Housing That Heals:

A Search for a Place Like Home for Families Like Ours

Housing That Heals Summary

For decades, thousands of families have been trying to build housing that will save our loved ones from living on the streets, jails, and grim care homes with untrained staff. The status quo forces clients, families, providers and communities to suffer needlessly.

The purpose of the Housing That Heals mission is to change the narrative and shatter the status quo by: 1. Defining the problem and forgotten population, 2. Sharing solutions and strategies to reform systems, 3. Educating and advocating for a shared action plan that will start building more housing that heals in order to stop the suffering.

A full continuum of psychiatric care includes all levels of Housing That Heals. That continuum must include Institutions for Mental Diseases (IMDs) and Adult Residential Facilities (ARFs) and congregate communities of tiered care that provide clinical and social supports on-site for those who cannot survive in supported independent living and do not deserve to be housed in a jail pod or a cardboard tent. In order to have a full continuum of the right care, at the right time and in the right place, housing and facilities for those with serious brain disorders and mental illness must be created to provide health, safety, and dignity.

A health care system that includes a tiered array of Housing That Heals as part of a full continuum of psychiatric care will help save lives, improve communities, and save money. Authentic partnerships must be encouraged to design systems that include a continuum of psychiatric care from crisis, acute, subacute, and an array of supported housing that allows everyone to live and die with dignity - Housing That Heals.

The problems of California's system for the seriously mental ill has resulted in the tragedy of untreated seriously mentally ill individuals on the streets and in jails. The lack of appropriate housing and treatment facilities denies the right to treatment before tragedy, incarceration, institutionalization, or homelessness - a reality that has occurred over and over again since California's deinstitutionalization wave. The State must move beyond the current fail-first / housing-first mentality.

- California must de-silo funding and delivery systems to provide true community integration for both SMI and SUD populations.
- California must ensure that any new waivers, policies, or legislation will not incentivize a Homeless Continuum of Care or the Drug Medi-Cal Organized Delivery System to displace vulnerable SMI residents who are currently living in ARFs or Board and Cares.
- California must stabilize the current supply of community-based beds.
- California must allow resources and funding to follow the patient. California must hospitalize those who need it and create community pathways to support assisted outpatient treatment for people who do not need hospital-based care.
- California must focus on getting FSPs, AOT clients, and those on LPS Conservatorship access to appropriate levels of housing and supports to intervene and prevent ongoing crisis. Keep the promise of "whatever it takes".

Defining the Problem:

The key drivers of despair and disparity in California care and treatment for the SMI population are:

- No shared definition of SMI in the medical, social justice, courts, detention, and community health delivery systems.
    - The lack of a common definition complicates analyzing and reporting the role and impact of SMI on the quality and need for care and treatment.
    - The multiplicity of definitions contributes to confusion among service providers and government programs of who will receive treatment and what that treatment will be.
- Fiscal discrimination codified in the California Welfare and Institution Code and Federal Medicaid Rules.
    - Unlike any other illness, California manages care of SMI populations “only to the extent resources are available”.
    - SMI and SUD populations are managed in two separate delivery systems with separate waivers and funding streams.
    - The California behavioral health system provides separate and unequal access to medically necessary care and appropriate housing for the SMI and SUD populations.
    - Diverting dedicated funding to other social entitlement programs prevents counties from providing adequate and medically necessary treatment in a Mental Health Rehabilitation Center (MHRC) or IMD for people living with SMI.
    - California law provides a right to shelter, a right to treatment, and a right to in-home supportive services to those with developmental disabilities. No equal entitlement exists for the SMI population.
- Bias towards the Recovery model vs the Medical model – prevents true system transformation for the SMI population. Marry the two models. Both/And, not Either/or:
    - Many in the SMI population are so ill that they do not respond to treatment in a voluntary community setting.
    - Due to the severity of one’s mental illness, some will experience acute episodes that require inpatient treatment.
    - Not all with SMI can achieve recovery to the point where they can live on their own without an intensive support system.
    - One size fits all fails many. Therefore, state programs and funds should support both the recovery and medical models of treating those with SMI.
- Lack of a tiered levels of care.
    - County jails are the largest providers of mental health services.
    - Gaps in access to housing options for individuals living with SMI have made that population most at risk of experiencing homelessness.
    - A lack of understanding and transparency exists about how housing placement decisions are made and prioritized for the SMI population.
    - The lack of a housing continuum of care for the most seriously mentally ill population has resulted in a humanitarian crisis of people with SMI flooding medical emergency rooms, psychiatric emergency rooms, psychiatric inpatient units, homeless shelters, IMDs, county jails, and courtrooms.

There is longstanding dearth of therapeutic care facilities and affordable permanent supportive homes in our communities for the thousands of California adults living with the effects of serious mental illnesses and substance use disorders. Their needs are not addressed by current policies and homelessness initiatives. This glaring gap in our system of care is increasing homelessness, exhausting family and public resources, and worse, it is perpetuating untold human suffering.

We ask that sufficient funding be devoted to fixing this gap now by investing in more therapeutic care facilities and affordable permanent supportive homes in our communities.

Many vulnerable individuals are ignored and unserved in current legislation and policies meant to solve homelessness.

- A growing population of mentally ill adults at risk of homelessness is not being counted in any Point in Time Count, and will not meet the "coordinated entry" guidelines.
- People in this population don't qualify for Project Roomkey or Project Homekey because they don't meet Continuum of Care Criteria.
- Project Roomkey helped Covid-vulnerable street people during the pandemic, but our loved ones were forced to stay in Covid-risky congregate settings.
- Housing First policies fail those at imminent risk of homelessness, and keep those ready for discharge stuck in restrictive and costly locked institutions.

Who are these forgotten people, and what happens to them now?

- No-fault chronic brain disorders like schizophrenia, schizoaffective and bipolar disorders typically strike in late adolescence or early adulthood, just when a person is set to launch a successful life, robbing him/her of the chance to establish a career, a home, and a network of friends.
- It can take years to find the right treatment, if it is available at all. Some turn to street drugs for relief.
- Though functional recovery can happen over time, this is impossible without a stable home and help, impossible with a monthly income less than $1000/month Social Security.
- Too many are unjustly sent away to locked institutions because there is no place for them in their home communities. Others end up on the street or incarcerated.
- Aging parents who've depleted their resources trying to help are asking themselves "where will my adult child live, and who will help him when I am gone?

Comparative Needs and Cost Benefit Assessments:

Psychiatric respite centers like the one that opened recently in San Francisco will serve some people with mental illnesses and co-occurring substance use disorders. However, people living with chronic mental illnesses, often require higher levels of medically necessary and clinically appropriate care. Homes for those living with a serious mental illness receive a maximum of $1,069 a month per person, without a patch. Homes for the IDD population receive a maximum of $9,515 a month per person. Board and Care operators have no incentive to serve those with a serious mental illness.

Additionally, recent investigative reports have suggested that the cost of Project Roomkey hotel rooms are not cost effective when compared with some of the Adult Residential Facilities (ARF) and Residential Care Facilities for the elderly (RCFE) that are discussed in the Housing That Heals paper.

For example, Psynergy, Inc. has created a cost comparison for their ARF/RCFE programs with other IMD/MHRCs across the state. However, you cannot compare the quality of the therapeutic community services provided at Psynergy at approximately $160/day to those provided at a Roomkey Hotel. And, their MediCal Specialty Mental Health Clinic services adjacent to the residential facility allow a resident access to a psychiatrist and therapist as needed. Counties are able to recoup FFP for these billable services which adds to the cost benefit.

Fairness and Equity:

While the state rightfully focuses on racial and other health disparities, we must not forget the population that is living with the greatest health disparity (see Dr. Tom Insel's equity slide attached.) According to the National Council of Behavioral Health, "People with serious mental illness die an average of 15 to 30 years younger than those without. This difference represents the largest health disparity in the U.S.; larger than gender, racial or socioeconomic differences. And unlike some of the other gaps that are slowly closing it isn't shrinking." Homes for the most seriously mentally ill people must be adequately funded at par with other vulnerable populations so that there will be no financial incentive to pick and choose who is helped first or who won't be helped at all.

There are solutions!

Successful models of Housing That Heals do exist, and can be replicated, with adequate funding. Below are examples from the Housing That Heals journey from the most restrictive to the least restrictive options:

- **California Psychiatric Transitions (CPT)**: is a 98-bed fully licensed Mental Health Rehabilitation Center, the equivalent of an Institute of Mental Disease/ commonly referred to as an IMD. It is not a state or county facility; instead, it is privately owned and contracts with many California counties who need a secured treatment and housing placement. The program is highly structured in a tiered level system and is a step down from hospitalization at a State hospital. Clients must attend groups based on treatment plan goals. The highest level of clinical and staffing support is provided. Offsite recreation and social activities are offered as appropriate. This is a treatment center that prepares people to enter an unsecured facility in a community setting. There should be a CPT in every region of the state.
- **Psynergy Programs** are prime examples of subacute, unlocked, therapeutic care facilities that can accommodate up to 90 residents. This "modified therapeutic community" model successfully helps people who may have been institutionalized become ready for more independent living in the community. We call it Housing that Heals because it offers so many health-promoting elements: deeply nutritious food, lovely surroundings, caring staff and (all too rare in such places) talk therapy, even equine therapy, and ready access to psychiatric and counseling help. We've seen our loved ones get their lives back while at Psynergy, even return to college classes. 27 counties now have a contractual relationship with Psynergy. Amazingly, base cost for Psynergy care is only $160/day (compared to $350 at other long term care facilities). We need a network of Psynergy Programs up and down the state.
- **John Henry Foundation** is a place where residents find a home in a community that is not cut off from the larger community; yet, provides the support needed to participate fully in life. It is a private non-profit. A Full Service Partnerships may lower the number of times an individual needs hospitalization, but what is the quality of life like for those who need to be surrounded by daily supportive services and people who they can easily interact with. Would it be possible to create programs like this in our public system? The yearly charge for someone to live here is $42,000 a year. In California, the cost to keep someone on the street is estimated at $41,000 a year, to keep someone incarcerated about $81,000+ a year. Both the human benefits and cost effectiveness of this program demand a focused policy to support scaling up therapeutic, enclave communities like this across the state.
- **Garden Park Apartments**, whose provider is the nonprofit organization, Hope Solutions, has developed a model of converting a rundown apartment complex into an oasis for families. Hope Solutions has used MHSA funds to build a Community Center that anchors the complex where all of the clinical services needed to support the residents are located. This model is safe with locked gates. The Community Center on-site allows both mothers and children efficient and effective access to licensed mental health providers in a timely manner. There are educational programs that support family life and enrich the future of both the children and mothers who live there. This residential program gets a gold star when it comes to being person and family-centered. The only problem is that so many more programs and residential opportunities like this are needed. This model needs to be duplicated for SMI 5600.3(b) adults between the ages of 25-65. Using available MHSA funds to build a Community Center provides access to effective, person and family-centered care that is efficient. The Psynergy Program, described earlier in this document, is an excellent comparable model.
- **Kirker Court** is a safe apartment community with pristine grounds. It is a person and family-centered facility located next to the faith community who donated the land upon which the

community sits. For residents who are able to live here in total independence, these residences are efficient, conveniently located in an area where daily life needs are within walking distance. Kirker Court also has is a ten-year wait list; this points to stability that is provided to the residents. The resident we spoke to wanted to re-establish a relationship with his case manager. Case managers can help provide necessary supportive services for many who live with a serious mental illness, so the effectiveness of housing for the SMI population at Kirker Court depends on whether they are connected with the supportive services they need. Kirker Court has an oasis-like feeling similar to the John Henry Foundation. However, it serves a different population and does not include the same clinical supports as JHF. Kirker Court is more of an independent living environment for people with any disability that falls along the moderate spectrum.

- **Gray Haven-** As you step up onto the porch and walk through the front doors of this beautifully restored mansion in Napa County, you know you are entering a special place. We were graciously welcomed and quickly introduced to all of the special people who were responsible for tucking healing and hospitality into every detail of every room of their health and wellness program. This post provides the passion and pictures of the visit https://www.facebook.com/housingthatheals/posts/331948271844725. To say that we were impressed with Gray Haven is an understatement. But, while our hearts were filled with hope and joy after this tour, they were also broken because of the "Stop Gray Haven" signs that lined the neighborhood streets as we drove away. There are future plans for expansion that would add additional beds and programs to build a big campus of Housing That Heals greatness for families like ours. We see a "Moms On a Mission" campaign to Save Gray Haven in our future. https://grayhavennapa.org/ (2021)
- **Hacienda Campus**-In 2007, Mental Health Systems, Inc. purchased the Hacienda, a once renowned resort. They transformed the abandoned resort into a comprehensive campus with many programs. The once empty structures now are home to a whole health environment with programs that provide mental health, substance abuse treatment and homeless services to individuals and families in Fresno County. Please see this post,https://www.facebook.com/housingthatheals/posts/360311485675070 , for a full picture of the possibilities when public/private partnerships are created to serve families like ours. The property is now operated by RH Builders, https://www.rhcommunitybuilders.com/. (2021)
- On September 9, 2021, Moms on a Mission were invited to a site visit for an Adult Residential Facility opened in 2021 in our own county of Contra Costa. **A and A Health Services** purchased and remodeled a former Senior Living Facility in the City of San Pablo in West Contra Costa County. This new program combines features of both the SNF and Senior Living Facility models into an Adult Residential Facility for people living with SMI/SUDs and other brain illnesses, like dementia. The "On My Own" program is described as "transitional" but if a resident wants to stay, this ARF will obtain a waiver to "age in place" This option prevents people from transferring to a SNF in order to receive medical care or hospice care and creates an "aging in place" model for ages 18-80. The tour showed us a facility that was welcoming, clean, and nicely appointed. Because these were previous senior living apartments, the rooms were able to be divided for privacy into two separate rooms shared with two residents. The med room was very well organized and well-staffed. The kitchen was clean and meal prep was in progress. The dining area was set up with social distancing precautions in mind. The staff training is grounded in treating residents with respect and dignity with a focus on building a successful treatment and recovery plan based on what the resident wants and needs. The programming was extensive with multiple options available. The grounds offered several healing places to sit among trees, flowers, and sunshine. A and A serves the "forgotten populations" who need more than a room key in order to live and die with dignity and definitely hold the "Housing That Heals" vision. https://www.facebook.com/housingthatheals/posts/380359863670232 (2021)

The California Behavioral Health Continuum of Care must include a range of person-centered solutions that include the needs of the “forgotten population.” A complete and effective care continuum would enable people living with special mental health and medical needs to live and die with dignity. It must include a variety of quality acute community hospitals, sub-acute secured residential treatment facilities, and permanent supported homes with all the necessary medical, clinical, rehabilitative, and social supports over the lifespan. Please see Housing That Heals report for additional examples, https://namica.org/community-voices/team-nami-spotlight-housing-that-heals-project-report/

California must move from “scarcity to abundance” to shatter the status quo. And, quantity must be balanced with quality standards to achieve the Housing That Heals vision.

Recommendations for Housing That Heals

We recommend the following considerations to develop a full continuum of psychiatric care and Housing That Heals in order to achieve the SMI Triple Aim in California.

1. Mandate a shared definition of serious mental illness in the medical, social justice, courts, detention, and community health delivery systems.
• California must mandate a standard shared definition of SMI, whether it be WIC 5600.3(b) or the common language Model Shared Definition.
• LPS Reform, Justice System Reform, and Payment and Delivery System Reform must clarify the definitions of medical necessity, grave disability, unserved, underserved with a focus on a right to treatment for SMI.
• Data must clearly be analyzed based on a shared definition of SMI. Continuous improvement cannot be measured accurately without identifying the population. You cannot collect data until you accurately define the population. Current Specialty Mental Health dashboards must be standardized across the state and provide a baseline to track all-cause mortality and morbidity in all levels of care, including jail, hospitals, residential, and community.

2. End the legal fiscal discrimination codified in the California Welfare and Institution Code and Federal Medicaid Rules.
• Eliminate the Specialty Mental Health Carve Out.
• Support parity enforcement for both private insurance and in the public system. California must strike the “to the extent resources are available” language from WIC. California cannot morally point the finger at private insurance while continuing to ration access to medically and socially necessary health care to the SMI population.
• Pursue the IMD Exclusion Demonstration Waiver for the SMI population. The IMD exclusion is fiscal discrimination and raises parity issues since for no other conditions are Medicaid services in certain medical institutions excluded.
• Protect MHSA funds for the WIC 5600.3 SMI population to ensure that the most ill receive the necessary medical and social support to intervene with crisis and prevent failing in the least restrictive Housing That Heals.
• Prevent the displacement of SMI clients by incentivizing providers with higher reimbursement.
• Stop pitting vulnerable populations against each other.

3. Eliminate the Ideological tension by marrying the Medical Model with the Recovery Model.

- Marry the Medical Model with the Recovery Model. It is not necessary to divorce these two models of care in order to achieve optimal health for the SMI population. End the ideology wars about the right to refuse treatment if you lack the capacity to know if you need it.
- Adopt a hospitality model across the psychiatric continuum of care in both hospital and community-based systems.
- Embed family, peer, clinical, and medical supports into Housing That Heals programs. Encourage the co-location of Specialty Mental Health outpatient clinics with ARFs, and RCFEs.

4. Build a tiered level of housing and a fluid system in and out of levels of care.

- Build capacity and abundance to increase supply, quality, and outcomes. Strategically and regionally add IMD and ARF placements across the state using Housing That Heals criteria.
- Remove regulatory and bureaucratic barriers that restrict growth (e.g., remove any requirement or preferences for using nonprofits only.)
- Focus on designing tiered levels of housing across the continuum of care and age span for the SMI/SUD population. Create congregate communities of tiered care that provide clinical and social supports on-site. This will create pathways of freedom from locked units and solitary cells.

We realize that this list of recommendations may not be exhaustive of all opportunities to unclog the human log jam in California. But it is a start, with heart.

We are not analysts, clinicians, or administrators. We do not know all the rules, regulations and fiscal/risk analyses that policymakers must navigate. But, we are two moms who do know what it is like to beg for help, hope, and housing for our adult sons living with SMI. We do know what it like to be forced to drop private insurance in order to save our son's life. We do know what it is like to call 911 in a mental health crisis. We do know that we have been forced to make our sons homeless in order for them to receive the medically necessary care needed for their stability, safety, and sobriety. We do know the pain of blame and shame. We do know the fatigue of fighting and the fear of dying and leaving our sons without a forever home. This is why we cannot wait any longer.