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History, Principles, Context, and Approach: The Special Homeless Initiative of the Massachusetts Department of Mental Health

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UNDERSTANDING THE HI AND HOW IT HAS WORKED

INTRODUCTION

Preventing homelessness or ending it quickly for Massachusetts residents with serious mental illness (SMI) has been a strong element of the Department of Mental Health's agenda for approximately two decades. The Department of Mental Health (DMH, or the Department) estimates that the Commonwealth of Massachusetts is home to approximately 48,000 adults with SMI. Of these, the Department serves the most disabled and the poorest. Client incomes hover around 15 percent of the area median income. Most clients are not employed, and rely on SSI-SSDI benefits for their income. DMH efforts to prevent or end homelessness for its clients have been greatly strengthened since 1992, when the legislature passed the first Special Homeless Initiative (HI) legislation. HI provides resources to reduce the incidence of homelessness among people with SMI. Housing development, both specifically for homeless people and more generally for people with SMI, has been a strong component of the overall DMH effort and the major focus of HI investment specifically. Related aspects of DMH policies and practices include protocols for discharge planning, staff training to focus on housing issues, outreach to people with SMI living on the streets or in shelters, development of specialized shelters, and other aspects of homelessness prevention and intervention.

In the spring of 2006, after 15 years of HI funding, DMH decided to take a formal look at what the HI has accomplished. It commissioned an evaluation to examine a range of issues and impacts. The evaluation tasks have been divided into several categories, including HI process, resources leveraged with HI funds, outcomes for clients who live in housing generated by HI, and the costs of homelessness to public agencies before and after housing placement. This report, the first for the evaluation, covers the process issues of interest to the evaluation funders, including HI history, how the HI fits into the larger context of departmental services and strategies, how the HI has been run, what types of projects it has supported and what types of agencies it has enlisted as partners, how those projects are distributed around the state, and information about some special HI projects.

A companion report[1] describes federal, state, and local housing resources that DMH housing coordinators and housing providers have leveraged using HI resources in the 15 years since the HI began. The HI resources assure the agencies providing capital and operating resources that DMH will provide supportive services to tenants who are DMH clients. These housing arrangements help prevent or end homelessness for DMH clients or those who are eligible for DMH services by reason of the severity of their disability.

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[1] Meschede, T., H. Levine, and M.R. Burt. 2007. Housing Resources Leveraged by the Special Homeless Initiative of the Massachusetts Department of Mental Health, 1992-2006. Washington, DC: Urban Institute.

Other reports from this evaluation will focus on HI impacts on clients and public costs. They will describe the total number of people served through various HI and DMH mechanisms, now and in the past; service histories and outcomes for people served by projects with HI investment, and the cost of public services avoided because HI and associated resources were able to house people and reduce their use of costly crisis services.

This report, which sets the scene for understanding the HI's effects by describing its origins, goals, and operations, describes and analyzes many DMH funding streams and programmatic initiatives in addition to HI. We do this because an appreciation of the full scope of DMH's housing and homelessness-related efforts is needed to understand how HI fits in, and how it has been used strategically to fill gaps that other funding sources were less able to address. Looking at the larger picture of DMH efforts also serves to emphasize that preventing and ending homelessness by providing housing and supportive services is a Department-wide focus and that the resources the Department devotes to it extend well beyond the HI itself.

HISTORY OF THE HOMELESS INITIATIVE

DMH has been evolving its current discharge planning and community-based system of housing, including homelessness prevention and mitigation, since the late 1980s. In the early 1990s, advocates from shelters and the Massachusetts Housing and Shelter Alliance (MHSA) provided a key stimulus for the Department's increased focus on homelessness by documenting the significant number of people with SMI who sought help from emergency homeless shelters within days or hours of being discharged from inpatient psychiatric facilities. The first statewide Special Initiative to House and Serve Homeless Persons with Mental Illness, most often referred to as the Special Homeless Initiative or just HI, is generally regarded as having its genesis in SFY 1992 with the formal enactment and operational creation of the special initiative account (5046-2000). This coincided with adoption of the term "Homeless Initiative" both inside and outside of DMH to identify the overall effort. Development and passage of HI legislation was made possible by a significant level of support from key parties, including homeless advocates and shelter organizations that lobbied for it in various circles; the state administration, which supported DMH and included appropriation language in the state budget; and the legislature, which enacted the new effort.

A number of converging factors helped bring the HI to reality. These included DMH's implementation of aggressive plans formulated in the 1980s to close or downsize state mental hospitals and develop the progressive alternative of a community-based residential service and outpatient treatment system; identification in the late 1980s of dedicated community housing staff at DMH Central and Area Office levels who among other things were charged with pursuing homeless housing and services strategies; the local and national movement to deal with homelessness as evidenced by HUD programs under the McKinney Act and the growth of national advocacy organizations to which Massachusetts including DMH had ties; and the availability of information in Massachusetts from relevant task forces, study groups, research initiatives, and similar efforts that documented how and why homelessness among people with serious mental illnesses should be addressed and explicitly recommended that DMH set up housing-oriented homeless programs throughout the state but especially in the greater Boston area.

One of the more significant and perhaps most valuable platforms for launching the new Homeless Initiative was the pioneering work in housing development and supportive services carried out by the DMH Metro-Boston Area Office in the years preceding the HI's formal enactment. The Metro Boston Area Office had sponsored some of the state's first projects offering homeless services and housing to persons with serious mental illness and co-occurring disorders. In collaboration with the City of Boston and other local partners, it was later able to parlay this experience into successful pursuit of some of the very first HUD McKinney homeless assistance grants to Massachusetts for the Boston community.

This initiative first received funding in SFY 1992 with state resources of $1 million, followed by a $2 million appropriation in SFY 1993. Ongoing advocacy from MHSA and collaboration with DMH and the governor's office resulted in rapidly rising investment for the next several years. In 2001, funding reached approximately $21.7 million, but state budget constraints held HI appropriations to minimal or no increases for SFY 2001 through 2006. Since 1999, HI has been supplemented with an additional $1 million annually in DMH services funding explicitly devoted to this population (see table 1, which shows the total SFY funding for HI and the supplemental services). The stability of DMH HI and supplemental homeless funding levels during the last few years testifies to the state's commitment to support approaches to prevent or end homelessness for people with SMI, without which the allocation would most likely have been reduced along with many other state budget items. With support from both the administration and the legislature, DMH received an additional state appropriation of $2.75 million for the HI for SFY 2007 (July 1, 2006 ending June 30, 2007). This report does not include the new capacity and housing resources that this new appropriation adds to the base HI program.

Table 1: Special Homeless Initiative and Supplemental Services Funding, SFY 1992–2006

State Fiscal Year	Funding	State Fiscal Year	Funding
1992	$ 1.0 million	2000	$21.4 million
1993	$ 2.0 million	2001	$22.7 million
1994	$ 7.4 million	2002	$22.8 million
1995	$11.2 million	2003	$23.0 million
1996	$13.9 million	2004	$23.1 million
1997	$13.9 million	2005	$23.1 million
1998	$16.0 million	2006	$23.1 million
1999	$19.1 million	Total, 1992–2006	$243.7 million

DMH has used these HI and other department funds to purchase services, leverage additional funds for housing development with supportive services supplied by DMH, and focus increasing attention and resources on preventing and ending homelessness for the target population. In addition to funding, DMH commissioners have understood the need for housing and the difficulties of homelessness for people with SMI. These commissioners have proactively led the department forward to develop housing and systems to prevent and end homelessness for its target population.

PUBLIC POLICY PRINCIPLES AND RATIONALE BEHIND THE HI'S CREATION

Stimulus for HI came from a number of sources, but none was more urgent than the prospect that state hospital closings were moving thousands of DMH clients into the community. Without appropriate housing resources and supports, many might become homeless, and homelessness was already a reality for some. In early 1991 then-governor William Weld established the Governor's Special Commission on Facilities Consolidation of Health and Human Services Institutional Facilities. The report issued several months later offered a blueprint for this transition, trying to assure that quality of care and residential stability for clients who had relied on state hospitals would not suffer following community placement.

The facilities consolidation plan affected DMH and the Department of Mental Retardation equally; both began implementing its recommendations as soon as the report came out. DMH adopted several major goals in this effort, of which the most important was to assure that resources were used to provide the most appropriate quality of care to meet the needs of individual clients, at institutional release and continuing into the future. Even before the Governor's Special Commission convened, DMH had established a housing focus through a small staff at its central office and a Housing Coordinator in each Service Area. Their mission was to develop an effective community-based system of care, which did not exist at the 1990s began. By the time the facilities consolidation plan was issued, the DMH central office housing unit and DMH Area Housing Coordinators had already been working for several years to find appropriate housing resources from state and federal housing agencies and bring them to Massachusetts. But those resources were scarce, as were DMH resources to provide a service match.

Closing state hospitals and developing community-based alternatives was a major reorientation of government activity, and one that had the potential to leave some very vulnerable people on their own in the community. The Secretary of the Executive Office of Health and Human Services (EOHHS) took a strong personal interest in shaping and directing this effort, in addition to endorsing and supporting it in his official role. Along with advocates and providers, he reasoned that homelessness was a serious risk for people leaving state hospitals, and that DMH would need to identify dedicated resources to assure that both housing and relevant supportive services were available to reduce or eliminate this risk. Along with allies, he began to put together the details of what became the Homeless Initiative.

At about the same time as the governor's commission was doing its work, and before its results were published, the Massachusetts Housing and Shelter Alliance (MHSA) and Boston's Pine Street Inn decided to document the spike in homelessness among people with serious mental illness that followed the closing of Boston State Hospital. Pine Street Inn did a survey at shelter intake to see how many people arrived at an emergency shelter within a few days of being released from a state hospital. The numbers were substantial. Armed with the survey results, MHSA and individual homeless assistance providers lobbied the state legislature and worked with EOHHS and DMH representatives to obtain new homeless-related funding. DMH housing staff quickly recognized that the HI provided the resources to support clients in community-based housing that offered independent or semi-independent living rather than the group home model that prevailed up to the 1990s. At about that time HUD was just starting to issue grants

under the new Supportive Housing Program authorized by the 1992 amendments to the Stewart B. McKinney Homeless Assistance Act of 1987, giving DMH the opportunity to pursue these new federal funds in conjunction with HI resources.

The rationale behind the HI was to give DMH flexible funding to prevent or end homelessness among its clients. From the beginning it was obvious that HI would never have the resources to accomplish this goal by itself. The initial and continuing strategy has been to use HI resources to leverage other resources, and to fill gaps in what DMH otherwise funded with its substantial departmental resources not geared specifically to address homelessness. Initial funding of $1 million was seen as a pilot and a promise – "let's get started, and more money will follow as we see how it goes." As Table 1 has already reported, within four years HI funding had increased more than ten-fold (to $11.1 million), and doubled that figure within another five years.

In collaboration with a variety of partners, especially DMH providers, DMH housing staff actively pursue opportunities to develop community-based housing projects by offering service matching funds, through HI and other departmental resources, for applications to federal, state, and local agencies with housing resources. They have been very successful in these stimulating and brokering roles, which continue actively at this time. In later sections of this report, we describe the array of partners that have provided housing resources in collaboration with DMH. A companion report describes the actual types of levels of funding that HI has been used to leverage (see footnote 1).

In addition to the housing development that accompanies HI investment, concern about the housing status and risk of homelessness of DMH clients prompted the legislature to create several other housing-related funding streams that predated the HI's creation. These include DMH rental subsidies and the Chapter 689 housing development program. The Facilities Consolidation Fund (FCF) housing development began at about the same time as the HI. All are jointly administered by DMH and the Department of Housing and Community Development (DHCD) in whose annual budget these line items appear. DHCD distributes the funds on DMH's behalf to local housing authorities and other entities for use by approved projects and individual renters.

THE COMPREHENSIVE DMH HOMELESSNESS PREVENTION AND MITIGATION CONTEXT

DMH has invested heavily, both directly and indirectly, in addressing homelessness among persons with SMI.[2] Elements of homelessness prevention and alleviation are present throughout the department's multi-faceted system of inpatient and outpatient continuing care. Most of DMH's core services are relevant to homelessness associated with SMI; in addition, the department sponsors initiatives aimed at preventing first-time homelessness and assuring that people with SMI who do become homeless are able to leave homelessness for stable housing before their homelessness can become chronic. The department's homelessness prevention

[2] Much of this description is taken verbatim or with minor modification or reordering from documents provided by DMH.

efforts are supported primarily with state-appropriated funds and implemented in conjunction with federal resources. Many of DMH's efforts to prevent homelessness are conducted through contractual arrangements with nonprofit and for-profit providers. DMH housing and service resources are also used extensively to end long-term homelessness for persons "on the street" who already are or would qualify as DMH clients.

Some of DMH's activities and programs address primary prevention of homelessness—trying to avert a *first* episode and keep people with SMI stably housed. Housing development coupled with attending to housing at discharge is important because many people stay in DMH continuing care units for many months. They may have been housed upon admission but lose that housing while they are in the hospital. Primary prevention involves assuring that housing is available for them once they are ready to leave. Other DMH activities and programs address *secondary* prevention—quickly identifying people with SMI who become homeless and supplying housing and services to assure that their period of homelessness is short and does not happen again. Finally, DMH has made a considerable effort to end long-term homelessness by facilitating the development of permanent supportive housing programs. More recently, safe havens have been developed to offer no/low barrier enriched housing to people with SMI who are not yet willing to enter programs that require participation in services or adherence to a medications regime. DMH pursued development of each service component at the same time it was developing others. The components work simultaneously to prevent initial homelessness and to end homelessness quickly for those who do become homeless.

BECOMING A DMH CLIENT

Publicly-funded mental health services in Massachusetts are jointly managed by DMH and the Behavioral Health Program of MassHealth, the state's Medicaid managed care program. Individuals who qualify for services through MassHealth due to SMI or serious emotional disturbance are served by one of two means. Some individuals enroll in a health maintenance organization that becomes responsible for all of their care, including mental health services. Others choose to enroll in the Primary Care Clinician Plan (PCC Plan), a primary clinician option. In this case, services related to their behavioral health needs and the funds needed to meet those needs are "carved out" and managed by the Massachusetts Behavioral Health Partnership (MBHP). MBHP is a private for-profit managed care organization that is a division of Value Options, one of the nation's largest managed behavioral health organizations. MBHP provides a comprehensive continuum of mental health and substance abuse treatment, including outpatient therapy and medication, acute inpatient and day treatment services, partial hospitalization programs, family stabilization teams, and a range of substance abuse services. Nearly all DMH clients receive MassHealth benefits similar to those described above, but not through the PCC Plan. The CEO of MBHP works closely with both the Commissioner of Mental Health and the Deputy Commissioner of MassHealth Behavioral Health.

DMH is a provider and purchaser of "continuing care mental health" services, which begin after a course of acute treatment when that treatment cannot achieve adequate improvement in an individual's status. DMH community services are provided contingent on an individual's eligibility for DMH services. Eligibility for adults, adolescents, and children is based on one or more qualifying mental health conditions (e.g. major affective, psychotic, severe personality, and

eating disorders), the duration of the condition (one year or longer, observed or predicted), significant functional impairment due to mental illness, and a need for at least one service that is only available from DMH. DMH services include program and home-based residential care, wraparound services, case management, Programs of Assertive Community Treatment (PACT), homeless outreach services, supported employment, and other day and vocational services.

HOUSING SUPPLY AND DEVELOPMENT

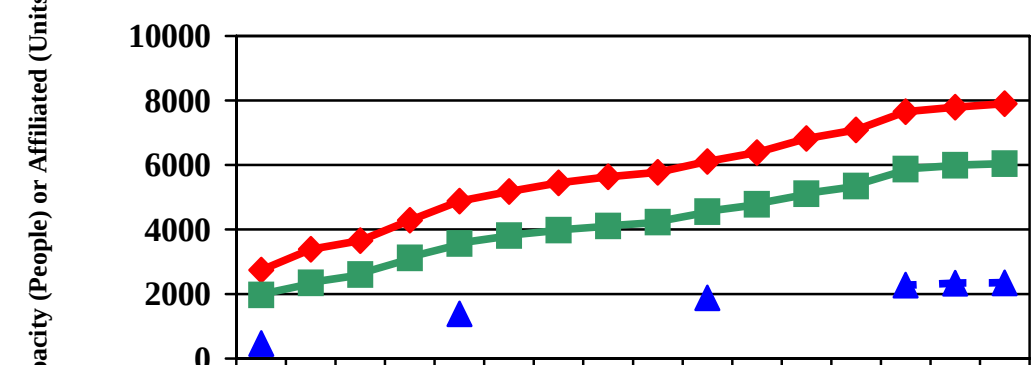
As of September 2006, DMH maintains 3,573 self-contained, mostly rental housing units of DMH-affiliated housing for people with SMI. At any given time, these units are able to house 6,039 people, with more people using the units over time as some leave and others move in. The Boston Metro Area has 2,278 DMH-affiliated housing units, with the remainder distributed throughout the state. Residents of this housing can receive a range of DMH supportive and other services as necessary and appropriate. Some of this housing is specifically targeted toward formerly homeless people, usually but not always in conjunction with the HI.

"DMH-affiliated housing" is any housing that DMH or its agents have been successful in providing or otherwise proactively securing for its clients by helping to build it, providing match money for grants and other financing, or other mechanisms. DMH-affiliated housing includes clients living independently under their own leases. The large majority of DMH clients have their own bedrooms and most have their own apartments. DMH uses the strict U.S. Census definition of a "housing unit," which may be a house, apartment, group of rooms, or single room occupied or intended for occupancy as separate living quarters. Separate living quarters are those in which the occupants live and eat separately from any other people in the structure and that have direct access from the outside of the structure or through a common hall, lobby, or vestibule that is used or intended for use by the occupants of more than one unit or by the general public. The Department therefore does not identify a housing unit in its Housing Inventory as a "bed" which is the traditional way of defining capacities in the mental health community. A DMH unit may have one or more beds.

In addition to DMH's affiliated housing stock as defined and described above, 1,858 other DMH clients receive DMH continuing residential community support services of several types while living in housing that DMH either did not secure or played a minor role in securing, such as by referring the client to a Section 8 wait list for subsidized units generally available in the local market. This additional non-DMH-affiliated stock brings to 7,897 the total number of people the Department served at the end of SFY 2006 through housing and services usually delivered in the resident's own home or that the resident is able to receive as necessary from the DMH community. Of the total number of DMH-affiliated and non-affiliated, permanent and transitional, self-contained housing units, an estimated 1,015 are connected to the Homeless Initiative (HI) affording DMH the capacity to house and serve 1,259 persons at one time (16 percent of the total). Over the course of a year, these additional housing resources serve about 2,400 people.

DMH has built up its housing inventory primarily since the early 1990s, and continues to add to it at every opportunity. The department's access to substantial resources through the HI and other community services initiatives has allowed it to provide services funding for many housing units to match the housing component most commonly supplied by federal resources (primarily the U.S. Department of Housing and Urban Development's (HUD) McKinney-Vento Homeless and Section 811 programs). DMH's statewide community residential capacity increased from 2,746 in 1991 to 7,897 in 2006, and DMH-affiliated housing went from an ability to accommodate 1,969 people to 6,039 people in the same period (see figure 1). In Metro Boston, capacity increased from 470 to the present 2,345 people (shown as separate triangles because not all data points are present).

Figure 1: Growth in DMH Residential Housing Capacity and Affiliated Housing Statewide, and Metro Boston Capacity SFY 1991-2006



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Capacity	2746	3386	3649	4291	4885	5180	5449	5629	5769	6108	6390	6822	7092	7651	7789	7897
Affiliated	1969	2342	2603	3119	3569	3815	3980	4112	4229	4558	4783	5105	5345	5869	5991	6039
Metro Boston	470				1389					1881				2278	2332	2345

RESIDENTIAL SERVICES OTHER THAN PERMANENT HOUSING

The HI has allowed DMH to serve and house an average of 2,400 homeless persons each year in approximately 1,400 units. In addition to extensive development of permanent supportive housing, HI has allowed DMH to enter into contracts with traditional shelters to provide supportive mental health services, to create five transitional shelters (DMH/TS) in the Boston area, and to develop several Safe Haven projects across the state, including two in Boston. All of these programs are intended as steps to help people with SMI who have become homeless to leave that condition as quickly as possible and avoid regressing. With many newly homeless people, these activities constitute secondary prevention efforts.

The four largest traditional shelters in the state, all in Boston, are operated by private agencies and have DMH-funded mental health services on site. These services help shelter guests directly,

but also make referrals to other services to help guests determine whether they are eligible for DMH continuing care services. If eligible, their prospects for ultimately becoming housed and receiving ongoing community supports through DMH increase substantially.

Metro Boston's DMH/TS programs, with a collective capacity of 165 beds, are affiliated with the area's mental health centers. Every effort is made to move homeless people with SMI from traditional emergency shelters and the streets to more appropriate settings, such as DMH/TS facilities. DMH/TS are better prepared than generic shelters to keep people with SMI safe and help them handle their mental health and other issues. Some people also come to DMH/TS from inpatient psychiatric units if another appropriate placement is not possible in the short term. DMH/TS facilities serve homeless people with SMI who are waiting for permanent housing or not yet ready and willing to participate in the Department's residential services programs. The goal in DMH/TS is for people to leave within 90 days, although average lengths of stay are approximately twice that goal, due in part to long stays of people who are difficult to place and the unavailability of suitable housing.

Safe Haven programs, another link in DMH's array of services, are aimed at reducing homelessness among people with SMI. These programs are mostly targeted toward chronically homeless people with SMI, typically with co-occurring substance abuse or other issues, and are not directly relevant to the present project's focus on primary or secondary prevention. Nine Safe Havens operate around the state and Metro Boston has recently opened its second Safe Haven as an enhanced facility offering services and housing referrals typically not found in traditional Safe Havens projects—three of its first eight residents are already moving into permanent housing. Another Safe Haven is under development in Metro Boston.

SERVICES IN SUPPORT OF STABLE HOUSING

DMH has devoted substantial resources to sustaining people with SMI in community-based living. These resources may offer primary or secondary homelessness prevention as part of treating people's SMI and helping to avert housing crises. These include Programs of Assertive Community Treatment (PACT) teams, which are programs funded jointly by MBHP and DMH that provide behavioral health services to MassHealth clients through a behavioral health carve-out arrangement, and other specialized services.

Programs of Assertive Community Treatment

In collaboration with MBHP, DMH has been actively developing PACT programs across the state. A nationally proven model for service delivery to adult clients with serious mental illness, PACT proactively offers outreach and highly individualized, flexible community supports customized to meet each client's needs through comprehensive service teams. PACT services are delivered to individuals in their own place of residence by a team of staff and are available as needed on a 24 hour, 7 days per week basis. PACT uses a comprehensive services approach that assists clients with both their mental health and other needs, including successfully maintaining housing and households. If appropriate for the client, assistance with finding employment or educational opportunities is offered.

Thirteen PACT teams funded with approximately $12.4 million in state resources each year serve approximately 750 people a year. PACT team efforts do not focus exclusively on homelessness and homelessness prevention, but they do address and prevent first-time or extended homelessness by helping people stay housed. Each PACT program sponsored by DMH and MBHP has a significant number of homeless or at-risk people in its caseload. PACT teams also work through their comprehensive services approach to prevent people with no homeless history from becoming homeless or at risk. Staffing standards for PACT teams require that the teams include employment and housing specialists.

Some PACT teams have collaborated with DMH housing staff to pursue grants related to homeless prevention or housing subsidies. DMH area offices often support the teams by providing them with access to the rental subsidy programs. Also, owners who know that a client without a rental history or with a poor rental history will be receiving PACT services are more readily convinced to rent to that client. Additionally, during the most recent fiscal year DMH obtained additional funding for PACT teams, which it tied to a requirement that the teams use some of the additional funds to help clients with housing, either through rental subsidies or deposits.

MBHP's Behavioral Health Care Services

MBHP manages mental health and addiction services for all people with MassHealth coverage who choose to participate in the Primary Care Clinician Plan for their medical care. Members go to their own doctor for physical health care, and to services paid for through MBHP for their behavioral health care. There are about 1,000,000 MassHealth eligibles in Massachusetts, of whom approximately 300,000 are enrolled in the PCC Plan and are therefore eligible to receive behavioral health services through MBHP. Of these 300,000, about 120,000 actually receive behavioral health services in any 12-month period. These people have the most complex needs, including homeless individuals and those with both mental illness and addictions problems.

Behavioral health service delivery occurs through a network of more than 1,200 credentialed inpatient, outpatient, and single-practice behavioral health providers, and is coordinated with more than 1,200 primary care clinicians. Services covered include inpatient and outpatient treatment, detoxification, medications management, and community support services.

Employment Services

As the majority of DMH clients are underemployed or not working at all, DMH sponsors several community-based employment programs to further employment or educational objectives for all clients. DMH contracts with private vendors to supply these services, which occur across the state but are concentrated in Metro Boston. The main types of services are Services for Education and Employment (SEE) and Community Support Clubhouses. SEE consists of 25 projects across the state that receive about $6.8 million annually in state funds. SEE projects help participants to secure employment in competitive settings, provide training, and address remedial, basic, or post-secondary education needs through flexible, individualized supports. In SFY 2005, SEE programs provided employment, training, and education services to over 1,500 persons, with 727 of them working during the year.

Community Support Clubhouses offer similar types of employment-related services as well as a "work-ordered day" in settings that include services and supports that extend well beyond employment-related activities. DMH allocates approximately $17.4 million each year to Clubhouses. Almost 1,800 individuals worked for pay during SFY 2005, with 1,223 employers participating.

Six SEE projects, two Clubhouse employment projects, and one other employment-related project have HI funding. We describe several of these at the end of this report, as HI projects with special focus.

DMH clients may also receive employment supports through PACT, along with other types of community support. For instance, in SFY 2004, among the 560 people served by the 13 PACT programs across the state, 123 were employed during the year, 40 were in educational programs, and 27 had participated in job training.

Specialized Services—Tenancy Preservation

DMH supports a range of specialized services, some with HI, some with other departmental monies, and some with seed money and staff time. In the first category is the Aggressive Treatment and Relapse Prevention Program (ATARP), described at the end of this report in the section on HI projects. In the third category is the Tenancy Preservation Project (TPP), which we describe here. Later reports will cover one or two additional projects with special focus in which HI has invested funds.

TPP began in Springfield as a pilot project jointly supported by the local Housing Court, MassHousing, DMH, DMR, the Department of Public Health, several local housing authorities, and the Mental Health Association, Inc. of Springfield. TPP was established to help tenants threatened with eviction because their mental illness, substance abuse, or cognitive disability led to lease violations and the exhaustion of landlord ability to handle the situation. Its goals have always been to preserve existing tenancies or to connect households to alternate and possibly more appropriate housing. If eviction prevention or relocation cannot be achieved, TPP refers to the local homeless outreach team for further work with the household. Evidence of the first TPP's success in preventing homelessness may be found in *Strategies for Preventing Homelessness*.[3] Following the success of the Springfield TPP pilot, similar projects were established in 13 of the 20 Housing Court jurisdictions throughout the state, with local nonprofit service providers playing the role of go-between or mediator to help resolve the housing crisis. Additional funding is being sought to expand the program to the remaining Housing Court jurisdictions.

Cases likely to be referred to TPP come into Housing Court when a landlord (either private or a housing authority) is planning to file eviction papers on a tenant after other efforts to resolve the issues have failed. The Housing Court judge, landlord, legal services staff, or other referring agency usually know or suspect that the tenant has a mental disability or other problems. They

[3] Burt, Martha R., Carol Pearson, & Ann Elizabeth Montgomery. 2006. Washington, DC: Department of Housing and Urban Development.

refer the person to TPP, where workers assess the situation, screen for eligibility, make referrals and establish linkages, and strive to stabilize the household through discussions and negotiations with housing managers, Housing Court mediators, relevant agencies, and the threatened tenants. The goal is to overcome problems that might otherwise result in loss of housing and potential homelessness through eviction or hospitalization.

DMH contributed a small amount of money to the Springfield TPP pilot, and continues to fund about 4 to 6 percent of its budget along with eight other funders. Other TPPs most commonly get their funding from MassHousing, DHCD, the Department of Transitional Assistance, and local housing authorities, but not from DMH. Following advocacy from a coalition of agencies and community advocates, $500,000 in new, additional TPP funding was appropriated in the state's FY 2007 budget.

Outreach and Referral

DMH sponsors outreach programs to streets, shelters, and other places where homeless persons may be found. These programs identify and engage individuals with mental illness and connect them to services and, ultimately, to residential programs and housing.

DMH uses federal Projects for Assistance in Transition from Homelessness (PATH) funding (approximately $1.4 million each year from DHHS's Center for Mental Health Services) for its statewide outreach, engagement, and referral activities, which mostly involve visiting adult homeless shelters across the state. Federal PATH funding is matched by $600,000 in state funds that include a significant portion from the HI. Clinical social workers offer eligible people on-site direct care, housing search and advocacy, and referrals to services such as housing, job training, literacy education, mental health and substance abuse services, and benefits and entitlements. People with SMI and a need for ongoing mental health services are referred to DMH to determine if they are eligible to enroll as a DMH client for continuing care services. During FFY 2005, PATH clinicians screened 8,152 individuals (up 55 percent from FFY 2003) and enrolled 4,674 as PATH clients (up 26 percent from FFY 2003).

PATH is an important mechanism for helping homeless people with SMI to receive the benefits to which they are entitled. Many homeless persons have SMI, and many people with SMI are or have been homeless. Many would qualify for SSI on the basis of their disability, but few among the homeless population actually receive this benefit (nationally, about 11 percent), or the Medicaid insurance that accompanies it. In late 2004, with technical assistance from the Center for Mental Health Services, U.S. DHHS, the DMH PATH program committed itself to increase the participation of homeless people in SSI by facilitating successful applications and otherwise helping clients with the application process. After spending some months in planning and training PATH staff, services began in early 2006. PATH staff provide assistance in completing SSI-SSDI applications to people with serious mental illness and co-occurring substance abuse disorders, and work closely with local Social Security Administration (SSA) staff to facilitate speedy, and positive, decisions. PATH staff also work with clients to help them *retain* their benefits, as many homeless people with SMI have had the experience of losing their benefits for one reason or another.

DMH has also funded a Homeless Outreach Team (HOT), partially supported by PATH funding, in the Boston Area for more than 15 years. Clinicians and homeless specialists search out homeless people with mental illness who are or could become eligible for DMH services, and encourage them to accept assistance from DMH or other sources. Team members visit shelters shelter and known street homeless populations in Metro Boston at least once a week. They connect eligible homeless people to DMH housing and residential services opportunities, as well as medical, psychiatric, and substance abuse treatment. They help people get public benefits such as SSI, prescribe and help regulate medications, help resolve any legal difficulties in which homeless people may find themselves, and help people fill out housing applications. HOT moves appropriate people from the generic shelter environment to DMH transitional shelters, where they have more privacy and can receive more intensive services to access permanent housing and address their behavioral health needs. HOT staff focuses on the smaller shelters, and DMH supplements its efforts in the largest shelters by placing a mental health specialist in each shelter on a regular basis. One HOT member is also assigned to work with MBHP to assist discharge planners in high-volume acute care facilities. The department's Aggressive Street Outreach program supplements PATH and HOT by proactively focusing on streets, parks, and similar places. It is funded by HUD McKinney funds through the Statewide Continuum of Care, in which DMH is an active participant.

HOW THE HI WORKS

HI MANAGEMENT AND INTEGRATION WITH OTHER DMH HOUSING AND COMMUNITY-BASED SERVICE EFFORTS

When HI started, and even before, DMH began to develop strategies for increasing housing resources and developing community-based services. The first steps involved seeking advice and technical assistance to learn how other communities made these decisions. DMH staff sought information from HUD about the rules governing its programs, including 811 (housing for disabled persons), 202 (housing for seniors), other public housing, Shelter + Care, Section 8, HOME, the Community Development Block Grant, and other federal resources. The Department engaged the Technical Assistance Collaborative to help develop initial plans, and sent staff to various training opportunities.

Next steps included developing training of its own and urging providers to attend, with the goal of helping teams to develop projects and seek funding. DMH maintains a housing staff of three people at its central office and one in each of the state's six regions, with Metro Boston being the most creative, proactive, and productive. Area housing coordinators offered technical assistance and worked with providers to identify available funding sources and complete applications. Early on, the biggest challenge was working with municipal housing and community development departments, many of which were anxious about accommodating DMH clients. But many local officials were quickly convinced of the advantages of collaboration, sometimes with the help of local advocates and providers. People in many positions began working with each other to take advantage of the opportunities offered by HI and other DMH resources, as DMH was the only agency that had significant service dollars to offer in support of housing should the clients need such assistance.

Today, DMH housing coordinators work with DMH providers and state and local housing agencies to promote housing supply efforts; increase housing subsidies to DMH clients; and assist case managers, discharge planners, and other DMH and provider staff to help DMH clients obtain housing or housing subsidies. The department identifies available housing resources and assists relevant agencies and providers to apply for all federal and state homeless and non-homeless housing opportunities. Policies and protocols emphasize the importance of housing for people with SMI, adding assistance to find and keep housing as part of the services considered essential. Training for department and contract staff stresses the importance of housing, and that treatment cannot work if people do not have stable housing.

THE HI-DMH DISCHARGE PLANNING RELATIONSHIP

Each year, DMH serves about 26,000 adult men and women with SMI, including about 3,500 children and adolescents. About 2,500 of these clients a year receive inpatient care in DMH continuing care facilities, which include about 930 beds in the remaining state hospital facilities plus some community mental health center programs. Criteria for acceptance as a DMH continuing care client were described earlier.

People leaving inpatient psychiatric facilities operated or paid for by DMH go through a discharge planning process to assure that they exit to stable housing and not to homelessness. The Department has an explicit written discharge planning policy that includes a housing search component and working with the client until appropriate housing is found. The policy prohibits DMH state hospitals and community mental health centers from discharging clients from inpatient wards with directions to seek housing or refuge in an emergency shelter. It directs staff to make every effort to place clients in suitable, affordable housing coupled with clinically appropriate services.

Many DMH clients with an inpatient episode, particularly those with longer stays, are at risk of homelessness because they lose their housing while a patient, through eviction; family, partner, or sibling abandonment; or other mechanisms. Such housing loss makes discharge planning (and developing appropriate housing resources) particularly important and a form of primary prevention. DMH has made great efforts to train staff to think that *housing* is half the job—people cannot respond well clinically unless their housing is secure and housing is a critical component of mental health or clinical care. This attitude is often missing from mental health systems, even those that operate at the community level. With the focus on the role that mental illness plays in long-term homelessness, however, some mental health agencies are realizing that helping their clients to find and keep housing is an important part of their job.

DMH discharge policy has received extensive publicity as a practice model. It is formally promulgated and referenced in departmental regulations. Regular trainings and refresher courses are offered statewide, and Metro Boston has its own procedures on implementing the policy due to the high volume of clients. However, as noted by DMH staff in charge of finding housing for clients at discharge, a do-not-discharge-to-homelessness policy is only as good as the housing options for people leaving psychiatric facilities. Therefore, DMH has long been committed to creating an array of options for clients with SMI who would otherwise be at risk of homelessness. HI is one of the funding streams that has made more extensive housing development possible.

WORKING WITH HOUSING AND SERVICE PROVIDERS

DMH has longstanding relationships with private providers, with whom it contracts to deliver a wide array of services and projects the Department has decided its clients need. Providers have often taken the lead in developing projects that DMH hopes to support if it has sufficient HI funds. Because of the timing of funding cycles, with applications for HUD funding having to be made before state budgets are finalized, providers have had to themselves or in collaboration with local public or private homeless agencies, write proposals for housing dollars and even begin the process of developing housing, with nothing more solid than a DMH support letter saying, in effect, "if this application is successful we'll fund the services for this project is we get enough money from the legislature." Providers have been in the vanguard of project development despite these uncertainties, risking their own funds on the expectation that DMH would eventually come through with the services funding that would make the project work. That these arrangements have survived and prospered is testimony to the determination of all partners to create good housing options for DMH clients.

INTERAGENCY, PUBLIC, PRIVATE, AND INTERGOVERNMENTAL COLLABORATION ON HI

The HI has been focused on establishing a comprehensive DMH service capacity dedicated to this population, and using the service funds to leverage and access transitional and affordable, permanent housing with services, as described below. Linkages and alliances with other departments and providers, statewide and regionally, have been important to develop the current level of housing. Statewide examples include the following.

- An agreement with MassHousing, the state housing finance agency, ensures that 3 percent of all units developed with MassHousing financing are directed to DMH and the Department of Mental Retardation (DMR) to house people with SMI or mental retardation. DMH clients now lease more than 400 such self-contained, scattered site units. These are affordable, high quality units, almost all one-bedroom apartments, integrated into multi-family developments serving a full range of incomes and household types. MassHousing and some local housing authorities contribute to TPP, to keep their tenants stabilized and housed.

- An agreement with Massachusetts Department of Housing and Community Development (DHCD) to operate several state funded programs includes a rental assistance program exclusively serving more than 600 DMH clients, a bricks and mortar housing development program through statewide DHCD grants to local housing authorities for DMH and DMR clients with a DMH capacity of more than 600 clients, and special project-based voucher allocations to DMH housing development projects.

- Through the two mechanisms just described, plus others, DMH works with 101 of the 254 state, regional, and local housing authorities in Massachusetts. Table 2 shows the number of housing authorities involved in providing housing resources to DMH clients. (Appendix A provides a complete list of housing authorities and their type of participation.) In addition to the state housing authority (DHCD) and 9 regional authorities, 13 of 50 Central Area housing authorities, 6 of 7 Metro Boston Area housing

authorities, 15 of 52 Metro Suburban Area housing authorities, 24 of 47 Northeast Area housing authorities, 19 of 55 Southeast Area housing authorities, and 14 of 38 Western Area housing authorities are involved. They may provide capital (65 authorities) or operating funds (94 authorities), participate in projects with HI investment (14 authorities), or participate in projects that DMH is involved with in other ways (61 authorities).

Table 2: Housing Authority Involvement with Community-Based Housing for DMH Clients
(September 2006)

Area	Regional/Local Housing Authority	Number of Housing Authorities That: Provide Capital Funds	Provide Operating Funds	DMH HI Involvement*	Other DMH Involvement*	Have Any Involvement
DHCD -- STATE HOUSING AUTHORITY		1	1	1	1	1
9 REGIONAL HOUSING AUTHORITIES		3	8	4	6	9
LOCAL HOUSING AUTHORITIES						
Central	50 Central Area Authorities	8	13 - 4 X(d) only	0	7	13
Metro Boston	7 Metro Boston Area Authorities	4	6	6	6	6
Metro Suburban	52 Metro Suburban Area Authorities	12	14 - 1 X(d) only	0	5	15
North East	47 Notheast Area Authorities	15	20 - 8 X(d) only	1	11	24
Southeastern	55 Southeastern Area Authorities	15	19 - 10 X(d) only	1	18	19
Western	38 Western Area Authorities	7	13	1	7	14
Totals	254 Housing Authorities	65	94 - 23 X(d) only	14	61	101

* an X in the column "DMH HI Involvement" means the housing authority has contributed housing resources to projects in which DMH has invested HI funds. An X in the column "Other DMH Involvement" means the housing authority has been involved in distributing DMH rental assistance, 689 funding, other DMH resources, or has contributed its own resources to projects to house DMH clients.

X(d) refers to operating funds resulting from discounted rent only

- DHCD operates the Facilities Consolidation Fund (FCF) bond program, providing grants and loans to nonprofit developers for DMH and DMR housing development and housing homeless persons with SMI. The FCF is an important source of capital resources for community-based housing. It originated in 1992 with bonding authority to invest capital into community-based housing instead of state hospital campuses. Since SFY 1994, DMH has used it to help develop 92 housing projects with a capacity to house 724 people. Of these, 225 people are in units dedicated specifically to serving homeless individuals, thereby ending their homelessness. FCF was renewed in 2005 for $101 million over the next 10 years, with $50 million earmarked for projects to serve DMH clients.

- Agreements with the state's Department of Capital Asset Management ensure housing for DMH clients as a part of rental housing projects being developed on five former DMH state hospital campuses.

- Linkages with the Department of Public Health (DPH) in the ATARP efforts include a housing component (see below).

- Interagency Services Agreements (ISA) with the Department of Transitional Assistance for food stamps, employment services, and housing assistance projects for homeless and non-homeless clients.

- Area Housing Coordinators for local Continuums and DMH central office staff participate in the Continuum of Care application process through DMH.

DISTRIBUTION OF HI PROJECTS AMONG MASSACHUSETTS CONTINUUMS OF CARE

Of Massachusetts's 21 Continuums of Care (CoC), all but 6 have currently operating projects that have support from HI (table 3). Most HI-supported projects are in the Boston and Balance of State CoCs (95 projects, or 72 percent of all HI projects), but 13 other CoCs have at least one HI project. Not all of the transitional and permanent supportive housing projects in a CoC serve the types of people with serious mental illness that would be DMH clients. While most projects probably house some people with a diagnosable mental illness, DMH would have been looking to invest its HI funds in projects dedicated to serving the types of severely mentally ill and extremely poor people who are its clients. These people probably need permanent rather than transitional housing, and also likely need a good deal of supportive services to keep them stabilized, at least when they first move in. These realities of DMH client vulnerabilities are reflected in the distribution of HI funding between transitional and permanent housing projects. HI has mostly been used to provide services for permanent supportive housing (85 percent of all HI projects), but 20 transitional housing projects currently enjoy support from HI as well.

Table 3: HI Investment in Massachusetts Continuums of Care

CoC NAME	Permanent Supportive Housing Projects	Transitional Housing Projects	Total Projects
Attleboro/Taunton/Bristol County CoC	1	0	1
Boston CoC	37	0	37
Brockton/Plymouth City & County CoC	0	0	0
Brookline/Newton CoC	3	0	3
Cambridge CoC	1	1	2
Cape Cod/Islands CoC	0	0	0
Fall River CoC	0	0	0
Framingham/Waltham CoC	1	1	2
Franklin/Hampden/Hamshire/Holyoke County CoC	3	0	3
Gloucester/Haverhill/Salem/Essex County CoC	1	0	1
Lawrence CoC	0	2	2
Lowell CoC	2	0	2
Lynn CoC	2	0	2
Malden/Medford CoC	4	1	5
Massachusetts Balance of State CoC	43	15	58
New Bedford CoC	0	0	0
Pittsfield/Berkshire CoC	0	0	0
Quincy/Weymouth CoC	6	0	6
Somerville CoC	0	0	0
Springfield CoC	2	0	2
Worcester City & County CoC	6	0	6
Grand Total	112	20	132

HOUSING PROJECTS AND LIVING ARRANGEMENTS IN DMH-AFFILIATED HOUSING, INCLUDING HI PROJECTS

In its housing operations, DMH classifies living arrangements according to the number of people in a unit, the level of independence the tenants or residents enjoy, the level of support they require, and the level of control that tenants have over their housing units as evidenced by lease/tenant-at-will agreements. The types of "units" vary greatly, from large group homes to independent single apartments. Four or more persons living in the unit/building was determined to be a reasonable criterion for differentiating between "group" and "non-group" living. DMH recognizes six types of living arrangements, of which HI has invested in at least one project conforming to all but the last type:

- **Staffed Group Living:** 4 or more persons live in the unit/building, with scheduled staffing in place. This arrangement is "typical" of a DMH group home. Staff are on site

consistently; they often have offices and maintain and administer medications within the unit. Staff coverage may be 24/7 or less, with staff generally working in shifts.

- **Supported Group Living:** 4 or more persons live in the unit/building, with flexibly deployed staffing supports. This is a more independent arrangement than staffed group living, and is less common within the DMH system. An example would be a large apartment where a DMH provider sends staff to provide more or less support in a flexible manner based on client need. Staff may visit the unit several times a day, or may only check in weekly or monthly, as needed. Usually staff do not maintain office space with the unit/building.

- **Staffed apartments:** 1, 2, or 3 persons live in the unit/building, with scheduled staffing in place. This arrangement is similar to "Staffed Group Living" but with fewer people, more privacy, and more independence. Clients may live alone in an apartment, when they have roommates, each person has their own bedroom.

- **Supported Apartments:** 1, 2, or 3 persons live in the unit/building, with flexibly deployed staffing. This arrangement is typical of the many "supported housing" arrangements in the DMH system. Clients live on their own or with one or two roommates, and have access to staff as needed. In general, this arrangement denotes a higher degree of independence and less staff presence than other arrangements – with perhaps daily, weekly, monthly or fewer check-ins.

- **Independent Apartments:** 1, 2, or 3 persons live in the unit/building, with no staffing at all. This is the most independent arrangement available within DMH-affiliated housing, which is affiliated by means of funding, but without linked housing services. Funding is more likely to be leveraged federal or state subsidies than "contract rent."

- **DMH Shelter Housing:** These are DMH homeless shelters in the Metro Boston Area only. Within each DMH shelter, each distinct shelter space constitutes one unit. Capacity is the number of persons the shelter can hold. Shelters are not included in the calculation of number of clients per bedroom that appears later in this section.

Living arrangements of DMH clients living in projects with HI investment are shown in the first panel of table 4. DMH has tried to use HI to support the most independent living arrangements possible, as can be seen in the predominance of clients in HI projects who live in supported apartments (63 percent), with only 16 percent living in group residential settings.

Table 4: Living Arrangements and Lease/TAW Status of DMH Clients in HI Projects

Living Arrangements			Lease/TAW Status		
	Number	Percent		Number	Percent
Staffed Group Living	180	14	Client	658	52
Supported Group Living	26	2	Both client and provider	69	5
Staffed Apartments	232	18	Provider	448	36
Supported Apartments	790	63	Other	84	7
Independent Apartments	31	2		1259	
Totals	1,259				

The level of independence and control a DMH client has over his or her housing situation is an important characteristic of the housing DMH provides. In general, when DMH clients sign a lease or tenant-at-will (TAW) document, they have greater legal and tenancy rights than they may have in less independent arrangements such as group homes. Although the Community Residency Tenancy law in place in Massachusetts does afford a level of tenancy rights and protection to persons residing in settings such as group homes, a lease/TAW provides more protection and promotes independence and mainstream community inclusion. Therefore, the proportion of persons with a lease/TAW at least partially answers a question about the independence levels of a person in DMH-affiliated housing.

The second panel of table 4 shows the types of leasing arrangements that prevail among DMH clients in HI projects. Fifty-two percent have their own lease or TAW, while another 5 percent are co-signers of a lease or TAW with their DMH service provider. The provider holds the lease for 36 percent of DMH clients in HI housing, while other arrangements prevail for 7 percent of HI housing occupants.

There are a number of reasons why a client in affiliated housing may not be offered the option of signing a lease or why a DMH service provider may co-sign a lease. For example, arrangements classified as residential programs (scheduled staffing, generally four or more clients in one unit or group home) often do not have lease/TAW arrangements. The DMH provider may own or lease the building and the client may sign a program participation agreement that involves some continuing residence guarantees in lieu of a lease/TAW document. In other cases, in order to secure the housing unit – either because of specific subsidies such as DMH-DHCD Rental Assistance or because a landlord requires it – the provider and the client co-sign the lease/TAW. While the client does retain legal/tenancy rights in these cases, in practice the control of the unit is viewed as being more firmly with the provider. If a client moves from one of these units, the provider usually retains the unit on DMH's behalf and may use it to house another client (with permission of the landlord).

SPECIAL HI PROJECTS—ATARP

DMH uses HI to support the Aggressive Treatment and Relapse Prevention Program (ATARP), a specialized program to keep homeless clients with co-occurring mental illness and substance abuse disorders in housing. ATARP was jointly conceived and is jointly overseen by DMH and DPH's Bureau of Substance Abuse Services. DMH and DPH provide the service match for a HUD grant under the McKinney-Vento Supportive Housing Program.

Now in its eighth year, ATARP includes five programs, each serving about 11 individuals and one family at a time. All must be homeless by HUD's definition, eligible for DMH services (i.e., seriously mentally ill), and have a recent history of substance abuse. At entry, participants must demonstrate a commitment to sobriety, willingness to participate in self-help, and the ability to handle their own medications. They must agree to the requirements of tenancy and complete a service plan.

ATARP promotes recovery by providing housing and the supports to help households retain it, through flexible but intensive services, using a harm reduction approach that works on relapse management rather than on terminating participants when they relapse. The staffing level is 17

full-time equivalents serving the approximately 60–65 individuals and 7–9 families participating in the course of a year. Turnover is low, varying between 10 and 20 percent a year. As a consequence, as the program has continued over the years, ever-higher proportions have been in ATARP for long periods. By the end of SFY 2005, 56 percent of the households served had been in ATARP for three years or more, and 35 percent had participated for more than five years.

This evidence of stability is a sign that something is going right for ATARP participants, who have many barriers to stable housing that contributed to their original homelessness. In addition to maintaining their housing, ATARP participants show evidence of stability in other areas. In any year, about half did some work for pay or engaged in job training, and 80 to 100 percent engaged in a variety of community-based services. Between half and two-thirds remained abstinent from alcohol or drugs, and of those who relapse, which is an inevitable part of the recovery process, at least three-fourths returned to the program after getting clean again (in SFY 2005, 94 percent returned), allowing the program to help them get back on track and stay there.

SPECIAL HI PROJECTS—EMPLOYMENT

DMH has used HI resources to support eight employment programs specifically targeted to help homeless people get and keep jobs. DMH has also partnered with JOB-NET (Boston's One-Stop Career Center), the Boston Private Industry Council (PIC), the Boston Office of Neighborhood Development (OND), the Metro Boston Housing Partnership, and the Boston Emergency Shelter Commission to win support for HomeWorks, one of five demonstration projects funded nationally under the 2004 HUD-DOL-VA competition to supply housing plus employment services to long-term homeless persons with serious mental illness. Under the auspices of the PIC and OND who are the federal grantees, HomeWorks houses chronically homeless individuals with SMI and uses the Employment Connections model (see below) to help them find and keep employment; 20 of the participants are DMH clients receiving DMH support services.

Through its Clubhouse and Services for Education and Employment (SEE) programs, DMH has invested HI funds to promote employment among its homeless clients. Projects that have benefited from HI money include:

- **Employment Connections (EC)**, operated in Boston by the Massachusetts Division of Career Services. EC provides specialized services for homeless and formerly homeless clients, operating through JOB-NET, a U.S. Department of Labor–funded One-Stop Career Center. EC gives DMH clients employment-related assistance in a setting (the One-Stop) that integrates with other people seeking employment help. DMH Metro-Boston and the state Department of Employment and Training collaborate in running EC, which served 67 DMH clients in SFY 2006 and helped secure 34 jobs for 34 participants who worked during the year.

- **Career Advancement Resources (CAR)**, operated in Boston by BayCove Human Services, helps homeless DMH clients prepare for, find, and keep jobs. CARE provides a resource center located in downtown Boston where clients may come for a variety of services. CAR staff do intensive outreach to homeless clients, and continue to work to

engage them in services. Peer advocates are an important part of this effort, helping to translate CAR services to potential new users by relating their own experiences and helping to support each person as he or she makes the decision to work toward employment. Once an individual is committed, CAR tries to place the person in a job as soon as possible, and then offers job coaching in a variety of settings. The same type of coaching is available for clients in education or training programs through which they are preparing for particular types of employment. Tuition assistance, tutoring, and supportive services are available to clients engaged in education or training. CAR helps clients use a variety of basic educational resources, including adult basic education, GED preparation, and English as a Second Language programs. In SFY 2006, CAR served 242 participants and helped secure 101 jobs, with 61 participants working during the year.

- **Community Career Links**, operated in Somerville by North Charles Mental Health Center, serves both homeless and nonhomeless DMH clients. In addition to pursuing the usual array of supports to help clients get ready for work and find and keep jobs, Community Career Links started two businesses of its own through which it provides jobs and teaches work and business skills. One is a pet-walking and cat-sitting service that has been in operation for four years. The second is a fitness program that offers classes and seminars at reduced prices to clients and people connected to the mental health system. Community Career Links served 55 participants in SFY 2006, helping to secure 49 jobs for 38 clients.

- **Supported Employment and Education**, operated in Framingham by South Middlesex Opportunity Center, has been functioning for nine years. It is part of the large array of wraparound services run by the Opportunity Center, along with a full continuum of shelter and housing resources. This project has a special focus on homeless adults with both SMI and a co-occurring substance abuse disorder. In SFY 2004 the program served 12 participants and helped to secure 7 jobs for 5 clients.

- **Job Link**, operated in Springfield by Human Resources Unlimited, is a SEE program operated through a Clubhouse. Job Link has many partner agencies in the Springfield area to assure continuity of care and support for employment through many aspects of client lives. In SFY 2004, Job Link served 35 participants and helped to secure 22 jobs, with 18 participants working during the year.

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients					
Area	**Regional/Local Housing Authority**	**Provides Capital Funds**	**Provides Operating Funds**	**DMH HI Involve-ment***	**Other DMH Involve-ment***
STATE HOUSING AUTHORITY					
	DHCD	X	X	X	X
REGIONAL HOUSING AUTHORITIES					
	Region 1 - Metropolitan Boston Housing Partnership (MBHP)		X	X	X
	Region 2 - South Middlesex Opportunity Council, Inc. (SMOC)				X
	Region 3 - South SHORE HOUSING DEVELOPMENT CORPORATION (SSHDC)	X	X		X
	Region 4 - community teamwork, inc. (CTI)	X	X	X	X
	Region 5 - HOUSING ASSISTANCE Corp (HAC)		X	X	
	Region 6 - RCAP Solutions		X		
	Region 7 - Hampden Hampshire Housing Partnership* (HAP)	X	X	X	X
	Region 8 - Franklin Cnty Regional Hsng & Redevelopment Authority(FCRHA)		X		X
	REGION 9 - Berkshire Housing Development Corp (bhdc)		X		
LOCAL HOUSING AUTHORITIES					
Central	ASHBURNHAM H.A.				
Central	ASHLAND H.A.				
Central	AUBURN H.A.	X	X[(d)]		X
Central	AYER H.A. c				
Central	BARRE H.A.				
Central	BELLINGHAM H.A.				
Central	BLACKSTONE H.A.				
Central	BOLTON H.A.				
Central	WEST BOYLSTON H.A.				
Central	BRIMFIELD H.A.				
Central	BROOKFIELD H.A.				
Central	NORTH BROOKFIELD H.A.				
Central	WEST BROOKFIELD H.A.				
Central	CHARLTON H.A. a				
Central	CLINTON H.A.				
Central	DUDLEY H.A.				
Central	FITCHBURG H.A. a/c/s	X	X		X
Central	FRANKLIN H.A. c				
Central	GARDNER H.A. c/s		X		
Central	GRAFTON H.A.	X	X[(d)]		X
Central	GROTON H.A.				

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients, Continued					
Area	**Regional/Local Housing Authority**	**Provides Capital Funds**	**Provides Operating Funds**	**DMH HI Involve-ment***	**Other DMH Involve-ment***
Central	HOLDEN H.A.				
Central	HOPEDALE H.A.				
Central	LANCASTER H.A.				
Central	LEICESTER H.A.				
Central	LEOMINSTER H.A.		X		
Central	LUNENBURG H.A.				
Central	MEDWAY H.A.	X	X[(d)]		X
Central	MENDON H.A.				
Central	MILFORD H.A.		X		
Central	UPTON H.A.				
Central	MILLBURY H.A. c		X		
Central	MILLVILLE H.A.				
Central	NORTHBRIDGE H.A.				
Central	OXFORD H.A. c				
Central	PEPPERELL H.A. a				
Central	SHREWSBURY H.A.		X		
Central	SOUTHBRIDGE H.A.	X	X		X
Central	SPENCER H.A. a/c				
Central	STERLING H.A.				
Central	STURBRIDGE H.A.				
Central	SUTTON H.A.				
Central	TEMPLETON H.A.				
Central	TOWNSEND H.A.				
Central	UXBRIDGE H.A.				
Central	WARREN H.A.				
Central	WEBSTER H.A.	X	X		X
Central	WESTMINSTER H.A.				
Central	WINCHENDON H.A. c	X	X[(d)]		
Central	WORCESTER H.A. a/c	X	X		X
Metro Boston	BOSTON H.A. c	X	X	X	X
Metro Boston	BROOKLINE H.A. a	X	X	X	X
Metro Boston	CAMBRIDGE H.A. a/c/s	X	X	X	X
Metro Boston	CHELSEA H.A. a		X	X	X
Metro Boston	REVERE H.A. a/s		X	X	X
Metro Boston	SOMERVILLE H.A. s	X	X	X	X
Metro Boston	WINTHROP H.A.				
Metro Suburban	ACTON H.A. a	X	X		
Metro Suburban	ARLINGTON H.A.				
Metro Suburban	BEDFORD H.A.	X	X		
Metro Suburban	BELMONT H.A. a				
Metro Suburban	BRAINTREE H.A. c		X		X
Metro Suburban	BURLINGTON H.A.				
Metro Suburban	CANTON H.A.				
Metro Suburban	CARLISLE H.A.				
Metro Suburban	COHASSET H.A.				
Metro Suburban	CONCORD H.A. c				
Metro Suburban	DEDHAM H.A. a	X	X[(d)]		
Metro Suburban	FOXBORO H.A. a				
Metro Suburban	FRAMINGHAM H.A. c/s	X	X		X
Metro Suburban	HINGHAM H.A. c				

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients, continued					
Area	**Regional/Local Housing Authority**	**Provides Capital Funds**	**Provides Operating Funds**	**DMH HI Involve-ment***	**Other DMH Involve-ment***
Metro Suburban	HOLLISTON H.A.				
Metro Suburban	HOPKINTON H.A.				
Metro Suburban	HUDSON H.A. a	X	X		
Metro Suburban	HULL H.A.				
Metro Suburban	LEXINGTON H.A.				
Metro Suburban	MARLBOROUGH H.A. a	X	X		
Metro Suburban	MAYNARD H.A.				
Metro Suburban	MEDFIELD H.A.				
Metro Suburban	MILLIS H.A.				
Metro Suburban	MILTON H.A.				
Metro Suburban	NATICK H.A. c				
Metro Suburban	NEEDHAM H.A. s				
Metro Suburban	NEWTON H.A. c	X	X		
Metro Suburban	NORFOLK H.A.				
Metro Suburban	NORTHBOROUGH H.A.	X	X		
Metro Suburban	NORWELL H.A.				
Metro Suburban	NORWOOD H.A.		X		
Metro Suburban	PLAINVILLE H.A.				
Metro Suburban	QUINCY H.A. s	X	X		X
Metro Suburban	RANDOLPH H.A.				
Metro Suburban	SCITUATE H.A.				
Metro Suburban	SHARON H.A. a				
Metro Suburban	SOUTHBORO H.A.	X	X		
Metro Suburban	STOW H.A.				
Metro Suburban	SUDBURY H.A.				
Metro Suburban	WALPOLE H.A.	X	X		
Metro Suburban	WALTHAM H.A. c	X	X		X
Metro Suburban	WATERTOWN H.A. a/s				
Metro Suburban	WAYLAND H.A.				
Metro Suburban	WELLESLEY H.A.				
Metro Suburban	WESTBOROUGH H.A.				
Metro Suburban	WESTWOOD H.A.				
Metro Suburban	WEYMOUTH H.A.				X
Metro Suburban	WILMINGTON H.A. c				
Metro Suburban	WINCHESTER H.A.				
Metro Suburban	WOBURN H.A.				
Metro Suburban	WRENTHAM H.A.				
Metro Suburbanl	LITTLETON H.A.				
North East	LYNN H.A. a/c/s	X	X		X
North East	AMESBURY H.A. a/s	X	X[(d)]		
North East	ANDOVER H.A. a	X	X	X	X
North East	BEVERLY H.A. c		X		X
North East	BILLERICA H.A. s				
North East	CHELMSFORD H.A. c				
North East	DANVERS H.A.	X	X[(d)]		
North East	DRACUT H.A. c				
North East	ESSEX H.A.				
North East	EVERETT H.A.		X		
North East	GEORGETOWN H.A.				
North East	GLOUCESTER H.A. s	X	X		

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients, continued					
Area	**Regional/Local Housing Authority**	**Provides Capital Funds**	**Provides Operating Funds**	**DMH HI Involve-ment***	**Other DMH Involve-ment***
North East	GROVELAND H.A.				
North East	HAMILTON H.A. c	X			
North East	HAVERHILL H.A.		X		X
North East	IPSWICH H.A. a	X	X(d)		X
North East	LAWRENCE H.A.	X	X		X
North East	LOWELL H.A.	X	X		X
North East	LYNNFIELD H.A.				X
North East	MALDEN H.A.	X	X(d)		
North East	MANCHESTER H.A.				
North East	MARBLEHEAD H.A.				
North East	MEDFORD H.A.				
North East	MERRIMAC H.A.				
North East	METHUEN H.A. c/s	X	X(d)		
North East	MIDDLETON H.A.				
North East	NAHANT H.A.				
North East	WEST NEWBURY H.A.				
North East	NEWBURYPORT H.A. a	X	X(d)		
North East	NORTH ANDOVER H.A. a/c				
North East	PEABODY H.A. c/s	X	X		
North East	READING H.A.				X
North East	NORTH READING H.A.				
North East	ROCKPORT H.A.				
North East	ROWLEY H.A.				
North East	SALEM H.A. c/s		X		
North East	SALISBURY H.A.				
North East	SAUGUS H.A. s				
North East	STONEHAM H.A.				X
North East	SWAMPSCOTT H.A.				
North East	TEWKSBURY H.A.	X	X(d)		
North East	TOPSFIELD H.A.				
North East	TYNGSBOROUGH H.A. c				
North East	WAKEFIELD H.A. c		X		
North East	WENHAM H.A.				
North East	WESTFORD H.A.	X	X(d)		
Northeast	MELROSE H.A. a/s		X		X
Southeastern	ABINGTON H.A.				
Southeastern	ACUSHNET H.A.	X	X(d)		X
Southeastern	ATTLEBORO H.A.	X	X		X
Southeastern	AVON H.A.				
Southeastern	BARNSTABLE H.A. a/c	X	X	X	X
Southeastern	BOURNE H.A.				
Southeastern	BREWSTER H.A.				
Southeastern	BRIDGEWATER H.A. c	X	X(d)		X
Southeastern	EAST BRIDGEWATER H.A. c				
Southeastern	HALIFAX H.A.				
Southeastern	WEST BRIDGEWATER H.A.				
Southeastern	BROCKTON H.A. a/c	X	X		X
Southeastern	CARVER H.A.	X	X(d)		
Southeastern	CHATHAM H.A. c				

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients, continued					
Area	**Regional/Local Housing Authority**	**Provides Capital Funds**	**Provides Operating Funds**	**DMH HI Involve-ment***	**Other DMH Involve-ment***
Southeastern	DARTMOUTH H.A. s				
Southeastern	DENNIS H.A.	X	X[(d)]		X
Southeastern	DIGHTON H.A.				
Southeastern	DUXBURY H.A.				
Southeastern	EASTHAM H.A.				
Southeastern	EASTON H.A.				
Southeastern	FAIRHAVEN H.A.				
Southeastern	FALL RIVER H.A. a/c	X	X		X
Southeastern	FALMOUTH H.A. a	X	X[(d)]		X
Southeastern	HANOVER H.A.				
Southeastern	HANSON H.A.	X	X[(d)]		X
Southeastern	HARWICH H.A.	X	X[(d)]		X
Southeastern	HOLBROOK H.A.				
Southeastern	KINGSTON H.A.				
Southeastern	MANSFIELD H.A.				
Southeastern	MARSHFIELD H.A. c				
Southeastern	MASHPEE H.A.		X		X
Southeastern	MATTAPOISETT H.A.				
Southeastern	MIDDLEBOROUGH H.A.				
Southeastern	NANTUCKET H.A.				
Southeastern	NEW BEDFORD H.A. a/s		X		X
Southeastern	NORTH ATTLEBORO H.A.				
Southeastern	NORTON H.A.				
Southeastern	ORLEANS H.A. a		X		X
Southeastern	PEMBROKE H.A.	X	X[(d)]		X
Southeastern	PLYMOUTH H.A.	X	X		X
Southeastern	PROVINCETOWN H.A. a				
Southeastern	RAYNHAM H.A.				
Southeastern	REHOBOTH H.A.				
Southeastern	ROCKLAND H.A.				
Southeastern	SANDWICH H.A. a/c	X	X[(d)]		X
Southeastern	SEEKONK H.A. a				
Southeastern	SOMERSET H.A.				
Southeastern	STOUGHTON H.A. c				
Southeastern	SWANSEA H.A.	X	X[(d)]		X
Southeastern	TAUNTON H.A. c		X		X
Southeastern	WAREHAM H.A.				
Southeastern	WELLFLEET H.A.				
Southeastern	WESTPORT H. A.				
Southeastern	WHITMAN H.A. a				
Southeastern	YARMOUTH H.A.				
Western	ADAMS H.A.				
Western	AGAWAM H.A. c				
Western	AMHERST H.A. a/c		X		
Western	ATHOL H.A.				
Western	BELCHERTOWN H.A.				
Western	CHICOPEE H.A.		X		X
Western	DALTON H.A.				
Western	EAST LONGMEADOW H.A. c				

Appendix A: Housing Authority Approaches to Supporting Community-Based Housing for DMH Clients, continued

Area	Regional/Local Housing Authority	Provides Capital Funds	Provides Operating Funds	DMH HI Involve-ment*	Other DMH Involve-ment*
Western	EASTHAMPTON H.A.		X		
Western	GRANBY H.A.				
Western	GREAT BARRINGTON H.A.				
Western	GREENFIELD H.A. c		X		X
Western	HADLEY H.A.				
Western	SOUTH HADLEY H.A.				
Western	HAMPDEN H.A.				
Western	HATFIELD H.A.				
Western	HOLYOKE H.A. c	X	X		X
Western	LEE H.A.				
Western	LENOX H.A. c				
Western	LONGMEADOW H.A.				
Western	LUDLOW H.A. c				
Western	MONSON H.A.				
Western	MONTAGUE H.A.				
Western	NORTH ADAMS H.A.				
Western	NORTHAMPTON H.A. a/c	X	X		X
Western	ORANGE H.A.		X		
Western	PALMER H.A.				
Western	PITTSFIELD H.A. c/s	X	X		
Western	SHELBURNE H.A.				
Western	SOUTHAMPTON H.A.				
Western	SOUTHWICK H.A.	X	X		
Western	SPRINGFIELD H.A. c	X	X		X
Western	WEST SPRINGFIELD H.A. c		X		
Western	STOCKBRIDGE H.A. c				
Western	WARE H.A.				
Western	WESTFIELD H.A. s	X	X	X	X
Western	WILBRAHAM H.A. c				X
Western	WILLIAMSTOWN H.A.	X	X		

* an X in the column "DMH HI Involvement" means the housing authority has contributed housing resources to projects in which DMH has invested HI funds. An X in the column "Other DMH Involvement" means the housing authority has been involved in distributing DMH rental assistance, 689 funding, other DMH resources, or has contributed its own resources to projects to house DMH clients.

X(d) refers to operating funds resulting from discounted rent only.