PEOPLE ARE WAITING

MAMH

Massachusetts

Association For

Mental Health, Inc.

United Way

United Way
of Massachusetts Bay

MAMH

Massachusetts Association For Mental Health, Inc.

February 2007

Dear Legislator:

This is our sixth ***People Are Waiting*** report.

In February of 1999, our first ***People Are Waiting*** report listed partially redacted DMH client identification numbers to document 3,138 adult clients of the Massachusetts Department of Mental Health (DMH) were on waiting lists for housing or residential support services.

Since that report, **DMH, with the full support and collaboration of the Legislature,** has embarked on a series of initiatives that have increased community based housing opportunities for DMH clients. For example,

- **During FY 2003,** DMH closed Medfield State Hospital, as well as a 20-bed unit at Worcester State Hospital and a 36-bed unit at Tewksbury. A significant portion of the savings from the closings ($10.2 Million) was used to create **255 community placements** for "discharge ready" patients formerly residing at Medfield and Westborough State Hospitals and other facilities in Massachusetts.
- **In FY 2004,** the Legislature requested DMH to prepare and file a comprehensive report outlining its inpatient needs and setting forth a plan for addressing the residential needs of "discharge ready clients." The Report *"Inpatient Study Report for the General Court"* (In Patient Study Report) was filed with the Legislature in March 2004 and, among other things, set forth **a timetable for placing 268** "discharge ready" (or about to become discharge ready) DMH clients into the community.
- **Over the next three years,** DMH, with full support of the Legislature began moving "discharge ready" clients from inpatient facilities into the community and met its three-year goal of creating no less than **268 community placements.**
- **In the FY 2007 budget,** The Legislature provided additional funding for the **homeless mentally ill** as well as **additional rental assistance for DMH clients.**

MAMH is proud to have been a part of this effort and we are very grateful for the attention and the support you have given to DMH, and to the community-based housing needs of its clients. We hope your interest and support will continue.

In this Report, we have set forth some information on DMH housing and recommendations as to how you can further address the housing needs of people with mental illnesses and their families. We have also set forth our DMH budget recommendations for FY 2008.

We hope you will continue the progress that has been made over the past several years and give our recommendations serious thought and attention. **We believe the more you know about the successes of our community based system of behavioral health care, the more you will want to support it.**

Thank you.

James Hooley
President

Bernard J. Carey, Jr.
Executive Director

Timothy O'Leary
Deputy Director for Policy

ABOUT MAMH www.mamh.org

MAMH Mission Statement: To promote and advance community based housing, education, health care, employment and treatment for children, adolescents, adults and elderly with mental illnesses or emotional disorders. To increase knowledge about mental illnesses and the effectiveness of treatment through educational outreach to the public at large or to specific segments, and to promote healthy life styles and behavior through preventative services and programs directed at children and adolescents.

Since 1913, the Massachusetts Association for Mental Health, Inc. (MAMH) has been an independent, non-profit Massachusetts corporation engaged in educational outreach and advocacy focused on promoting mental health, and community based services, including housing, treatment, education and employment for people with mental illnesses and their families. The National Institute for Mental Health (NIMH) has designated MAMH as its Massachusetts partner for educational outreach under its Outreach Partnership Program.

MAMH also works with individuals with mental illness and their family members or friends to help them access services, whether housing, treatment, education, employment, or health insurance. Our referrals come from the United Way of Massachusetts Bay, as well as from our network of supporters, including legislators, family members, business leaders, advocates and others.

The membership of our board of directors – 74 strong – includes people from virtually every profession in Massachusetts – law, banking and finance, health care, government, education, housing, human services, child welfare and insurance. Our board includes consumers, their family members and community activists. We have clinicians on our board who are experienced in the delivery of behavioral health care and in the management of that care and we have a committee on housing, which focuses on creating additional housing opportunities for people with mental illnesses and their families.

A listing of our board members is on the back cover.

EXECUTIVE SUMMARY

The Department of Mental Health (DMH) and its residential service providers have an array of affordable housing models for clients. DMH has promoted development of transitional as well as permanent housing through new construction or the rehabilitation of existing buildings. With the support of the Legislature, DMH has been able to increase its housing stock over the past several years, but there are still many DMH clients on waiting lists for housing or residential services. The most conservative number is 800, but most concede it is probably higher.

DMH, consistent with the trend across the nation has moved towards the development of more integrated housing – that is—where units set aside for DMH clients are part of a larger housing complex. DMH, depending upon the client's needs, provides an array of residential support in the client's home or residence. This integrated, independent, supported housing model has been found to serve the client better and at least one study shows it reduces re-hospitalization.

However, the shortage of rental assistance at both the federal and state level threatens the supported housing model and has significantly slowed the rate of construction of new housing units for DMH clients. Federal Section 8 rental subsidies are virtually non-existent and HUD now prohibits "project based" section 8 certificates from being targeted to a specific subset of clients (i.e. DMH clients)

In order to rejuvenate and increase housing opportunities for DMH clients, MAMH has proposed several recommendations, only one of which would require the appropriation of additional dollars.

The recommendations are:

(1) **Rental Assistance: I**ncrease Appropriation Line-Item 7004-9033 by $500,000, bringing the total appropriation to $3,5000,000.

(2) Support legislation requiring the set-aside of affordable housing for DMH clients on the site or within the service area of land formerly used for DMH Facilities and support legislation that requires up to 50% of the proceeds of any sale to be used for DMH Housing.

(3) Support legislation to provide additional flexibility to the *Facilities Consolidation Fund* (Chapter 52 of the Acts of 1992) to allow construction of more housing for DMH clients.

- Increase from 50% to 100% (or at least 75%) of total development cost as the allowable amount for a FCF equity loan.
- Expand the universe of eligible FCF developers by allowing private developers, including those pursuing housing tax credits and those securing housing financing through MassHousing, to participate.
- Allow FCF funds to provide an operating subsidy for those units set aside for DMH clients

PART ONE: INCREASING HOUSING OPPORTUNITIES FOR PEOPLE WITH MENTAL ILLNESSES AND THEIR FAMILIES.

Introduction

Because this is the first year of a new legislative session, we thought it was appropriate to provide some general information on housing for people with mental illnesses, the kinds of residential services DMH and its community-based providers offer, the significant progress that has been made in creating housing opportunities, the unmet need, and some specific recommendations we urge legislators to consider to increase housing opportunities for DMH clients. We hope this Report will not only spur additional support for DMH housing and residential services, but also provide legislators, staff and others with the kind of information they need to make the important decisions that are entrusted to their position.

General Background

When deinstitutionalization led to the need for more community based housing, most of the initial residential programs that were developed replicated institutional programs. Although residential homes varied in the degree of oversight and services, they tended to group clients by disability, assigned them to residential program "slots" in group homes with staff monopolizing decision-making and supervision. Living in "group homes" added to the stigma and in Massachusetts, as well as across the nation, there was movement away from group homes and towards a supported housing model, where the consumer lives in conventional housing with support services, which fluctuate over time. With consumers living in conventional housing (i.e. an apartment within a complex) the stigma and siting issues that delayed construction of group homes are avoided. Moreover, a number of studies have concluded that consumers in supported housing models experience better mental health, more self-determination, and re-hospitalizations are reduced.[1]

DMH Housing and Residential Support Services

In Massachusetts, the Department of Mental Health (DMH) and its residential service providers have an array of affordable housing models for clients. DMH has promoted development of transitional as well as permanent housing through new construction or the rehabilitation of existing buildings. The housing produced has included small, staffed group homes with private bedrooms, studios, single resident occupancy units, congregate independent apartments, and scattered-site independent apartments, including condominium rentals.[2]

As of September 2006, DMH maintained 3,573 self-contained, mostly rental housing units of "DMH-affiliated housing" (housing that DMH or its agents secured for the client). At any given time, these units are able to **house 6,039 clients,** with more clients using the units over time as some leave and others move in. Residents of this housing receive a range of DMH supportive and other services as necessary and appropriate. Some of this housing is specifically targeted toward formerly homeless people.[3]

The large majority of DMH clients have their own bedrooms and most have their own apartments. DMH uses the strict US 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. DMH 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.[4]

In addition to DMH's affiliated housing, 1,858 other DMH clients receive DMH continuing residential community support services of several types while living in housing that DMH did not secure, but may have referred 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 clients the Department serves 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.**[5]

DMH has built up its housing inventory primarily since the early 1990s, and continues to add to it at every opportunity. With the support of the Legislature, the Department's access to resources has increased through the Homeless Mentally Ill Initiative and other community service initiatives, and through the closing of state hospitals with reinvestment of the savings, and that has allowed it to provide service funding for many housing units to match or leverage 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

A number of studies have concluded that consumers in supported housing models experience better mental health, more self-determination, and re-hospitalizations are reduced.

– Surgeon General Report (1999)

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.[6]

The housing and residential support needs of DMH clients vary and it is entirely appropriate to have a variety of housing models across the Commonwealth. It is a common misperception that people with mental illnesses need to live in urban areas or close to their therapist. DMH clients are successfully living in urban and suburban areas. They drive automobiles, ride bicycles, enjoy long walks, take cabs or use public transportation. They enjoy libraries, museums, movies, "people watching", shopping, eating out or staying home. In short, their interests and dislikes vary and the housing opportunities should include neighborhoods or geographic areas that will allow the client to enjoy and experience whatever it is s/he enjoys.

Waiting Lists

As noted earlier, in 1999 MAMH in consultation with DMH reported 3,138 adult clients were waiting for housing or residential support services. This number included clients who were in the following categories:

(A) Homeless or living in shelters or facilities designed to provide temporary accommodations.

(B) Clients who were in a state hospital who were either discharge ready or within 6 months would be discharge ready, and were waiting for a community placement.

(C) Clients who were ready to move out of a group home or staffed apartment but were waiting for placement in a less intensive setting (supported housing).

(D) Clients who were ready to move from a group home model but needed rental assistance to move to more independent living.

(E) Clients who are living in a clinically inappropriate setting (e.g. with aging parents, overcrowded housing, substandard housing, or paying over 50% of monthly income for rent.)

For a number of reasons, DMH refined its waiting lists in order to isolate (1) the discharge ready clients; and (2) those DMH clients who were receiving no housing or residential support services.[7] In essence, the focus was shifted to the clients described in categories (A) and (B). It is those numbers that are cited in DMH's current Mental Health Plan and the corresponding filings with the federal government as part of the Community Block Grant Program. As a result, those clients who are in a group home, but who could move to a less intensive setting (and free up space for a discharge ready client) are not included in the wait list count. Also missing are those living in clinically inappropriate settings, overcrowded or substandard housing and those paying more than 50% of monthly income for rent. According to the latest data available, DMH reported 7,366 of its adult clients were receiving residential support services at the end of FY 2005, and **800 were on waiting lists.**[8] As recently as January 2007 the "unofficial wait list" number was stated to be 1051.

While, as previously noted, DMH, with consistent legislative support, has made significant progress in creating new community-based residential units; there is still significant unmet need. We believe the 800 number, while accurate, does not reflect the total actual need since it does not include all the clients in categories (C)(D)(E). Moreover, we note the 800 number appears to be an increase over the comparable numbers we reported in 1999. If you were to go back to the first People Are Waiting Report, which identified by redacted DMH identification numbers 3,138 adults waiting for housing and residential support services, and counted only those falling within category (A) or (B) the number would be 681. Lastly, the number will fluctuate as DMH adds new clients being identified as needing housing while dropping those who are successfully placed.

We understand that given other pressing needs and fiscal realities, there will always be some unmet housing and residential support service needs among DMH clients. The waiting lists grew over years, and they will not be eliminated with a single appropriation. Whatever waiting list number is used, there needs to be consistent and substantial support for increasing the affordable housing and residential support services opportunities for people with severe and persistent mental illness, or the number will continue to grow with a resulting increase in more expensive hospitalizations, homelessness, and deaths.

RECOMMENDATION 1

Rental Assistance – Increase Appropriation Line-Item 7004-9033 by $500,000, bringing the total appropriation to $3,5000,000.

Background

Line Item 7004-9033 is a special rental assistance account administered by the Department of Housing and Community Development (DHCD) through local public housing authorities for clients of the Department of Mental Health.

When originally established in the early 90's, the special rental assistance for DMH clients was an appropriation of $3.1 Million to DMH. The funds were then transferred to

DHCD under an Interagency Service Agreement. In FY 2002, the appropriation went to DHCD. In FY 2003, as a result of budget deficits, the account was reduced to $2.5 Million. For the current (FY 2007) budget, the Legislature bumped the account up to $3 Million.

Under this rental assistance program, DMH local staff refers clients for rental assistance, and DMH providers work with landlords and property managers to find housing for the clients. The local housing authorities execute and oversee the apartment leases under the auspices of DHCD. Any DMH program coordination and services are managed at the DMH local area or site office.

There is a mix of clients with their own leases and some instances where DMH providers locate housing and enter into joint leases on the client's behalf.

The Rental Assistance apartments are scattered throughout the Commonwealth and are lower in cost than market rate apartments because local DMH staff and providers work hard to find affordable rents to stretch program funds. By the end of FY 2007, approximately 850 to 880 DMH clients will be receiving rental assistance.

The Need or Problem

Most of DMH's clients fall into the "very low income" category subsisting on SSI or SSDI payments. Very often, their annual income may be as low as 15% of the area median income. This is important because most "affordable housing" units developed in the Commonwealth are designated for persons whose annual income does not exceed 80% of the area median income. This creates a large subsidy gap which precludes many DMH clients the opportunity to access "affordable housing" unless they can secure significant rental assistance to make up the gap.

Number Served

Increasing this account by $500,000 will provide important rental assistance to approximately 85 DMH clients.

Recommendation 2

Support legislation requiring the set-aside of affordable housing for DMH clients on the site or within the service area of land formerly used for DMH Facilities and legislation that requires up to 50% of the proceeds of any sale to be used for DMH Housing.

Background

Within the past ten years, DMH has closed three state hospitals (Danvers, Metropolitan and Medfield). Once the property is declared as surplus, the responsibility of disposing it falls to the Division of Capital Assets Management. (DCAM). As a matter of general practice, DCAM prepares a reuse plan, in consultation with the city or town in which the land is situated, prospective developers and other consultants. Once agreement has been secured, DCAM then seeks legislative authorization to sell the property.[9]

Generally speaking, there are two approaches to the issue: One is to require that a specific percentage of any housing developed on the site be set aside for clients of the Department of Mental Health; the other is to set aside a percentage of the sale proceeds to build or acquire housing for clients of DMH. An example of the first approach is section 6 of chapter 309 of the Acts of 1996 relative to the disposition of the property of the former Metropolitan State Hospital required any future developer of the site to "devote no less than ten percent of any housing on the site to housing for clients of the department of mental health…." An example of the second approach is proposed legislation filed last session by Representative Kay Khan and others (HOUSE 3428) which directs the establishment of a state hospital disposition fund into which would be deposited 50% of the proceeds of any sale for housing and other services for clients of DMH and the Department of Mental Retardation.

There are advantages and disadvantages to either approach. A percentage set aside of any housing constructed on site provides DMH with long-term assets (housing), which theoretically could be used for decades to come. The disadvantage is that one must be very careful in determining the percentage to ensure it is fair to DMH, but not so high as to discourage any developer to bid on the property. As mentioned previously, clients of DMH are in the very low-income category and the subsidy gap is significant. Developers are used to affordable housing targeted to people at 80% of median income and DMH clients are as low as 15% of median income. It can be a time consuming process, but developing housing that includes units for DMH clients can be done and the resulting housing units are there for generations of DMH clients.

The "cash proceeds" approach has the potential advantage of being quicker in that the development issues noted above are not present. However, many of the properties declared as surplus have significant environmental clean up issues, easements which interfere with future development, and other issues, all which tend to lower the bid price. As a result the net proceeds of a sale are often less that what is necessary to acquire a significant amount of housing.

Already filed for consideration in this legislative session are at least two bills relative to providing housing on the site of former DMH facilities or state land declared as surplus. Representative Kay Khan and others (Docket number 732) have filed legislation similar to House 3428 (as discussed above), and Representative Lida Harkins and others have filed special or specific legislation (docket No. 2026) relative to the disposition of the former Medfield State Hospital. This legislation would require any developer to include 24 units for DMH clients on site and for the construction of no less than 20 additional units elsewhere in the Metro Suburban DMH service area.

Recommendations

We believe any legislation, which would require, encourage, or promote the development of housing and residential services for DMH clients is worthy of support.

- When the legislation is specific such as in the case of Medfield State Hospital, we believe it is better to require a specific percentage or amount of housing on the site, or in the appropriate DMH service area.
- When the legislation is general, such as that filed by Representative Khan it is appropriate to talk about proceeds because given the nature and disparities of land, no one fixed percentage would be economically feasible or workable for all developments. Moreover, if housing were not being developed at the site then nothing would be gained. However, we believe that under the sale proceeds approach, the proceeds should be targeted to housing and perhaps some rental assistance. Since these would be proceeds from the sale of a capital asset, we think it makes sense to expend them for the acquisition or construction of other capital assets.

Recommendation 3

Support legislation to provide additional flexibility to the Facilities Consolidation Fund to allow construction of more housing for DMH clients.

Background

The Department of Mental Health (DMH) operates a large community-based service system for thousands of its clients. Depending on client needs, varying levels of services are provided to clients living in their homes or apartments, which they independently accessed through such routes as families, friends or their own initiative. Many others, however, including those with histories of homelessness, require housing and services, which DMH and its contracted providers strive to provide.

As previously noted, in the earliest years of the movement to discharge people with chronic mental illness from hospitals or similar institutions and into the community the programs which were established tended to be large, staffed shared-bedroom group homes, which while community-based, still had institutional dimensions.

The chronic shortage of affordable housing opportunities in Massachusetts required the Commonwealth to provide incentives to the housing community to create housing, which would be available for low-income clients of DMH and DMR. One such incentive was the Facilities Consolidation Fund (FCF), established in 1993 to help both DMH and the Department of Mental Retardation (DMR) expand their respective community based residential systems.

The Facilities Consolidation Fund

FCF, created by Chapter 52 of the Acts of 1993, reallocated bond authorizations formerly earmarked for maintaining or expanding older DMH and DMR facilities to create a fund to capitalize the development of new affordable housing for clients of DMH and DMR. The legislation initially established a $50 Million equity loan fund to promote affordable housing development. A non-profit developer working with DMH or DMR on an FCF affordable housing project could receive a deferred payment FCF equity loan for up to 30% of the project's total development costs. The loan is not repaid unless or until the property is no longer used for affordable housing.

The FCF statute also required that the loan program operate under a facilities consolidation plan prepared by EOHHS, reviewed and approved by the Department of Housing and Community Development and filed with the Secretary of A&F and the Senate and House Committees on Ways and Means. The Plan *(A Plan for the Development of Community-based Housing and Programs for Clients of the Departments of Mental Health and Mental Retardation)* was filed by EOHHS in January 1994.

In 2002, the Legislature enacted legislation that increased the maximum amount of loan funds FCF could contribute to a project from 30% to 50% of a given project's total developmental cost. Also, there was a reauthorization of the act and the loan authority was increased to $100 Million for DMH and DMR.[10]

While there is still reluctance on the part of the majority of mainstream housing developers to take on the difficult task of developing housing for people with mental illnesses, DMH, its community collaborators, and sister state agencies have used the FCF to create a range of housing and service opportunities for clients. Between 1994 and December 2002, 138 FCF loans for a total of $22,785,408 were granted to DMH and DMR housing projects. Of this amount $11,395,545 in FCF funding was awarded to projects serving DMH clients, including 18 projects with 149 units for the homeless mentally ill.[11]

The Need or Problem

Much has changed since the establishment of the FCF, and the housing environment is very different today. Accordingly, we believe changes need to be made to the FCF law in order to maximize usage of the FCF and to create more housing opportunities for DMH clients.

When the FCF program was originally conceptualized in the early nineties, the overriding focus at the time was on closing state hospitals and developing group homes for DMH and DMR clients. Other federal capital financing, such as the HUD Section 811 program and certain McKinney programs were available for combination with FCF. Federal Section 8 rental assistance to go along with the FCF and other capital funds was more readily available and could be targeted to DMH or DMR clients.

Today there are virtually no new Section 8 rental subsidies. Moreover, HUD will not allow section 8 project based subsidies to be targeted to a specific disability class such as DMH clients. In short, an apartment with a project based section 8 subsidy (meaning the rental subsidy is attached to the unit, as opposed to a mobile certificate which goes with the tenant) must be available to all persons eligible for a subsidy and cannot be limited to DMH clients.

Without project based section 8 rental subsidies, DMH and developers have had to develop creative rental assistance solutions to make the units "affordable" for DMH clients. This has considerably slowed the process and lowered the number of FCF projects over the past year (See chart on next page).

Another change is that DMH has decreased its reliance on traditional group home projects. Instead, they have been pursuing development projects that foster independent, integrated living and supported housing.

In an integrated housing approach DMH and the developer agree to have a fixed number of units within a housing development set aside for DMH clients. FCF financing would be available for up to 50% of the total development costs for those specific units. As previously noted, making those units "affordable" for DMH clients is a significant challenge. As a result, these project developments have been slow and difficult.

The third significant change or condition, which we believe warrants modifications to the FCF is the fact the original FCF statute excluded private (for profit) developers from participating. Today, private developers produce the largest amount of rental housing units, including median-income affordable units in the Commonwealth. As a result, as DMH pursues an integrated, independent living, supported housing approach, FCF is not available for the developers who produce most of that housing.

The shortage of rental assistance at both the federal and state levels threatens the supported housing model and has significantly slowed the rate of construction of new housing units for DMH clients.

■ FCF PROJECTS

Fiscal Years	Total Projects	Non Integrated Projects	Integrated Projects*	Total Units	Non-Integrated Units	Integrated Units
FY 02	14	14	0	146	146	0
FY 03	9	7	2	54	39	15
FY 04	4	3	1	24	20	4
FY 05	8	2	6	52	16	36
FY 06	8	4	4	49	25	24
FY 07 **	7	2	5	36	16	20
Total	50	32	18	361	262	99

* Integrated housing represents those projects where DMH units comprise less than 20% of total units.
** FY 2007 information is incomplete.

The chart above provides some information on the FCF projects that have been certified by DMH since FY 2002. Even the most cursory examination discloses the number has leveled off since FY 2002. We believe the two major contributors to the leveling off are the shortage of section 8 rental assistance and other federal funding, and the decision to pursue integrated housing.

At a time when significant numbers of DMH clients are on waiting lists for community based housing, the number of housing units created through the FCF has slowed, while the waiting lists grow each day. The FCF requires no new capital authorizations, and the current balance available for DMH housing is estimated to be in excess of $30 Million. We urge the Legislature to make changes to the FCF law to reflect the current realities of the housing market and to expedite the construction of housing for DMH clients. Our recommendations are as follows:

Recommendations

- **Increase from 50% to 100% (or at least 75%) of total development cost as the allowable amount for a FCF equity loan.**

This would provide additional incentives for participation and could help in the rental assistance issue by lowering the developer's overall carrying costs. The Commonwealth's Department of Housing and Community Development would have the discretion to determine the amount of financing, but the range should be up to 100%. Developers who actively plan for and pursue an allocation of state or federal rental assistance should receive a higher percentage than those who do not.

- **Expand the universe of eligible FCF developers by allowing private developers, including those pursuing housing tax credits and those securing housing financing through MassHousing, to participate.**

This would allow and promote increased production of housing and DHCD, with appropriate consultation from DMH and DMR, could by regulation set standards and other conditions for participation. To exclude the largest producers of housing from a program designed to encourage housing production makes little sense.

- **Allow FCF funds to provide an operating subsidy for those units set aside for DMH clients**

The absence of project based section 8 rental assistance has made it exceedingly difficult to make new units "affordable" for DMH clients, who on average earn 15% of area median income. If, subject to regulations adopted by DHCD in consultation with DMH, developers were eligible for an operating subsidy for those units set aside for DMH clients, the need for high level rental assistance would be obviated.

In this regard, we should note that DMR's annual appropriation budget provides for the operating costs of its housing. As a result DMR has been able to avoid the necessity of state or federal rental vouchers.

We are not suggesting that DMH receive huge increases to its budget to provide for the operating costs of its housing, but we are asking that it be allowed access to FCF to provide an operating subsidy for those units set aside for DMH and developed through the FCF, as well as for Mass Housing set aside units.

Conclusion

We have attempted through this report to provide detailed and comprehensive information on the housing needs of DMH clients and the housing climate in general. We hope you will use this report as a resource as housing issues arise. We respectfully request that you give all of our recommendation serious consideration, as together we work to provide DMH clients and their families with community housing and support services.

PART TWO: MAMH BUDGET RECOMMENDATIONS FOR FY 2008

(A) Language Recommendation (No Funding Required):

- Continue to provide in Line Item 4000-0300 the oversight authority to DMH over any proposal to limit access to medications used in the treatment of mental illness. This legislative initiative has appeared in every budget since FY 2004.

(B) Funding Recommendations:

- **Maintain DMH Base Funding Levels:**
  DMH has reduced its FTE count by 1,031 (21%) since FY 2002. No agency or organization in or outside of government can sustain quality in its programs and services if it continues to reduce personnel at this rate. **At a minimum, we ask that the Legislature not reduce DMH below the levels required to maintain its base and current services.**
- **Rental Assistance ($ 500,000):**
  We also recommend and urge you to support another $500,000 to Account 7004-9033 (Department of Housing and Community Development). This would provide rental assistance to approximately 85 additional clients of the Department of Mental Health.
- **Adult Mental health Services (line Item 5046-000):**
  We recommend and urge you support adding an additional $3 Million to the Adult Mental Health Services Account (5046-000). The waiting lists at DMH are the result of more than a decade of under funding, which has only been addressed in the past three years. An additional $3 Million will allow the Department to provide housing and residential support services to adults as well as youth who are transitioning into the adult system.

ENDNOTES

[1] U.S. Department of Health and Human Services. Mental Health: *A Report of the Surgeon General*. Rockville, MD: SAMHSA, CMS, NIH, NIMH, 1999, pg.293.

[2] Testimony of Walter Jabzanka, DMH Director of Community Systems Implementation, Joint Legislative Committee on Housing and Urban Development (March 19, 2003)

[3] Burt, Martha *Evaluation of the Special Homeless Initiative of the Massachusetts DMH*, Urban Institute, Washington DC (October 13, 2006) pg. 6

[4] Id.

[5] Id.

[6] Id. Pg. 7

[7] The focus on discharge ready is understandable in light of the *Olmstead Case* where the United States Supreme Court concluded the Americans with Disabilities Act requires states to provide care for persons with disabilities in community based settings, rather than institutions, if the community placement is clinically appropriate and will not fundamentally alter the state's programs and services. *Olmstead v. L.C.,* 527 U.S. 581 (1999).

[8] Massachusetts Department of Mental Health Fiscal Years 2005-2007 *State Mental Health Plan FY 2007* Submission, pg. 35 (September 2006).

[9] In the FY 2004 General Appropriation Act, the Legislature established a process whereby DCAM could dispose of surplus property without further legislative authorization. However, this authority expired on June 30, 2005. (St. 2003, c. 23, sect. 548)

[10] The legislation did not create separate funds for DMH and DMR. However, the FCF has always been operated as providing equal sums of money for DMH and DMR. The current "balance" or unused authorization for DMH is approximately $30 Million.

[11] Overview of the DMH Facilities Consolidation/Community Housing Development Fund, Pg. 5-7, (December 2002).

M A M H

Massachusetts Association For Mental Health, Inc.

MAMH BOARD OF DIRECTORS | 2006 – 2007

Emily Anderson
Michael Annunziata
Lauren Baker
Paul Barreira
Kathleen Betts
James T. Brett
James Callanan
Michael Charbonnier
Domenic Ciraulo
Martin Cohen
Gerald Cohen
Rachelle Cohen
Pamela Corradino D'Amore
Katherine Craven
Caleb DesRosiers
Derek Davis
William Delahunt
Maria Depina
Michelle DiLisi Donohue
Paul Drew
Deborah Enos
Heidi Finnegan
Robert D. Fleischner
Brian Flores
Herbert Friedman
Thomas Glynn
Robert Griffin
Paul Guzzi
James Hooley
Robert Hughes
Reginald Jackson
William Kantar
Bethany Kendall
Martin Kelly
Steven Kadish
Nasir Khan
William Kilmartin
Fran Kochman
Stuart Koman
Gary Lamson
Linda Lanton
Gloria Larson
Barbara Leadholm
Kendell K. LeBray
Richard C. Lord
Sarah MacEachern
Robert Macy
Danna Mauch
Vincent McCarthy
James E. McDonald
Loretta McLaughlin
Barry Mintzer
Carole Montgomery
Gisela Morales-Barreto
William Mosakowski
Nancy Nager
Frank P. Ollivierre
Edward C. O'Malley
Elizabeth Pattullo
Christopher Pilkington
Paul Pimental
Sandra Pimental
Maureen Pompeo
Jeanie Quirk
Peter Scanlon
Thaleia Schlesinger
David Shapiro
Marylou Sudders
Christine Sullivan McMahon
Paul Summergrad
Patricia Wada
Barry White
Eleanor White
Anne Whitman

Massachusetts Association For Mental Health, Inc.

James Hooley, President • David K. Shapiro Past President • Bernard J. Carey, Jr., Executive Director
130 Bowdoin Street • Boston, Massachusetts 02108
Phone 617-742-7452 • Fax 617-742-1187 • E Mail infomamh@mamh.org