

CONNECTICUT LEGAL RIGHTS PROJECT, INC.

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TESTIMONY OF JAN VAN TASSEL, ESQ.
APPROPRIATIONS COMMITTEE
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Good evening. My name is Jan Van Tassel, and I am the Executive Director of the Connecticut Legal Rights Project (CLRP). CLRP is a statewide non-profit agency that provides free legal services to adults with psychiatric disabilities on matters related to their treatment and civil rights.

Since I became Executive Director of CLRP in 1998, the most consistent recurring legal challenge confronting our clients has been the unnecessary institutionalization of persons who no longer require a hospital level of care, but remain in an inpatient setting due to the lack of community services and housing to meet their needs. I was hopeful the following year, when the U. S. Supreme Court's *Olmstead* decision upheld the state's affirmative legal duty to provide services in the most appropriate integrated setting. This means a setting which maximizes the individual's opportunity to interact with persons who do not have disabilities, not just outside of a hospital.

Unfortunately, when I convened a group of advocates to discuss enforcing this legal mandate, we concluded that Connecticut already had a mental health system that was in crisis, and it was not prepared to serve more people. The lack of housing and community services was pushing people with mental illness into prisons, shelters and nursing homes. The primary cause of this dilemma was that the state, like so many others, failed to invest the savings generated by the closure of two large state hospitals into the community system. Instead, millions of dollars were shifted to the general fund, and appropriations for mental health services stagnated for years while the demand for services increased annually.

This was a recipe for disaster; one which was documented in the report issued by the Governor's Blue Ribbon Commission on Mental Health in July of 2000. Exacerbated by declining private hospital beds for persons with mental illness, restrictive insurance coverage for mental health care, and low provider Medicaid rates and grant payments, the mental health system was stretched to a breaking point.

I would like to tell you that we have rebounded in the past decade, but we have not. Despite a number of very promising initiatives, we still have hundreds of people in the hospital and the community whose lives are on hold because they cannot access the housing and services they need. They struggle to survive, often in shelters, because they cannot afford to pay market rent, and the waiting lists for Section Eight and Rental Assistance is years long. They try to cover the cost of food, transportation and other necessities while they manage a set of complex medications, and attempt to navigate the bureaucratic labyrinth of programs that are supposed to help them. On top of that, they must confront recurring stigma and discrimination from potential landlords, employers, and on occasion, the staff who assist them. It is overwhelming and dehumanizing.

Now there is another plan to close a state hospital and invest only half of the projected savings into housing and community services. It doesn't take a rocket scientist to predict what will happen. We've been there and done that. Doing it again borders on willful and malicious negligence.

Please understand that I do not believe that Cedar Crest Hospital is essential to the state's mental health system. In fact, at the time at the Governor proposed closing Cedar Crest, CLRP was compiling data and legal research in preparation for filing an *Olmstead* suit against the state for violating the right to community integration. We had concluded that the resources used to maintain that facility might be better utilized to stabilize and expand the community system and serve persons unnecessarily hospitalized in state facilities. We have already entered into a memorandum of understanding with DMHAS and the Department of Justice which requires CVH to establish a system to identify patients who no longer need hospital care and establish a list of such individuals and their barriers to discharge. We expect that will promote timely community integration from that facility.

However, the fact that the state is prepared to divert half or more of the funds generated from closing Cedar Crest is beyond short-sighted. It is just plain incomprehensible. By simply addressing the immediate short term needs of persons who will be discharged in order to close Cedar Crest, the state ignores the need to sustain the capacity of the overall system. This is the same short-sighted approach used before and there is every reason to expect the same results; emergency room back-ups, gridlock and cost shifting that the state has been trying to reverse for a decade.

Perhaps the most frustrating element of this scenario is the fact that we have learned from our mistakes and have developed new innovative models to help persons with mental illness not just live, but thrive in the community. The most noteworthy of these is supportive housing which combines housing and access to a range of services, and has been demonstrated to reduce Medicaid expenditures for hospital services, increase the engagement of tenants in education and employment activities and even contribute to increased neighborhood property values. It works for taxpayers, tenants and communities.

Supportive housing can also be adapted to provide age-appropriate housing for young adults transitioning from DCF to DMHAS. As you know, there continue to be an increasing number of DCF clients being identified as eligible for DMHAS services every year. In fact, the lack of an increase in this DMHAS line item is the cause of serious concern. Developing interagency, collaborative housing arrangements is one approach to improve transitions.

In addition, DMHAS is collaborating with other state agencies to develop supportive housing models for veterans, persons who have been frequent service users and persons with mental illness who are being released from prison.

Supportive housing is not a cure all. However, it is an evidence-based, cost-effective model that provides a stable living environment for persons with mental illness. Such a foundation has been shown to be instrumental in supporting recovery, and enabling tenants to pursue the education and employment opportunities required to be self-sufficient.

Therefore, I urge this committee to reject the failed policies of the past and use hospital closure as a mechanism to strengthen the community system, not to help balance the budget. You can do this by setting aside all of the savings derived from closing Cedar Crest Hospital for the adult community mental health system, and dedicating half of those funds to supportive housing.

You have the opportunity to do it right this time. I hope you will take it.

If this committee chooses to continue its opposition to closing Cedar Crest, I urge you to set aside housing vouchers for DMHAS clients being discharged from institutions, transitioned from DCF or who are homeless.