MAMH

Massachusetts Association for Mental Health

People are waiting

MAMH

Massachusetts Association for Mental Health

February 2009

Dear Legislator:

This is our seventh ***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 active participation of the Legislature, embarked on a series of initiatives that have increased community based housing opportunities for DMH clients.

- **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.
- **FY 2004:** DMH, in response to a legislative request, filed 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, was filed with the Legislature in March 2004 and, among other things, set forth **a timetable for placing 268 "discharge ready"** DMH clients into the community.
- **FY 2005, 2006 and 2007:** DMH moved "discharge ready" clients from inpatient facilities into the community and met its three-year goal of creating no less than **268 community placements.**
- **FY 2005, 2006,2007, 2008 and 2009,** the Legislature provided annual increases of $500,000 for a special **rental assistance** account for DMH Clients, bringing the total in the account to $4 Million.
- **FY 2008:** The Legislature enacted and the Governor signed into law a housing bond bill, which among other things, reauthorized the **Facilities Consolidation Fund (FCF),** which provides financing assistance for developers to create housing for clients of DMH and DMR. In addition, the legislation amended the FCF to allow participation by for-profit housing developers, a provision DMH had long been advocating.

MAMH is proud to have been a part of these housing efforts, and we are grateful for the attention and support the Legislature has given to the community-based housing needs of DMH clients. We hope your interest and support will continue.

Because this is the first year of a new legislative session, we have used this Report to set forth some historical information about DMH and its housing models. We have also set forth some recommendations to further address the housing needs of people with mental illnesses and their families as well as our DMH budget recommendations for FY 2010 and 2011.

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.

Thomas P. Glynn
President

Bernard J. Carey, Jr.
Executive Director

Timothy O'Leary
Deputy Director

People are waiting for housing

I. EXECUTIVE SUMMARY

The Department of Mental Health (DMH) and its community-based 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. Consistent with the trend across the nation, DMH has emphasized the development of 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 supports 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.

Critical to the ability of a DMH client to live in the community is the availability of rental assistance. In recent years, the shortage of rental assistance at both the federal and state level threatened the supported housing model and significantly slowed the rate of construction of new housing units for DMH clients. Federal Section 8 rental subsidies became non-existent and HUD prohibited "project based" section 8 certificates from being targeted to a specific subset of clients (i.e. DMH clients).

In order to increase housing opportunities for DMH clients, MAMH has proposed a series of recommendations for the current two-year legislative session (2009-2010).

These recommendations are:

(1) Rental Assistance: Increase Appropriation Line-Item 7004-9033 by $500,000 in each of the next two fiscal years (FY 2010 & FY 2011), bringing the total appropriation to $5 Million.

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

(3) Existing Community Placements: Maintain annualized costs of all community placements created since Fiscal Year 2005 for homeless mentally ill adults who are "discharge ready" and in hospitals or continuing care facilities, or who are in shelters or are homeless. (Line-Item 5046-0000, and 5046-0000 General Appropriation Act)

(4) New Community Placements: Increase by $1 Million in each of the next two fiscal years funding for new housing and residential support services for the mentally ill adults and families who are either homeless, in hospitals, shelters or other transitional housing.

(5) Communities First: Support Communities First, the Commonwealth's Olmstead Plan (Community based housing for disabled people and seniors currently residing in institutions).

People are waiting for homes

II. 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 helping a constituent or family member.

The membership of our board of directors – 80 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 two former DMH Commissioners, a sitting US Congressman, and others familiar with state and federal government, as well as consumers, family members and community activists.

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

III. INCREASING HOUSING OPPORTUNITIES FOR PEOPLE WITH MENTAL ILLNESSES AND THEIR FAMILIES

(A) Introduction

Since this is the first year of a new legislative session, we wanted 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, 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.

(B) General Background

Massachusetts has been a leader in caring for people with mental illness since it built the first public asylum in America. The Worcester State Hospital opened in 1833, serving as the model that other states followed. Over the next century, Massachusetts established a network of public hospitals, responding to needs as they arose.

The Community Mental Health Centers Act of 1963, signed by President John F. Kennedy, espoused treating people with mental illness locally, rather than in large isolated state hospitals, and led to the construction of federally funded community mental health centers across the country, including several in Massachusetts. Mental health care reform in Massachusetts has grown and changed since, when the Legislature enacted the Comprehensive Mental Health and Retardation Services Act. Its purpose at the time was to decentralize DMH and set up a network of services within each community so that people could receive help close to their homes.

The process to increase the availability and quality of community programs was enhanced in 1978 when the Brewster consent decree was initiated. The consent decree asserted the right of mentally disabled persons in the Western Massachusetts Area to receive care in the least restrictive setting. It signaled a shift in the locus of treatment from institutional to community settings and aimed to reduce the Northampton State Hospital census. As a result, significant resources were directed to this DMH Area to implement the decree, accomplished through contracts with local providers. It became a model for community-based service delivery statewide. MAMH was a party to the litigation leading to the Brewster Consent Decree.

(C) From the Hospital to the Community

As 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 integrated, conventional housing (i.e. an apartment within a complex of apartments) the stigma and siting issues that delay 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]

In 2008, the Legislature enacted and Governor Patrick signed a Housing Bond Bill. This law reauthorized the Facilities Consolidation Fund (FCF), which provides financing assistance to developers creating housing for clients of the Department of Mental Health and the Department of Mental Retardation. In addition to providing $25 million in reauthorized funding for the program, the law contains a provision for which DMH had long been advocating. This provision allows FCF funding to be given as to "for-profit" housing development organizations in addition to the long eligible non-profit organization. DMH expects to obtain a greater volume of new, scattered-site apartments as a result of this provision.

The state hospital census in Massachusetts has dropped drastically from 23,000 in the 1950s to approximately 850 in 2008. These are spread among three DMH-operated state psychiatric hospitals, seven community mental health centers (CMHCs), two contracted adolescent units housed in a state psychiatric hospital, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total capacity, which includes beds for forensic patients, includes 820 adult beds and 30 adolescent beds. All are extended stay beds with the exception of three 16-bed CMHC acute units. Children, adolescents and most adults receive acute inpatient care in private or general hospitals, with the

exception of adult admissions to the CMHC acute units and some forensic admissions.

Much of this reduction in hospital census occurred with the closure of four adult state hospitals and the only state-operated inpatient facility for children under age 14 between 1992 and 2003. **Funds saved from the hospital closures were redirected into a variety of innovative and community-based programs.**

In February 2004, DMH presented the Legislature with a plan that proposed further downsizing and restructuring of the DMH adult inpatient system. The final report, prepared by the Facility Feasibility Commission, has led to further community expansion and the approval of a bond bill to consolidate two of the oldest hospitals and replace them with a new state-of-the-art psychiatric facility. This new facility will provide an optimal environment of care that is respectful and dignified, and that supports recovery and shorter lengths of stay so that individuals can return to productive lives in the community.

(D) DMH Housing and Residential Support Services

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.

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.[2]

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.[3]

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.**[4]

DMH's work has resulted in creating a housing capacity for approximately 6040 individuals in its community services system. Of this capacity, 77% of the housing units receive federal or state subsidies leveraged by DMH. These living arrangements provide a range of options from congregate living to independent apartments integrated fully within the community.[5]

But mere numbers do not adequately tell the story of community-based housing. For example, one of DMH's Central Massachusetts Area Providers, Riverside Community Care, opened an adult residence, Hamilton House, where eight individuals, who had spent a combined total of 120 years as patents at Worcester State Hospital, are now living in the community.[6] Eight individuals once confined to a hospital ward now walk the streets, enjoy the air, the shops, diners, and whatever else the community offers.

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.

People are waiting for the safety of a home

IV. OUTREACH TO HOMELESS

(A) Homeless Mentally Ill Initiative

DMH confronts homelessness through significant efforts in increasing and improving housing options and services for homeless individuals as well as through interagency collaboration. This collaboration includes a number of task groups dealing with both policy and service delivery issues. One major collaboration is the Homeless Mentally Ill Initiative, which provides clinical and residential services to support clients in community-based housing and leverages over $150 million in federal and other housing resources to fund both the development of and client access to housing units. Most of this funding is obtained through the U.S. Department of Housing and Urban Development (HUD) McKinney funds.

Since FY 1992, the DMH Homeless Initiative has enabled DMH to create a capacity for serving and placing an average of 2,400 homeless individuals with mental illness each year. DMH also has developed or gained access to more than 1,200 new units of housing during that time. The program is operated statewide with a concentration in the Boston area. In FY 2007, DMH received its first appropriation of new, additional Homeless Initiative funds in four years, totaling $3.2 million. This increase in funding allowed DMH to leverage 150 new units of housing. DMH was able to launch supported housing projects throughout the state and access housing resources from private non-profit housing developers, municipalities, and through several state and federal housing programs such as HUD's McKinney Homeless programs.

(B) PATH Program

Another DMH statewide outreach and services effort is supported by a $1.4 million per year federal Projects for Assistance in Transition from Homelessness (PATH) grant from the Center for Mental Health Services and $600,000 in state funds. Under the program, clinical social workers regularly visit mainly adult homeless shelters, across the state to connect with persons with mental illness and provide them with such assistance as direct care, housing search and advocacy and referrals to key services. The referrals are to such programs as job training, literacy education, mental health services, substance abuse treatment, and benefits and entitlements. Adults and older adolescents with a serious and persistent mental illness are referred to DMH for eligibility determination. In federal FY 2006, PATH clinicians reached and screened 7,578 individuals throughout the state, with 4,555 becoming PATH clients and receiving onsite assistance and referrals to a range of services. Partners include the Mass Housing and Shelter Alliance, numerous homeless shelters and local Continuums of Care.

(C) Street Outreach Programs

DMH contributes funding for outreach to homeless individuals with mental illness in transitional housing, on the streets and in less populated areas of the state. Members of outreach teams do active street work, ride in medical vans and visit emergency shelters. Physicians from affiliated agencies are available to provide medical care to homeless individuals who will not come into a center or shelter for treatment. The street outreach program serves individuals and families living in shelters or on the streets in Boston, Waltham, Lowell, Lawrence and Quincy. The program includes successful referrals to housing, detoxification and mental health services.

(D) Aggressive Treatment and Relapse Prevention(ATARP).

ATARP is a supportive housing program targeted to serve homeless individuals and families diagnosed with co-occurring substance abuse and psychiatric disorders. ATARP fosters recovery and stability through provision of intensive, flexible support services offered by skilled, empathic staff in conjunction with permanent housing in the form of individual apartments.

People are waiting for the dignity of a home

The program is a collaboration between the Departments of Mental Health and Public Health, Bureau of Substance Abuse Services initiated in 1998 with a $2.4 million three year grant from the U.S. Dept of Housing and Urban Development, now in its tenth year the HUD annual grant is $660,772 with additional matching funds provided by DPH, Bureau of Substance Abuse Services $165,000 and DMH $211,000.

Most participants are housed in scattered-site, one-bedroom units. In FY08 the program served a total of 82 participants, 57 single adults, 10 adults in families and 15 children from 9 families.

(E) Commission to End Homelessness

DMH is a member of the Massachusetts Commission to End Homelessness, which in FY 2008 issued its report and the Massachusetts 5-Year Plan to End Homelessness. DMH is also an active member of the Massachusetts Interagency Council on Homelessness and Housing, chaired by the Lt. Governor.

IV. RECOMMENDATIONS

We understand that given other pressing needs and fiscal realities, there will always be unmet housing and residential support service needs among DMH clients. The waiting lists grew over years, and they will not be eliminated by a single appropriation. **What we do ask is for a continuing commitment to do what is possible to maintain and increase the affordable housing and residential support services opportunities for people with severe and persistent mental illness.**

RECOMMENDATION 1

Rental Assistance – Increase Appropriation Line-Item 7004-9033 by $500,000 in FY 2010 and 2011, bringing the total appropriation to $4.5 Million for FY 2010 and to $5 Million in FY 2011.

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.

Under this rental assistance program, local DMH 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 2009, approximately 900 DMH clients will be receiving rental assistance from this account.**

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 million.

Beginning with the 2006 Fiscal Year budget, MAMH with the aggressive support of both the House and Senate embarked on an effort to obtain annual increases of $500,000 in this line-item. We were successful in this effort because rental assistance represents the best return on investment and provides the most flexibility in addressing the housing needs of DMH Clients. **The steady growth of this line-item is best represented in the following chart.**

Fiscal Year	Amount of Increase	Statutory Cite	Amount in Line-Item
FY 2009	$500,000	CH. 182 Acts of 2008	$4 Million
FY 2008	$500,000	CH. 61 Acts of 2007	$3.5 Million
FY 2007	$500,000	CH. 139 Acts of 2006	$3 Million
FY 2006	$500,000	CH. 45 Acts of 2005	$2.5 Million

Why Rental Assistance is Critical

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.

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 State and Medfield). Because of the severe budget reductions that DMH will experience in FY 2010, there may well be another closure.

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.

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.

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, unless the net proceeds of a sale can be leveraged, they are often less than what is necessary to acquire a significant amount of housing.

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

RECOMMENDATION 3

Maintain annualized costs of all existing community placements created since Fiscal Year 2005 for homeless mentally ill adults who are "discharge ready" and in hospitals or continuing care facilities, or who are in shelters or are homeless. (DMH Line-Items 5046-0000 or 5046-2000)[7]

The falling local, state and national economies have resulted in significant reductions to the DMH FY 2009 budget, though the so-called 9C cuts, and the budget proposed by the Governor for FY 2010 (House 1) proposes additional cuts.

The Department has continued to make housing and residential supports a priority and there have been no specific reductions in this area. However, as the Department reprocures its community- based system and moves from a program model approach to a flexible community supports, it is critical that at a minimum there be no reductions to the existing community based placements.

RECOMMENDATION 4

Increase by $1 Million in each of the next two fiscal years funding for new housing and residential support services for the mentally ill adults and families who are either homeless, in hospitals, shelters or other transitional housing. (Line-Item 5046-0000 or Line-Item 5046-2000)

This Report has outlined the good work of DMH and its community-based providers have done in the area of providing housing opportunities for clients of DMH, including the homeless and those "stuck" in hospitals or continuing care facilities waiting for a community placement.

While the unmet need would warrant a larger increase, we understand the fiscal realities and therefore suggest that you consider adding $1 Million for new community placements in each of the next two fiscal years. Whether you do it within line-item 5046-0000 or 5046-2000 (see footnote 6) or portions in both, it would be a wise investment and provide much needed help to individuals with mental illnesses and their families.

Moreover, as has been well documented, DMH received a disproportionate share of the 9C cuts among the agencies and department in EOHHS. MAMH never asked DMH to be immune from cuts, but we did expect fairness. Thus, to the extent any additional funding can be restored to DMH, we request that it be directed towards community-based housing and residential supports.

RECOMMENDATION 5

Support Communities First, the Commonwealth's Olmstead Plan (Community based housing for disabled people and seniors currently residing in institutions).

Communities First is the Commonwealth's Olmstead Plan. It is the state's response (in part) to Olmstead v. L.C., 527 U.S. 581, in which the United State Supreme Court concluded that the Americans for Disabilities Act requires states to provide care for persons with disabilities in community based settings, rather than institutions, if the community placement in clinically appropriate and will not fundamentally alter the state's programs and services.

The Olmstead Plan – self-described as "a work in progress" – incorporates an initial 18-month implementation strategy and is designed to maximize the extent to which seniors and people with disabilities of all ages are able to live successfully in their homes and communities. The fundamental goals of the Olmstead Plan are (1) to help individuals transition from institutional care; (2) expand access to affordable and accessible housing and supports; (3) promote employment of persons with disabilities and seniors; and (4) promote awareness of long-term supports.

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DMH has been active in the development and design of the Community First 1115 Research and Demonstration waiver, which has been submitted to the federal government for approval. This waiver is focused on diverting and discharging individuals from nursing facilities. It will expand Medicaid financial and clinical eligibility criteria, while providing access to a broad range of community-based services.

We hope legislators will take an interest in the further development and implementation of the Olmstead Plan and as specific legislative requests arise lend their support to this effort.

To see a copy of the full plan, go to:
www.stavros.org/documents/Olmstead_plan_FINAL_PRINT_VERSION_2.pdf

Conclusion

We have attempted through this report to provide information on the housing needs of DMH clients and on various initiatives, which address these needs.

We understand the dire economic circumstances presently confronting the Commonwealth and our nation. The sums we have requested are modest. Yet they will provide significant relief and assistance in helping DMH clients move to the community.

We respectfully request that you give our recommendation serious consideration, as together we continue the work to provide DMH clients and their families community housing and support services.

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

3 Id.

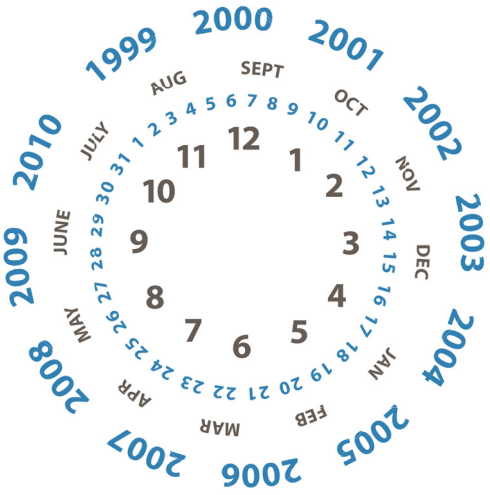
4 Id.

5 Commonwealth of Massachusetts, Department of Mental Health FY 2008 – 2010 State Mental Health Plan.

6 *Recovery Through Partnership,* DMH 2008 Annual Report, pg.8.

7 The Governor's proposed budget (House 1) proposes to consolidate 5046-2000 (homeless mentally ill account) into 5046-2000 (Adult mental health services) Whether or not the Legislature decides to adopt this consolidation, it is critical that the funding provided by both not be reduced.

People are waiting for your support



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