SMHPC
MEETING NOTES: 7/3/25

ITEM	NOTES
Metro Boston Homeless Outreach Team	• Developed in early-to-mid 80s, primarily to serve newly unsheltered men with mental illness (vs. traditional alcohol use only). Many DMH services (e.g. Case Management) had not yet been formed. Families unable to serve these individuals. No peer services yet. • Mission to identify individuals within Boston city limits who are homeless with MH challenges, who are otherwise unknown to the DMH system. Note: everyone is a family member of someone. Need to earn their trust and earn their respect, and not vice-versa. • 4 outreach/engagement teams they work with: Eliot PATH, Pine St, BPHC, St. Francis House. Must continue to try to bring people in. • HOT has a process to engage and assess people who meet our criteria but who will not submit a DMH application, re: consultation with the Area Medical Director. • Average age 50+, most not using substances, many with multiple college degrees. • Seven Safe Havens in Boston and one additional to open next month – 70 total beds. Serving people homeless for 2+ years in Boston. Medication is not required. DMH eligibility is weighed against risk to the safe haven population for entry. Symptoms may manifest differently / more acurely when individuals are in group settings. • Four DMH shelters in Boston. Initially set up for unsheltered persons willing to apply to DMH. Currently used for a variety of situations: step down from hospital care; children who can no longer stay at home; etc. • Count of Boston Homeless population (count usually happens in the last week of January). Last year: 6,500 unaccompanied single adults. Long Island Shelter is over capacity (660 vs. 500 beds) and turning people away. Overcrowding may make living outside safer.

	• Mass-and-Cass population (homeless and substance-using) swelled during Covid. Attracts people without services from other areas. Victimization is high, inc. human-trafficking. • Question about access for people coming from hospitals: many people are living in ERs. Discharge planning must start on day of admission, which involves collaboration with the hospitals. Had a staff stationed in a hospital dedicated to discharge planning. Acute care discharges are priorities for the DMH shelter beds. Ongoing need for contacts at the hospitals. • Question about age range of HOT clients, inc. 25 yrs and under: uptick in Spring and Summer. HOT has a staff esp. gifted in working with young adults. Fenwood Inn shelter has a younger population. • Question about how DMH Eligibility via AMD assessment works: requires assent from person for HOT to work with them. Clinical assessment from the street-team incorporated into info for AMD review. • Library services and the Women's Lunch Place provide important services. • Question about CBHCs as alternatives to ERs and use of Peer Specialists: It's complicated – CBHCs are not understood well enough as a resource yet for them to be used as a resource. Shelters have historically tried to solve homeless problems on their own. o HOT is smaller than it used to be: currently 8 staff. Do not have MH peers per se, but do have individuals with relevant life experience , e.g. family with MI or homelessness. Has collaborated with Peer Specialists in specific cases. • Question re: if there's a way to report a person in need to HOT: HOT staff are on-site at least 4 days a week. Often neighbors support people. Yes – people can contact HOT at 617-626-8629; specific information re: location and behavior is important. • Question re: how to work with families (for adults): HOT works with single-adults 18+, but sometimes will work with a parent of an adult-child, or partners who both have MH symptoms. Sometimes each partner will have their own HOT staff.
Commissioner Report	• Commissioner's Update presented by Dr. Amam Saleh. • Staffing Changes: New Medical Director (Dr. Gregary) for OIM following Dr. Saleh. Cheri Divari, EPI Program Manager, leaving DMH. • BHTRP (Behavioral Health Treatment Referral Platform) now live. Average ED Boarding time is down 2024 vs. 2023. Assisting with referrals to CBHCs. Phase II to launch shortly. • DLC Question re: ED Boarding: number of hours remains too high. DPH oversees EDs via CBH regulations – nothing re: de-escalation. (1) Diversion for people to get care sooner. (2) Restraints in EDs are not governed by meaningful regs – low standards and oversight. What can be done to incorporate similar types of standards as DMH uses into EDs? Is there work happening with DPH re: de-escalation techniques?

	ED staff are good, but untrained, with harmful results, esp. when people want to leave the ED and are restrained. o Boarding level is est. 50% what it was a year ago (est. 600 → 300). o Wait time is dramatically lower – admission in even a few minutes. The BHTRP Obviates the need for referrals and phone calls. People with low medical complexity can be admitted quickly. o Many people are being diverted via CBHCs, BHHL, and 988. • Question: is the lawyers' strike affecting judges willingness to send admit people for SU or psychiatric treatment? o DMH is not seeing this impact yet.
Subcommittee Reports	• HOUSING: To review goals and demographics of membership. Survey sent to members, to be reviewed at next meeting 10/7. Housing Plan workgroup completed its report and presented to DMH. Housing Plan in final stage of completion. Causing Access and Collaboration workgroup to update youtube video re: DMHRSP and create a DMHRSP centralized training tool. Plan to break up the youtube video into segments. State housing budget submitted to the governor, inc. plan for broker fees to be paid by whomever hired the broker; DMHRSP level-funded; Safe-Havens $3M short. ACCS and Adult Respite fully funded. Federal funding is unknown. • EMPLOYMENT: Identified a number of needed website updates, inc. contact info, accomplishments, and plan. Updates in the next 2 months. Recruitment of several new members, inc. MassAbility Counselor, MassAbility Director, Employment-Service User, NAMI MA, SEA PACT provider, and MCC Director.
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