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July 19, 2021

The Honorable Julian Cyr
Chair, Joint Committee on Mental Health, Substance Use, and Recovery
24 Beacon Street, Room 312-E
Boston, MA 02133

The Honorable Adrian Madaro
Chair, Joint Committee on Mental Health, Substance Use, and Recovery
24 Beacon Street, Room 134
Boston, MA 02133

RE: Testimony in support of S.1287, *An Act to increase investment in behavioral health care in the Commonwealth*; H.2081/S.1274, *An Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation*; H.2083, *An Act relative to behavioral health urgent care*; and S.1275, *An Act establishing an Office of Behavioral Health Promotion*

Dear Chair Cyr, Chair Madaro, and Honorable Members of the Joint Committee on Mental Health, Substance Use, and Recovery:

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for strong and steadfast leadership in advancing the health of people with behavioral health conditions and their families across the Commonwealth. I am writing to respectfully submit this testimony in support of H.1287, *An Act to increase investment in behavioral health care in the Commonwealth*; H.2081/S.1274, *An Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation*; H.2083, *An Act relative to behavioral health urgent care*; and S.1275, *An Act establishing an Office of Behavioral Health Promotion*. These pieces of legislation are critical to the promotion of positive behavioral health in our Commonwealth, increasing resources for a behavioral health system that has been chronically underfunded, and better supporting individuals and families in need of urgent or crisis mental health and substance use services.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

S.1287, An Act to increase investment in behavioral health care in the Commonwealth

Behavioral health services have long been underfunded, which has resulted in gaps in care, limited capacity in care settings, and low reimbursement rates. The low reimbursement rates in turn drive low salaries and underfunding of expenses in provider programs, financial losses for providers offering significant volume of behavioral health services, and problems in recruitment and retention of qualified clinical staff.

These conditions driven by underfunding create significant barriers to receiving timely and appropriate care for individuals and their families. Failure to provide behavioral health treatment when and where it is needed leads to preventable behavioral health symptoms and disabling conditions, increased demand for intensive treatment, and associated higher costs of care. In the most tragic cases, delays in access to needed care lead to preventable deaths. Investing in a behavioral health system that ensures timely access to appropriate care can prevent these adverse outcomes and improve the wellbeing of individuals, their families, and our communities.

This bill creates a timeline and process for increasing investment in behavioral health expenditures, using the Health Policy Commission's (HPC's) existing cost growth benchmark and annual Cost Trends hearings to guide the process. MAMH strongly supports this proposed increase in behavioral health expenditures. Currently, behavioral health services and supports represent too small a portion of total medical expenditure (TME) in the Commonwealth. Given the high and increasing prevalence of these conditions in the population, increased investment over the long term is imperative.

Failing to address behavioral health conditions at their onset, which, for the majority of conditions, occur between ages 14 and 24, has and will continue to have serious impacts on individuals, families, and communities.¹⁻² These impacts include but are not limited to the development of multiple chronic health conditions, poverty, homelessness, and incarceration. According to the Substance Abuse and Mental Health Administration (SAMHSA), only a fraction of those needing treatment for a substance use condition (13.0%) and any mental health condition (42.6%) receive treatment.³ Given its historical under-investment, the behavioral health system routinely misses opportunities to treat emerging conditions among children, adolescents, and their families before clinical status deteriorates and threatens healthy development.

In addition to the timely treatment of emerging conditions, investing in upstream behavioral health services prevents avoidable and more costly acute, specialty, and emergency care. With judicious investments in gaps in specialty care (e.g., care for those with co-occurring behavioral health and autism spectrum disorder), expansion of integrated behavioral health and primary care, and attention to inadequate reimbursement rates, TME could be rebalanced in a way that incentivizes screening, early intervention, and addressing problems at their root cause. The proposed investment in behavioral health care represents an important first step toward sufficient investment in a comprehensive health system that acknowledges and addresses the critical intersection between physical and behavioral health. The two are inextricably linked, and for too long the silos and fragmentation in our health care system have failed to address whole person health. The proposal to increase spending on behavioral health by 30 percent over three years is critical to advancing the health of the people of our Commonwealth.

To inform this increase, a six-month task force, chaired by the HPC, will develop guiding principles and practice specifications that will assist health care entities in meeting their annual behavioral health expenditure target.

¹ World Health Organization. (2018). Retrieved from https://www.who.int/mental_health/world-mental-health-day/2018/en/.

² Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalance and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.

³ Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). National Survey on Drug Use and Health. Available at: <https://www.samhsa.gov/data/release/2017-national-survey-drug-use-and-health-nsduh-releases>.

This task force will be instrumental in helping health care entities understand concrete ways in which to increase spending on behavioral health care such as evidence-based practices in health promotion, prevention, and integrated care. Such as task force will also ensure that objectives align with the Legislature’s and Administration’s visions for systemic reform, that is, a stronger community-based system that addresses access, integration, and whole person care.

The chronic and longstanding underfunding of behavioral health services has created a system wherein there are significant barriers to timely and appropriate behavioral health care. These delays and barriers leave new behavioral health needs untreated, causing symptoms to escalate over time, resulting in many avoidable behavioral health crises. The behavioral health impacts of COVID-19 have yet to be fully understood, but the toll the pandemic is taking and will continue to take on individuals and families is severe. There has never been a more important need for timely access to behavioral health care. Measuring behavioral health expenditures and accordingly increasing investment in behavioral health care over the long term is crucial to building a system that meets the needs of individuals and families in the Commonwealth.

H.2081/S.1274, *An Act to better coordinate suicide prevention services, behavioral health crisis care, and emergency services through 988 implementation*

In October 2020, the U.S. Congress passed the bipartisan National Suicide Hotline Designation Act of 2020. This law creates 988 as a universal number for national suicide prevention and mental health crisis response, with a deadline of July 16, 2022, for 988 to be available nationwide. The intent of Congress is for states to fund local 988 systems through small levies on telecommunications bills, similar to the way states fund 911. States also have flexibility and opportunity in implementing 988, that is, to transform crisis response services – emergency services programs/mobile crisis response, suicide prevention hotlines, and 911 (in cases where there is threat of imminent harm or death) – to an effective and coordinated system of care. In Massachusetts in particular, there is opportunity to build on the “Front Door” concept presented by EOHHS in its Roadmap for Behavioral Health Reform in planning, designing, and implementing 988 crisis response services in our Commonwealth.⁴

Too many people are involuntarily hospitalized, arrested, injured, or killed by police due to mental health or substance use conditions (together, behavioral health conditions) and related unmet social service needs. As a result of under-investment in behavioral health treatment and social supports like housing, individuals and their families increasingly find themselves in crisis with nowhere to turn but 911. Our 911 emergency response system in Massachusetts is designed for health emergencies, fires, and criminal activity. However, behavioral health and social service emergencies are not well handled by an ambulance, a fire truck, or a police officer. Too often, the response to a behavioral health emergency results in a decidedly un-therapeutic result.⁵

When a 911 operator dispatches law enforcement officers, the individual in crisis might feel threatened and/or traumatized. Police often do not have the de-escalation tools they need for this situation, and instead use the tool they have and are trained to use, that is, force. The person in crisis can end up injured, arrested, or killed. Ambulance personnel are often untrained in working with individuals in a behavioral health crisis using de-escalation techniques and defer to police as they resort to restraint. People with behavioral health conditions are 16 times more likely to be killed by police than the general public.⁶ In a survey of police chiefs in Middlesex

⁴ MA Executive Office of Health and Human Services. February 2021. Roadmap for Behavioral Health Reform. Retrieved from <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

⁵ Massachusetts Association for Mental Health (2021). Criminal Legal System Diversion: Creating a Behavioral Health Emergency Response System. Accessible at: <https://www.mamh.org/library/criminal-legal-system-diversion-creating-a-behavioral-health-emergency-response-system>.

⁶ Treatment Advocacy Center (2015). *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*. Accessible at <https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>.

County Massachusetts, the Middlesex County Restoration Center Commission found that up to 75% of officer time may be spent on behavioral health calls for service, though only about 6% of those calls for service are catalogued as such in 911 call logs and dispatch codes.⁷

This mismatch between the type of need and the type of dispatched responder is a contributing factor in the high level of disparity in the arrest of individuals with behavioral health conditions. Among prisoners in Massachusetts, 36% of male and 81% of female prisoners have a mental health condition, while 28% and 75% respectively have a serious mental health condition.⁸ Similarly, between 60 and 70% of Massachusetts youth in the custody of the Department of Youth Services (the juvenile justice carceral entity) have been found to have at least one mental health condition.⁹ The disparity among individuals with behavioral health conditions being over-represented in the criminal legal system is highly related to the racial and ethnic disparities in that system: among incarcerated people with a mental health condition, non-white individuals are more likely to be held in solitary confinement, be injured, and stay longer in jail.¹⁰ Jails and prisons are intentionally places of significant liberty restrictions and, often, of trauma, which is widely understood to be highly correlated with mental health symptoms.¹¹ Behavioral health symptoms can thereby be exacerbated by institutional settings, increasing the likelihood of potential future encounters with emergency services and repetition of this cycle.

A traditional medical response that can be dispatched in response to a 911 call also is not ideal: the individual in crisis might be transported to an Emergency Department (ED) with the goal of evaluation and hospitalization. For a number of reasons, including a lack of community crisis stabilization options and a shortage of available psychiatric hospital beds, the person may spend days or even weeks in the ED with no psychiatric treatment waiting for that hospitalization.¹² This time spent untreated, waiting for a hospital bed is referred to as “ED boarding,” and in addition to being traumatic for the individual, it is expensive and resource-consuming for the health care system. Further, hospitalization itself is often not necessary to treat a mental health emergency; some hospitalizations could be avoided entirely or diverted to alternative levels of care including crisis stabilization, intensive outpatient, in home services, and respite capacity, with appropriate levels of supports and staffing.

The good news is that enhancements are being made to the community-based behavioral health system to better support individuals and families in crisis. In February 2021, the Executive Office of Health and Human Services (EOHHS) released a “Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it.” Elements include Community Behavioral Health Centers with access to real-time urgent care services; a new regional crisis system embedded within Community Behavioral Health Centers that will deliver 24/7 community and mobile crisis intervention; and new Community Crisis Stabilization (CCS) services for youth to provide short-term, intensive 24-hour treatment, expanding a service currently only available for adults.¹³

Innovations are also happening at the intersection of policing and behavioral health crisis response. The

⁷ Middlesex County Restoration Center Commission (2020). *Year Two Findings and Recommendations*. Accessible at <https://www.mamh.org/library/middlesex-county-restoration-center-commission-year-two-findings-and-recommendations>.

⁸ Massachusetts Department of Correction Research and Planning Division (2020). *Prison Population Trends 2019*. Accessible at <https://www.mass.gov/doc/prison-population-trends-2019/download>.

⁹ Grisso, Thomas & Davis, Maryann & Vincent, Gina. (2004). *Mental Health and Juvenile Justice Systems: Responding to the Needs of Youth with Mental Health Conditions and Delinquency*.

¹⁰ National Alliance on Mental Illness (2021). *Mental Health By the Numbers*. Accessed at <https://www.nami.org/mhstats>.

¹¹ Angela Sweeney, Beth Filson, Angela Kennedy, Lucie Collinson, and Steve Gillard (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances*, vol. 24(5): 319-333. Doi: 10.1192/bja.2018.29.

¹² For an analysis of the causes of ED boarding, see Stefan, Susan, *Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements* (2006) Oxford University Press, [https://books.google.com/books?id=XAESDAAAQBAJ&lpg=PR7&ots=aQ2aw4MrDQ&dq=Susan%20Stefan%](https://books.google.com/books?id=XAESDAAAQBAJ&lpg=PR7&ots=aQ2aw4MrDQ&dq=Susan%20Stefan%20).

¹³ Massachusetts Executive Office of Health and Human Services. (2021). *Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it*. Available at: <https://www.mass.gov/doc/stakeholder-presentation-on-the-roadmap-for-behavioral-health-reform/download>.

Middlesex County Restoration Center Commission, which I co-chair with Sheriff Peter Koutoujian, is in its third year of analytic research and implementation planning to create an urgent care, crisis reception, and stabilization center to which police, ambulances, or individuals can bring an individual as an alternative to jail or emergency room care. An initial operating budget of \$1 million and a trust fund set to receive federal and foundation grants is included in the FY22 state budget thanks to the leadership of the Legislature. Just last week, the *Boston Globe* ran a story on the City of Lynn's \$500,000 allocation in its budget for an unarmed crisis response team. "Its purpose is to provide a behavioral health response to 911 calls when there's not a worry of either a medical emergency or injury to self or others."¹⁴ Under the leadership of Dr. Sarah Abbott, Advocates Inc. developed a pre-arrest Co-Response Program that now operates in multiple police departments across the Commonwealth. "Clinicians train and work alongside police officers to help respond to crises and determine appropriate outcomes... Police departments report that the number of re-occurring calls has decreased as people are referred to more appropriate services."¹⁵ Likewise, there is also \$9 million in the Department of Mental Health (DMH) FY22 budget to support similar initiatives to divert individuals in behavioral health crisis away from the criminal justice system.

Even with the best systems in place, some individuals will still have a behavioral health crisis. We must be prepared to respond to a crisis without causing further trauma to the individual and setting up the individual to succeed after the crisis. To do this, we must create a specific behavioral health emergency response system. First, the separate behavioral health crisis phone number – 988 – would provide an alternative to the 911 emergency system, which is forced to handle situations it was not designed for. 988 would open the door to a suite of services that could be deployed as needed to meet the specific needs of individuals and families and would be designed to favor the least restrictive possible setting to reduce the trauma experience.

H.2081/S.1274, *An Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation*, helps facilitate this for our Commonwealth by:

- Requiring the Secretary of EOHHS to designate a crisis hotline center (or centers) to provide crisis intervention services and crisis care coordination to individuals who call 988, 24 hours/day, 7 days/week. 988 shall include chat and text functionality.
- Requiring EOHHS and EOPPS to develop regulations to allow for information sharing and community across crisis and emergency systems for real-time response.
- Requiring the hotline center(s) to provide linguistically and culturally competent care.
- Financing 988 through the creation of a Behavioral Health Crisis and Suicide Prevention Trust Fund. The Secretary of EOHHS shall establish a fee on each resident that is a subscriber of commercial mobile and/or IP-enabled voice services at a rate that provides for the robust creation, operation, and maintenance of a statewide 988 number.
- Creating a 988 Commission to accomplish the planning required for implementation and ongoing oversight. The 988 Commission shall review national guidelines and best practices and make recommendations for implementation of 988 in Massachusetts by December 31, 2021, for implementation by July 2022.

It is critical to move this bill expeditiously through the Legislature, as its passage is required for Massachusetts to fund and implement 988 before the federal government sets aside the number in July 2022. Likewise, planning and implementing 988 in our Commonwealth presents a tremendous opportunity to address our largely ineffective and fragmented behavioral health crisis response. 988 in conjunction with the "Front Door" in EOHHS' Roadmap can help foster an alternate response by trained behavioral health professionals instead of law enforcement whenever possible, avoiding unnecessary traumatization, arrest, injury, and even death.

¹⁴ Scott, Ivy (11 July 2021). *Lynn allocates \$500,000 to set up an unarmed crisis-response team*. Boston Globe. Available at: <https://www.bostonglobe.com/2021/07/11/metro/lynn-allocates-500000-set-up-an-unarmed-crisis-response-team/>.

¹⁵ Advocates. *About our Co-Response Jail Diversion Program*. Available at: <https://www.advocates.org/services/jail-diversion>.

H.2083, An Act relative to behavioral health urgent care

COVID-19 created unprecedented levels of behavioral health needs, especially among young people. The Centers for Disease Control and Prevention (CDC) reported that almost 75 percent of people aged 18-24 reported at least one adverse behavioral health symptom due to the COVID-19 pandemic and that roughly 1 in 4 seriously considered suicide.¹⁶ Just last month, the CDC reported that visits to emergency departments for suspected suicide attempts for adolescent girls increased roughly 50 percent in early 2021 compared with the same period in 2019.¹⁷

Even prior to the pandemic, research demonstrated that approximately one in five children and adolescents experienced the signs and symptoms of a diagnosable mental health condition each year.¹⁸ Moreover, we know that 50 percent of all behavioral health conditions onset by age 14 and 75 percent onset by age 24.¹⁹⁻²⁰ At a time when our understanding of the importance of getting upstream of life threatening behavioral health crises has been thrown into high relief by the pandemic and its increased demands on our hospitals' emergency departments, we need to take swift action to implement behavioral health urgent care.

As the COVID-19 pandemic continues to impact children and youth, the Commonwealth must be prepared to support these emerging and exacerbated behavioral health concerns. Urgent care is a key strategy for addressing emerging behavioral health crises at the earliest possible time and reducing the need for children to access care for acute behavioral health needs in an emergency department (ED).

When children and families seek emergency behavioral health care in EDs and are evaluated to require inpatient psychiatric care, they are often left waiting for days or even weeks, referred to as ED boarding. Boarding among children and youth is significantly worse than boarding for adults. In 2020, children who boarded engaged in the Expedited Psychiatric Inpatient Admissions (EPIA) process (run by the Department of Mental Health) experienced increased wait times compared with 2019 (2.1 days in 2019, 3.3 in 2020). Adults between 18 and 64 did not experience a change in wait time from 2019 to 2020 (stable at 1.8 days). Therefore, children are now waiting approximately 1.5 days longer for a placement than adults.²¹ Within the child and adolescent population, children with Autism Spectrum Disorder/Intellectual and Developmental Disabilities (ASD/IDD) are most likely to board and to board for longer than their neurotypical peers, sometimes waiting months for an appropriate placement (data not typically captured in the EPIA process). Urgent behavioral health care is key to addressing emerging behavioral health crises and ensuring children and families can access timely and appropriate treatment.

EOHHS Secretary of Health and Human Services, Marylou Sudders, recently released the Roadmap for Behavioral

¹⁶ Czeisler MÉ, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1049–1057. DOI: <http://dx.doi.org/10.15585/mmwr.mm6932a1external icon>.

¹⁷ Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:888–894. DOI: <http://dx.doi.org/10.15585/mmwr.mm7024e1>.

¹⁸ Centers for Disease Control and Prevention. Mental health surveillance among children – United States, 2005–2011. *MMWR* 2013;62(Suppl; May 16, 2013):1-35.

¹⁹ World Health Organization. (2018). Retrieved from https://www.who.int/mental_health/world-mental-health-day/2018/en/.

²⁰ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.

²¹ EPIA Dashboards. 2021. The Department of Mental Health. Retrieved from <https://www.mass.gov/lists/epia-dashboards>.

Health Reform that incorporates urgent care into the enhanced services continuum.²² To implement a system of behavioral health urgent care, there are many regulatory changes that must occur. A key component is the creation of regulations for urgent care centers by the Department of Public Health (DPH). Currently, urgent care centers are not regulated and therefore do not have specific requirements for the care that they provide. This legislation would not only require that DPH regulate existing urgent care clinics through a licensing process, but that it would also require expansion of the services provided in urgent care clinics to include behavioral health. Behavioral health services provided in these settings must be provided by qualified behavioral health clinicians and such services shall include evaluation and stabilization services and referrals to appropriate treatment in community or inpatient care. Importantly, this legislation also requires urgent care centers to coordinate behavioral health care with patients' primary care providers and/or existing behavioral health providers. By expanding settings in which urgent behavioral health services are offered, children and families will have access to necessary services both before an emergency even occurs and during behavioral health crises that do occur.

S.1275, An Act establishing an Office of Behavioral Health Promotion

Behavioral health promotion and early intervention are essential. As stated earlier, we know that 50 percent of all behavioral health conditions onset by age 14 and 75 percent onset by age 24.²³⁻²⁴ Parents often report concerns about their children before the age of 5.²⁵ Early onset of mental, emotional, and behavioral concerns has been shown to be correlated with lower education achievement and increased likelihood of involvement with the criminal justice system.²⁶ The good news is that there are both evidence-based and promising policies, programs, and practices aimed at reducing risk for developing behavioral health conditions and increasing strengths that can reduce the number of new conditions and significantly improve the life trajectories of young people.

Unfortunately, there is currently no dedicated staffing or office to set goals, engage in planning, integrate health equity principles, implement and/or coordinate programs, or evaluate behavioral health promotion activities for the Commonwealth. What has resulted is a fragmented approach across numerous executive offices, state agencies, independent agencies, and state commissions. The numerous behavioral health awareness campaigns that have run out of multiple agencies in the past year are a recent example: "What If?" campaign to combat loneliness from the Department of Mental Health; "HandHold" for parents and caregivers from the Massachusetts Department of Mental Health, Office of the Child Advocate, and Executive Office of Health and Human Services (EOHHS); "Isaac's Story" for children with behavioral health conditions and their families; "More to the Story" by the Department of Mental Health to encourage conversations; "State Without Stigma" to fight the stigma associated with opioid addiction by the Bureau of Substance Addiction Services; "Just Ask" to encourage help seeking funded by EOHHS and managed by MAMH. All these campaigns are extremely important, and a centralized office would be instrumental in optimizing strategy, messaging, coordination, and resources.

²² MA Executive Office of Health and Human Services. February 2021. Roadmap for Behavioral Health Reform. Retrieved from <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

²³ World Health Organization. (2018). Retrieved from https://www.who.int/mental_health/world-mental-health-day/2018/en/.

²⁴ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.

²⁵ National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington (DC): National Academies Press (US); 2009. 1, Introduction. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK32773/>

²⁶ Institute of Medicine. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board on Health Care Services. Washington, DC: The National Academies Press; 2006b. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.

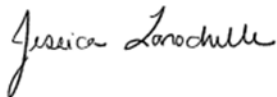
S.1275, *An Act establishing an Office of Behavioral Health Promotion*, establishes an Office of Behavioral Health Promotion within EOHHS to coordinate activities, set goals, and facilitate interagency collaboration on the promotion of behavioral health and wellness in the Commonwealth. The office will set goals for promotion and the prevention of mental health conditions, while integrating health equity principles and a health equity lens into all of its work. The office will facilitate the development of interagency initiatives informed by the science of promotion and prevention, advance health equity and trauma-informed care, and address the social determinants of health. The office will also provide needed staffing support for the EOHHS Community Behavioral Health Promotion and Prevention Commission. In sum, the bill will create infrastructure within state government for behavioral health promotion and prevention and promote coordination across multiple state agencies.

Please do not hesitate to be in contact should you have questions, would like additional information, or if MAMH can serve as a resource to your critical work at dannamauch@mamh.org and jessicalarochelle@mamh.org. We urge you to report these bills favorably out of Committee. Thank you.

Sincerely,



Danna Mauch, PhD
President and CEO



Jessica Larochelle, MPH
Director for Public Policy and Government Relations