The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Mental Health
25 Staniford Street
Boston, Massachusetts 02114-2575

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

BROOKE DOYLE
Commissioner

(617) 626-8000
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February 14, 2025

The Honorable Aaron Michlewitz, Chairman
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Dear Chairman Michlewitz:

As required in the Fiscal Year 2024 Budget Line Item 5046-0000, Chapter 165 of the Acts of 2014, Establishment of Outpatient Commitment Program and Reporting Requirement, enclosed please find the Department of Mental Health's report on the progress and results of the pilot program, Enhanced Outpatient Treatment Pilot in Fiscal Year 2024, formerly named the Assisted Outpatient Treatment Pilot.

I appreciate the assistance our agency has received from you and your staff. Please do not hesitate to contact me if you need additional information.

Sincerely,

Brooke Doyle

Brooke Doyle, M.Ed., LMHC
Commissioner

cc: Katherine O'Reilly, Budget Director

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The Honorable Michael J. Rodrigues, Chairman
Senate Committee on Ways and Means
State House, Room 212
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cc: Christopher Marino, Budget Director

THE OFFICE OF

GOVERNOR MAURA T. HEALEY

LT. GOVERNOR KIMBERLEY DRISCOLL

Kathleen E. Walsh

SECRETARY OF THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Brooke Doyle

Commissioner

Enhanced Outpatient Treatment Pilot

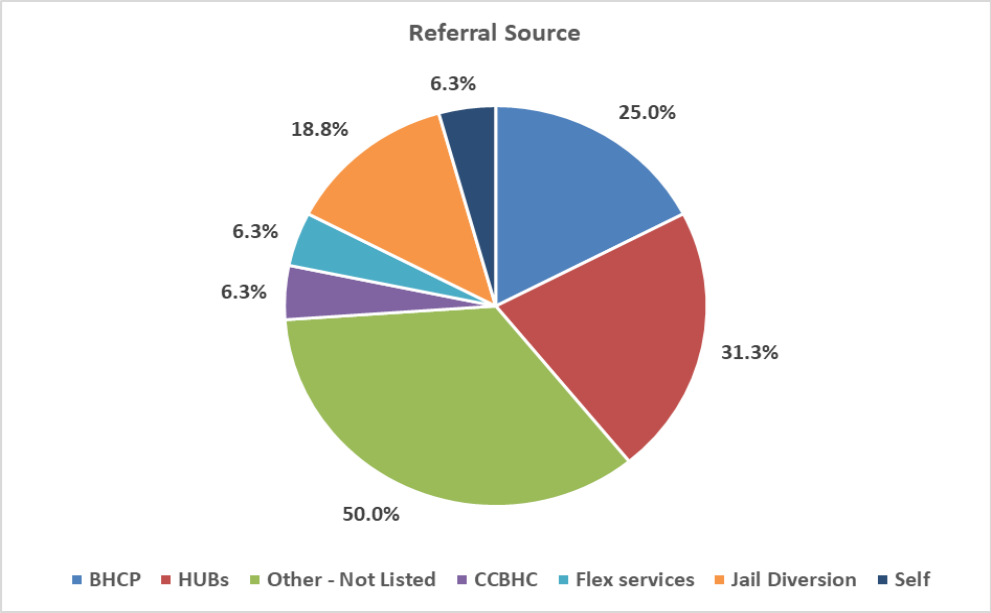
Fiscal Year 2024

February 2025

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

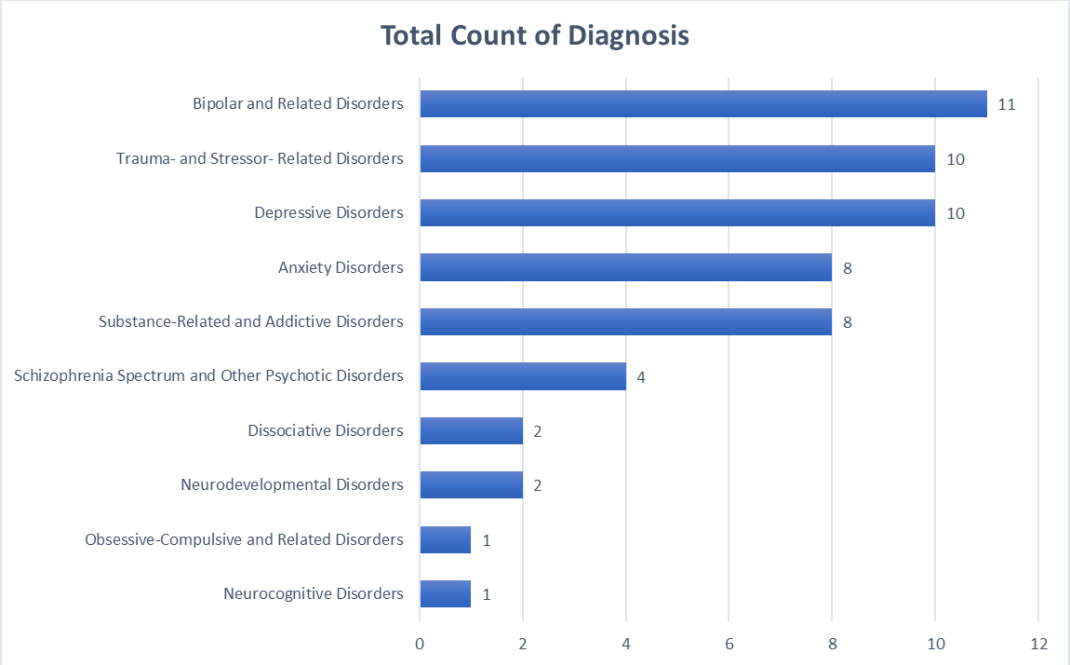
Enhanced Outpatient Treatment

The Department of Mental Health's (DMH) Enhanced Outpatient Treatment (EOT) program, in partnership with Eliot Community Human Services, focuses on providing assertive community outreach, engagement and support to the most under-served behavioral health population in the greater Metro North area. The Eliot EOT team is multidisciplinary and includes a Clinical Coordinator (LMHC), a Nurse Practitioner (PMNHP), Case Managers (BA) a certified Recovery Coach and a Peer Specialist. EOT referrals are not insurance based which frees the team from potential fee-based restrictions, utilization demands and limitation on referrals to the program. In turn, this allows team members to focus on consistent engagement based on an individual's personalized needs, and their motivation and readiness for change. This low threshold approach to enrollment allows police departments, community mental health collaboratives (HUBs) and traditional providers struggling to support and engage clients to refer to EOT. In fact, of the 23 new admissions to EOT this past year, 31.3% were referred by police departments or HUBs and 50% were referred directly by community providers. In 2023 the average length a client was active in EOT by discharge was approximately 1.09 years.



Of the individuals served, 60% experienced a dual diagnosis of trauma related and substance abuse disorders, resulting in compounding needs including:

- Homelessness and unstable housing;
- Mental health acuity resulting in reliance on Emergency Services and Emergency Departments;
- Current or past involvement with the criminal justice system;
- Disengagement and lack of health providers and health care;
- Poor social determinants of health; and
- Loss of community and natural supports.



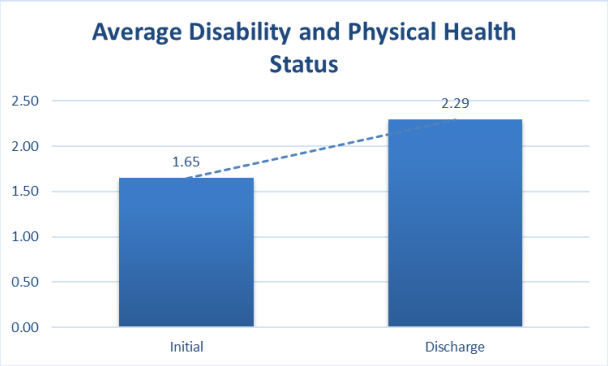
This target population demonstrates a great need for services; yet traditional behavioral health treatment that would reduce stress, experience of symptoms and reliance on emergency-based services are not effective at promoting engagement. This population often needs immediate access to treatment services and community supports due to struggles navigating the behavioral health and larger health system. Even with the implementation of Accountable Care Organizations (ACOs) and Behavioral Health Community Partners (BH CPs), and Community Behavioral Health Centers (CBHC) we have seen that this population struggle to engage with care coordination teams. This not only includes difficulty maintaining appointments with their Primary Care Physicians (PCPs) and assigned ACO, BH CP and OneCare care coordinators, but difficulty engaging with these entities to even start services. The EOT team has focused on creating partnerships with care coordination entities as a means to increase EOT individuals access to care.

The team outreaches and engages clients in the community, at their homes, or wherever they are to ensure services are provided. Engagement is the core strategy to deliver services and includes:

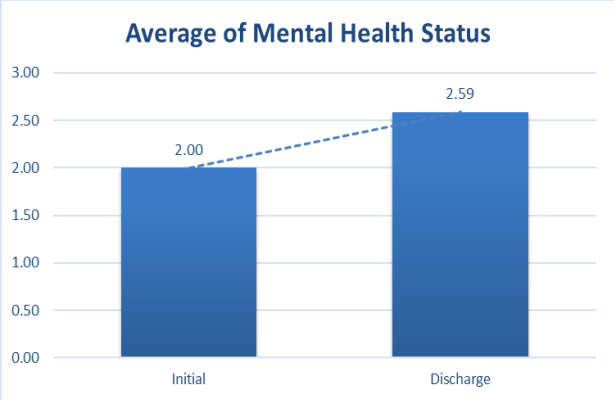
- In person outreach with consistent in-person follow up;
- Transportation;
- Assistance with accessing stable food and housing resources;
- Immediate and in time addiction services including recovery coaching and Medication Assistance Treatment; and
- Support and advocacy within the criminal justice system.

The EOT team's engagement strategies and approach to each individual has resulted in improving the services and supports available to each individual serviced. Compared to admission, EOT clients have seen up to a 90% increase in accessing benefits, including Food Stamps, SSDI, SSI, EAEDC, and Rep Payee services.

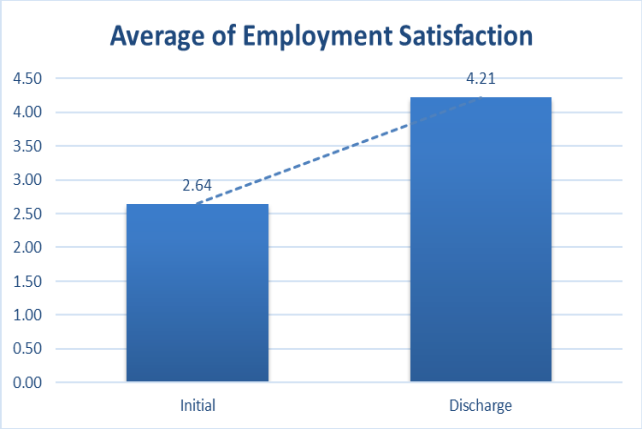
The following includes information about service outcomes that were derived from an outcome tracking measure that Eliot developed. EOT staff administer the outcomes measure directly with clients at 6-month intervals. The responses are based on a scale from 1 to 5, with 1 being in crisis and 5 as thriving. (Tool is attached for review).



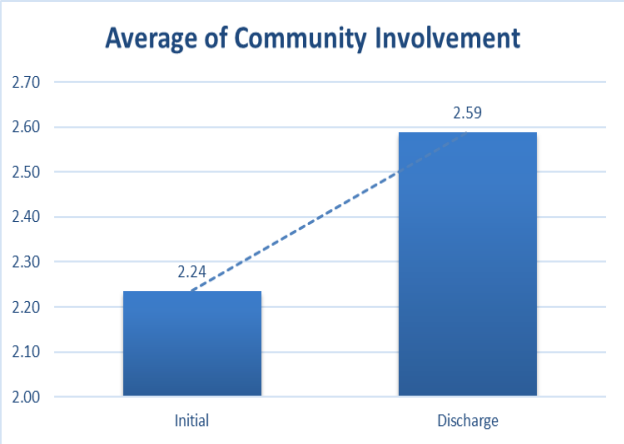
At admission, most clients identified being in crisis level and that acute or chronic symptoms were affecting housing, employment, social interactions, etc. Upon discharge, clients identified as being safe and that their medical symptoms were rarely affecting housing, employment, and social interactions.



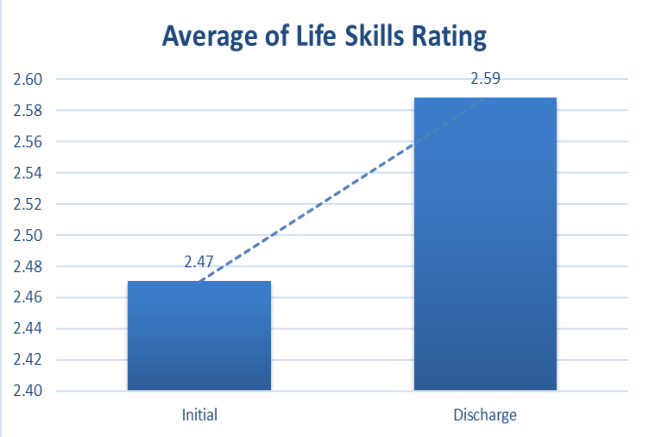
At admission, most clients identified being in crisis level, meaning that they were a danger to themselves or others, experienced recurring suicidal ideation, and were experiencing severe difficulties in their day-to-day life due to their mental health. Upon discharge, clients identified as building greater coping capacity.



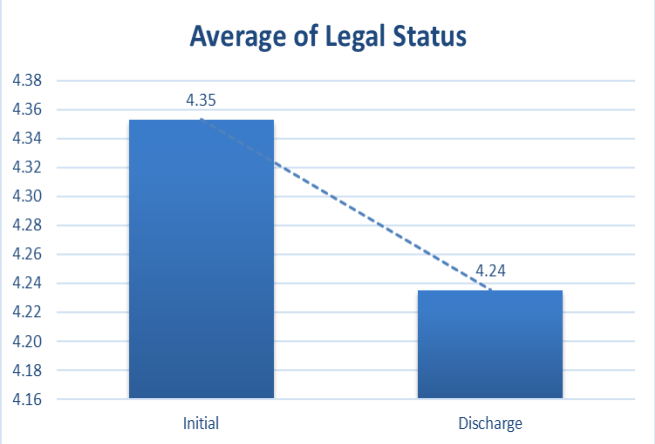
At admission, most clients identified being closer to crisis level, meaning they were unemployed. Upon discharge, they were employed full-time with adequate pay and benefits.



At admission, most clients identified being closer to crisis level, meaning they did not have community involvement due to being in "survival mode." Upon discharge, clients identified as having adequate social skills and motivation to engage with their community.

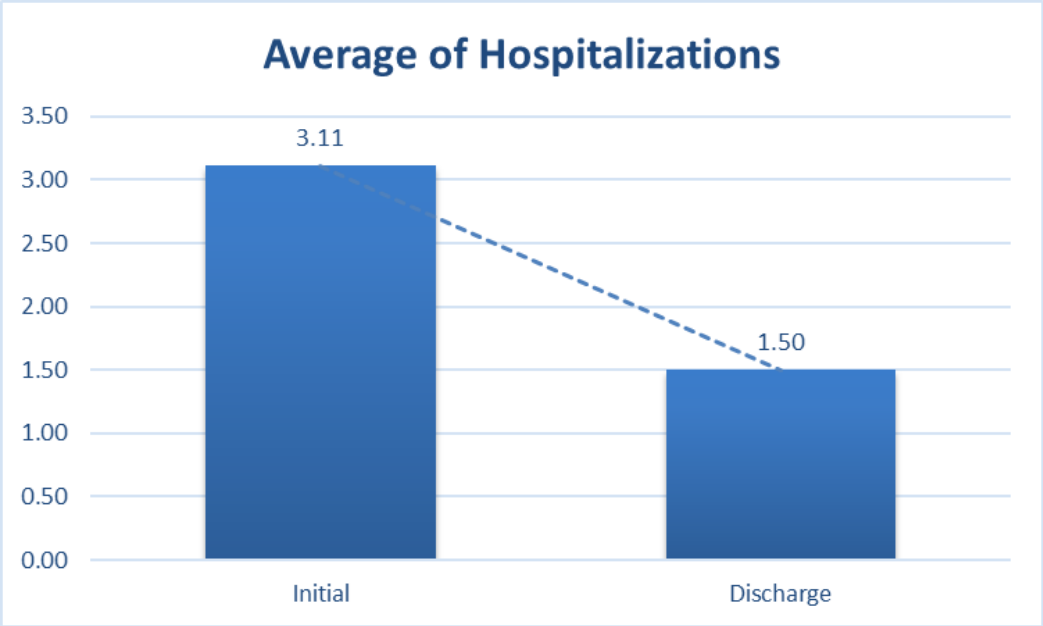


At admission, most clients identified being in crisis level, meaning that they were unable to complete any basic life skills without assistance. Upon discharge, clients identified as being able to complete between 2 and 3 skills without assistance.



At admission many EOT clients identify having legal status, which is often due to untreated SMI, homelessness, poverty and lack of natural supports. At discharge clients reported an improvement in their legal status due to accessing supportive resources through the EOT program.

EOT client hospitalizations have shown a significant decrease compared to utilization at admission:

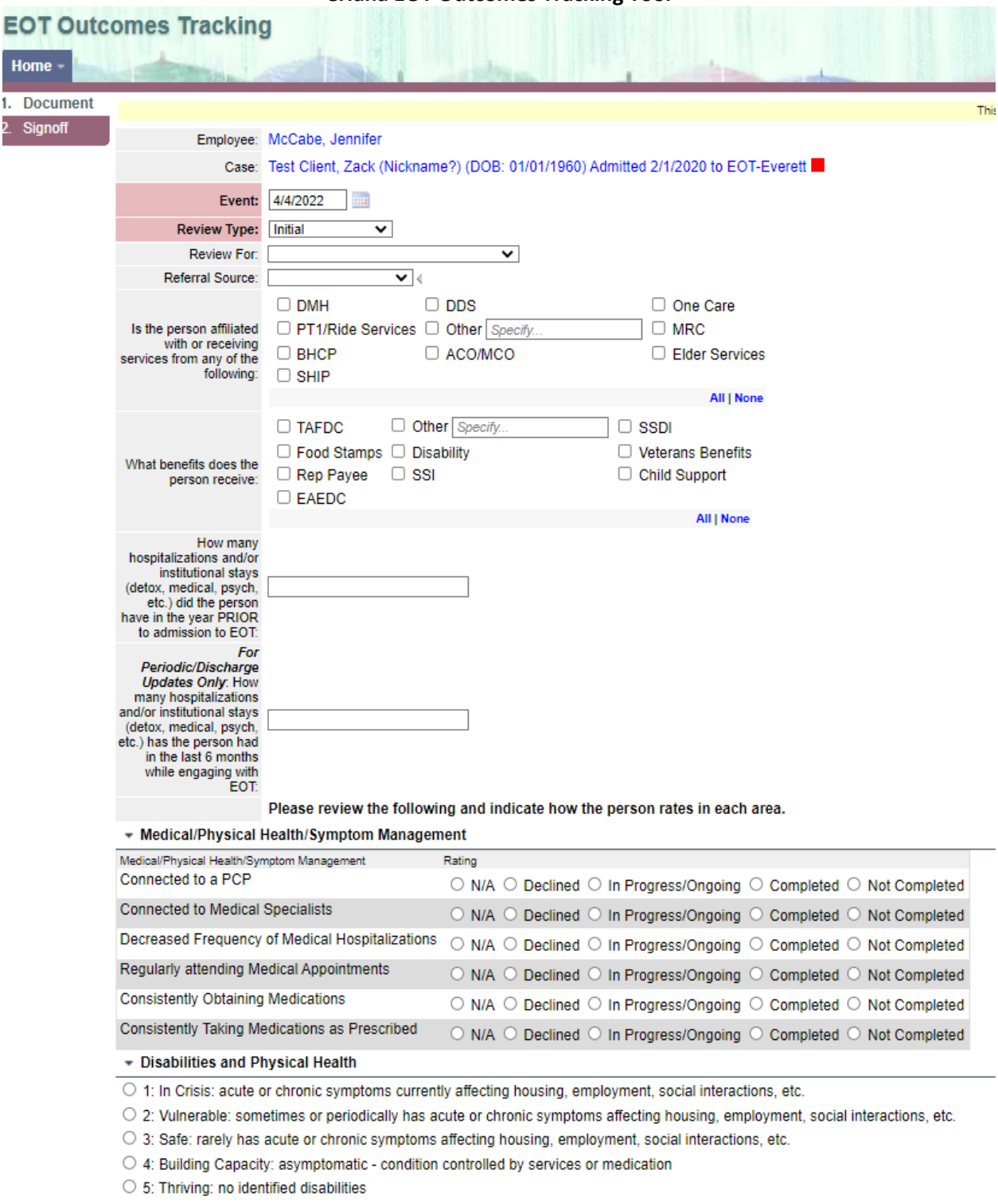


Over the past six years, EOT has seen an increase in the number of entities referring individuals for service and the number of individuals we have served on an annual basis. Additionally, since 2018, EOT has been able to partner with BH CP, ACOs, and OneCare providers to leverage and coordinate services. Even though Eliot's CCBHC program ended in October of 2023, the coordination with our new CBHC programs in Lynn and Danvers have created another new avenue for cyclical collaboration of referrals from them to EOT; as well stepping down EOT clients to a lower level of care in a team-based treatment environment, when appropriate.

In 2023, a total of 36 persons were served, of which 23 clients were newly enrolled in 2023, which is an increase compared to recent years and there have been several remarkable outcomes from the team's hard work. For example, EOT worked extensively with a client who was referred by Eliot's CCBHC program due to her complex needs and lack of engagement due to homelessness and executive functioning difficulties. The client had long-term homelessness when she was referred to EOT, complex PTSD, was a domestic violence survivor; and had major medical concerns which had resulted in emergency room admissions without follow up care. She had significant loss in her hierarchy of needs, was malnourished, pregnant, and living out of a tent with her dog and pet rat. It took the EOT team time to collaborate with internal and external resources to develop a workable treatment plan. After a lot of work with community partners and other Eliot departments, the EOT team was able to engage with the client, connect her to medical care and get her safely housed.

EOT has been able to maintain a high percentage of face-to-face contact with individuals served. During 2023, over 80% of EOT's services were provided face-to-face. As clients begin to stabilize and needs are met, they often decrease contact from daily to multiple times weekly, weekly, and down to biweekly as aftercare services are determined. In 2023, 85% of clients who were discharged, were discharged successfully. Successful discharges were most typically stepped down to outpatient services or were discharged to more long-term outreach services once stabilized, which including BHCP, OneCare, DMH, Mystic Valley Elder Services and CBHC.

Eliot Community Human Services, Inc.
eHana EOT Outcomes Tracking Tool



Psychiatric Presentation/Symptom Management

Psychiatric Presentation/Symptom Management	Rating
Connected with a Therapist	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Engaging in Therapy	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected with a Psychiatrist	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Attending Psychiatrist Appointments	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Mental Health

- ○ 1: In Crisis: Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to mental health problems
- ○ 2: Vulnerable: Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms
- ○ 3: Safe: Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems
- ○ 4: Building Capacity: Minimal symptoms that are acceptable responses to life stressors; only slight impairment in functioning
- ○ 5: Empowered: Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns

Substance Use/Abuse

Substance Use/Abuse	Rating
Engaging with Recovery Coach	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected with Medication Assisted Treatment (MAT)	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Regularly attending NA/AA/SMART Recovery Meetings	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Achieved Sobriety	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Achieved Intermittent Sobriety/Decreased Use	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Please indicate where the individual is in relation to the Stages of Change:

- ○ N/A
- ○ Precontemplative
- ○ Contemplative
- ○ Preparation
- ○ Action
- ○ Maintenance
- ○ Relapse

Housing

Housing	Rating
Submitted Housing Applications	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Access to Hygienic Living Conditions	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Achieved Temporary Housing	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Achieved Long-Term Housing	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Housing Status

- ○ 1: In Crisis: Homeless or threatened with eviction
- ○ 2: Vulnerable: In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of total income)
- ○ 3: Safe: In stable housing that is safe, adequate subsidized housing
- ○ 4: Building Capacity: Household is safe, adequate subsidized housing
- ○ 5: Empowered: Household is safe, adequate unsubsidized housing

Legal Issues/Concerns

Legal Issues/Concerns	Rating
Connected with a Lawyer	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Adhering to Probation Parameters	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Following Through with Court Obligations	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Legal

- ○ 1: In Crisis: Current outstanding warrants
- ○ 2: Vulnerable: Current charges/trial pending, noncompliance with probation/parole
- ○ 3: Safe: Fully compliant with probation/parole terms
- ○ 4: Building Capacity: Has successfully completed probation/parole within past 12 months, no new charges filed
- ○ 5: Empowered: No active criminal justice involvement in more than 12 months and/or no felony criminal history

Community Resources

Community Resources	Rating
Connected with Appropriate Cultural Resources	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected with Appropriate Religious Resources	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected with Community Centers	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected with Appropriate Coalitions	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected to Hobbies/Sports	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Community Involvement

- ○ 1: In Crisis: Not applicable due to crisis situation; in "survival" mode
- ○ 2: Vulnerable: Socially isolated and/or no social skills and/or lacks motivation to become involved
- ○ 3: Safe: Lacks knowledge of ways to become involved
- ○ 4: Building Capacity: Some community involvement (advisory group, support group) but has barriers such as transportation, childcare issues)
- ○ 5: Empowered: Actively involved in community

Risk Factors/Concerns

Risk Factors/Concerns	Rating
Using Crisis Lines/Service Appropriately	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected to Domestic Violence Resources	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Life Skills

Life Skills Options	Rating
Achieving ADLs	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Connected to Services to Support ADLs	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Learned Budgeting/Appropriate Money Management Habits	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Appropriately Advocating for Self	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Learned Time-Management Skills	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Learned Technology Skills	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Learned Problem Solving Skills	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Life Skills Rating

- ○ 1: In Crisis: Unable to meet basic needs such as hygiene, food, activities of daily living
- ○ 2: Vulnerable: Can meet a few but not all needs of daily living without assistance
- ○ 3: Safe: Can meet most but not all daily living needs without assistance
- ○ 4: Building Capacity: Able to meet all basic needs of daily living without assistance
- ○ 5: Empowered: Able to provide basic needs of daily living for self and family

Employment

Employment	Rating
Searching for a Job	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Volunteering	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Working Part Time	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed
Working Full Time	○ N/A ○ Declined ○ In Progress/Ongoing ○ Completed ○ Not Completed

Satisfaction

Rate your/the person's satisfaction with their employment status

- ○ 1: Not At All
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10: Full Satisfied
- ○ Declined to answer