicians, psychiatrists, psychologists, psychiatric clinical nurse specialists (CNSs), licensed clinical social workers (LCSWs), licensed independent clinical social workers (LICSWs), SUD counselors, licensed mental health counselors (LMHCs), and licensed marriage and family therapists (LMFTs).
- Many behavioral health professionals require a state license to practice in Massachusetts, including psychologists, psychiatrists, social workers, and licensed alcohol and drug counselors (LADCs).[51,52] Licensing standards are set by the state legislature and administered by licensing boards. A table of licensing requirements by provider type, where applicable, is included in Appendix C.
- Some behavioral health staff obtain certification to provide services, including certified peer specialists, recovery coaches, and therapists in alternative practices (e.g., art/music therapy).[53,54] Professional certification demonstrates to the public, payors, and employers that the individual has met the state or national standards set by the profession.

The distribution of licensed mental health providers varies across regions of the state.

- Across all regions, LCSWs and LICSWs are comparatively more abundant than LMHCs, licensed psychologists, and psychiatrists.
- When considering all provider types, mental health providers appear most concentrated in the Boston and Metro West regions of the state.

TABLE 3: GEOGRAPHIC DISTRIBUTION OF LICENSED MENTAL HEALTH PROFESSIONALS IN MASSACHUSETTS*

	2016 Population Estimates		Licensed Clinical Social Workers (LCSWs) / Licensed Independent Clinical Social Workers (LICSWs)		Licensed Mental Health Counselors (LMHCs)		Licensed Psychologists (PsyDs, PhDs)		Psychiatrists (MDs)		Total Licensed Mental Health Professionals	
	n	%	n	n/100k	n	n/100k	n	n/100k	n	n/100k	n	n/100k
Total	6,811,779	100%	18,163	267	5,665	83	5,408	79	2,866	42	32,102	471
Region 1: Western MA	835,331	12%	2,484	297	794	95	621	74	297	36	4,196	502
Region 2: Central MA	883,047	13%	1,541	175	786	89	398	45	255	29	2,980	337
Region 3: Northeast	1,352,100	20%	2,989	221	1,010	75	536	40	225	17	4,760	352
Region 4: Metro West	1,602,907	24%	5,841	364	1,501	94	2,490	155	976	61	10,808	674
Region 5: Southeast	1,295,038	19%	2,693	208	1,073	83	472	36	324	25	4,562	352
Region 6: Boston	843,356	12%	2,615	310	501	59	891	106	789	94	4,796	569

* This does not include licensed marriage and family therapists.
Sources: Massachusetts OCABR and BORIM Licensure Data, 2016; U.S. Census, City and Town Population Tools Datasets, 2010-2016.

WORKFORCE CAPACITY IN MASSACHUSETTS

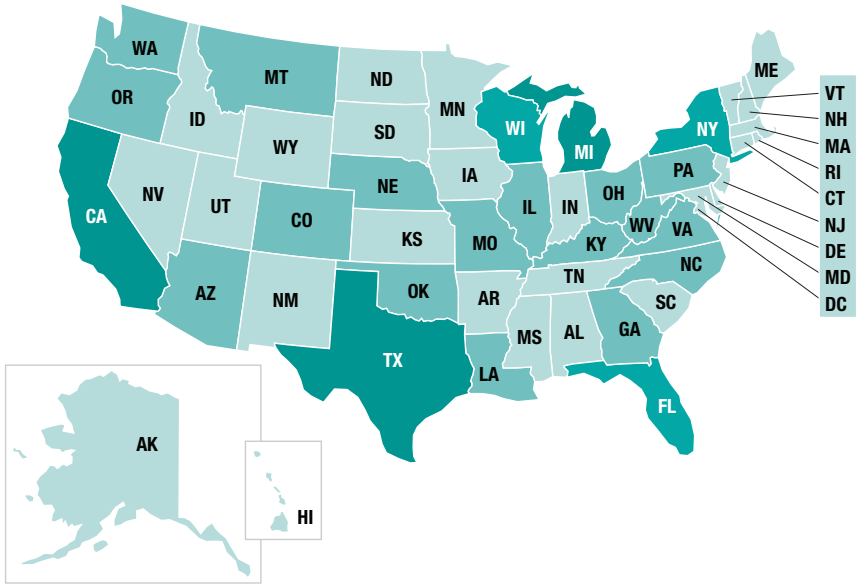
Massachusetts faces shortages of mental health professionals across the state.[55,56]

- There were 56 mental health care health professional shortage areas (HPSAs) in Massachusetts as of January 1, 2017. HPSAs for mental health professionals are defined as those with fewer than one provider per 30,000 people or fewer than one provider per 20,000 people in high-need areas. (High-need areas are defined as having one or more of the following characteristics: at least 20 percent of the population has income less than or equal to 100 percent FPL, youth ratio exceeds 0.6, elderly ratio exceeds 0.25, high prevalence of alcoholism or substance use.[57])
- This designation positions Massachusetts as having relatively fewer HPSAs for mental health than many other states. These areas of unmet need may be whole counties, particular health centers, Indian tribes, or correctional facilities where the need for mental health professionals outstrips their supply.[55]

The language and culture of behavioral health providers in Massachusetts are not always aligned with those of the client population in their geographic area.

- There is evidence that provider racial/ethnic concordance with clients can improve engagement and retention in care. A 2015 study of access to SUD treatment in Massachusetts found the current behavioral health workforce is insufficient to accommodate the needs of Massachusetts' diverse population, for reasons including a lack of capacity to offer services in a client's native language.[58]

FIGURE 14: NUMBER OF MENTAL HEALTH CARE HPSAs IN MASSACHUSETTS RELATIVE TO OTHER STATES



Note: Providers include: Psychiatrists, Clinical Psychologists, Clinical Social Workers, Psychiatric Nurse Specialists, and Marriage & Family Therapists.
Source: HRSA, 2017.

BEHAVIORAL HEALTH SYSTEM CAPACITY

BEHAVIORAL HEALTH SERVICES AND SETTINGS

- The Commonwealth's behavioral health system encompasses a number of services across the care spectrum, including services in community, outpatient, residential, and inpatient settings that provide prevention, early intervention, treatment, and recovery support services.
- The four main types of services along the behavioral health continuum of care are:
  - **Prevention** includes identifying individual and environmental risk and protective factors for mental and substance use disorders and includes evidence-based programs, policies, and strategies to address these factors.[59]
  - **Early Intervention** involves screening and detecting behavioral health problems at an early stage and providing brief intervention, as needed.
  - **Treatment** consists of medications, therapy, and psychosocial services to support wellness and recovery.
  - **Recovery Support Services** include a range of social, educational, legal, and other services that promote recovery, wellness, and improved quality of life. Services may include access to supported employment, education, and housing; assertive community treatment; and peer services.

Figure 15 depicts the types of behavioral health care services according to their position on the continuum of care of behavioral health care services. Additional information about Massachusetts' behavioral health treatment services can be found in Appendix B.

FIGURE 15: BEHAVIORAL HEALTH SPECTRUM OF SERVICES AND PROGRAMS[60]

Prevention[61]	• Massachusetts Opioid Abuse Prevention Collaborative • Substance Abuse Prevention Collaborative • Partnerships For Success • Partnership For Prevention • Massachusetts Coalition for Suicide Prevention • Community Conversations Initiative • School and Family Intervention Programs
Early Intervention	• Massachusetts Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Technical Assistance Program • Children's Behavioral Health Services (CBHI) Primary Care Screening
Treatment	• CBHI Services • Community and Outpatient Care • Inpatient and Continuing Care • Intermediate Care • Residential Care • Community-Based Acute Treatment (CBAT)[62] • Diversionary Services (partial hospitalization and day treatment) • Emergency Services Programs (ESPs) • Medication-Assisted Treatment (MAT)[58]
Recovery Support	• Recovery and Family Support Services • Recovery Learning Centers • Clubhouse • Community Support Agencies (CSAs) • Community-Based Flexible Supports[63]

Source: U.S. Department of Health and Human Services, 2016.

BEHAVIORAL HEALTH TREATMENT CAPACITY

- DMH licenses hospital psychiatric units, private acute psychiatric hospitals, and clinically intensive residential treatment programs.
- BSAS within DPH licenses SUD treatment programs, including outpatient programs, acute services, detoxification, residential rehabilitation, and medication-assisted treatment (MAT).
- As of April 1, 2017, there were 8,674 beds and an additional 346 programs licensed in Massachusetts to serve residents with mental health and substance use disorders. These include facilities for older adults, adults, adolescents, and children, including facilities segregated by gender.[64]
- MassHealth covers mental health and substance use disorder services in addition to those provided through DPH and DMH , including:
  - Observation beds and detoxification
  - Diversionary services, including community-based acute treatment (24-hour treatment service for children under 18)
  - Acute treatment services (detox)
  - Clinical stabilization services (short-term residential SUD treatment services)
  - Outpatient services, including family consultation, behavioral therapy, group treatment, and medication visits
  - Intensive home- or community-based services for youth, including intensive care coordination
  - Emergency services

TABLE 4: DEPARTMENT OF MENTAL HEALTH AND DEPARTMENT OF PUBLIC HEALTH LICENSING DATA

Program Type	Total Operational Licensed Capacity as of April 1, 2017
DPH Acute Treatment Services (levels 4.0 and 3.7 detox), Adult	953 Beds
DPH Clinical Stabilization Services	454 Beds
DPH Transitional Support Services	342 Beds
DPH Adult Residential Recovery	2,405 Beds
DPH Youth Stabilization Services	48 Beds
DPH Second Offender Residential	58 Beds
DPH Adolescent/Transitional Youth Residential Services	86 Beds
DPH Family Residential	110 Families
DMH Adult Psychiatric	2,025 Beds
DMH Geriatric Psychiatric	458 Beds
DMH Adolescent & Child Psychiatric	292 Beds
Section 35* Men's Services	308 Beds
Section 35* Women's Services	163 Beds
DPH Outpatient Treatment Programs – MAT	41 Programs
DPH Outpatient Counseling and Outpatient Detox Programs	192 Programs
DPH Office-Based Outpatient Treatment (buprenorphine) – MAT Sites Funded by DPH	30 Programs
Sober Homes Certified by Mass. Association of Sober Houses	83 Homes, 1,082 Beds

Note: These counts do not include DMH Continuing Care beds.

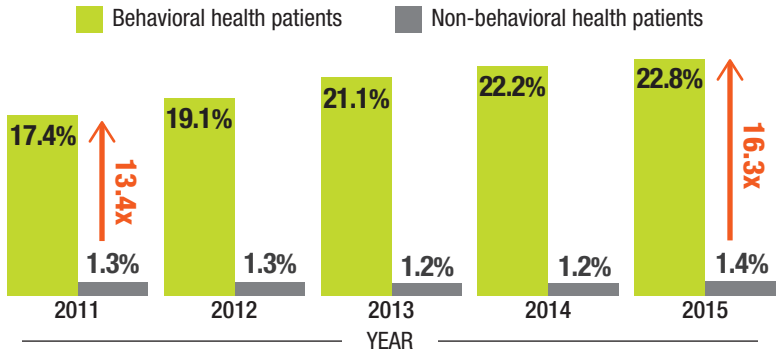
*These counts include treatment beds for individuals committed under Section 35 of Chapter 123 of the General Laws, which permits the courts to involuntarily commit someone who has an alcohol or substance use disorder and for whom there is a likelihood of serious harm as a result of his/her alcohol or substance use. Such a commitment shall be for the purpose of inpatient care in a facility licensed or approved by DPH or DMH for a period of up to but not to exceed 90 days.

Sources: Governor Baker's Opioid Addiction Working Group, 2016; Massachusetts DMH and DPH, personal communication, 2017.

Individuals with behavioral health–related visits to a hospital emergency department (ED) are significantly more likely than patients without a behavioral health–related condition to experience ED boarding (i.e., a wait in an ED more than 12 hours from time of registration to time of discharge).

- Between 2011 and 2015 the share of behavioral health patients who have boarded in an ED has steadily increased, while the share of patients without a behavioral health condition who have boarded has remained consistent.[65]

FIGURE 16: PERCENT OF PATIENTS WITH AN EMERGENCY DEPARTMENT STAY OF 12 HOURS OR MORE, 2011–2015



Notes: The categories of behavioral health and non-behavioral health are based on a patient's primary diagnosis. Behavioral health emergency department visits were identified using NYU Billings algorithm and includes any discharge with a primary "mental health, substance abuse, or alcohol"-related diagnosis code. Hours spent in the emergency department calculated from time of registration to time of discharge.

Source: HPC analysis of CHIA Emergency Department Database, 2011–2015.

BEHAVIORAL HEALTH AFFORDABILITY

The rising cost of insurance premiums and cost sharing (e.g., deductibles, copayments) may deter individuals from seeking needed behavioral health care services.

- 4.1 percent of all respondents to a 2015 Massachusetts survey reported an unmet need for mental health care or counseling due to cost in the past 12 months.[66]
- The 2014 National Survey on Drug Use and Health found that approximately 30 percent of individuals who reported an unmet need for SUD treatment, and 45 percent of those who reported an unmet need for mental health disorder treatment, did not receive treatment because they lacked health coverage and/or could not afford it.[67]

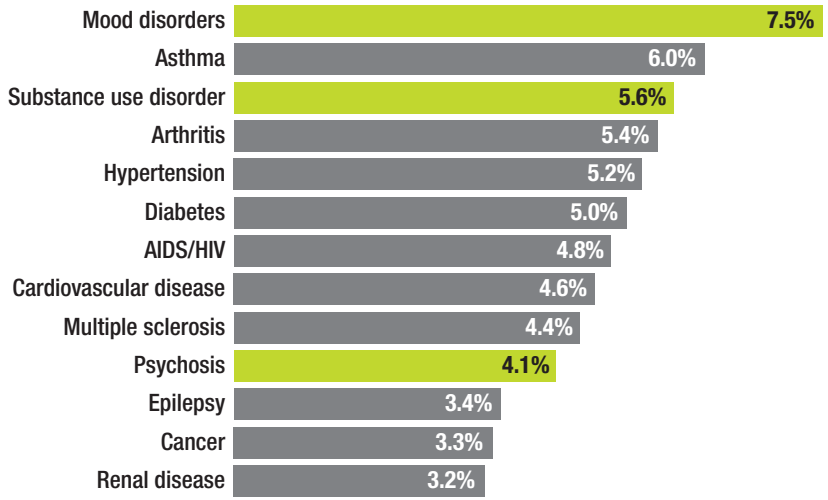
Compared with other medical conditions, behavioral health disorders are associated with a high rate of cost sharing (including co-pays and deductibles) as a percentage of total health care spending.

- A 2013 Massachusetts Health Policy Commission (HPC) review of medical claims found that individuals with a diagnosed mood disorder paid a higher proportion of their total health expenses out of pocket than did individuals with 12 other health conditions.[68]
- Similarly, cost-sharing rates for individuals with a diagnosed SUD or psychosis were greater than for individuals with cancer or renal disease.[68]

National trends show that spending—both by insurers and consumers—for inpatient behavioral health treatment has increased for both mental health and substance use disorders in recent years.

- A review of all-payor spending for inpatient admissions found that per capita spending for inpatient SUD treatment rose from $5.45 in 2007 to $10.06 in 2011, and per capita spending for inpatient mental health treatment increased from $13.50 to $21.33 during the same time period.[69]
- Overall, per capita spending on admissions for mental health disorders and SUDs grew faster between 2007 and 2011 than per capita spending on medical and surgical inpatient admissions over the same time period.[69]

FIGURE 17: COST SHARING (INCLUDING CO-PAYS AND DEDUCTIBLES) AS A PERCENTAGE OF TOTAL SPENDING FOR INDIVIDUALS WITH GIVEN DIAGNOSED CONDITIONS, 2013



Note: Presence of a condition is measured using Expanded Diagnosis Clusters (EDCs) in the ACG software. Cost sharing is calculated as patient payments for deductibles, coinsurance, and copayments divided by total patient and insurer payments towards covered medical services in the year. Prescription drug spending covered under a pharmacy benefit is not included in this exhibit. Each row reflects medical spending among only enrollees with the specified condition.

Source: HPC analysis of Massachusetts All-Payer Claims Database.

QUALITY OF BEHAVIORAL HEALTH SERVICES

- Behavioral health quality measures are collected by a number of entities in Massachusetts, including MassHealth, the Center for Health Information and Analysis (CHIA), DPH, Massachusetts Health Quality Partners, the Massachusetts Group Insurance Commission (GIC), and commercial payors.
- CHIA maintains the Standard Quality Measurement System (SQMS), which tracks 17 behavioral health–related quality measures. A report of these data found that Massachusetts providers were generally performing at or above national benchmarks; however, inconsistency across providers on the measures they collect is a concern, and data are not reported publicly for all measures.
- MassHealth has identified several measures it will be tracking as part of its delivery system reform efforts and movement to ACOs, including nine behavioral health–related quality measures.
- HPC found over 300 different quality measures relevant to behavioral health and general health care were being collected by a sample of health care stakeholders. Though the general areas of performance being measured were similar, the indicators were often unique and could not be compared across entities.[70]
- Table 5 shows the publicly available behavioral health measures collected by different state entities as of February 2016.

TABLE 5: PUBLICLY AVAILABLE BEHAVIORAL HEALTH MEASURES (AS OF FEBRUARY 2016)

Measure	National Measure Set	State or Federal Program or Entity Collecting Data						
		Center for Health Information and Analysis, Standard Quality Measure Set	Group Insurance Commission Clinical Performance Improvement Initiative	Department of Public Health	Centers for Medicare and Medicaid Services "Compare" Programs	Massachusetts Health Quality Partners Healthcare Compass	Centers for Medicare and Medicaid Services Accountable Care Organizations	Meaningful Use (eReporting 2015 and 2016)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	HEDIS	●						●
Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI							●
Antidepressant Medication Management	HEDIS	●	●			●		●
Follow-Up Care for Children Prescribed ADHD Medication	HEDIS	●	●			●		●
Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use	N/A							●
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	N/A	●					●	●
Depression Assessment Conducted	OASIS				●			

(continued)

(continued)

Measure	National Measure Set	State or Federal Program or Entity Collecting Data						
		Center for Health Information and Analysis, Standard Quality Measure Set	Group Insurance Commission Clinical Performance Improvement Initiative	Department of Public Health	Centers for Medicare and Medicaid Services "Compare" Programs	Massachusetts Health Quality Partners Healthcare Compass	Centers for Medicare and Medicaid Services Accountable Care Organizations	Meaningful Use (eReporting 2015 and 2016)
Patients Discharged on Multiple Antipsychotic Medications (HBIPS 4)	HBIPS	●						
Follow-Up After Hospitalization for Mental Illness	HEDIS	●						
Percent of Residents Who Have Depressive Symptoms (Long-Stay)	N/A			●	●			
Depression Remission at 12 Months	N/A							●
Depression Utilization of the PHQ-9 Tool	N/A	●						●
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	N/A							●
Maternal Depression Screening	N/A	●						●
Depression Screening by 18 Years of Age	N/A	●						
Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS	●						
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (SSD)	HEDIS	●						
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	●						
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	HEDIS	●						
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	N/A	●						
Depression Acute Phase Diagnosis	N/A							
Percent of Long-Stay Residents Who Received an Antipsychotic Medication	N/A			●	●			
Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication	N/A			●	●			
Mental Health Utilization	HEDIS							

Note: HEDIS = The Healthcare Effectiveness Data and Information Set; AMA-PCPI = American Medical Association-convened Physician Consortium for Performance Improvement; OASIS = Outcome and Assessment Information Set; HBIPS = Hospital-Based Inpatient Psychiatric Services.

GAPS IN UNDERSTANDING ACCESS TO BEHAVIORAL HEALTH CARE

To better understand the behavioral health system and the factors that impact access to care, reliable data are needed. Gaps in data collection and reporting exist in several areas, limiting the ability of policymakers, providers, advocates, and researchers to draw conclusions about the scope of the issues and make improvements to the system. Reporting on behavioral health quality measures and service utilization varies widely by payor and provider, and in some cases data are not collected or are difficult to obtain. Additional focus on behavioral health data and reporting will increase the Commonwealth's understanding of the system. Below are examples of gaps in publicly available reports or datasets about the Massachusetts behavioral health system:

Gaps in Workforce Capacity Data

- Up-to-date data are needed on the size and geographic distribution of the entire behavioral health workforce in Massachusetts, including licensed, certified, and unlicensed providers, and those working outside the insurance market. Information on the size and statewide distribution of the SUD treatment and recovery workforce is particularly not well represented in public reports or datasets. Without a thorough understanding of the size and regional distribution of the behavioral health workforce, it is difficult to determine the numbers and types of providers in short supply generally and by area.
- Additional information on the composition (e.g., profession, race/ethnicity, gender, language) and capacity of the behavioral health workforce to provide services across the continuum of care. More data are needed to assess whether adequate services can be delivered to all those in need.

Gaps in Behavioral Health System Data

- Comprehensive and consistent data that capture capacity and service utilization across the entire behavioral health system are needed. Data should capture licensed, certified, and unlicensed community service utilization; currently available capacity; and wait times for services. Insufficient and inconsistent information about capacity and service utilization inhibits the Commonwealth's ability to understand access barriers and to take necessary actions that can reduce prevalence rates of behavioral health conditions. Data that better characterize specialized needs of consumers and the capacity of providers and the behavioral health system to treat those with specialized needs are needed.
- Systematic identification and tracking of the types and locations of behavioral health services provided in primary care settings, including locations offering co-located or integrated behavioral health and physical services, are needed. Inadequate information about behavioral health service delivery models limits knowledge about the amount of behavioral health services provided across the entire Massachusetts health care system.

Gaps in Affordability Data

- Additional and more detailed costs of behavioral health services provided within the state are needed. To understand the cost of services, cost data on types of treatment and recovery support services, service delivery area, client population and payor, and other variables need to be publicly available. Insufficient cost data make it difficult to analyze variations in expenditures across the continuum of care and to determine the affordability of services for behavioral health clients.
- Accessible information on the types of behavioral health services covered by commercial payors, reimbursement rates for such services, and the "final" costs to individuals and employers (including premiums, deductibles, and co-pays) is needed. The lack of transparency about rates, coverage, and affordability makes it challenging to provide a comprehensive picture of costs and coverage issues.

Gaps in Quality Measures and Data Reporting

- A standardized approach to define and measure behavioral health quality and access across agencies and payors is needed. The absence of a standard framework to measure and evaluate quality and utilization creates inconsistencies in how access and quality issues are interpreted by policymakers and other stakeholders working to improve the system.
- Consistent quality and performance measures should be developed for use across payors and organizations. Gaps also exist in the collection of standardized outcome measures and the reporting of data from all payors. Consistent and standardized data collection and reporting are necessary to perform rigorous analysis and gain a full picture of the performance of the behavioral health system.

APPENDIX A: GLOSSARY

Continuum of Care: An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.[60]

Federally Qualified Health Center (FQHC): FHQCs include all organizations receiving grants under Section 330 of the *Public Health Service Act*, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid and grant funds to offset the costs of uncompensated care and other key enabling services. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.[71]

Major Depressive Episode (MDE): A period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.[72]

Managed Behavioral Health Organization (MBHO): MBHOs manage mental health and SUD services and ensure quality of care, access to providers, and accountability for positive outcomes through performance measurements and standards. Some MBHOs operate independently of any health insurance plan, while others are a part of a health insurance plan. Other MBHOs are associated with academic and/or provider organizations. MBHOs manage utilization and modify reimbursement structures. MBHOs also coordinate delivery systems for mental health, substance misuse, and workplace services using a specialized network or delivery system of behavioral health providers.[73]

Massachusetts Mental Health Parity Law (MHPL): This law requires insurers to cover the diagnosis and treatment of select biologically based mental health conditions at parity with physical health conditions. These conditions must be covered at parity with regard to cost sharing and benefit limits.

Medicaid Managed Care Organizations: Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.[74]

Medication-Assisted Treatment (MAT): A "whole-patient" approach to the treatment of SUDs that uses medication in combination with counseling and behavioral therapies.[75]

Mental Health Disorder: Syndromes characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental health disorders are usually associated with significant distress in social, occupational, or other important role functioning activities.[4]

Mental Health: Mental health is a level of emotional, psychological, and social well-being or absence of mental illness. It affects how an individual thinks, feels, and acts. It also helps determine how a person handles stress, relates to others, and makes choices.[76]

Mental Illness: See **mental health disorder**.

Prevention: Delivered prior to the onset of a disorder, preventive interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse, and illicit drug use.[77]

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[60]

Serious Mental Illness (SMI): A mental, behavioral, or emotional disorder (excluding developmental disorders and SUDs) that is diagnosable currently or within the past year, is of sufficient duration to meet diagnostic criteria, and substantially interferes with or limits one or more major life activities.[78]

Substance Misuse: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute as misuse (e.g., underage drinking, injection drug use).[60]

Treatment: Services or a set of services provided to a client for mental health disorders and/or SUDs, with the intent of addressing the disorder and associated physical and behavioral health problems and restoring the client to maximum functional ability. These services typically should be tailored to fit individual needs. For many people with behavioral health conditions, the most effective approach involves a combination of counseling and medication. Supportive services, such as childcare and employment support, can also play an important role in promoting health and recovery.[79]

APPENDIX B: BEHAVIORAL HEALTH SERVICES AND SUPPORTS IN MASSACHUSETTS

MENTAL HEALTH DISORDER TREATMENT AND RECOVERY SERVICES IN MASSACHUSETTS

Service/Support[80]	Definition[80]
Inpatient and Continuing Care	Acute or extended inpatient psychiatric hospitalization services.
Intermediate Care	Services provided as a transition out of or alternative to inpatient care.
Residential Care	Care provided in a 24-hour residential program.
Community and Outpatient Care	Care in an ambulatory service setting such as a mental health center, hospital outpatient clinic, or a professional's office.
Community-Based Acute Treatment (CBAT)[61]	Acute short-term inpatient psychiatric services for adolescents under the age of 18.
Community Support Agencies (CSAs)	Community-based organizations that provide care planning, care coordination, and family/caregiver support services.
Community-Based Flexible Supports[62]	Community-based services tailored to each individual's need and allowing for independent living.
24-Hour Diversionary Services	Services provided as alternatives to inpatient services for short-term care.
Non-24-Hour Diversionary Services (partial hospitalization and day treatment)	Outpatient and daytime services provided in order to maintain patients' functional level and prevent full hospitalization.
Department of Mental Health Clubhouses	Care provided in rehabilitation centers that provide activities and opportunities to reengage with the community.
Recovery and Family Support Services	Programs to help people support each other in their recovery from mental health disorders and to support families of children with serious emotional disturbance.
Recovery Learning Centers	Peer support services sponsored by consumer-based networks.
Emergency Services Programs (ESPs)	Care provided in hospital emergency departments and in specialized programs of emergency mental health services as well as in homes and in the community for patients experiencing a mental health crisis.

SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES IN MASSACHUSETTS

Service/Support[80]	Definition[80]
Inpatient and Other Acute Care	Care in hospitals and nonhospital settings for acute detoxification, stabilization, and other SUD treatment.
Intermediate Care	Care provided as a step down from or alternative to acute care.
Residential Care	Rehabilitation services with a planned care program in a 24-hour residential setting.
Community and Outpatient Care	Care in an ambulatory setting such as a community health center, SUD treatment program, hospital outpatient department, professional's office, or patient's home. Case management, which consists of discrete services to manage SUD care or to coordinate with other health or social services, is often part of community and outpatient care.
Medication-Assisted Treatment (MAT)	Regulated use of medications to help lessen cravings and manage withdrawal.
Recovery Support Services	Programs to help people maintain their recovery and support each other in recovery.
Recovery Learning Centers	Peer support services sponsored by consumer-based networks.
Emergency Response	Care and other services provided for substance misuse or SUD-related emergencies.

APPENDIX C: PROVIDER LICENSING REQUIREMENTS

Provider Type	Licensing Board	Licensing Requirements
Advanced practice registered nurse (APRN) (e.g., psychiatric clinical nurse specialist)	Board of Registration in Nursing	Valid Massachusetts RN licensure in good standing (reciprocal applicants may submit applications for RN licensure and APRN licensure at the same time). Good moral character as required by M.G.L. c. 112, § 74 and as established by Board policy. Compliance with the following academic requirements: a) Graduation from an educational program designed to prepare the graduate for practice as an APRN in the clinical category for which the applicant is applying that is approved by a national accrediting organization for academic programs acceptable to the Board. b) Successful completion of, at minimum, core content in advanced assessment, advanced pathophysiology, and advanced pharmacotherapeutics.[81]
Alternative practices (e.g., art/ music therapy, homeopathy)	None	N/A
Certified peer specialist (CPS)	The Transformation Center	Completion of CPS training and a written and oral examination.[82]
Licensed certified social worker (LCSW)	Board of Registration of Social Workers	A master's degree in social work (no other field will be accepted).[83]
Licensed independent clinical social worker (LICSW)	Board of Registration of Social Workers	a) Master's or doctoral degree in social work (no other field will be accepted). b) A current license as an LCSW. c) 3,500 hours of post-MSW clinical social work experience (or post-LCSW clinical social work experience, if degree conferred after 8/31/2011) under the supervision of someone who is currently licensed as an LICSW or holds an equivalent license in another state. The 3,500 hours of experience must be accumulated over not less than two years post-MSW. d) A total of 100 hours of individual one-to-one supervision from someone who is currently licensed as an LICSW or holds an equivalent license in another state, at a rate of 50 hours per year, or one hour for every 35 hours of work experience.[84]

(continued)

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Provider Type	Licensing Board	Licensing Requirements
Licensed mental health counselor (LMHC) (e.g., marriage or family therapist, rehabilitation counselor, mental health counselor)	Board of Registration of Allied Mental Health and Human Services Professionals	As described in M.G.L. c. 112 § 165: a) Good moral character. b) Has not engaged or is not engaging in any practice or conduct that would be grounds for refusing to issue a license under section 169. c) Demonstrates to the board the successful completion of a master's degree (or, per 262 CMR 2.05(2)(b), a doctoral degree) in a relevant field from an educational institution that is licensed by the state in which it is located and that meets national standards for granting of a degree with a subspecialization in marriage and family therapy, rehabilitation counseling, counseling, or other relevant subspecialization approved by the board. Must have two additional years of supervised clinical experience in the relevant field in either a clinic or a hospital licensed by the DMH and accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute or under the direction of a supervisor approved by the board. For purposes of this clause, "supervision" shall be defined as no less than 200 hours of supervised clinical experience, at least 100 hours of which shall consist of individual supervision with a clinician who has expertise in marriage and family therapy, rehabilitation counseling, educational psychology, or counseling and who holds a master's degree in social work, marriage and family therapy, rehabilitation counseling, educational psychology, counseling, or an equivalent field or holds a doctorate degree in psychology or a medical degree with a subspecialization in psychiatry. d) Passes a written or oral examination administered by the board to determine the applicant's qualifications for licensure for each profession licensed pursuant to this section. e) An individual licensed under the provisions of this section who also holds a valid license as a licensed certified social worker pursuant to the provisions of section 131 or section three of chapter 818 of the Acts of 1977 shall designate which of such licenses governs each practice in which he or she is engaged and except when engaged in practice as a lecturer, teacher, or researcher, he or she shall use the designated governing license and license title in connection with said practice, including in advertising and on business cards or announcements.
Peer support providers	None	N/A
Psychiatric aides and technicians	None	N/A[84]

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Provider Type	Licensing Board	Licensing Requirements
Psychiatric rehabilitation counselor[85]	Board of Registration of Allied Mental Health and Human Services Professionals	a) A master's or doctoral degree in rehabilitation counseling or a related field from a recognized educational institution. The graduate degree program of study must have included an internship. If an applicant's master's or doctoral degree program of study consisted of fewer than 48 semester hours, or if the applicant's master's or doctoral degree program of study did not include the courses listed in 262 CMR 4.01(3)(b) and/or an internship, evidence of completion of graduate-level courses and/or an internship outside of the degree program sufficient to meet the 48 semester hour, course, and internship requirements must be submitted to the board for review and approval. An applicant who was awarded a graduate degree from a combined professional graduate program must submit the program of study for such combined program for review and approval of such program by the board. b) Successful completion of one graduate-level course in each of the following content areas (total courses required = 5): Job Placement/Development/Vocational Analysis/Transferable Skill Development, Vocational Assessment and Evaluation, Vocational and Affective Counseling, Rehabilitation Plan Development, and Medical Aspects of Disabilities. c) A minimum of two years full-time, post-master's-degree supervised clinical experience or equivalent part-time work experience in rehabilitation counseling in a clinic or hospital licensed by DMH, or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute, or under the direction of an approved supervisor. Applicants who have completed a qualifying master's degree consisting of a 48 semester-hour program of study that included an internship may be credited a maximum of half of the total number of hours of the internship experience toward the clinical experience requirement. d) Successful completion of a supervised clinical experience. e) Achievement of a passing score on the licensure examination. If an applicant is currently in good standing with the Commission on Rehabilitation Counselors (CRC), a copy of the applicant's CRC membership certificate may be submitted with the licensure application in lieu of an examination score report from the CRC.
Psychiatrist	Board of Registration in Medicine	a) Be 18 years of age or older. b) Possess good moral character. c) Have pre-medical education as described in 243 CMR 2.02(2)(a). d) Have a medical school education as described in either 243 CMR 2.02 or 2.03. e) Have post-graduate medical training as described in either 243 CMR 2.02 or 2.03. f) Pass a professional examination as described in 243 CMR 2.02(3) or (4). g) Complete pain management training, as described in M.G.L. c. 94C, § 18. h) Participate in a risk management program as described in M.G.L. c. 112, § 5. i) Agree to refrain from balance-billing Medicare recipients, if the applicant has agreed to treat Medicare recipients, as provided in M.G.L. c. 112, § 2. j) Sign and swear to the contents of his or her licensing application. k) Pay a registration fee, as described in 243 CMR 2.05(1) and 801 CMR 4.02 (243). l) Demonstrate proficiency in electronic health records, as required by M.G.L. c. 112, § 2 as of January 1, 2015. m) Obtain professional liability malpractice insurance of at least $100,000/$300,000 coverage amounts, as provided in 243 CMR 2.07(16), if providing patient care in the Commonwealth. n) Certify that he or she is in compliance with the laws of the Commonwealth relating to taxes, the reporting of employees and independent contractors, and the withholding and remitting of child support, pursuant to M.G.L. c. 62C, § 49A.

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Provider Type	Licensing Board	Licensing Requirements
Psychoanalyst	N/A	Licensing may vary depending on the psychoanalyst's professional degree. Professional conduct is monitored by local institutes such as the Boston Psychoanalytic Society and Institute, as well as by the board that issued the license.[86]
Psychologist	Board of Registration of Psychologists	a) Complete an application for licensure. b) Complete a doctoral program in psychology that is designated as a doctoral program in psychology by the Association of State and Provincial Psychology Boards or the National Register of Health Service Psychologists or is accredited by the Commission on Accreditation of the American Psychological Association, at the time the degree is granted or within three years thereafter, and meets the criteria as described in 251 CMR 3.03. c) Complete professional experience requirements as described in 251 CMR 3.04. d) Complete supervision requirements as described in 251 CMR 3.05. e) Obtain professional and ethical endorsement from three individuals with standing in the psychological field as described in 251 CMR 3.07. f) Complete national psychology exam and Massachusetts Jurisprudence examinations as described in 251 CMR 3.08.
Substance use counselor	Department of Public Health	**Licensed Alcohol and Drug Counselor I:**[87] a) Master's or doctoral degree in behavioral sciences. b) Minimum of 270 hours of training that addresses the full range of education related to substance misuse counseling. c) 300 hours of supervised practical training. d) 6,000 hours of supervised alcohol and drug counseling work experience. e) Successful completion of a written examination. **Licensed Alcohol and Drug Counselor II:**[87] a) Minimum of 270 hours of training that addresses the full range of education related to substance misuse counseling. b) 300 hours of supervised practical training, c) 6,000 hours of supervised alcohol and drug counseling work experience (4,000 if applicant holds a bachelor's degree). d) Successful completion of a written examination. e) Proof of high school diploma or equivalent. **Licensed Alcohol and Drug Counselor Assistant:**[87] a) Proof of high school diploma or equivalent. b) 2,000 hours of work experience in the alcohol or drug misuse field. c) Minimum of 50 hours of training that addresses the full range of education related to substance misuse counseling. d) Successful completion of a written examination.

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