history of previous suicide attempts, and the fact that he had been hospitalized two months prior at John George for suicidal ideations, L.L. was only briefly placed on Inmate Observation Log (IOL) status, a form of suicide watch employed by the Jail, before being removed from observation later that same day by mental health staff and placed in administrative segregation. The doctor who made this decision stated that this was appropriate because L.L. was not expressing suicidal ideation at the time of his intake and was being cooperative. L.L. received no follow-up mental health evaluation between the time of his intake and his suicide only a few weeks later. Another example involves 20-year-old A.A., also described above, who police brought to Santa Rita Jail while he was experiencing a mental health crisis. A.A.'s parents reportedly informed the police that he was not a danger and was in need of mental health treatment. A.A.'s parents say deputies ignored their requests that their son receive a mental health evaluation. A lieutenant allegedly ordered A.A. chained to a cell door, in violation of the Sheriff's office restraint policy, while he was still experiencing severe symptoms. Left unattended, A.A. appears to have attempted to strangle himself with the chains, and later died.[31]

Other prisoners have suffered harm as a result of the Jail's inadequate provision of mental health care. C.C., a 38-year-old male prisoner with a with a history of bipolar disorder, was incarcerated on January 8, 2019, on a charge of narcotics possession. Although he was assigned to Unit 9 upon intake, he did not receive an initial evaluation until nine days after he was admitted, and then only after his sister called the Jail to inform them that her brother was connected to a community provider, receives injections of Haldol (a psychotropic medication), and "decompensates quickly without medication." C.C. started on Haldol on January 22, 2019, but a clinician's note indicated that he was not seen that day due to overbooking. During a medical evaluation the next day, C.C. reported that he felt like he was in a "dream state," "fired up," and "mildly hallucinating." It also appeared that he was having seizures. Because he reported no thoughts of self-harm, he was not placed on IOL status. The next day however, C.C. was "acting strange, shaking, sweating, and appearing confused." He was observed banging his head on the wall and had a cut on his lip and forehead. When the mental health clinician saw him, he was lying on the floor of his cell naked, picking at the floor, and talking to himself. C.C. was sent to John George later that day, and subsequently transferred from John George to Highland Hospital, where it was ultimately determined that he had several high impact hip fractures.

D.D., a 22-year-old with schizophrenia and over 600 interactions with the County's behavioral health system, including multiple incarcerations at the Jail, and with a history of bipolar disorder was incarcerated on February 22, 2019. He was placed on IOL "for muteness and safety" after he refused to respond to medical or mental health questions. Clinicians did not follow up with D.D. until four days later. Three days after that, on March 1, 2019, a deputy reported to a clinician that D.D. had flooded his cell the day before and was naked, talking and laughing to himself. Despite this behavior, there is no record of any specific therapeutic treatment for D.D., other than a clinician's note that the clinician spoke with D.D. about "coping strategies." The clinician made several cell-side visits while D.D. was on IOL, noting that nothing could be seen because there was no light available to see into the cell. Despite his long

[31] Despite multiple requests, Alameda County did not provide records related to this incident.

history of mental health needs, and behaviors that presented a clear management problem on the unit, D.D. received only limited cell-side visits, and was not prioritized to receive therapy.

The lapses in mental health treatment for prisoners with serious mental health needs are even more acute for such prisoners in administrative segregation. Those prisoners generally speak with mental health staff infrequently, and only through their cell doors, which, as noted, raises privacy concerns.

The Jail's mental health program lacks meaningful access to substance use disorder treatment, a deficiency that is particularly acute because prisoners with serious mental health needs have a high rate of co-occurring substance use disorders. Over 70% of the charts our expert reviewed indicated that the prisoner had significant substance use problems, sometimes reflecting the use of multiple substances. Several prisoners were noted to be in distress from opioid withdrawal at the time of their mental health assessments in the Jail. But very few charts contained any mention of treatment plans, interventions, or referrals related to those disorders. Typically, the most that mental health staff provides these prisoners is some information in the form of handouts, and in some cases a single educational class, rather than any treatment.

Having enough mental health professionals is an essential part of any constitutionally adequate correctional mental health program. Mental health staff must be employed in numbers sufficient to identify and treat prisoners who have treatable mental illness in an individualized manner. *See Cabrales v. Cnty. of Los Angeles*, 864 F.2d 1454, 1460–61 (9th Cir. 1988) (upholding district court's determination that understaffing of mental health personnel such that prisoners only could receive 12 minutes of care per month created constitutionally inadequate care), *judgment vacated on other grounds*, 490 U.S. 1087 (1989); *Coleman*, 912 F. Supp. at 1298; *Madrid*, 889 F. Supp. at 1256–58; *Balla*, 595 F. Supp. at 1577.

Several factors contribute to the lack of adequate mental health coverage at the Jail. First, when there are not sufficient security personnel present, mental health staff are hampered in their ability to see prisoners. In records we reviewed, it was not unusual to see notes from mental health clinicians documenting this problem. One note regarding a prisoner in administrative segregation, stated: "Writer spoke with [prisoner] at cell door due to shortage of available deputies in the [housing unit]." In another example, a clinician wrote about a prisoner with schizophrenia and schizoaffective disorder who had previously been at John George, Napa State Hospital, and multiple other inpatient settings: "Writer interviewed [prisoner] at the door in H[ousing] U[nit] 2 for follow up d[ue to] shortage of deputies. [Prisoner] repeatedly requested to be taken out to the tables, even after multiple explanations from writer and Sergeant . . . that there was not enough staffing in the HU to do so." In fact, in over 85% of the charts our expert reviewed for this issue, there was a notation of a deputy shortage, resulting in limitations on the ability of mental health staff to adequately assess prisoners.

Second, on Unit 9, in a restriction imposed by security staff, mental health staff are permitted only a two-hour window during each weekday in which to see any prisoners for treatment. Because they have to fit visits with all of the individuals on their caseloads into a two-hour window, mental health staff are not able to spend sufficient time treating prisoners with

serious mental health needs. In fact, as they explained to us, they are only able to spend approximately 10 to 15 minutes at a time with each prisoner on their caseloads. Further, mental health staff members with whom we spoke informed us that they do not have the time to run treatment groups or therapeutic programs. This is borne out by notes in records such as, "unable to see inmate due to caseload," or "today this clinician was overbooked." Finally, the Jail does not have sufficient numbers of mental health practitioners for the population it serves, as the Sheriff himself has noted publicly.

2. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of Inadequate Treatment Planning, Including Discharge Planning

The Jail fails to provide individualized treatment plans to prisoners with serious mental health needs, which represents a substantial deviation from a constitutionally sound mental health care program. *See, e.g.*, *Sharp v. Weston*, 233 F.3d 1166, 1168–69, 1169 n.2 (9th Cir. 2000) (upholding denial of request to lift an injunction that included individualized treatment plans as a requirement in providing constitutionally adequate mental health care); *see also Braggs*, 257 F. Supp. 3d at 1206 n.34 (explaining that treatment planning is part of a minimally adequate mental health care system). Treatment plans should be developed, implemented, and monitored by treatment teams to provide adequate focus, purpose, and direction for the delivery of service. Our expert observed that clinicians' notes in the overwhelming majority of the charts she reviewed merely indicate whether or not a prisoner is stable, and clinicians often provide seriously mentally ill prisoners nothing more than handouts that list coping skills or describe deep breathing techniques that may help reduce stress.

In addition, the Jail should provide bridge medications and transition planning. *See Charles v. Orange Co.*, 925 F.3d 73, 84–85 (2d Cir. 2019) (finding plausible the allegation that discharge planning, including interim medication and referrals, "is an essential part of in-custody care"); *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (state has constitutional duty to provide medication to outgoing prisoner in a supply sufficient "to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply"); *United States v. County of Los Angeles*, No. CV 15-05903-DDP, 2016 WL 2885855, at * 7, n. 7 (C.D. Cal. May 17, 2016) (finding that *Wakefield* extends to discharge planning for mentally ill inmates as required to provide them medical care after release from custody, and noting that "[i]f anything, a public entity may be more responsible for mental health treatment where the incarceration itself has aggravated or exacerbated the harmful symptoms of mental illness"); *Matysik v. Cnty. of Santa Clara*, No. 16-CV-06223-LHK, 2018 WL 732724, at *12 (N.D. Cal. Feb. 6, 2018) ("[T]here is evidence from which a jury could conclude that Defendants' failure to adopt policies requiring greater coordination related to the release of mentally disabled inmates amounted to a policy or custom [amounting] to deliberate indifference."). The Jail typically does not provide access to sufficient medication and a connection to needed care upon release for prisoners with serious mental health needs.

The Jail also excludes prisoners with serious mental health needs from existing transition services. The Jail has developed a transitional center where prisoners in general population can meet community providers and a program, called Operation My Home Town, which connects

soon-to-be-released prisoners to community-based programs assisting with housing, employment, drug and alcohol treatment, and other needs. However, prisoners with serious mental health needs on Unit 9 or in administrative segregation do not have access to these discharge services. These prisoners are among those with the greatest need for such services, in order to ensure that they receive needed mental health treatment in the community. But they often receive little more than a sheet of paper that lists programs in the community.

When prisoners are not provided with discharge planning that connects them to community providers, it is unsurprising that they frequently cycle back to the hospital or the Jail. One such prisoner is E.E., an administrative segregation prisoner who has a history of schizoaffective disorder and polysubstance use disorder and, when not incarcerated, has been connected with a mental health provider or admitted to the hospital at least 135 times. E.E. was in and out of the Jail 13 times during the 13-month period from August 2018 to August 2019. During those 13 incarcerations, the Jail's limited efforts to prepare E.E. for reentry into the community were inconsistent and incomplete. For example, in June 2019, E.E. himself—not his clinician—suggested that he go to a substance use treatment program upon discharge. However, instead of connecting him to the program, Jail staff simply provided bridge medications and a prescription, and spoke with E.E. about the importance of medication compliance to prevent re-arrest. E.E. was back at the Jail a month later. Despite his extensive contacts with the Jail and BHCS, there is no indication that the Jail made any meaningful effort to connect E.E. with community mental health services.

The lack of discharge planning contributes to the cycling we so often observed, as individuals with serious mental health needs are drawn deeper into the criminal justice and public mental health systems through relapse, re-arrest, and re-institutionalization, with fewer and fewer opportunities to stabilize in the community. One prisoner's mental health notes from July 2019 explain that the prisoner was made aware of the "B[ay] A[rea] C[ommunity] S[ervices] Re-entry program" but "does not appear to have engaged." Several lines down in the notes, the clinician writes that this prisoner "has been incarcerated at [the Jail] 15 times since 2015." If the Jail did more than simply making the prisoner aware of community services—if, for instance, it reached out to providers and set up appointments—the prisoner would have been more likely to have engaged in treatment that could reduce his likelihood of repeated hospitalization or incarceration.

C. Officials at the Jail Have Known of the Risk to Prisoner Health and Safety Posed by Inadequate Mental Health Care and Disregarded It

Jail officials have been put on notice that inadequacies in the Jail's mental health system pose a substantial risk of serious harm to prisoners. The Jail has failed to take steps to eliminate these risks, evincing deliberate indifference to prisoner health and safety. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (holding that a prison official may be liable under the Eighth Amendment if he "knows of and disregards an excessive risk to inmate health or safety").

There are numerous sources that should have put Jail officials on notice of the risks posed by their deficient mental health care system. Alameda County has long known of the problems related to the provision of mental health care to prisoners with serious mental health needs. In

July 2017, a public presentation was given to the Alameda County Board of Supervisors Health Committee on the need to decrease the incarceration of those with mental illness in the County. The Alameda County Mental Health Advisory Board's Criminal Justice Subcommittee investigation[32] noted the "revolving door between John George [and] Alameda County jails."[33] The Criminal Justice Subcommittee identified factors that contributed to this situation including, among other things: the Jail's inadequate discharge planning and coordination of services; frequent inadequate access to psychiatrists; and inadequate substance use disorder treatment.

In addition, lawsuits alleging inadequate mental health care at the Jail have put officials on notice of the risks to prisoner health and safety. *Cf. Disability Rights Mont., Inc. v. Batista*, 930 F.3d 1090, 1099 (9th Cir. 2019) (finding that two prior lawsuits "complaining about factually similar conditions at the prison" supported finding of deliberate indifference) (citing *Lemire v. Cal. Dep't of Corr. & Rehab.*, 726 F.3d 1062, 1078 (9th Cir. 2013) (concluding that plaintiffs stated a claim for deliberate indifference where "litigation specifically alerted prison officials to the acute problem of inmate suicides")). For instance, *Babu v. County of Alameda*, a federal district court case filed in December 2018, concerns the very subject of this Notice—deficiencies in mental health care provided by the Alameda County Sheriff's Office. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 22, 2020), ECF No. 111-1. In the Complaint's first paragraph, it states, "The Alameda County Jail system is broken, especially when it comes to the way it treats people with psychiatric disabilities. . . . Alameda County relies almost entirely on the unconstitutional use of isolation to manage prisoners, including prisoners with significant . . . mental health needs, resulting in horrific suffering."[34] Although the Jail has recently reported its commitment to improve mental health care as part of the ongoing settlement negotiation process in *Babu*, it is not clear what, if any, remedial measures have been put in place, whether they have been incorporated into the Jail's policies and procedures, or whether any measures actually put in place will prove durable. Likewise, Disability Rights California, the federally-mandated protection and advocacy entity for California, issued a letter to Alameda County in November 2019 alleging, after an investigation, that "people with mental health disabilities regularly cycle in and out of . . . the jail system," and noting that "people with mental health disabilities held in jail face dangerous and damaging isolation conditions and inadequate access to programming or meaningful mental health treatment."[35]

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[32] The Criminal Justice Subcommittee conducted interviews with Oakland Police Department officers, BART Crisis Intervention counselors, social workers, program directors, and program managers to gather information on gaps within the County system. The Criminal Justice Subcommittee also compared the situation in Alameda County with national statistics on the relationship between mental illness and the criminal justice system.

[33] BRIAN BLOOM & DR. NOHA ABOELETA, DECREASING INCARCERATION OF THE MENTALLY ILL IN ALAMEDA COUNTY at 4 (2017), http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_7_24_17/GENERAL%20ADMINISTRATION/Regular%20Calendar/Community_Mental_Health_7_24_17.pdf.

[34] Complaint at ¶ 1, *Babu v. Cnty. of Alameda*, No. 5:18-cv-07677 (N.D. Cal. Dec. 21, 2018), ECF No. 111-1.

[35] Letter from Disability Rights Cal., to Karyn Tribble, LSCW Dir., Alameda Cnty. Behavioral Health and Services, and Donna Ziegler, Counsel, Alameda Cnty. (Nov. 1, 2019), https://www.afsc.org/sites/default/files/documents/2019-11-01%20DRC%20Findings%20Letter%20%20Access%20Requests%20Alameda%20Cty%20-%20Signed%20%281%29.pdf.

Finally, numerous media reports have raised concerns about the provision of mental health care to prisoners with serious mental health needs at the Jail. The Department's investigation has also provided Jail officials with notice of deficiencies in mental health care. Department attorneys and staff, accompanied by experts, visited the Jail several times in 2017, and again in 2019. At the conclusion of these visits, we provided Jail officials with exit briefings, during which our experts shared their preliminary observations. Our experts expressed their opinions that mental health care for prisoners with serious mental health needs was deficient, and specified the various areas in which such care is inadequate, as described above. Nevertheless, most of the conditions we identified in 2017 were still present when we returned in 2019.

VI. THE JAIL'S USE OF PROLONGED RESTRICTIVE HOUSING UNDER CURRENT CONDITIONS, INCLUDING THE FAILURE TO PROVIDE ADEQUATE MENTAL HEALTH CARE, VIOLATES THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL ILLNESS

The Jail's use of restrictive housing for prisoners with serious mental illness in current conditions—in which prisoners can spend months, if not longer, locked in their cells, with only three to five hours out of cell per week, and with little to no mental health treatment, therapy, and programming—places prisoners with serious mental illness at a substantial risk of serious harm in violation of the Eighth and Fourteenth Amendments. *See Disability Rights Mont.*, 930 F.3d at 1099 (finding plausible Eighth Amendment claim that placing prisoners with serious mental illness in restrictive housing of 22 to 24 hours per day for months poses substantial risk of serious harm); *Palakovic v. Wetzel*, 854 F.3d 209, 226 (3d Cir. 2017) (holding that, "in light of the increasingly obvious reality that extended stays in solitary confinement can cause serious damage to mental health," there was a plausible claim that placing prisoner with history of suicidality in restrictive housing for multiple 30-day stints violated the Eighth Amendment); *Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 946 (N.D. Cal. 2015) ("While housed in segregation, the mentally ill are especially vulnerable, and their mental health symptoms—including depression, psychosis, and self-harm—are especially likely to grow more severe."); *see also Braggs*, 257 F. Supp. 3d at 1247 (noting the "consensus on the substantial risk of harm of decompensation for these mostly severely mentally ill prisoners" from segregation); *Madrid*, 889 F. Supp. at 1265 (using prolonged restrictive housing on prisoners who are, because of their serious mental illness, "at a particularly high risk for suffering very serious or severe injury to their mental health" is "the mental equivalent of putting an asthmatic in a place with little air to breathe"); *Coleman*, 912 F. Supp. at 1320–21 (adopting finding that restrictive housing can "cause further decompensation" to prisoners with mental illness); *Casey*, 834 F. Supp. at 1549 (finding that an extensive use of lockdown in place of mental health care "clearly rises to the level of deliberate indifference to the serious mental health needs of the inmates and violates their constitutional rights to be free from cruel and unusual punishment").

As discussed above, prisoners at the Jail with serious mental illness are regularly placed in administrative segregation, where they spend almost every hour of their days locked in their cells, alone or with one cellmate, with little to no treatment, therapy, or programming. When they do get out, each prisoner is alone (or with their cellmate only), so they do not have any

opportunities for social interaction. Jail mental health staff have estimated that approximately 50% of the prisoners in administrative segregation have serious mental illness. As a result, these prisoners are at increased risk of physical self-harm, extreme mental distress, and unnecessary suffering. In fact, we have seen evidence of such harms, as discussed further below, including prisoners swallowing objects, not eating, smearing or eating feces, banging their heads against the wall, and attempting or completing suicide.

The Alameda County Sheriff has acknowledged that one hour per day of out-of-cell time is not sufficient. "We do not like to keep people in those cells for any length of time," he has said.[36] Yet, despite his statements, until very recently the Jail continued to keep individuals locked down with less than one hour out of cell each day for months at a time.[37] In fact, at the time of our last visit, in July 2019, there were 75 prisoners in administrative segregation who had been there for over 90 days, at least 75% of whom had indications of serious mental illness. Thirteen of those prisoners with indications of serious mental illness had been in administrative segregation for more than a year.

Jail officials say that prisoners are placed in administrative segregation if they cannot co-exist with other prisoners, are violent, or need protection, among other reasons. However, our review of classification records for prisoners placed in administrative segregation revealed many instances of prisoners being assigned to such housing for reasons that seemed directly related to their serious mental illness and not due to Jail officials' stated reasons. For example, F.F. had a history of suicide attempts in administrative segregation when a classification deputy approved F.F.'s request to be transferred to a less restrictive pod. The deputy understood that the move could help F.F.'s mental health: "Having a cellmate might help [F.F.] cope with being incarserated [sic]," he wrote. But several weeks later, F.F. was returned to administrative segregation, because of his serious mental illness. The classification deputy explained that F.F. was being re-classified to administrative segregation "due to" his flag as "mental". The deputy made this recommendation despite the fact that the behavioral health professional who had just evaluated F.F. recommended against the transfer, indicating instead that F.F. should be housed in the less restrictive behavioral health unit. Over an approximately three-month period, two behavioral health professionals made five separate recommendations that F.F. be moved to a less restrictive unit. Each time, they were overruled by classification deputies. Their reasons often explicitly cited F.F.'s mental illness. "Due to [F.F.'s] recent mental instability," a deputy wrote, for example, "he will remain in [administrative segregation] at this time."

Another example is G.G., an individual who was sent to John George at least twice during his incarceration at the Jail, and who reported to the Jail that he had previously been housed in minimum security. His classification report from February 2019 from the Glenn Dyer

[36] Lisa Fernandez, *Death Rate at Santa Rita Exceeds Nation's Largest Jail System as Critics Call for Reform*, KTVU (Oct. 1, 2019) https://www.ktvu.com/news/death-rate-at-santa-rita-exceeds-nations-largest-jail-system-as-critics-call-for-reform.

[37] We note that, as part of the ongoing settlement negotiation process in the *Babu* case, the Jail reportedly has taken steps to increase out-of-cell time for prisoners. We have not yet seen evidence of how much more time prisoners may get, or how widespread the change is, and there is no evidence that this is memorialized in any policy. Moreover, it is not clear whether such remedial measures will prove durable.

Jail, which was operated by the Alameda County Sheriff's Office until it closed in 2019, notes that he "suffers from bipolar [disorder] and is on heavy psychiatric medication that [the Glenn Dyer Jail] doesn't carry. The nurse said that if he missed more than one dose of his [medication] he is likely to have a serious mental breakdown." After several weeks at the Glenn Dyer Jail, G.A. was observed "visibly shaking," "making the sign of the cross," and "displaying bizarre" behavior, and was therefore placed in administrative segregation. A few weeks later, when he was transferred to the Jail, a classification deputy acknowledged that G.G. had been housed in administrative segregation "due to acting strangely during his classification interview"—in other words, for reasons related to his mental health status. The deputy suggested that G.G. "may be suitable for . . . the behavioral health unit." Although two mental health professionals agreed with that assessment and recommended on at least four separate occasions that G.G. be transferred to the behavioral health unit, he remained in administrative segregation. At the time of our visit to the Jail in July 2019, he had not been reclassified.

A. Prisoners with Serious Mental Illness Are Subject to a Substantial Risk of Serious Harm as a Result of the Jail's Use of Restrictive Housing

The Jail's practice of subjecting prisoners with serious mental illness to prolonged periods of restrictive housing places these prisoners at substantial risk of serious harm. As described above, as of our last visit, prisoners in administrative segregation were, by policy, permitted only five hours outside of their cells per week at most, and our review of a sample of records revealed many receiving only one or two hours outside of their cells on any given week.

The lack of access to adequate mental health care is especially harmful for prisoners who are suicidal. Instead of receiving the constitutionally adequate mental health care required, such as intensive therapeutic interventions, they receive minimal engagement from limited interactions with mental health staff. Notably, despite the known harms of prolonged restrictive housing for people with serious mental illness, at least six of the prisoners who have died by suicide at the Jail since January 1, 2014, were in restrictive housing at the time of their suicide.[38]

One such example is H.H. He was arrested on April 4, 2018, and booked into the Jail early the next morning. During his initial screening, he was observed to have "delusional thoughts," and as a result he was referred to mental health staff. While awaiting re-classification, H.H. was found with fecal matter smeared on his face, and he stated to a deputy that he wanted to be killed or would kill himself. He was moved to a safety cell and put on an IOL. The following day, April 6, a mental health clinician determined that H.H. was no longer suicidal, and he was moved from a safety cell to administrative segregation. There, on April 8, H.H. was found with a bed sheet tied around his neck and tied to another sheet that was wrapped around the top bunk. When a deputy entered his cell, he found H.H. unresponsive, with pale skin. The cell was flooded with water and fecal matter, which had also been spread onto the floor, walls,

[38] In addition, in February 2021, an individual in the Jail's quarantine unit for newly booked prisoners died by suicide. The County and the Sheriff's Office have reported that newly-booked individuals at the Jail must complete a 14-day quarantine upon intake, and that on average, those individuals receive approximately one hour of out-of-cell time per week. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 7, 2021), ECF 239 at 7.

and window. A fellow prisoner reported that in the hours leading up to his suicide, H.H.'s requests to see mental health staff were ignored. In addition, although according to Jail policy H.H. was supposed to be observed every 30 minutes, he had not been observed for over an hour, during which time he took his own life.

Other individuals suffer a variety of other significant harms. Indeed, over half of the episodes of self-injurious behavior that our expert reviewed occurred while prisoners were in restrictive housing. For example, I.I., a prisoner in restrictive housing with serious mental illness, smeared his feces, wrote words on the walls with his feces, and even ate his feces. He suffered delusions, believing himself to be Jesus Christ; engaged in head banging; and tried—unsuccessfully—to hang himself. One clinician hypothesized that I.I. may have been in a "safer placement" in a mental health unit in another jail, but noted that the Jail "does not have a mental health unit," apologizing to I.I. for this fact and "encourag[ing] him to try his best to manage in" administrative segregation while the clinician tried to help him get "to a quieter pod."

Other examples of people who were harmed include J.J., whose chart shows that he told a clinician that he had instructed his wife not to visit him because he was "losing [his] mind" in administrative segregation; F.F., who attempted to suffocate himself on several occasions, including by wrapping clothes around his neck and putting a bag over his head; and K.K., who swallowed pencils, a razor, a screw, and a comb. One prisoner in administrative segregation who had returned from a short stay at John George less than two months earlier was "refusing to lockdown, naked, urinating all over . . . , putting his bread in the urine then eating it, sticking his finger up his rectum and threatening to kill himself by taking pills." The experiences of these prisoners mirror that of the many prisoners who told us during our visits to the Jail about "going crazy" and "flipping out" in restrictive housing, due to the isolation they experienced. Chart notes confirm that the Jail's mental health professionals believe restrictive housing exacerbates prisoners' mental health issues. As one psychiatrist noted about a prisoner who reported a history of schizophrenia, "Unfortunately patient appears to be doing worse, compared to initial evaluation. This may be due to continuing to be in administrative segregation."

B. Officials at the Jail Have Known of, and Disregarded, the Substantial Risk of Serious Harm of Placing Individuals with Serious Mental Illness in Restrictive Housing

Prisoners with serious mental illness in restrictive housing have died by suicide, attempted suicide, or otherwise harmed themselves, as discussed above. These incidents—most of which were known to Jail officials—should have put Jail officials on notice that they were putting prisoners with serious mental illness at a substantial risk of serious harm by placing them in restrictive housing for prolonged periods. Moreover, as discussed above, mental health clinicians and other Jail staff specifically raised concerns about whether placement in restrictive housing, such as administrative segregation, was appropriate for prisoners with serious mental illness, further putting officials on notice of the risk to these prisoners.

Following our 2017 visits, the Jail made some changes to its restrictive housing practices, apparently in part in response to the concerns expressed by our experts. Most notably, the Jail

instituted a "Maximum Separation" or "Max Sep" program, which represents a step-down from administrative segregation, allowing prisoners more time out of cell, and allowing them to be out with other prisoners. Nevertheless, the "Max Sep" program is available only to a small percentage of those in administrative segregation. The Jail did not reasonably respond to reduce the risk of serious harm to prisoners with serious mental illness until the very recent—and limited—steps taken as part of the *Babu* negotiations, *see supra* note 37, evincing deliberate indifference to prisoner health and safety.

VII. THE JAIL'S TREATMENT OF PRISONERS WITH MENTAL HEALTH DISABILITIES VIOLATES THE AMERICANS WITH DISABILITIES ACT

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; *see also Pierce v. Cnty. of Orange*, 526 F.3d 1190, 1214 (9th Cir. 2008). To establish a Title II claim, one "must show: (1) he is a 'qualified individual with a disability'; (2) he was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities, or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability." *Duvall v. Cnty. of Kitsap*, 260 F.3d 1124, 1135 (9th Cir. 2001) (citation omitted). Title II has been found to "unmistakably" cover correctional institutions. *See Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 209–10 (1998) (applying Title II in the prison context); *Bell v. Williams*, No. 18-CV-01245-SI, 2019 WL 2358971, at *3 (N.D. Cal. June 4, 2019) (applying Title II in the jail context); *see also Pierce*, 526 F.3d at 1214 (noting that Title II applies to county jails' "services, programs and activities for detainees"). The ADA offers the same protections to prisoners with disabilities whether those disabilities stem from physical or mental impairments. 42 U.S.C. § 12102. Thus, prisoners at the Jail with mental health disabilities are entitled to this protection. Further, the ADA applies to prisoners even if they are not in the general population. "A prisoner's misconduct does not strip him of his right to reasonable accommodations, and a prison's obligation to comply with the ADA and the RA [Rehabilitation Act] does not disappear when inmates are placed in a segregated housing unit, regardless of the reason for which they are housed there." *Furgess v. Pa. Dep't of Corr.*, 933 F.3d 285, 291 (3d Cir. 2019).

Some prisoners are placed in administrative segregation or other restrictive housing due to their mental health disabilities, and all prisoners in Unit 9 are placed there precisely due to their mental health disabilities. Yet, prisoners at the Jail who are on Unit 9 or in administrative segregation do not receive the same programming that is available to prisoners in general population. For example, the Alameda County Sheriff's Office provides an array of programs to many prisoners in general population at the Jail, including, educational programs, art therapy, culinary arts, computer coding, job readiness training, financial literacy, and hospitality. And the Jail's transition center allows many prisoners in general population to receive additional services from community-based organizations in areas such as education, employment, housing, and substance use disorder. But none of these programs and services are available to prisoners with mental health disabilities placed on Unit 9 or in administrative segregation. The Jail provides just one program, "Breaking the Chains," on Unit 9, and it is limited to the topic of substance use

disorder. As discussed above, Jail officials place prisoners with mental health disabilities in Unit 9, the "mental health" unit, precisely because they have a serious mental illness. As also discussed above, the Jail often places other prisoners with mental health disabilities in administrative segregation for reasons that are directly related to their mental illness, as, for example, with F.F. and G.G., discussed in Section VI, *supra*.

Thus, but for their mental health disabilities, prisoners in Unit 9 and those prisoners placed in administrative segregation due to their mental health disabilities would be able to access the programming provided to the general population. For example, approximately 41% of the stays on Unit 9 over a 19-month period that we examined were classified as "Mental Min." This means that these individuals would have been classified as minimum custody, and housed accordingly, with the attendant access to programming, but for their "mental health" classification. Thus, by virtue only of their mental health disabilities, they were placed in a housing unit where they were denied access to programs that they otherwise would have been able to access, as minimum custody prisoners.

Denying prisoners with a mental health disability equal access to programming and services available to those without disabilities violates Title II of the ADA. *See Love v. Westville Corr. Ctr.*, 103 F.3d 558, 561 (7th Cir. 1996) (affirming conclusion that prison officials intentionally discriminated against an inmate in violation of the ADA when they excluded him from prison programs and services on account of his disability).

VIII. MINIMUM REMEDIAL MEASURES

To remedy the constitutional and statutory violations identified in this Notice, we recommend that the County implement, at minimum, the remedial measures listed below.

A. Providing Mental Health Services in the Most Integrated Setting

1. Provide evidence-based community-based services in the most integrated setting that are effective at meeting the needs of eligible adults with mental health disabilities in and at serious risk of entering psychiatric institutions in Alameda County and preventing them from unnecessary institutionalization, including:
    a. Implement a comprehensive crisis response system, including an array of integrated crisis residential services, in sufficient capacity to serve adults with mental health disabilities in the most integrated setting and effective mobile crisis services that can respond to individuals wherever they experience crises and that works with law enforcement where appropriate to de-escalate crises and prevent unnecessary arrest and detention, involuntary commitment, or hospitalization.
    b. Implement a sufficient number of Full Service Partnership teams that can provide sufficiently intensive community services to those who need them.
    c. Implement a sufficient quantity of scattered-site, permanent supported housing slots to ensure adults with mental health disabilities can maintain housing in integrated settings.

d. Implement sufficient community-based services including case management, personal care services to assist with activities of daily living, and supported employment services in the amount, frequency, and duration needed by adults with mental health disabilities in Alameda County.
e. Implement peer support services provided by trained and certified peers with lived experience with mental illness in sufficient quantity to be integrated in all aspects of the mental health service system.
f. Implement sufficient community-based services that can appropriately support people who have co-occurring diagnoses, such as intellectual disability, substance use disorder, or chronic illnesses.

2. Provide transition and discharge planning, beginning upon admission, to all eligible adults with mental health disabilities in psychiatric institutions in Alameda County.

3. Provide transition and discharge planning, beginning upon admission, for prisoners with mental health disabilities in Santa Rita Jail to prevent needless psychiatric institutionalization for those individuals following release from Jail.

4. Identify eligible individuals who may be at serious risk of psychiatric institutionalization and connect them with appropriate community-based services, including by using the crisis services described above, and by utilizing identified intercepts where individuals with mental health disabilities are known to come into contact with County services or the criminal justice system.

5. Ensure that community-based services and supports are designed to engage and support individuals with mental health disabilities who may be involved in the criminal justice system.

6. Implement systems, including through close coordination between Alameda County BHCS, Alameda County Sheriff's Office and Santa Rita Jail, that ensure people with mental health disabilities can initiate or maintain connections with community-based services while incarcerated and transition seamlessly into such services upon release.

B. Jail Mental Health Care

1. Ensure that prisoners with serious mental illness receive timely treatment from mental health professionals as clinically appropriate, in a setting that provides privacy.

2. Ensure that appropriate, individualized treatment plans are developed for prisoners with serious mental illness, and implement procedures whereby treatment plans are regularly reviewed to ensure that they are being followed.

3. Ensure that all prisoners with serious mental illness receive regular, consistent therapy and counseling, in group and individual settings, as clinically appropriate.

4. Ensure that prisoners at risk of suicide receive appropriate mental health care. The Jail's suicide prevention program should include:
   a. Individual assessments of prisoners to determine whether and when they should be placed on some form of suicide watch, the individualized conditions of that watch, and whether and when they should be removed from that watch; and
   b. Conditions in suicide watch placements that are therapeutic, rather than punitive.

5. Provide transition and discharge planning to prisoners with serious mental illness, including services for prisoners in need of further treatment at the time of discharge to the community. These services should include the following:
   a. Arranging an appointment with community mental health providers for all prisoners with serious mental illness and ensuring, to the extent possible, that prisoners meet with that community mental health provider prior to or at the time of discharge to facilitate a warm handoff;
   b. Providing a supply of bridge medications to prisoners sufficient to last until a prescription can be refilled; and
   c. Arranging with local pharmacies to have prisoners' prescriptions renewed to ensure that they have an adequate supply to last through their next scheduled appointment with a mental health professional.

C. Restrictive Housing in the Jail

1. Ensure that prisoners with serious mental illness are not placed in restrictive housing for prolonged periods, absent exceptional circumstances, and review prisoners in restrictive housing periodically to ensure that restrictive housing remains appropriate for them.

2. Ensure that if a prisoner shows credible signs of decompensation in restrictive housing, the prisoner's mental health needs are assessed by a mental health professional and promptly addressed.

3. Ensure that prisoners expressing suicidality are not placed in restrictive housing and instead are provided clinically appropriate mental health care.

4. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to prisoners with serious mental illness, and take appropriate corrective action.

D. Jail Compliance with the Americans with Disabilities Act

1. Ensure that prisoners with mental health disabilities have the opportunity to participate in and benefit from services (including transition services), programs, and activities available to prisoners without disabilities consistent with significant health or safety concerns.

IX. CONCLUSION

We have reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at Santa Rita Jail and that Alameda County violates the ADA in its provision of public mental health services. The remedies we propose are narrowly tailored to correct the conditions found during our investigation and seek to address changes to policies, practices, training, supervision and accountability systems necessary for the County to overcome existing deficiencies and to come into compliance with the Constitution and the ADA. We look forward to working cooperatively with the County to identify appropriate responses to the violations have identified.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if County officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, April 26, 2021 1:58 PM
To: Works-Wright, Jamie
Subject: FW: Alameda County Mental Health Advisory Board Public Notice - Adult Committee Meeting (April 27th)
Attachments: Housing_That_Heals_2020.pdf; SHCLA Workplan_Timeline.pdf; EBSHC Letter.pdf; Supportive Housing Community Land Alliance SummaryOct2020_March2021.pdf; Adult Committee Agenda 4-27-21.pdf

Please see the information below.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH [mailto:ACBH.MHBCommunications@acgov.org]
Sent: Monday, April 26, 2021 11:55 AM
Subject: Alameda County Mental Health Advisory Board Public Notice - Adult Committee Meeting (April 27th)

Greetings,

Please find attached the agenda and meeting materials for the **Alameda County Mental Health Advisory Board, Adult Committee Meeting on April 27, 2021 from 12:00 pm – 2:00 pm.**

Thank you.

Alameda County Mental Health Advisory Board

Housing That Heals:

A Search for a Place Like Home for Families Like Ours

By Teresa Pasquini and Lauren Rettagliata

May 2020

Contact: HousingThatHeals@gmail.com

Special acknowledgement to Lauren's granddaughter, Olivia, at age 6, for creating our *Housing That Heals* logo. She worked on it for three days and is enormously proud of her lettering and coloring, stating that she "had developed a special technique!" When asked why there was a dog in the picture, she kindly replied, "It's a cat! I put it there because everyone needs someone to love." ❤️💜❤️🤎❤️

"When hearts are broken, minds are open."

Erika Jensen, Deputy Health Director, Contra Costa County

What would drive two moms to go on a 3,170-mile journey looking for the housing options available to the most vulnerable people in California—those with a serious mental illness?

The answer is that for decades, we and 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.

Teresa Pasquini and Lauren Rettagliata on the Road in 2019

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A Mom's Mission

By Lauren Rettagliata

There are many people who think that hell is a place for the damned—I am not one of them. I am consumed by the fires of hell when I see my child being harmed and am powerless to stop it. In 1975, my oldest son was diagnosed with Autism at Stanford Hospital. The doctors explained to us that it was still classified as Childhood Schizophrenia. When we sought early childhood intervention for my son in 1975, we were told that he did not qualify for admittance to the programs offered in the school districts, and he was to attend the Agnew State School in Santa Clara, California. My husband and I went for a visit and recoiled in horror… over our dead bodies would our son be institutionalized! We scoured the nation for a system that allowed our precious son to stay in his community. We found this in Northwest Harris County, Texas; they had an Early Childhood System that accepted children most other systems deemed uneducable.

In the early 1980s, Texas was still in the process of opening its state facilities for those with "Mental Health and Mental Retardation." We made new friendships with families who also had children in "Special Education." I became a Board Member of the Association for Retarded Citizens of Northwest Harris County.

Children and adults with serious mental illnesses were being brought back into the community from state institutions, and group homes were opening to house them. Entrepreneurs realized that squeezing many bodies into a small house could generate a decent income. The problem was that most of these entrepreneurs knew little about the services and supports the people they were taking into their group homes needed. As a result, many individuals were living in tortuous and abusive situations, being raped, beaten, and abandoned behind locked doors in their own communities. Men, women, and even children were placed in these horrific group homes.

As a member of my local ARC (we were called the "mad mommies"), we stepped up and declared that there is a better way. We quickly learned the ropes of acquiring state funding to build a better group home model that provided treatment and care; not just three meals per day and a bed. We educated the state and county government administrators about the caregivers' need to have a deep understanding of the person they were caring for. Our local ARC formed a nonprofit, Reach Unlimited, that would receive the federal, state, and local funding needed to build and operate housing with the supported services. Reach Unlimited brought dignity and respect to every resident who resided in their new home. Today, Reach Unlimited has grown to provide more than residential services; it now has six group homes and provides supported employment, a learning activity center, and home and community support services. Sadly, group homes run sheerly for profit still exist, but now families have a choice and state and local administrators have better options.

Our family moved to Colorado in 1990. This new community was facing the impossible situation of having the YWCA's Women & Children Crisis Shelter shut down if they could not generate funding for a costly renovation. The turnaround time for this was a brutal eighteen months. With a dedicated Executive Director, Diane Porter, I accepted the challenge and used the grant writing skills I acquired in Texas to help deliver the funding and architectural planning needed to transform the historical building into a state of the art Crisis Shelter.

The lesson I learned from that experience was that determination can transform what was initially seen as impossible into the possible.

In 1997, we moved back to California to care for our parents. This is when our youngest of four sons had his first psychotic break. Our health care provider immediately recognized that our son had Schizophrenia and placed him in a treatment facility. Our son refused to stay in treatment. He also suffers from a condition known as Anosognosia, a lack of insight which impairs his ability to understand and perceive the severity of his illness. He has attempted suicide multiple times and threatened harm to others. He has fallen into homelessness and addiction and has lived in flea and rat infested room and board homes. My son perceives himself to be unworthy of living in decent surroundings and instead believes that a rundown single room, jail, or being homeless on the street is where he belongs. His psychosis has trapped him in a world where he sees his only relief as overdosing on drugs and alcohol.

My son needs intensive treatment and a decent place to live so that he can get up each morning and experience a life worth living. That is why I have traveled over 3,000 miles in California studying what has been built to house those who suffer with a serious mental illness. For far too long, we have attended countless planning meetings but have yet to witness the execution of plans that will end the human log jam for those who need more than *Housing First*.

It is now time for Housing That Heals.

A Broken Heart Drives My Mission for Housing That Heals

By Teresa Pasquini, Mom

I am a recovering, angry mom on a mission with a trauma tattoo on my heart. I am willing to partner with anyone who will help me shatter the status quo that is forcing too many families like mine to suffer needlessly. I am grateful that Lauren Rettagliata invited me to join her on a journey in search for "Housing That Heals." Like Lauren, I am just a mom who became an accidental activist in order to save my son's life.

I am the proud mom of Danny, who has been living heroically with schizoaffective disorder since the age of 16. Danny had been diagnosed early upon his first break. He had a psychiatrist, psychologist, and pediatrician all working in sync with our family. He was in treatment, on meds, in supported education, received a high school diploma and had a job. Danny was in a peer support group, and my husband and I were in a parenting support group to learn everything we could to help our son. We thought we had managed his care.

On his 18th birthday, Danny fell off the edge of a cliff and into the black hole of the adult system of care. After 18 years of Lanterman Petris Short (LPS) Conservatorships and a lot of suffering, he is only now beginning to show some promise of long-term stability. But, he is still conserved; and he is doing well enough that the conservatorship may not continue. I am afraid that he will, once again, fall into the black hole of the adult system of care for those with the most serious mental illnesses and not be able to find his way back out.

Currently, I spend all of my free time focused on advocating for a full continuum of psychiatric care that includes all levels of Housing That Heals.

That continuum must include Institutions for Mental Diseases (IMDs) and Adult Residential Facilities (ARFs) for those who cannot survive in supported independent living and do not deserve to be housed in a jail pod or a cardboard tent.

I am a mom on a mission to ensure that there will be a place for my son to live in health, safety, and dignity when I am no longer here. And, I want that for all people who live heroically with serious brain disorders and mental illness.

I am a former Contra Costa County Mental Health Commissioner, serving for nine years from 2006-2015. I was also a founding member of a Behavioral Health Care Partnership that began in 2009 at Contra Costa Regional Center, our county's public hospital. It was one of the first patient and family partnerships in the nation that focused on Psychiatric units; the forgotten units with forgotten patients. It is this work that taught me the importance of partnering with patients, families, and the staff who serve both.

I have traveled extensively telling my family story in a variety of forums, including the Institute of Healthcare Improvement, a Grand Rounds at the University of Michigan with our Chief of Psychiatry, an event at the National Quality Forum with a Contra Costa Sherriff Deputy, and a media event on Capitol Hill in 2015. I was one of three family members from California who told our stories of failed first care that ended with tragic consequences for all three families. It is hard to capture the depth of despair that my family and so many others have experienced. However, because of luck, heroics, and partnerships, my son is living safe and free today in the community.

My purpose for taking this journey is to start a crucial conversation that will not leave my son uncounted.

This is a moment in time when our collective community purpose must be fluid, flexible, adaptable, and ever present when people are their most vulnerable. And, vulnerability must always be viewed as ***an opportunity to empower health and healing through our shared humanity***. In order to do that, we must stop blurring the lines of our health system and just remove the lines.

No more "us and them." No more "carve outs."

Teresa & her son, Danny

No more cherry picking based on luck, heroics, zip code, or diagnosis. No more drivers of disparity and discrimination for sons like mine.

We must all work together in authentic partnerships where we can design a system that includes a continuum of psychiatric care from crisis, acute, subacute, and an array of supported housing that allows everyone to live and die with dignity.

This is Housing That Heals. I have seen it. I know it is possible.

Introduction

It is said that "home is where the heart is." We agree, as two moms who have trauma tattoos on our hearts from years of watching our sons suffer because of a serious mental illness (SMI).

A health care system that includes a tiered array of *Housing That Heals* as part of a full continuum of psychiatric care will help mend our broken hearts and bend the harm curve for families like ours.

This document is not a white paper; it is a *heart paper* that weaves together the story of two families living the "California Dream" that turns into a nightmare of navigating California's mental health care system. It is about two *Moms on a Mission* to find Housing That Heals for people who are living heroically with SMI. It is about two moms who have sat in local and state meetings for years, watching minutes endlessly taken while our life clocks tick away and our sons fall off the edge of cliff, after cliff, after cliff, taking us with them. We have witnessed countless housing plans envisioned, planned, and prioritized but never implemented, while our sons have been either homeless, incarcerated, or placed in multiple levels of poor quality hospital-based or community housing. Like so many other parents, we carry the fear about what will happen when we are gone and wonder if our sons will be left with "no place like home."

In January 2019, we set out on a journey to see if we could find the best models of Housing That Heals in California. We set out in search of knowledge that might help answer some of the questions that we have heard endlessly debated while the fiscal and human waste grows. We set out looking for solutions that will cure a health system that is often too rigid, harmful, inhumane, and broken. We set out with a focused vision of hope that we would find existing Housing That Heals for the most severely mentally ill populations who rely on the California health care safety net. We wanted to know where the homes of hope are in California for those living with SMI. We wanted to explore whether a strategic expansion of Housing That Heals for the SMI population would help reduce suffering, save money and possibly our state's soul.

We did find hope. We found people who care deeply, building what we dream of for our families. We found compassionate, kindhearted people who are committed to helping families like ours. We discovered that there are places of healing and humanity sprinkled across the state. We found that when California counties invest in building a psychiatric continuum of care, people who live heroically with SMI will come, and they will stay, and they will live in optimal health, stability, safety, and peace. And we found that if you move with deliberate determination to grow relationships, you will develop purposeful partnerships that will use common ground to build health, humanity, and Housing That Heals, together.

However, we also found that housing for those who have SMI is impacted at every level. This heart paper is not only about the current California *homeLESSness* crisis. It is also about building a system of *homeFULLness* along a quality continuum of psychiatric care. This paper will reflect the listening and learning tour we have taken through many California counties. It is our intention to personalize the policy, process, and political parts of health and care. We will include in this heart paper, data to inform and also *data of the soul* to identify solutions that can lead to systemic change. We will present our positions coming from the perspective of being mothers, community volunteer advocates, and activists focused on the SMI population that includes our beloved sons.

We believe that when you start from a place of pain, feel it, and then share it, you will shatter the shame of the patients, the families, and the providers who serve them. You will come to understand that it is a universal pain for all who depend upon and work within the mental health care system.

Defining the Housing That Heals Problem in California

The Institute for Healthcare Improvement's (IHI) Triple Aim[1] framework suggests that if you improve both the patient experience and the population's health, you will reduce health care costs. This framework is considered a compass for optimizing a health system's performance. It has been used as a value-based goal in numerous health care system improvement efforts for the larger "mental health" or "behavioral health" populations. It has been said that the Triple Aim will not be achieved until there is a focus on the SMI population. This focus will reveal one of the greatest health disparities presenting in our California communities and public health and safety systems.

According to a 2006 report by the National Association of State Mental Health Program Directors, "people with SMI experience health disparities and die early. Many of the causes of premature morbidity and mortality are related to the vulnerability of the population with SMI."[2] The report suggests that providing "safe housing" for the SMI population is one factor that could help ease the burden of these illnesses.

What are the key drivers of the inequalities in health and care for this complex population that has led to what some refer to as a humanitarian crisis? This crisis has filled our jails, streets, hospital emergency rooms (ERs), elderly parents' back bedrooms, and graveyards with people who need(ed) help and care. We hypothesize that there are four key drivers of despair and disparity impacting the ability to develop a continuum of psychiatric care and Housing That Heals in California:

- Lack of a shared definition of SMI in the medical, social justice, courts, detention, and community health delivery systems.
- Legal fiscal discrimination codified in the California Welfare and Institution Code and Federal Medicaid Rules.
- Ideological tension – Medical Model vs. Recovery Model – prevents true system transformation for the SMI population.
- Lack of a tiered level of bed capacity and a fluid system in and out of levels of care.

[1] http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
[2] Parks J, Svendsen D, Singer P, Foti ME, eds. Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors. 2006. https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08_0.pdf

Drivers of Despair and Disparity for SMI in California

Does the Lack of a Shared Definition of SMI Create a Barrier to Housing That Heals?

The current lack of a universally accepted definition for SMI in California may be preventing progressive and coherent reform for this most vulnerable population. While we know that there is a spectrum of mental illnesses from mild to severe and often co-occurring developmental and substance use disorders (SUDs), California has intentionally segregated and conflated their delivery systems and funding streams, all in the name of Behavioral Health Integration and Whole Person Health Care Reform.

California's specialty mental health population is still carved out and separated.[3] Despite years of tests, pilots, and promises of integration, this most vulnerable population is historically lost in the shuffle. Therefore, it might be said that one of the main drivers of despair and disparity for the SMI population is the lack of a universal definition of serious mental illness. Because different definitions produce different numbers, populations, and population characteristics, the lack of a common definition complicates analyzing and reporting the role and impact of SMI.[4] It was noted as early as 1999 by the LPS Reform Task Force that the original Lanterman-Petris-Short (LPS) Act intentionally omitted a definition of mental illness based on the changing social views at the time and that the LPS Act's "lack of clear definition and common misinterpretation of its provisions have caused inconsistent application from county to county."[5] The Task Force recommended that the LPS Act should be amended to include a clear definition of mental illness that represents the current scientific knowledge.

According to the *Californian Mental Health Master Plan: A Vision for California Report* delivered to the Legislature in 2003, "With the passage of the realignment legislation in 1991, the adult target population definition was put in statute. Welfare and Institutions Code Section 5600.3 describes the target population for adults with mental illness who are served by the public mental health system. That definition states that a client's mental illness must be severe in degree and persistent in duration; may cause behavioral functioning that interferes substantially with the primary activities of daily living; and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time."[6] The 2003 California Master Plan further described the managed care definitions of "medically necessary care" for recipients of specialty mental health services when the Short/Doyle Medi-Cal mental health services were combined with the fee-for-service Medi-Cal: "Eligible care for medically necessary services must be focused on the impairment, the client must be expected to benefit from the intervention, and the conditions should not be responsive to treatment that could be provided by the physical health care system."[7]

[3] https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx
[4] https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3771-research-weekly-what-is-qserious-mental-illness
[5] https://mentalillnesspolicy.org/states/california/a-new-vision-for-mental-health-treatment-laws-a-report-by-the-lps-reform-task-force-pdf.html
[6] https://www.dhcs.ca.gov/services/MH/Documents/CA%20Master%20Plan.pdf, p.68
[7] Ibid.

In 2004, the generous voters of California supported Proposition 63, a "millionaires' tax" by initiative. When the implementation began in 2004-2005, Proposition 63 became the Mental Health Services Act (MHSA) and was promised to be the defining law for the Specialty Mental Health delivery system transformation and a dedicated funding source for the long-studied and proven model "system of care for children, adults and older adults who were defined by WIC 5600.3." The original ballot language clearly defined how this Act would be applied to the carved out public specialty mental health population.[8] However, the history of the MHSA's implementation has been controversial and widely debated. It has been the source of multiple state and local audits, lawsuits, Little Hoover Commission reports, a variety of formal research studies, and independent investigative reporting.

As a result, the legislature and Governors have modified the purpose and intent of the original Act and re-defined the definition of the Welfare and Institutions Code (WIC) 5600.3 specialty mental health population numerous times since 2004. The latest amendment made to the WIC 5600.3 population definition was in January 2019.[9]

In 2012, the LPS Task Force II report issued several recommendations.[10] The first recommendation was in regard to the definition of "grave disability" and suggested that a determination of grave disability should be altered based on a person's capability to provide food, shelter, safety, and medical care for themselves. It also called for the grave disability standard to be redefined with specific criteria that considered both the historical course of the illness and the current capacity of the individual to make informed medical decisions along with the probability of significant harm without adequate treatment.

In August 2017, a criminal justice-focused workgroup in California agreed that a shared definition of *serious mental illness* was an important first step to create a universal language across counties. The group made a collaborative decision to interpret WIC 5600.3(b) into simpler common language and to promote its use as a *model shared definition*. However, this definition is offered as a guidance tool only and is not mandated.[11]

Model Shared Definition

A common language interpretation of Welfare and Institutions Code (WIC) §5600.3(b)

Serious mental illness is a severe disabling condition which impairs behaviors, thoughts, and/or emotions. Without treatment, support, and rehabilitation, serious mental illness may interfere with the ability to do any or all of the following: manage activities of daily living, function independently, maintain personal or community safety, achieve emotional or cognitive stability, and/or develop and sustain positive relationships. Serious mental illness includes, but is not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. Individuals with serious mental illness may also have substance use problems, developmental disabilities or other physical illnesses.[11]

[8] https://repository.uchastings.edu/cgi/viewcontent.cgi?article=2224&context=ca_ballot_props
[9] http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5600.3
[10] http://www.vchca.org/images/BH/PDF/BHAB/Adults/LPS_Reform_Task_Force_Report_March_2012.pdf
[11] https://stepuptogether.org/wp-content/uploads/2018/04/Model-Shared-Definition-of-SMI-Practical-Strategies-for-Its-Use-to-Reduce-the-Number-of-People-with-Mental-Illnesses-in-California%E2%80%99s-Jails.pdf

In this section, we have highlighted the history of the multiplicity of definitions that clearly contribute to the confusion of who will receive treatment and what that treatment will be. The State lumps any mental illness and substance use disorders under a "behavioral health" umbrella and calls them "mental health challenges" or "behavioral health problems." These terms imply that they are just *bad behavioral choices* rather than symptoms of a brain illness that require medical care, adding to the public's misperception. Further complicating the matter, California has 58 counties ranging in size from under 100,000 to over 12 million in population. Some counties contract out for all mental health services, some provide all services themselves, and others form a consortia to jointly provide or contract for the full array of services. Even the definition of SMI is left to individual counties to decide in negotiation with the managed care plans. Therefore, it is not surprising that there is a wide divergence of services.

In this paper we will use the current WIC 5600.3(b) definition[12] because this is in California statute and is the legal definition.

Does Fiscal Discrimination Drive Housing Disparity for the SMI Population of California?

In 2019, CalMatters.org wrote an exposé providing useful data that helps frame the "sweeping crisis" that is permeating our state.[13] While the report states that "1 out of every 24 [Californians] have a mental illness so serious it becomes difficult for them to function in daily life," it also notes the co-occurrence of substance use with mental illness. This highlights one of the State's delivery system design and financing flaws since *SMI and SUDs are managed in two separate delivery systems with separate waivers and funding streams*.

The California behavioral health system continues to create separate and unequal access to medically necessary care and appropriate housing programs for both the SMI and SUD populations. There is no true integration, parity, or equity for the carved out specialty mental health population of California.

Not even the billions of dollars of MHSA funding have been able to systemically bend the harm curve for this population. The complexity of the California public mental health funding history is well documented. However, how that money is distributed among different mental health populations is not an easy path to follow.

Many advocates believe that it is hard to "cry poor" when so many California counties are sitting on millions of dollars in MHSA funds. And, while many politicians, policymakers, and stakeholders are focused on parity for the privately insured, many ignore the lack of access to a full continuum of care for the WIC 5600.3(b) specialty mental health population. This lack of focus is keeping too many people with serious and persistent mental illnesses housed in bedbug-infested single-room occupancies, solitary jail pods, cardboard tents, or in locked Institutions for Mental Diseases (IMDs) far away from family, friends, conservators, and case managers.

It is criminal negligence for counties to be sitting on funding while so many diagnosed with SMI are suffering without access to appropriate and medically necessary hospital-based or community-based treatment, quality housing and other social determinants of health.

[12] http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5600.3.&lawCode=WIC
[13] https://calmatters.org/articles/breakdown-californias-mental-health-system-explained

National conversations about the broken mental health system often refer to a lack of dedicated funding. When it comes to California, people from other states often wonder why things are in such crisis since we have dedicated Realignment funding,[14,15] MHSA billions and the large influx of funding from the Affordable Care Act (ACA) Medicaid Expansion.[16,17] Few people understand the legal and fiscal discrimination against the 5600.3 specialty mental health population in California. When we divert funding to other social entitlement programs or to "any mental illness" that may or may not be "serious" and then cut the Realignment budget, we prevent counties from providing adequate and medically necessary treatment in a Mental Health Rehabilitation Center (MHRC) or IMD for people living with SMI.

Realignment or County General Funds are the sole source of funding for locked IMDs in California because the Federal Medicaid IMD Exclusion[18] prevents states from using federal Medicaid funding for long-term psychiatric hospital beds in facilities with more than 16 beds. This is one of the main reasons that acute and sub-acute hospital beds have closed in California. There is often a direct correlation made between the closing of hospital beds and the increase in mental health jail cells occupied.[19]

Many do not realize that federal and state parity does not apply to those on Medicaid/Medi-Cal and Medicare. Mental health parity is a widely discussed topic among all mental health and behavioral health stakeholders. Most health advocates agree that there must be equity in access to mental health care equal to physical health care. National and state mental health organizations call for parity accountability under the ACA and the new Mega Rule.[20] However, there is a lack of discussion about the codified fiscal discrimination that exists in the WIC for the carved out 5600.3 SMI population. We do not manage care "only to the extent resources are available"[21] for any other illness in California. Efforts to correct this inequity go back to the heroic work of California Representative Helen Thomson in 1999 when she succeeded in passing the California parity law, AB 88, for the commercially insured population. Unfortunately, Thomson's effort to strike the fiscal discrimination language from WIC 5600.3 was rejected by the legislature in 2002; thus, leaving the public Specialty Mental Health Services (SMHS) unequally funded and its beneficiaries unequally treated.[22]

The ACA added "essential benefits" for "mental health" care if you have a mild or moderate mental illness. However, they do not apply to specialty mental health clients. Therefore, county conservators are unable to access step down programs for their clients in locked settings, so the clients end up in higher, more expensive levels of care for longer than medically necessary.

[14] https://www.cibhs.org/sites/main/files/file-attachments/1_25_2019_sc_issues.pdf?1549648341
[15] https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf
[16] Ibid.
[17] https://www.ppic.org/publication/the-affordable-care-act-in-california
[18] https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/imd-exclusion-and-discrimination.pdf
[19] https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
[20] https://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx
[21] https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/157/Report157.PDF
[22] http://file.lacounty.gov/SDSInter/dmh/224072_LittleHooverReportonProp63.pdf

This is an Olmstead violation that no one seems to address.[23] The SMI population served in California's public mental health system is denied parity – the right to treatment for the carved out specialty mental health population is waived.

While California's current 1115 Waiver allows SUD patients to receive Medi-Cal-covered care in an IMD, there is no current equivalent waiver for the specialty mental health population. The Center for Medicare & Medicaid Services (CMS) has issued guidance that would allow California to amend their 1115 Waiver and receive reimbursement for up to 30 days of medically necessary treatment for SMI in an IMD. However, the California Department of Health Care Services (DHCS) leaders continue to question the feasibility of the waiver.[24] This *must be a priority* for California's DHCS and legislature in the upcoming waiver process. The IMD exclusion is the key driver of discrimination from the Federal Government.

California furthers this financial discrimination by funding community services "only to extent resources are available" and then spending those resources on the populations and social programs who have a right to treatment under the ACA and other regulatory avenues, such as Autism, Intellectual and Developmental Disabilities (IDD), Mild/Moderate Mental Illnesses, Foster Care.[25,26]

The lack of understanding about the different funding entitlements available to different populations also leads to extreme confusion. The California Lanterman Act[27] was a hard fought win for the IDD community that established critical resources that would allow this population to live in the community versus institutional settings and receive supports commensurate with level of ability. These entitlements can range from $1,058 to $8,319 a month.[28] This population has a right to shelter, a right to treatment, and a right to in-home supportive services which provide an improved quality of life opportunity in the least restricted environment. However, there is no equal entitlement for the SMI population. This pits two vulnerable, disabled communities against each other in a fight for resources.

Does Ideology Drive Disparity for the SMI Population – Medical Model vs. Recovery Model?

There are many people in the SMI population who are so ill that they do not respond to treatment in a voluntary community setting. The "no wrong door" mantra of recent years is laudable. However, there are people who are not capable of answering the door when their family, Full Service Partnership (FSP) clinician, or peer is knocking.

Treatment needs for some people living with SMI are more complicated than what was envisioned when the state hospitals were emptied with the assumption that community treatment would replace the need for large institutional settings. There is now the recognition that, due to the severity of one's mental illness, some will experience acute episodes that require inpatient treatment. There is also the reality that not all people living with SMI can achieve recovery to the point where they can live on their own without an intensive support system.

[23] https://supreme.justia.com/cases/federal/us/527/581
[24] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/BH-Workgroup-SMI-SED-IMD-Discussion-11-08-19.pdf
[25] https://www.auditor.ca.gov/reports/2017-117/sections.html
[26] https://mentalillnesspolicy.org/wp-content/uploads/statewide-mhsa-misspending.pdf
[27] https://www.dds.ca.gov/transparency/laws-regulations/lanterman-act-and-related-laws
[28] https://www.dds.ca.gov/wp-content/uploads/2019/12/CCF_Rates_January2020.pdf

There needs to be a continuum of care available to everyone, not just for those who are well enough to open the door.

- The **Recovery Model** is a holistic, person-centered approach to mental health care. This has allowed it to gain momentum and is becoming the standard model of mental health care. This model is based on two simple principles: 1) It is possible to recover from a mental health condition; and 2) The most effective recovery is patient-directed. The fact that many people do not fully recover from a mental illness or that they experience life altering relapses brings in the necessity of the Medical Model.
- The **Medical Model** holds that mental illness is a psychiatric disease with a physical explanation that can be addressed with medical treatment. It has proven highly successful and even indispensable in many contexts; it is difficult to name a plausible alternative to medical diagnosis and treatment for a person who is a danger to themselves or others. The medical model embodies basic assumptions about medicine that drives research.

There is much strife within the community dedicated to helping those with a mental illness. The Recovery Model holds that no one gets better unless it is voluntary. The Medical Model holds to the principle that medical intervention, conservatorship, and assisted outpatient treatment are often necessary when a person lacks insight into their condition. There does not have to be an either/or system. There can be a system of care that is both/and. For some the Recovery Model is successful; yet, for others it has been disastrous. These outcomes create the need to marry the Medical Model and the Recovery Model and weave the medical and clinical supports into the daily living environment to support recovery.

Does the Lack of Tiered Levels of Care Capacity Create Human and Fiscal Waste?

There is no lack of information about the current humanitarian crisis due to an inadequate supply of psychiatric beds in California for the SMI population. And it is no longer a secret that county jails are the largest providers of mental health services.[29] Extraordinary investigative reporting has brought awareness to the clogs and bottlenecks occurring due to the lack of a continuum of care. This paper will refer to this phenomenon as "*the human log jam*" because it is human beings that are being impacted, not widgets in a machine or parts on an assembly line.

"Our jails have become the beds that never say NO."

Mark Gale, NAMI Los Angeles County Council, Criminal Justice Chair

There is a human and fiscal shell game taking place and a bed dance that shuffles individuals with SMI from ERs and crisis stabilization units to the streets and to solitary confinement and back around again. The inhumane revolving-door crisis – sometimes grossly called "catch and release" – is now widely known.

And, because families are no longer staying silent, it is no surprise that they often go to heroic measures to house and care for their seriously mentally ill family members, sometimes risking their own health and security.

[29] Susannah Cahalan. The Great Pretender: The Undercover Mission That Changed Our Understanding (Grand Central Publishing, 2019).

A recent Facebook blog diary called "Broken" has been capturing this chilling California care crisis in real time over the past several months.[30] It is a typical and classic story of a parent who will go to any length to provide care and safety for her family member living with SMI. This story should be required reading for any administrator or policymaker that is leading a whole health system reform.

Some say that the first thing that must be done to solve a problem is to reach an agreement on what the problem is that needs to be solved. While there is no longer a debate about the current humanitarian crisis in California, there is still great social, political, financial, and ideological conflict about how it must be resolved. There is still tension over who deserves a bed instead of a tent, a jail pod, or mom's back bedroom. Some people believe that a right to shelter and housing must come first with promises of support and treatment to follow. This was the argument made to the voters in 2018 when they supported Proposition 2's No Place Like Home (NPLH) bond plan.[31] Many SMI advocates opposed this housing bond plan because it would drain one of the only sources of funding for community-based treatment and put more SMI people at risk of homelessness. While the unsheltered homeless crisis has reached a tipping point and is rightfully being addressed, there is not enough attention on the SMI subpopulations most at risk of or intermittently experiencing homelessness, including those who are:

- living with aging parents.[32]
- discharged from Emergency/Crisis Stabilization Units/Psychiatric Emergency Services.
- living in inappropriate community levels of care without adequate support.
- at risk of eviction from an Adult Residential Facility.[33]
- displaced by natural disasters.[34]
- displaced by business failures.[35]
- transitioning from state hospitals, locked acute or IMD settings to community placement due to inadequate support.
- transitioning from incarceration.[36]

Recent reporting focusing on San Francisco highlights the decision-making mystery surrounding placement decisions and filling beds. "At least 18 ARF patients and their families were blindsided by a recent 60-day relocation notice. Outrage over the move grew after it was revealed that 32 of the 55 ARF beds have gone unfilled for nearly a year, despite an urgent need for assisted living placements. Department of Public Health leaders have cited staffing issues as a reason for the empty beds and said the ARF beds were underutilized."[37]

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[30] https://www.facebook.com/OurBrokenSystem
[31]https://ballotpedia.org/California_Proposition_2,_Use_Millionaire%27s_Tax_Revenue_for_Homelessness_Prevention_Housing_Bonds_Measure_(2018)
[32] https://www.socialworktoday.com/archive/111511p18.shtml
[33] https://sfist.com/2019/08/26/breeds-bed-cuts-to-residential-mental-health-programs-draw-outrage
[34] https://keyt.com/news/2018/05/10/crews-working-to-restore-burned-down-ventura-mental-care-hospital-as-soon-as-possible
[35] https://www.sfchronicle.com/business/article/Anka-Behavioral-Health-files-for-bankruptcy-13811596.php
[36] https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Reentry-After-a-Period-of-Incarceration
[37] https://www.sfexaminer.com/news/supervisor-presses-for-quick-reopening-of-long-term-mental-health-beds

While there is extensive new reporting on the issue, there are also reams of historical process and papering that demonstrate that this has been an ongoing policy debate in California since the deinstitutionalization from state hospitals. Sadly, instead of following the well-studied, evidence-based recommendations provided in the California Master Plan of 2003[38] when Proposition 63 was passed in 2004, endless new *stakeholder theater* sessions were commenced to develop *new* recommendations and plans, seemingly intent on "reinventing the wheel."

The recent work of the California Behavioral Health Planning Council (CBHCP) have added in-depth knowledge to the recent reporting burst on this issue. The 2018 report on ARFs coupled with the great work in Los Angeles and San Francisco Counties,[39] have enlightened policymakers and the public and brought much needed attention to the gaps in access to housing options for individuals living with SMI. These papers, along with the attention from The Steinberg Institute at their April 2019 forum,[40] has created a surge in clear calls for plans of action, not just more planning.

While there is a new and welcomed wave of information on the SMI housing crisis, there is still a serious gap of understanding and transparency about how placement decisions are made and prioritized. The following questions must be answered:

- Who holds the key to unlock the door to free the SMI human log jam in California? Is it the DHCS, Dr. Tom Insel (California's current Mental Health Czar),[41] the Legislature, or the Governor?
- Where is the oversight? Is it the Mental Health Services Oversight and Accountability Commission or the local Mental Health Boards? Or, is it left up to reporters, families, and moms to blow the whistle?
- Who are the gatekeepers of acute psychiatric beds, IMD beds, MHRCs, and Board and Care/ARF beds in each county?[42]
- How do Specialty Mental Health Plan Administrators and Public LPS Conservators make placement decisions?
- What is the court's role in determining who gets a bed instead of jail cell?
- How do families know if all levels of treatment beds are being fully utilized?
- How can the public trust "the system" to create solutions when there is endless reporting of entire units being unused and front page wars between city mayors, Board of Supervisors, line staff, labor unions, hospitals, and health plan leadership?[43]

California has had many mental health "blueprints" and "roadmaps" over the years. What may be needed now is a moral compass.

[38] https://www.dhcs.ca.gov/services/MH/Documents/CA%20Master%20Plan.pdf
[39] https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf
[40] https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/April_2019_Leg_Packet.pdf
[41] https://californiahealthline.org/news/governors-mental-health-czar-seeks-new-blueprint-for-care-in-california
[42] https://www.sfchronicle.com/politics/article/Mayor-pulls-out-of-talks-on-San-Francisco-mental-14468605.php?psid=jPeXz
[43] https://www.sfchronicle.com/politics/article/Mentally-ill-man-moved-from-jail-to-treatment-so-14471643.php

Evidence: Data + Data of the Soul

There is plenty of evidence to demonstrate *the human log jam* across California counties due to the lack of a housing continuum of care for the most seriously mentally ill population. A visit to any medical emergency room, psychiatric emergency room, psychiatric inpatient unit, homeless shelter, IMD, county jail, or courtroom will reveal the humanitarian and moral crisis. A historical review of California's mental health care reform efforts going back to the eighties and nineties reveals mountains of mission statements, visions, strategic models, and Master Plans.

Years of learning led to the bold effort to pass Proposition 63 in 2004. The California Master Plan of 2003 was issued to the legislature and might be considered as a baseline report to measure California's specialty mental health system of care progress in 2019. The 2003 Master Plan included years of prior studying, data collection, meetings, and mappings. It has been followed by *years* of high-cost consulting, "stakeholder theater," and plans created. And, those plans have led to multiple "pilot projects to nowhere" while people who live with SMI are slowly dying.

We include what we call "data of the soul" throughout this document, which is our lived experience with care and housing to augment the evidence base for our Moms on a Mission journey. The recent investigative reporting cited in every major newspaper in California hits the hot spots facing California's mental health systems of care and provides clear evidence and context to consider whether a lack of a full continuum of psychiatric services that includes quality Housing That Heals for the SMI 5600.3(b) population is contributing to a humanitarian crisis. However, we offer the view through the prism of a mom's tears and hopes.

The Journey Begins

As Moms on a Mission, we drove over 3,170 miles during 2019 on a journey to look at the housing options available to those living with SMI because, for decades, many families like ours have been trying to get housing built that meets the needs of their family members who are unable to live with them. These family members were residing on the streets, in jails, or leading a grim existence in care homes with insufficient or untrained staff because all potential placements were full. Our goal was to discover, and then highlight for county, state, and federal administrators, what is working and what is not working in the current continuum of care in California for those living with SMI.

For this project we have concentrated on twenty-two facilities that range from a Mental Health Rehabilitation Center to a Peer Respite Center. The criteria we used to evaluate the housing options we visited was the Institute of Medicine's six specific aims[44] that a health care system must fulfill to deliver quality care, including:

- **Safe:** Care should be as safe for patients in health care facilities as in their homes.
- **Effective:** The science and evidence behind health care should be applied and serve as the standard in the delivery of care.
- **Efficient:** Care and service should be cost-effective, and waste should be removed from the system.
- **Timely:** Patients should experience no waits or delays in receiving care and service.
- **Patient-centered:** The system of care should revolve around the patient, respect patient preferences, and put the patient in control based on ability and capacity.
- **Equitable:** Unequal treatment should be a fact of the past; disparities in care should be eradicated.

At the start of our journey we had hopes of finding at least one facility that could be a blueprint for others to follow; it turned out that we found many good facilities that were effective in providing care and treatment.

However, most would not accept individuals who had a difficult history. This causes the phenomenon that we moms call "cherry-picking," leaving the hardest-to-treat people relegated to the streets and shelters.

We found two things that all the facilities we visited had in common:

- They are safer than the streets.
- They were not always available to those who needed them.

[44] Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press. https://doi.org/10.17226/10027.

Facilities Visited January – December 2019

Facility Name	Organization	County	Program Type
Moore Village	John Henry Foundation	Orange County	Community-based residential treatment on-site mental health services/licensed ARF
Kirker Court Apartments	Eden Housing	Contra Costa County	Affordable housing designated for SMI
Garden Park Apartments	Hope Solutions	Contra Costa County	Affordable housing/family-only On-site mental health services
AOT Pittsburg	Mental Health Systems	Contra Costa County	Master leased shared housing
AOT Antioch	Mental Health Systems	Contra Costa County	Master leased shared housing
The Family Courtyard	United Family Care, LLC	Contra Costa County	Residential care facility for the elderly with a mental illness/licensed RCFE
Brookside Shelter	Shelter, Inc.	Contra Costa County	Adult emergency shelter
Anne Sippi Ranch	Riverside Ranch, ASC Treatment Group	Kern County	Community-based residential treatment facility with direct access to a specialty mental health outpatient clinic/licensed ARF
Enclave at the Foothills	Ever Well Integrated Health Care	Kern County	Community-based residential treatment facility (currently under construction)
Foothills at the Alta	Psych/Social Rehabilitative Services	Tulare County	Residential care for elderly with psych/social rehabilitative services/licensed RCFE
Enclave at the Delta	Ever Well Integrated Health Care	San Joaquin County	Community-based residential treatment facility with psych/social rehabilitative services/licensed ARF
Delta at the Sherwoods	Ever Well Integrated Health Care	San Joaquin County	Community-based residential treatment facility for seniors providing psych/social rehabilitative services/licensed ARF
Delta at the Portside	Ever Well Integrated Health Care	San Joaquin County	Residential care facility for the elderly with psych/social rehabilitative services (currently under construction)
California Psychiatric Transitions	California Psychiatric Transitions	Merced County	Mental health rehabilitation center
The Farmhouse	Yolo Community Care Continuum	Yolo County	Adult residential treatment facility
Crestwood Healing Center	Crestwood Behavioral Health, Inc.	Contra Costa County	Community-based residential treatment facility providing psych/social rehabilitative services/licensed ARF
Nueva Vista Morgan Hill	Psynergy Programs, Inc.	Santa Clara County	Community-based residential treatment facility with direct access to a specialty mental health outpatient clinic/licensed ARF
Nueva Vista Sacramento	Psynergy Programs, Inc.	Sacramento County	Community-based residential treatment facility with direct access to a specialty mental health outpatient clinic/licensed ARF
Second Story	Encompass Community Services	Santa Cruz County	Peer respite center
Oxford House	Oxford House, Inc.	Contra Costa County	Self-run, self-supported addiction recovery homes

The John Henry Foundation (JHF) – Moore Village

Moms on a Mission began with a trip to Santa Ana in Orange County to visit with Mary Ellen Stuart, a member of the JHF Board of Directors. When one passes through the gates of JHF, one enters a therapeutic enclave created for approximately 37-42 people living with schizophrenia spectrum disorders. There are beautiful grounds surrounded by yellow and white cottages. The cottages each house 4-6 residents who have their own or shared rooms. The residents in each cottage share a bathroom and common room with a couch and TV. Various community buildings surround the beautifully-kept grounds.

As Mary Ellen shared with us: "My brother was never hospitalized during his nine years living at John Henry. That was a blessing with untold value, both in terms of money and emotional toll." Mary Ellen also shared the loving care that was provided to her brother when he was diagnosed with a terminal illness. He received ongoing support from the JHF peer and clinical community while receiving hospital care. In order for him to return to JHF during recovery from treatment, JHF staff trained to care for his feeding needs which eventually included feeding tubes.

The JHF community is designed to accommodate individual differences through structured clinical, recreational, educational, employment, and volunteer opportunities. They have found that family interaction is a vital component in the treatment of its residents. Life at JHF revolves around the community model with a structured program that instills freedom of choice coupled with consistency of quality clinical care. Daily morning meetings where all of the residents meet in the community room brings everyone together and facilitates a daily check-in. Following the morning meeting, there are regular outings and opportunities for work and school. There are other weekly event requirements that the residents can select to attend, such as group sessions and outings.

Dr. Andrew Kami, the Clinical Director, specifically discussed the need to limit meetings for people on the schizophrenia spectrum based on their brain illness. This is in contrast to many IMD/MHRC programs where there are mandated meetings, sometimes eight or more a day, which many people with SMI are incapable of managing.

Another unique strength is the opportunity to participate in computer games specifically designed to improve cognitive skills. This may account for the remarkable fact there has been only a handful of 5150s during Dr. Kami's seven years with the program.

JHF has been able to bring in UC Irvine Psychiatric Interns who receive training and real-world experience with SMI. JHF also has Psychology Interns through local colleges, so it is truly a winning combination for the residents and for the people who are committing their careers to serve this population. This is an excellent model for workforce development which could be a partial solution to the California crisis of care providers. Facilities such as JHF are a gift to their residents and, in turn, to the families of their residents.

While it costs $42,000/year to let someone live at the John Henry Foundation, it is estimated to cost $40,000/year to let someone live on the streets and $81,000/year to let someone live in a jail cell.

Kirker Court Apartments

The semi-rural area of Concord on Kirker Pass Road is the site of ten one-bedroom apartments and ten two-bedroom apartments where many people living with SMI reside. This community was developed by one of the largest nonprofit housing developers in the Bay Area in 1994, Eden Housing. The mission of Eden Housing is to build and maintain high quality, well-managed, service-enhanced, affordable housing that meets the needs of low-income families, seniors, and persons with disabilities. Eden Housing was sought out in the early 1990's by dedicated and committed families who were very concerned where their loved ones would live when living with their parents was no longer a workable option because of their parents' age or their child's mental illness. These families arranged to have Clayton Valley Presbyterian Church donate the land where these beautiful units were built.

This area is pristine. The gardens surrounding each group of apartments is lush and creates a park-like setting. It seems as if one were out in the country; however, a large grocery store and many shops are located in a complex less than a quarter mile away. Residents interviewed on-site said they had waited for ten years for an apartment.

Garden Park Apartments

Located in Pleasant Hill, Garden Park Apartments is an outstanding example of what a provider such as Hope Solutions can do with a private/public partnership. At one time, this building was a dilapidated apartment complex; now it is an amazing space. The complex has twenty-two one-bedroom and six two-bedroom apartments, a swimming pool, play areas, and a garden. Each apartment comes furnished so that families can move into a truly functional home.

MHSA funds were used to build a Community Center that now houses offices for a Psychologist and Master Level Clinicians. Through the use of this Community Center, Garden Park residents have access to many needed supported services that assist them with their individual needs, including:

- Full-time licensed mental health providers for case management, crisis intervention, family counseling and support, and assistance with completing individualized family self-reliance plans.
- Four days per week homework club and pre-school programs focused on measurable academic outcomes, emotional health, and social development for youth.
- Summer youth enrichment programs.
- Educational programs that support employment, healthy lifestyles, and successful parenting and family life.
- Activities and social events aimed at creating a healthy and vibrant community.

Mental Health Systems' AOT Housing – Antioch & Pittsburg

Mental Health Systems is the Assisted Outpatient Treatment (AOT) provider of transitional housing in Contra Costa County. Mental Health Systems provides shelter through their own master leasing program for clients who request assistance. They have three master leased properties: one large new home in Antioch, a smaller home in Pittsburg, and a duplex in Richmond. In most cases, clients have at least one or more roommates. The homes are kept in good condition with housekeeping services and have well-stocked refrigerators and pantries.

The home in Antioch has a beautiful backyard, patio, and pool table. Staff visit the homes for meetings and to check on the residents' well-being. Support services are on call 24/7 but are not located on-site (one staff member does reside at the Antioch home).

Mental Health Systems' Vice President, Rich Penksa, has an extensive background in housing for the most vulnerable. He manages over 700 units of permanent supportive housing and transitional supportive housing across the state. His understanding of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, HUD programs on housing, and Public Housing Authorities has given him the ability to augment housing funding streams.

When asked his opinion on how housing resources could be increased, Mr. Penksa gave the following observation:

> *"Mental Health Systems uses MHSA funding for an array of housing for our clients. Those funds are best spent on short term stays and master leasing, while a client prepares for a permanent supportive housing (PSH) subsidy. A mature program utilizes subsidy carve outs received through either a carve out for special populations from the local public housing authority (PHA) or as a direct recipient of Continuum of Care – "New Projects." The Contra Costa FSP and ACTiOn team have no PSH subsidy commitments at this time. The effect of not having PSH subsidies means the program will sustain a stagnant housed census with little movement and limited ability to serve more clients with housing. PSH carve outs shifts the funding burden to the PHA, allowing program MHSA Housing dollars to be freed up to spend on more clients."*

The critical problem of where clients will live upon graduating from AOT still remains; all permanent supported housing opportunities are full, especially for those living with SMI that also have disqualifying histories that prevent access to any housing units that do become available.

Family Courtyard

Part of the *Moms on a Mission* journey focused on Contra Costa's West County. One of the largest Board & Care facilities, the Family Courtyard, is located here. Seventy people reside here, mostly adults age 60 and older who are diagnosed with a serious mental illness and who are uninsured or receive Medi-Cal or Medicare benefits.

The Family Courtyard assists clients with personal hygiene, daily living skills, prescribed medication, and transportation to medical appointments. When the MHSA Program and Fiscal Review of the Family Courtyard showed a lack of supportive services available to enrich daily life, the County began and staffed on-site enrichment programs for the residents.

Calli House & Brookside Shelter

The Moms on a Mission West County tour also included the property shared by Calli House and the Brookside Shelter. On a continuum of care, temporary supported housing is essential. Since this location is so close to the Family Courtyard, it was important to check in on this multi-purpose site. The information below is provided on the County website:[45]

"At Calli House, there are daytime Drop-In services for runaway or homeless youth age 18-24 years and overnight Emergency Shelter for runaway or homeless youth age 18-24 years.
All youth entering the shelter are provided a comprehensive assessment that identifies their needs and form the basis of their housing plan. Transitional age youth who cannot return home or are not ready to live independently may have the option to live at Appian House or Pomona St. Apartments."

Prior arrangements had not been made to tour the inside of Brookside Shelter, so our tour was of the surrounding grounds. This area of Contra Costa County experiences a high rate of homelessness. The shelter accommodates approximately 80 men and women, providing them with the opportunity to connect with many essential life sustaining services such as meals, showers, laundry, phone, mail, and also, just as importantly, to connect with case management which includes mental health services and housing placement.

[45] https://cchealth.org/h3/calli-house.php

There are many shuttered buildings on the Brookside Shelter site. There is a kitchen being operated by county programs out of the back of a large facility adjacent to the shelter. The front half of this building is no longer in use. The grounds of this property were clean and the parking area was maintained.

At the time of the visit, some people who were homeless had set up camp at the abandoned buildings on-site. There is also a tent encampment on the other side of the fence. It was most disturbing to find young children's homework assignments and drawings littering the area of the encampment.

The Farmhouse

The Farmhouse in Yolo County is a rural residential program founded by the Yolo Community Care Continuum in 1979 by a group of parents who wanted a home-like environment for their adult children who were diagnosed with mental illness. They envisioned a place where their children could receive professional and compassionate treatment in the community in which they grew up in. Though it began as a farm program, the Farmhouse has evolved into a rehabilitative transitional treatment environment where adults can learn the skills necessary to make a successful transition from a highly-structured treatment environment to a less restricted form of independent living. The prevocational program improves skills by providing the opportunity for residents to care for farm animals, tend the garden and assist in running the farm.

Lauren at The Farmhouse

Anne Sippi Ranch

Families in Contra Costa County tried for years, without success, to create a residential rural farm program with not only supportive services but also opportunities to explore expressive craft and artistic activities. It was envisioned that the residents would have equine therapy and the opportunity to work with the Master Gardening Program of the UC Extension Service. In the early 2000's, NAMI Contra Costa members visited Anne Sippi outside Bakersfield to see another rural property that was attempting a rural farm program. We wanted to touch base again with Anne Sippi to see how the project had evolved.

Things have changed. Anne Sippi's main house, which was part of the original Merle Haggard Estate, was still in use, complete with the guitar-shaped pool. Now, most of the residents have a dual diagnosis of mental illness along with a developmental disability. Residents under the care of the Regional Center with the dual diagnosis of mental illness and developmental disability are allotted a much higher amount of funding for their care than those who have a single diagnosis of serious mental illness.

There are no longer farming activities available. Instead, Anne Sippi has just opened a beautiful new treatment facility, beautifully appointed, dedicated to residents from Ventura County who have a serious mental illness. It is dedicated to serve residents that "nobody else would take." Anne Sippi has a Specialty Mental Health Clinic on-site so that billable, intensive therapy can be available to its residents. Anne Sippi also has plans to restore and renovate the guest house on the property into a housing opportunity where residents would have their own apartments. Anne Sippi provides its residents with much needed safety and security in a rural setting where they may live for months or years, depending on their need.

Having programs that give people second, third, and fourth chances is so needed for those living with a serious mental illness.

It touched both of our hearts since we both have sons that have burned many bridges.

Ever Well Integrated Health

Ever Well Integrated Health now has many facilities in different stages of development in the Central Valley of California. Founders Chris Zubiate and Andy Fetyko have a vision to provide compassionate treatment and care for those that no one else will take, and to build a system of abundance, not scarcity.

Their largest project is an immense undertaking; they are converting the old Lutheran Orphanage in Terra Bella. This project is located in a breathtaking rural setting at the base of the Sierras. A wing of this property has been fully renovated and will accommodate 40 people. There is amazing capacity and potential at this site. Ever Well has renovated a senior living facility in Dinuba with the latest design elements that will help residents feel more at home and less in an institution.

Ever Well Integrated Health has three facilities in Stockton. The first facility (pictured above) is in the countryside north of Stockton. Almost all residents living here have previously been at locked facilities. Many residents have a dual diagnosis of addiction and mental illness in addition to primary health problems that have prevented other providers from caring for them. This is a niche that Ever Well is filling; they are providing care for people no one else is willing to take, helping them to leave locked facilities and enter community settings.

Ever Well has a second facility in the heart of Stockton. It is a Residential Care Facility that provides mental health care and treatment to older adults. This facility is still in the process of renovation but has begun operation. The residents in this program have multiple medical issues along with a serious mental illness. This is not a locked facility, but most residents stay on-site. During the day, the schedule offers many activities. Art produced by those who live there enlivens every room on the premises.

A third Ever Well facility is located in the Port area of Stockton and had just been acquired. It is located in an older neighborhood adjacent to a large beautiful city park and recreation area. The staff training at Ever Well is rigorous. Food and its preparation are also seen as essential ingredients in attaining wellness.

As we left Stockton that evening, we got lost and ended up in a homeless encampment area. The significance of this was not lost upon us.

California Psychiatric Transitions

California Psychiatric Transitions (CPT) is located in Merced County. Many California counties send their clients here who have struggled in lower levels of care. CPT is a 98-bed fully-licensed Mental Health Rehabilitation Center (MHRC) consisting of three facilities completely staffed with qualified, compassionate, and competent personnel. The Diversion Program is designed to serve court-ordered diversion and Incompetent to Stand Trial-Penal Code 1370 (IST 1370) individuals.

The Main Unit is focused on developing social skills, daily living skills, and in-depth awareness of behavior management and tools to support self-reliance. The focus of the Re-Entry Program is learning skills associated with independent living and vocational rehabilitation. The Disruptive Behavioral Unit program provides individuals with an intensive therapeutic program that focuses directly on minimizing disruptive behaviors in a highly-structured setting. The program is highly structured in a tiered-level system and is an alternative to hospitalization at a state hospital. Clients must attend groups based on their individual treatment plan goals. The highest level of clinical and staffing support is provided. Off-site recreation and social activities are offered as appropriate. The program is very client and family centered. It provides a perfect blend of treatment and rehabilitative supports needed to stabilize symptoms, manage life skills, and restore health.

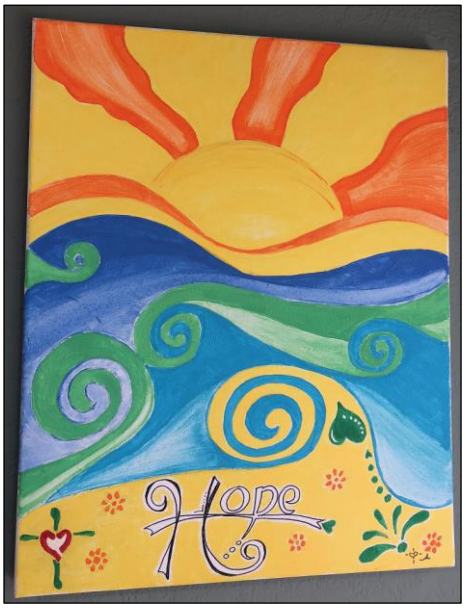
Teresa's son, Danny, was sent to CPT in 2016 on a 1370 IST in a unique arrangement between Contra Costa County and the Napa Superior Court. Because Contra Costa had maintained Danny's LPS Conservatorship during a four-year effort to establish competency, the Napa Superior Court, in partnership with the DA, Public Defender and CCC, agreed to send Danny to CPT instead of back to a state hospital. This freed up a state hospital bed and allowed Danny to go to a smaller, more therapeutic environment with a bed instead of a solitary cell. All criminal charges were eventually dismissed and the LPS Conservatorship was maintained. Danny was still in an involuntary program but free to heal and stabilize. He needed to be in a locked facility for a period of time in order to learn life skills that allowed him to successfully transition to a community placement at Psynergy in 2018. CPT was the "least restrictive" care that allowed Danny to free himself from the symptoms and the broken California system of care.

For 20 years, Danny and his family endured several acute hospital stays, PHFs, two state hospitals, many IMDs, MHRCs, and both small and Super Board & Care facilities. However, none were as successful as CPT. There should be a facility like CPT in every county. However, we need to stop federal, state, and local funding discrimination to make that happen. Some people think that people like Danny need to live in a state hospital for life. Not true. But people like Danny cannot live alone either without the right support and Housing That Heals. In Danny's case, CPT was the right level of Housing That Heals that allowed for his successful transition to a community placement.

Family Photo During a Visit with Danny at CPT

Crestwood Pleasant Hill

Crestwood Pleasant Hill is a facility that family members fought hard to open in 2003. The NIMBYism was horrible, but the fears have been proven unfounded. This treatment facility has not deterred families from making this area of Pleasant Hill, known as Poets' Corner, one of the most sought-after neighborhoods in Contra Costa County.



As Mental Health Commissioners, we both toured this facility between 2006 and 2015. Since then there have been needed upgrades made. Travis Curran is the Director and his office is filled with residents' artwork and photos, a testament to his commitment to his work.

Today, sixty-four people reside in this augmented "Super" Board and Care facility. The mission at Crestwood Healing Center is to enhance quality of life, social interaction, and community involvement for its residents so that they may attain a fulfilling life.

In addition, this facility has a sixteen-person program that provides clinical mental health specialty services for up to a year for those residents considered the most compromised by mental health issues. This program provides intensive training to promote independent living. Its objective is to ready residents for their own residence.

Second Story Peer Respite Center

Second Story is a six-bed home which serves as a respite and a voluntary opportunity for individuals to learn how to use their relationships and skills to establish a solid foundation that will enable them to return to their life in the community. This home is staffed by peers (people with lived experience).

Here, one has the opportunity to connect with others who are experiencing many of the same challenges they are. Dedicated trained peers guide those who are seeking respite. The hope is to generate some moments of connection and trust. It is hoped that lessons learned in this community experience will spill over into the future.

Along with creating a temporary home, this peer respite program exists to build a path towards wellness. It is not a substitute for psychiatric hospitalization. Those who are drawn to the program develop with staff a plan for dealing with feelings and behaviors that, in the past, have led to inpatient stays.

Second Story offers a stay of 13 days in a home environment and provides guests with opportunities to identify and plan for changes they feel will benefit them once they have returned home. All former guests are offered ongoing telephone support and are welcome to visit when they need encouragement from their peers and peer staff.

Second Story is part of Encompass Community Services, a nonprofit organization in Santa Cruz County, with over 40 programs providing services in behavioral health, family and social well-being, early childhood education, housing, and more.

Psynergy

Psynergy has state-of-the-art residential treatment centers located in Morgan Hill, in Greenfield on the Central Coast, and in the City of Sacramento. Each campus is dedicated to fostering a journey back to health for people with serious mental illness. It provides a team of licensed therapists, farm-to-table meals, personalized exercise plans, and equine therapy. Psynergy allows individuals to move out of locked settings and into successful community living. *Together Achieving More* is their motto. When one enters the Psynergy campus in Morgan Hill one does not get the sense of an institution. The grounds and common areas provide a beautiful area where a person can sit and be with friends. The meals served are prepared with meticulous care at achieving both nutrition and flavor. Psynergy knows that rejoining the community is an important step to wellness. From the campus, residents can easily access shopping, restaurants and parks enjoyed by the greater community.

What sets Psynergy apart from most programs is the caliber of treatment professionals on-site. There is a resident Psychiatrist, a Psychologist, Master Level Clinicians, and well-trained Care Staff. The ratio of care providers to residents is exemplary. A resident at the Morgan Hill campus has the ability to come from a locked facility and move from a shared room to living in an apartment on-site. Each level of support comes with the needed level of care and supervision. Assessment, Plan Development, Individual Therapy, Individual Rehabilitation Counseling, Family/Collateral Counseling, Medication Support (MD and Non-MD), Crisis Intervention, and Case Management are tools used by the Psynergy team. Specialty Mental Health Clinics are co-located next door to the Adult Residential Facilities, giving Psynergy the ability to provide a higher level of care to its residents. Ninety-five percent of the residents are Medi-Cal, Medicare, SSI, or Veteran Affairs beneficiaries.

Psynergy is developing new campuses in Sacramento. When construction is complete, Psynergy will have a campus where residents can choose from different housing options which they can call home, such as living in a dorm-like setting or in their own cottage. Psynergy recognizes that while some residents will only be with them for a few months, others may live there for many years.

Oxford House Self-Run/Self-Supported Recovery Houses

Oxford House has three recovery houses located in Contra Costa County. Their mission is to help clients who have a substance use disorder with a co-occurring mental illness. Acceptance into an Oxford House begins with an interview with the house residents, and eighty percent of the house residents must agree that the applicant will be a good fit for the house. The Oxford Houses are run and supported by those who live in each house.

The residents interviewed said that the least amount of money you take from others, the more self-directed you can be. The residents emphasized the importance of being in control of their own destiny. They felt that the motto of "Recovery, Responsibility and Replication" was essential to success for each person and the Oxford House Movement. Each house is a rented, ordinary, single-family residence.

Each home operates under a charter from Oxford House which is a 501(c)(3). The charter has three conditions:

- the group must be democratically self-run following the Oxford House Manual.
- the group must be financially self-supporting.
- the group must immediately expel any member who returns to using alcohol or illicit drugs.

Residents govern themselves, elect house officers, hold regular house meetings, and pay their own way. Rent in Contra Costa County is $750 a month and includes power, water, and electrical needs.

Oxford House administrators, who once started out as residents, help to sustain and replicate the houses. A contract with the county also enables these administrators to keep the houses self-regulating effectively.

Oxford House is a recovery home for those addicted to alcohol and addictive drugs. There was discussion among the administrators and residents about what happens if someone relapses. Their answer was that they are immediately removed from the house. For each resident, there is a written emergency departure plan that is in place so that if a relapse does occur, their departure is done in the most supportive manner.

Contra Costa County has the most Oxford Houses in California. Oxford Houses are either all female or all male residences. The residents are hoping to expand soon with one more home for women. There are three homes now. The women's house has twelve residents and the men's houses have eight and thirteen residents. Oxford Houses have been in Contra Costa County since July 2019.

Moving Towards Housing That Heals

As two Moms on a Mission, we have assembled evidence of California's lost promise to our families and local communities.[46] We have found clear evidence of some of the most amazing programs of promise. Right now, in 2020, we have concerns about whether the State will be able to find the right leadership to guide California towards the promised land of Housing That Heals for families likes ours.

We have intentionally spotlighted the WIC 5600.3(b) specialty mental health population's housing needs only. This population has been forgotten too often. We spotlight those who have been promised a right to treatment before tragedy, incarceration, institutionalization, or homelessness over and over again since the deinstitutionalization wave. We refuse to allow the current generation of this population to be forgotten any longer. Our loved ones are not *the disposables.*

We spent twelve months traveling across California to visit housing programs and attend local and state meetings. We traveled with open hearts and minds. We invited partners to join us along the way with the pure intention of developing a shared vision of hope, health, and home. While we did find hope sprinkled across the state in our travels, we must conclude by stating emphatically that *hope is not a system of care and we are determined to see California go beyond hope in 2020.*

We are grateful that housing is clearly on California's political, social, and legislative agenda in 2020. But, will it be "Housing That Heals?" And, will the State's housing agenda focus only on homeLESSness or will it recognize the need to build a system of homeFULLness for the WIC 5600.3(b) population? Will the legislative agenda replicate plans that have failed for years? Or, will it embrace the perspectives of families like ours who understand where the weakest links exist and the ways they can be fixed? Will the State focus on action instead of more meetings, missions, and mappings?

Our families expect the State to build a shared agenda and co-create a clear, collective action plan in 2020. While the current efforts in Sacramento are attempting to course correct, we must do better than aim in 2020; we need to hit the target. We believe that our research, reflections, and recommendations will help the State move beyond a *fail first,*[47] *housing first*[48] mentality that currently exists in the third world reality found in our cities, counties, and communities. We know we can do better and *must do better* in this first world country of ours. California cannot afford to wait any longer.

Our families have partnered with patience while waiting for the system to care. Families are often begging for treatment before tragedy and we are told to wait. We wait for the police to come and make a medical decision about treatment based on limited training. We wait for the health providers to feel safe enough to provide medical assistance. We wait for medical beds that are nonexistent.

We are worried that the current focus on only unsheltered homelessness, regardless of diagnosis, will force the SMI clients and families who have been waiting for the right care, at the right time, in the right place... to just keep waiting.

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[46] Appendix: A Spotlight on Contra Costa County provides further discussion on the system in our home community.
[47] https://www.propublica.org/series/right-to-fail
[48] https://www.manhattan-institute.org/housing-first-effectiveness

We cannot wait forever for the State to fix every social, climate, and political crisis while our loved ones are still "slipping away." When will the sweeping crisis of SMI be the focus?

Our focus is purposeful. It is to use Housing That Heals as a quality improvement strategy for the SMI population. It is to move our system of treatment beds from scarcity to abundance. It is a strategy that will break the human log jam and relieve the firefighting mentality of the current system. When a "familiar face"[49] is placed in Housing That Heals, there will be less risk, less restriction, less restraints, and less suffering. There will be stability, dignity, and humanity. The models we have highlighted can and must be replicated. We need to support the quality housing and treatment providers who say "yes" to those who are hard to treat. Currently, the only beds that welcome all SMI people, regardless of diagnosis or payor source, are jail beds. This must end. We cannot promise to reduce incarceration, criminalization, and homelessness until we provide alternatives. We cannot divert from solitary confinement, higher levels of care, or more restrictive care without building bed capacity in the community. Our families want no more and no less than what any family member wants for a sick loved one. We want a full continuum of the right care, at the right time and in the right place. We want a right to treatment with dignity and a system of care to support both the medical and social determinants of health. We seek common ground to build that system of care for those who have been waiting for a chance to heal. As the State aims to fix the current crisis, the people who live heroically with an SMI must not get lost or forgotten again in the State's human and fiscal shell game. California must address all four drivers of death, despair, and disparity that we have identified.

If we want a "Healthier California for All,"[50] then all disparities must be the focus. California must formally designate SMI as a health disparity. Health disparities are usually addressed in relationship to socioeconomics, culture, race, and gender, which are critically important. However, the definition of "unserved" and "underserved" is defined in the California Code of Regulations (CCR, Title 9) as "individuals who may have SMI and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved." Underserved individuals are also those "who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support sustained stability and recovery." The definition dilemma goes beyond SMI.

The current State planning discussions have bold aims. One of the current aims under the "CalAim"[51] Medi-Cal 1115 and 1915b Medi-Cal Waiver discussions[52] is to change the way medically necessary treatment is defined. The proposal would expand medical necessity eligibility to include those who might have any mental health or substance abuse problem without having to obtain a formal diagnosis.

[49] The term "familiar face" refers to refers to a population defined as individuals who are frequent utilizers of emergency, acute, jail, crisis services. https://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx
[50] https://www.gov.ca.gov/2019/12/18/governor-newsom-announces-healthy-california-for-all-commission
[51] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM-High-Level-Summary.pdf
[52] http://www.itup.org/wp-content/uploads/2019/10/ITUP_DiscussionGuideOct_101419.pdf

This would be a shift in focus away from a diagnosis and towards a definition based more on "level of functional impairment." With a current dearth of both hospital and community beds for both SMI and SUD, we worry how the State will create bed capacity and additional staffing capacity for an expanded population.

And, while the State studies this test of change, we worry about what will happen to the population of people who are already diagnosed with SMI, classified as disabled, and incapable of independent living. This is a population who has been waiting for access to medically necessary health care and housing. This is an underserved population that must be prioritized.

We are grateful for the current 1115 Waiver discussions to improve outcomes for all Medi-Cal beneficiaries. But, with plans to change the definition of medical necessity to allow more access for undiagnosed people while threatening another MHSA reform,[53] we fear that the system will implode, not improve. The MHSA was the promised funding source for the Specialty Mental Health "system transformation," and that promise for transformation remains unfulfilled. In addition, it seems as if the California aim is to focus mostly on people who are experiencing homelessness. This is honorable. This is humanity. But, many of the current unsheltered homeless population do not have an SMI as currently defined, the way our sons' adult lives have been defined based on a Diagnostic and Statistical Manual of Mental Disorders diagnosis and their level of disability and functioning. We do not want anyone to live unsheltered, but we worry about the system's ability to provide adequate capacity for all of the most seriously mental ill population. We worry about those at risk of homelessness who have been waiting for quality housing and care.

If we are going to build a continuum of care, then many bureaucratic, licensing, and funding barriers must be removed for the IMDs, ARFs and RCFEs in order to scale up and save lives. The cost savings of providing the right care will support the investment. This too is prevention and intervention. And, California cannot claim to be addressing parity and discrimination while allowing the IMD Exclusion Waiver[54] opportunity to stall for the SMI population. **How can California allow the ideological tension over involuntary care to be an excuse when we use jail or prison as a system of care for the severely mentally ill population?**

In order to create a "Healthier California for All," California must not only focus on the Medi-Cal population but put a laser focus on all public and private policies that lead people and their families off the cliff with only the public system's mental health system as the safety net. While putting a spotlight on parity for private insurance will be helpful for future generations, the State must not abandon those already in the public specialty mental health system who have been waiting for a whole system of care to be fully funded.

[53] https://www.chcf.org/blog/addressing-homelessness-high-governor-newsoms-agenda
[54] https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/imd-exclusion-and-discrimination.pdf

The state legislators and Governor have rightfully called out private insurance for parity negligence. However, we must respectfully call out the State for ensuring that parity will never be achieved for the Medi-Cal population due to the funding discrimination with a Welfare and Institution Code that covers serious mental illnesses, "only to the extent resource are available." The State must reflect on its own history of maintaining this inequity for our most vulnerable. There will never be equity or integration with minor legislative tweaks to private parity only.

California must bust funding and delivery system silos in order 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. **For example, we have learned that one ARF owner has been offered $1000 more per bed for unsheltered homeless individuals.** This would displace the current SMI residents who are only funded at $35/day. To achieve an SMI Triple Aim, we must stabilize the current supply of community-based beds.

We do applaud all efforts to prevent and intervene with suffering, but we refuse to allow the current SMI adult and older adult generation to be forgotten. Those already diagnosed with SMI who are living in unregulated, substandard room and boards, locked IMDs, revolving in temporary shelters, or living with their elderly family members must not be considered adequately housed. Shelters and locked IMDs are not homes. And, we must not forget that our main question when starting this journey was "What will happen when we are gone?"

California must address this at-risk population, too. We need prevention and intervention tools for those already diagnosed "stage 4" SMI. MHSA was not just intended to only serve children or homeless populations. Both Laura's Law and LPS Conservatorship are preventative tools that must be used when necessary in order to save lives. However, without a full continuum of psychiatric care that includes public and private hospital beds, community-based programs, and a full continuum of tiered Housing That Heals, then tweaking parity laws, reforming LPS and raiding MHSA will not prevent the crisis from growing.

We caution the state Behavioral Health stakeholders whose focus may be narrowed by age group, insurance category, or other special interest to widen your views. Will more millions of dollars spent on more of the same really make a difference? Or, do we need a whole new way of looking at whole person care across the age span for the SMI populations? Should we only focus on building community services or should we finally understand that we need to rebuild the psychiatric hospital-based system as well? There are no quick fixes. No "one size fits all" approach. But, if we are going to unclog our prisons, streets, and morgues, then we need a system of care that includes a right to shelter and a right to treatment in California. **California must lower the bar for "grave disability" and raise it higher for incarceration.**

We need a way to hospitalize those who need it and community pathways to support assisted outpatient treatment for people who do not need hospital-based care. A community system and resource allocation must be flexible to move money around for the people who need it most.

People living with SMI are dying while elected officials and legislators have endlessly planned with good intentions but without constancy of purpose. Our state will continue to be in "condition red" until we recognize the weakest links. We know that California will not solve the homeless crisis, the justice system crisis, the emergency room crisis, and the crisis of not caring until we break common ground for a hospital and community-based continuum of psychiatric care that includes a continuum of Housing That Heals.

The data dashboards used by the State to guide improvement and measure priorities are not adequately reflecting the 5600.3(b) SMI population. We must dive deeper into the data to determine who will be helped first. Who will be forced to fail once, twice, three times… eight times at a minimum, before help is given? Who will continue to be left psychotic, homeless, and helpless? And, who will continue to be left psychotic, housed, and helpless? California has a moral obligation to ensure that BOTH of these vulnerable populations are properly housed and healed.

California must stop pitting vulnerable, disabled communities against each other all in the name of civil rights. Ideological battles must end if California is to prevent the death spiral related to serious mental illnesses. There is nothing civil or right about the data of the soul of our families and communities.

As we traveled across California, we witnessed the housing crisis explode on all levels; it has reached the tipping point. The suicide rates grew, both in and outside of jails and prisons.[55,56,57] We saw task forces created, policies debated, and bills proposed. But, we are left to wonder if the current proposed reforms, refreshes and realignments will truly be the true north star for all. Or, will it leave the most vulnerable SMI population still reaching for a life raft while the deck chairs are being rearranged and the ship is going down? Whose moral compass will guide us forward? Who holds the keys to the locked doors? Who holds the keys to open the doors of Housing That Heals?

We are confident that we have identified four key drivers of despair and disparity that have prevented California's ability to build a scalable, sustainable continuum of psychiatric care. These drivers have clearly contributed to the lack of access to safe, effective, person and family-centered, timely, efficient, and equitable Housing That Heals for the specialty mental health WIC 5600.3b population as currently defined. These drivers have also contributed to deaths of despair and a continuous circle of suffering.

We must all focus together on solutions that will design these drivers of despair, disparity, and death out of our California health and justice systems.

[55] https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained
[56] https://www.sfchronicle.com/bayarea/article/Suicides-in-California-prisons-rise-despite-14476023.php
[57] https://www.sacbee.com/news/investigations/california-prisons/article236991514.html

Recommendations for Housing That Heals

We recommend the following considerations to develop a continuum of psychiatric care and Housing That Heals for the specialty mental health WIC 5600.3(b) population as currently defined 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.[58]
- 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[59] 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.

[58] https://stepuptogether.org/wp-content/uploads/2018/04/Model-Shared-Definition-of-SMI-Practical-Strategies-for-Its-Use-to-Reduce-the-Number-of-People-with-Mental-Illnesses-in-California%E2%80%99s-Jails.pdf
[59] https://medical-dictionary.thefreedictionary.com/all-cause+mortality

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.

"when you are forever fighting a degenerating sense of 'nobodiness,' then you will understand why we find it difficult to wait. There comes a time when the cup of endurance runs over, and men are no longer willing to be plunged into the abyss of despair."

Martin Luther King Jr., Why We Can't Wait

Our families and loved ones have experienced enough "nobodiness." We will partner with anyone who is willing to shatter the status quo and join us to build Housing That Heals, together.

Appendix: A Spotlight on Contra Costa County

Contra Costa families have been on a long mission to build a continuum of care that includes Housing That Heals for our seriously mentally ill loved ones. We have successfully built strong partnerships with our public health and safety systems, community partners, the faith-based community, and policy and decision-makers. Together we have created a vision of hope for optimal health for all. However, in spite of the best intentions and tireless efforts, we have a small, vulnerable population that needs more focus and a new way to live at home in Contra Costa County.

This heart paper is our effort to shine a light on the California housing crisis as it relates to the WIC 5600.3(b) population. We defined the problem using our drivers of disparity. We assembled some general evidence and data providing historical and current context. We traveled to nine counties covering over 3,000 miles to visit existing housing facilities.

Now, we will take that learning and combine it with our experience as both family members and authentic partners with the Contra Costa County public health system to consider the various alternatives we have seen. As residents of Contra Costa, we will give careful attention to the cost-effectiveness and the cost-benefit of the status quo, and make recommendations for immediate improvements. As moms, we will focus on value and care that must always start with heart, health, and healing.

First a Look Back: Dreams of a Residential Farm in Contra Costa for the SMI Population

In planning our itinerary for the Moms on a Mission tour, we looked back to 2001 when family members became determined that they could mobilize funding from donations to build a rural community for their loved ones. The dream was to build a supportive community made up of residents and staff that incorporated the support of families to help SMI adults achieve the most improved health, purpose, and sustained stability. This therapeutic farm might be a transitional stay for some, but for many it could become a forever home.

Under the leadership of Gloria Hill, it was amazing what this band of volunteers accomplished. By 2002, A Beautiful Night Housing Corporation (ABN) nonprofit was established through the generosity of Alameda and Contra Costa families who collectively raised over $623,000. And, with the generosity of the Reynolds family, a 10-acre agriculturally-zoned property was purchased in Knightsen, California, a small agricultural community of East Contra Costa County, and held by ABN.

The ABN Board eventually chose Bonita House, Inc. to receive the farmland and the $623,000. Bonita House did not realize the opposition it would face from local rural residents in applying for a use permit for the property. After a strong community outpouring of support against the NIMBYs,[60] a use permit was finally granted for 10 residents in 2011. However, some of the constraints placed on the residents, such as not having a co-occurring substance use disorder, would limit the access of many in need of this environment. Both families and Bonita House remained undeterred and approached the County's MHSA Planning process for a yearly augmentation of $220,000/year which was granted in late 2013.

By this time, the property had been left unattended and was in great disrepair. Family members sought funding from the Community Development Block Grant program.[61] With the support of Bonita House, the County Planning Commission awarded Knightsen Farm $707,000. The County and Bonita House met to discuss increasing the ongoing programming budget in the MHSA Plan to $330,000 in order to move forward with improvements and programming. Sadly, an accord was never reach. Today, the land remains in a broken state that mirrors the broken and unfulfilled dreams of so many families. The Los Angeles Times covered this sad story of lost hope and dreams.[62]

In 2019, with the dream of a residential rural community still not forgotten, we remembered that one of the most dedicated family members in the early years of planning a residential farm, Mary Ellen Stuart, had found a "forever home" for her brother at the John Henry Foundation in Orange County. Her brother has since passed, but she had remained dedicated to JHF and recently had joined their Board of Directors. So, in December 2018, we reached out to Mary Ellen Stuart and planned a trip to Orange County in January 2019.

[60] NIMBY is an acronym for "not in my backyard."
[61] https://www.contracosta.ca.gov/4823/Community-Development-Block-Grant
[62] https://www.latimes.com/local/california/la-me-adv-farm-20151025-story.html

Building a Vision of Housing That Heals for Contra Costa County

As mentioned previously, we began our site visits across California using our experience as moms as our guiding north star. Our first visit to the John Henry Foundation in Orange County set the bar high. It was a model that appeared to meet the highest medical, social, rehabilitation, and quality standards. And, it was affordable, licensed, and humanity-centered with great outcomes achieved. It definitely passed the medical, social, and family standards of care criteria we wanted for our loved ones.

JHF did fit the dream ideal "Housing That Heals" model that we had in mind. The fact that the clinical care provided was both science and person-centered was a heart note. The fact that only a handful of 5150s had taken place there during the past several years was huge. The fact that residents could have their own bedrooms, allowing for privacy and dignity, was so important. And, the respect for families as partners-in-care was key. A unique feature of this program is the fact that all residents have a diagnosis on the schizophrenia spectrum. This is such an important distinction of care because the symptomology for schizophrenia spectrum illnesses are unique to other brain disorders. Therefore, a program designed for this population only is also unique and noteworthy.

It is a program that one can only access if their family can afford to pay $3,500/month. But, is it a program that would accept a client who "did not look good on paper," a comment that has been made about our sons*?* While we do understand the fiscal and legal risks of caring for this population, the stringent licensing requirements, and the right of a private owner or nonprofit to choose their residents based on their own business model, we left Santa Ana wondering if this model could be replicated for a public system of care that chooses to serve all, not some.

We plotted our path forward as follows, considering the current state of Specialty Mental Health housing in Contra Costa. We assumed that our county would be reflective of other counties.

Situation: Contra Costa County does not have sufficient Housing That Heals as part of a full continuum of psychiatric care for the specialty mental health 5600.3(b) population that we are spotlighting. All housing placements are full. Some people are being housed in placements that do not meet even the basic criteria of safety.

Background: A variety of concerns about the shortcomings of Contra Costa's mental health system was brought forward to the County's Board of Supervisors in 2016, when the Mental Health Commission (MHC) issued a White Paper.[63] The MHC White Paper was created in partnership with a broad coalition of both hospital and community-based stakeholders and offered as an improvement "tool, not a hammer." Since the White Paper was issued, it has been the source of many community conversations, Grand Jury Reports, and Board of Supervisor hearings. As part of the original stakeholders who wrote the MHC White Paper, we support the ongoing collaborative efforts to work on the issues raised and we have also participated in those efforts.

[63] MHC White Paper: http://64.166.146.245/docs/2016/BOS/20160913_807/26920_White%20Paper%20-%20Signed%20by%20Duane%20Chapman%205.24.16.pdf

However, we believe that one of the most critical issues mentioned in that White Paper that has not been adequately addressed is the section entitled "Housing That Heals" (excerpt below).

Housing That Heals

The number of persons with a serious mental illness who are homeless and in county shelters is rising. All MHSA-funded supportive housing for those with a serious mental illness is at capacity and our in-patient psychiatric unit is full. There is a tremendous unmet need for mental health residential treatment and long-term supportive housing, yet we are holding millions of dollars in unspent MHSA funds.

More alternative treatment residential programs that lead to permanent, service-enriched housing models for people with serious mental illness need to be explored, invested in, and implemented. Although "Housing First" was been adopted and promoted in our county several years ago, it cannot be effectively implemented without an adequate inventory of housing that is embedded with services that support consumers in developing skills to maintain their health and recovery. A true supportive housing model that includes teaching many consumers "direct skills" to maintain their health and recovery will prevent many high costs and reduce out-of-county placements.

The housing needs of our consumers and families present many challenges that follow a continuum from least restrictive to locked settings. Some see a need for more permanent supportive and shared housing; others see a need for more shelters, while others are calling for more residential alternative treatment settings. There may be a need for all. Behavioral Health is committed to working with stakeholders to look at the whole picture and to define solutions to the housing crisis, but planning meetings without action plans that are implemented remain only a dream, not a needed solution.

Creating a well-planned system for moving those with serious mental illness into the most appropriate housing model will be a savings to the county. There will always be a need for locked facilities and skilled nursing facilities, but many patients could be more effectively served in alternative residential treatment programs and permanent supportive housing in this county. Permanent supportive housing will also give those living in shelters or transitional housing a better path to optimal health. The county budget process must take a deep look at the funding streams that could make supportive housing a reality for people with serious mental illnesses."

The original response from the County's Behavioral Health Services stated, "Housing and housing with treatment are complex issues. Given that housing is a scarce resource, the Behavioral Health Division organizes a number of housing committees to address the various needs of our consumers. These committee meetings solicit community stakeholder input as required by our funding stream. This includes, for example, the recent development of our Coordinated Housing Entry Program."[64]

[64] CCCBHS White Paper Clarifications:
https://drive.google.com/open?id=10HmrRodoRCSQk_he0T3w6xoIuuDRnGLJ

We understand the pressures and competing priorities that our public safety net system is experiencing. However, as former Contra Costa Mental Health Commissioners and members of our County's original MHSA Planning process, we have attended many community stakeholder meetings where housing priorities were debated. We have watched the dots put on the walls and witnessed housing being voted on as the number one system gap indicator year after year.

However, while claiming that the MHSA is a stakeholder-driven process, the wisdom of the SMI community is too often ignored and "funding streams" and political or special interest agendas seem to influence decision making. Consequently, housing opportunities were either missed or focused on short-term shelter beds and rental subsidies instead of on long-term systemic solutions.

In addition to the MHC White Paper, there was a quantitative "System of Care Needs Assessment" performed by the Contra Costa County Behavioral Health Services (CCCBHS) in 2016.[65] Using a baseline report from 1981, *A Model for California Community Mental Health Programs*,[66] the needs assessment declared that "overall, CCCBHS Mental Health is reaching the target population it is mandated to serve." The assessment recommended "that CCBHS Mental Health continue to improve its capacity to assist consumers move from higher levels of care, such as locked facilities, to lower levels of care that are community based."[67] This has been a continued discussion point in recent stakeholder meetings without a clear solution for the adult specialty mental health population.

These were not the first reports identifying the need for housing development in Contra Costa. There have been numerous previous housing reports and studies done in Contra Costa that could also provide planning guidance. The excellent 1994 report by the Contra Costa MHC could have been a great baseline report for the community planning process to use when the MHSA was being implemented beginning in 2004.[68] This report identified that 47% of the County's SMI population was living with aging family members. There are recent anecdotal claims that this is still true. This begs the question, "Is Contra Costa County adequately preparing for the inevitable increase of homelessness when our aging family members are no longer here to support their loved ones?"

Another excellent report was prepared by Contra Costa's Mental Health Consumer Concerns in 2013, *Augmented Residential Care Facility Project Report*.[69] It was vetted through the Contra Costa County MHC who recommended the report be used as a guide to be followed. That report called out the precarious state of the Board and Care Home model. Since so many people were placed outside of Contra Costa County, this report also made recommendations about the need to develop new in-county residential options and was part of what was called the "Bring 'Em Home" campaign.[70]

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[65] https://cchealth.org/mentalhealth/mhsa/pdf/2016-ccbhs-needs-assessment.pdf
[66] http://histpubmh.semel.ucla.edu/sites/default/files/archival/d8485804_Doc_7._1981_California_Model.pdf
[67] https://cchealth.org/mentalhealth/mhsa/pdf/2016-ccbhs-needs-assessment.pdf
[68] Contra Costa County Mental Health Commission Housing Report 1994:
https://drive.google.com/open?id=16IzwZy9NHaBIxkH2KD75Ts1otX8j7h2o
[69] Augmented Residential Care Facility Project Report 2013:
https://drive.google.com/open?id=19AcbkCTInelq06Q8_fS1z0hJ0_Wzz9wF
[70] https://cchealth.org/mentalhealth/mhc/pdf/2012-1107-agenda-qoc.pdf

An excerpt from the Augmented Residential Care Facility Project Report reads:

> *"The number of available licensed homes for adults with psychiatric disabilities in Contra Costa County is barely holding its own. During the course of the monitoring period, Alpine Care Home in East County closed and Blessed Care Home opened. Therapeutic Residential Services on Belmont Road in Concord had just closed, and Gina's Residential Care Home in Walnut Creek is scheduled to close. Considering the almost $35 million spent by Contra Costa County on out-of-county placements in fiscal years 08-09, 09-10, and 10-11 (per Public Records Act request made twice in 2012 by then Executive Director of MHCC, Brenda Crawford), it is an understatement that it would be fiscally wise to develop more in-county options, such as the Bonita house therapeutic farm in Knightsen, for consumers able to live in the community and who need care and supervision."*

Additionally, in 2014, as a result of the statewide concerns regarding the oversight of MHSA funding, CCCBHS, in partnership with MHC, developed a Program and Fiscal Review Tool. This tool was a collaborative model created to ensure that services are being provided in accordance with the values of the MHSA. Mental Health Commissioners are included as part of the Review Team and all reports are vetted through the Commission. These reviews have been invaluable in supporting quality assurance, client and family-centered service, transparency, and fiscal security of the programs.

And in 2014, Contra Costa used their MHSA Capital Funds for a state-of-the-art Crisis Residential Program intended to prevent SMI specialty mental health clients from being placed in locked settings or higher levels of care unless medically necessary. This facility has provided many people the respite needed to prevent acute levels of care. However, there is no evidence that this facility has stemmed the rising human and fiscal costs in IMDs, state hospitals or jails. Or, prevented increased homelessness. Additionally, when people are discharged from all County Crisis Residential Facilities, there is an inadequate housing continuum.

❤ Heart Note from Lauren

My son was discharged from Hope House to the street. During his time on the street he turned to using methamphetamines. Because our family knew how to advocate, we pushed hard to get our son into AOT. His provider is doing everything they can, but they are hamstrung as to what they can do since he is not conserved. Because of his illness, our son seldom answers his door. He has not taken his prescribed medication in months. He does not use his Supplemental Security Income (SSI) to pay his rent; instead, he uses it to buy alcohol, marijuana, and illicit drugs.

In 2015, Contra Costa adopted Laura's Law[71] as another tool to provide evidence-based and high-level assisted outpatient treatment to prevent higher levels of care at higher costs.

[71]https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=2.&article=9

Part of the original plan was to set aside funding for housing to support this program. However, many of the AOT and FSP clients are not safely or appropriately housed which may lead to fewer successful outcomes.

Heart Note from Teresa

I shared my family story with NBC Bay Area when Laura's Law was first being implemented in San Francisco and Contra Costa County.[72] My son was lost in the shuffle of solitary confinement to state hospitals at the time. I had worked for over 10 years to get Laura's Law adopted in my home county of Contra Costa so that people could receive treatment before tragedy or torture.

One of the first clients to enter the Contra Costa Laura's Law program was a young woman named Arises, who I had come to know through her mom, Jackye. Jackye was a tenant of ours and had reached out to my husband for help when her daughter was in early psychosis. I navigated a 5150 with Jackye and helped her daughter get into a Full-Service Partnership for Transitional Age Youth. That program worked for a while, but when it stopped working, Jackye reached out to me again for help. I helped Jackye navigate the referral process for the new Laura's Law program in Contra Costa County.

This success story with Jackye was covered in a 3-part investigative series by Sheyanne Romero and the Visalia Times.[73] It blends the story of Arises Collins, my son Danny, and the tragic story of Linda Mudge. Linda might still be alive had she been offered Laura's Law and "Housing That Heals." We need access to both in all counties of California. Access to lifesaving tools should not depend on who you know, your zip code, or your diagnosis.

In 2017, Contra Costa experienced the same tension as other California counties over the debate to build jails instead of funding adequate diversion programs. For people who have an SMI, the primary diversion program should be AOT. The community has successfully lobbied for new innovative diversion programs for many underserved subpopulations, and our Health Services Department has partnered with the community and demonstrated a clear vision of authentic partnership and one care for all. The Rapid Improvement Events[74] focusing on the detention health services is an improvement model to be shared state and countrywide.

However, like all California counties, there is still a population that cannot be diverted to community-based programming and are left waiting for "a bed instead"[75] of a solitary cell. So, the jail debate must continue until there is truly one care for all in Contra Costa County and no one is jailed and criminalized unnecessarily. The Sequential Intercept Mapping[76] process that began in 2018 is a beginning to this end.

[72] https://www.nbcbayarea.com/on-air/as-seen-on/Bay-Area-Mother-Takes-On-Mental-Health-Care-System_s-Revolving-Door_Bay-Area-315653531.html
[73] https://www.visaliatimesdelta.com/story/news/2019/03/21/lauras-law-mental-illness-treatment-cost-tulare-county/1695063002
[74] https://cchealth.org/video/2017-1201-dh-report-out.php
[75] https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3661-a-bed-instead-advocacy-campaign-launches-take-the-pledge
[76]http://64.166.146.245/docs/2019/BOS/20190514_1286/37290_SIM%20Final%20Report%20PRA%20Associates%20April%202019.pdf

Notably, there is no mention of using the empty unit at our local county hospital, Contra Costa Regional Medical Center, that was closed in 2008. Using this unit would be a humane solution to treating the gravely disabled inmates who are now placed in “safety cells” instead of a hospital bed.

❤ Heart Note from Teresa

My son had been in many IMDs but was unable to successfully sustain stability once in the community until the past year. We were told that the "best" IMD in California was California Psychiatric Transitions (CPT) in Merced County. BUT… we were told that it was a higher cost contract that was not available unless you were only on Medi-Cal. We had maintained our son's private Kaiser Insurance as a disabled adult for 8 years and tried to support the horrors of juggling his private insurance and public LPS Conservatorship which often pitted one system against the other with our family stuck in the shuffle. So, we were encouraged to drop the private insurance in order to get our son access to CPT.

He was placed at CPT twice, and both times were successful. The first time resulted in a failed transition due to the community placement's failure to provide my son's injection of anti-psychotic medication. This cost him a lot.

He ended up being re-hospitalized and nobody would take him back. So, he ended up at Napa State Hospital as one of the small percentage of patients placed there on a civil, not criminal commitment. The medical care was not collaborative, the medications were wrong and my son ended up lashing out and was arrested as a patient. He was IST for four years, in and out of two state hospitals and solitary confinement in jail before being diverted back to CPT.

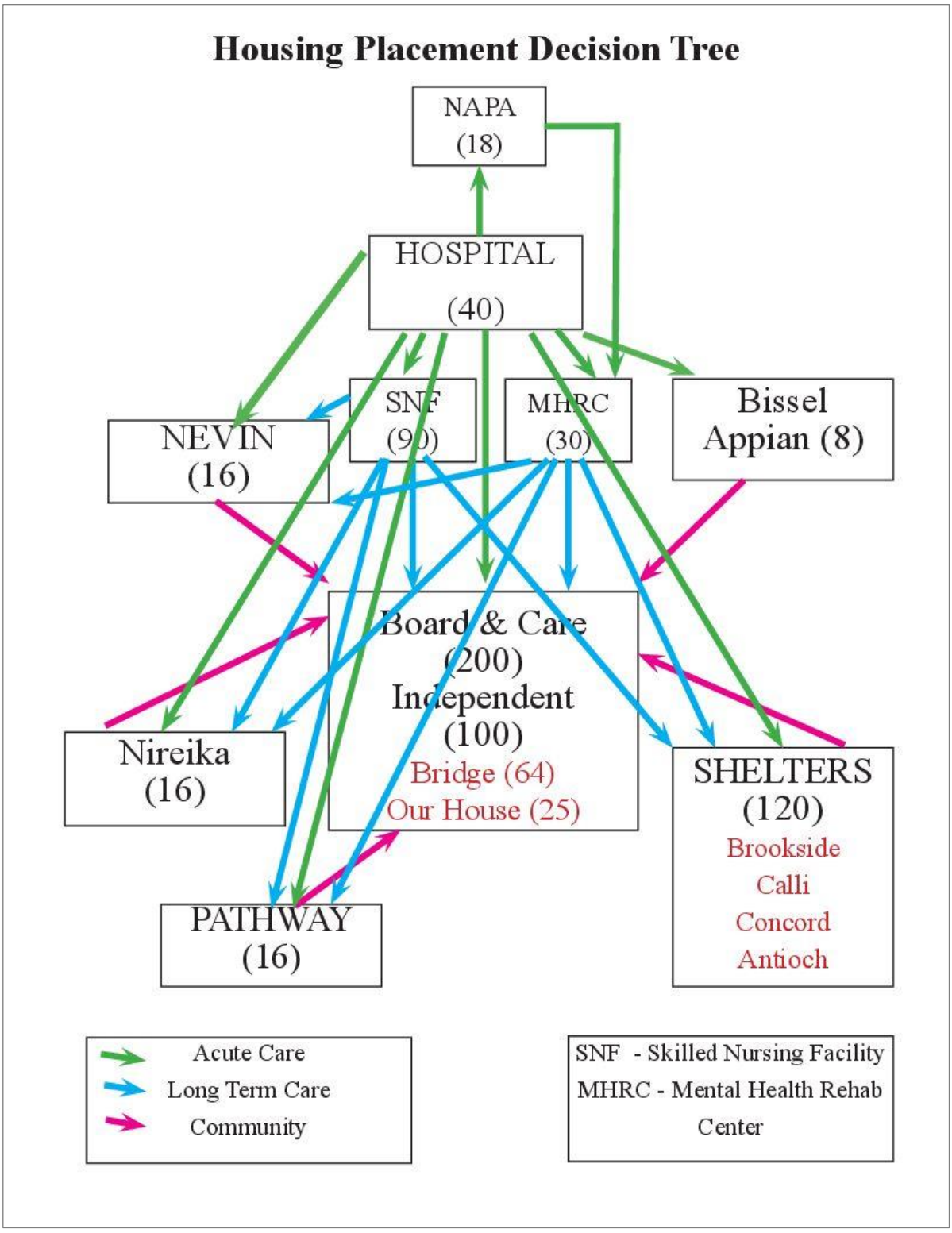
He soared to success and stability on his second stay at CPT. He was given the perfect combination of medication, structure, and compassionate care, allowing him to graduate for the first time from an IMD and successfully transfer to a community placement at Psynergy, Inc. in Morgan Hill. For the first time in 20 years, he was given the right amount of time to stabilize and move through the CPT levels of care. He then transitioned successfully to the community through the Psynergy model of outreach and engagement. Danny has continued his recovery process at Psynergy for a year due to their on-site clinical, medical, and recovery supports. This is prevention, intervention, and person and family-centered, value-based care.

Danny would not have survived solitary confinement in jail if he had not been provided the tiered levels of both CPT and Psynergy. I consider CPT to be the gold standard for IMDs in California. CPT was the least restrictive care at that time. A locked IMD is less restrictive and more therapeutic than a solitary jail cell.

Psynergy is one of the few gold standard ARFs in California. CPT is locked. Psynergy is unlocked. My son needed CPT in order to be accepted into Psynergy. Both are what I call "Housing That Heals"

We need a both/and state of mind in California, not either/or. Medicaid should pay for both if medically necessary. No one should be forced into solitary confinement and criminalized for their illness when there are models of less restrictive care that must be used, funded, and replicated.

A search of local news articles over the past years shows a trail of lost beds, lost opportunities, and lost lives. In reviewing this local history, we located an old *Housing Placement Decision Tree* document that was publicly distributed in Contra Costa as a teaching tool demonstrating the "human log jam" that our Specialty Mental Health administrators must navigate.



We have requested an update from Contra Costa Behavioral Health Administrators on this placement decision tree, along with additional data to inform current and future planning.

At this time, we know that a bed committee meets every week to make placement decisions based on utilization and review data. We know that our health, housing, and homelessness providers meet and discuss high utilizers of multiple systems (HUMS). We do not know how these two divisions interface. We know that there are more people to juggle and believe that there are fewer beds to place them in. However, we do not know how the Specialty Mental Health Services (SMHS), Alcohol and Other Drug Services, and Health, Housing and Homelessness (H3) services intersect when beds are prioritized. This begs many questions.

Who are the "bed keepers?" What drives the decision making for the specialty mental health population in Contra Costa or any California county? Who is at the table and how is it decided who gets a bed, when and which bed? Are Conservators present? What role do they or case managers play? Does the patient or family have any choice in the placement? Are bed decisions based on the person's clinical needs, their capacity, or their past experiences? Is it program-based, value-based, funding-based, or diagnosis-based? Or, is it based on who you know, who is at the table, or who has the best pitch for their patient that day? We feel that the answers to these questions should be public knowledge.

We do believe that in order to know if a housing program is healing, it must have the ability to continuously connect to a system of care that meets the Institute of Medicine's six quality aims[77] and measurable outcomes. These six aims must not only be recognized quality standards of care for hospital and community-based care for serious mental illnesses, they should also apply to the essential health element of housing for this vulnerable population.

There should be a standardized, transparent process that is not system-centered or based on luck and heroics. However, that would require a full continuum of Housing That Heals based on "abundance, not scarcity." And, that simply does not exist in any California county. There must be equal standards of care for physical illnesses and brain illnesses. They must be based on both science and a "Family Standard of Care." Just as the Cancer Center of America has established the *Mother's Standard of Care*[78] test, Housing That Heals in California must not just be an open bed that a care provider or insurance company designates appropriate. It must also be a bed that any family member would want for their own child, mother or loved one.

While the Housing First model[79] claims success based on few restrictions or criteria, Housing That Heals must first include treatment and stability supports appropriate to the resident's current needs but also considers future potential needs.

***Housing That Heals* is a lifespan plan for those who live with serious mental illnesses.**

[77]http://www.ihi.org/resources/Pages/ImprovementStories/AcrosstheChasmSixAimsforChangingtheHealthCareSystem.aspx, https://www.ahrq.gov/talkingquality/measures/six-domains.html
[78] https://www.cancercenter.com/become-a-patient/patient-experience/mother-standard-of-care
[79] https://endhomelessness.org/resource/housing-first

Assessment of Site Visits

In this assessment, we will do a selective analysis of some of the facilities that we visited across the state using our experience with the Contra Costa County public mental health system as our context. Our intention is that this assessment will be applicable to other county systems.

We propose the following adapted *Housing That Heals Criteria* for the 5600.3(b) specialty mental health population of Contra Costa County to ensure quality standards of care:

1. **Safe:** The public mental health system will provide safe Housing That Heals that is clean, comfortable, clinically appropriate, and secure.
2. **Effective**: Housing That Heals will include evidence-based, medically-necessary supports that will offer continuous access to BOTH clinical care and social rehabilitation needs.
3. **Person and Family-Centered:** Housing That Heals will offer a stable living environment that allows personal choice that meets the individual's medical, cultural, social, and spiritual needs and abilities.
4. **Timely:** Housing That Heals will be immediately available to all of the 5600.3(b) public health specialty mental health population without waiting at higher or lower levels of care than is medically necessary.
5. **Efficient:** Housing That Heals will be available in a fluid, flexible system and in conveniently accessible locations based on the resident's clinical and family supports. Housing That Heals will reduce suffering before costs. Least restrictive care is not necessarily the best, appropriate, nor cost effective.
6. **Equitable:** Housing That Heals will be free of discriminatory restrictions based on race, culture, ethnicity, sexual orientation, diagnosis, or history while untreated.

The current state of Contra Costa's specialty mental health system of care will demonstrate that our county has a wide range of community and hospital-based Mental Health programs which are considered essential programs for a quality continuum of psychiatric care. These programs include:

- Psychiatric Emergency Service at Contra Costa Regional Medical Center
- Psychiatric Inpatient Unit
- Shelter Beds
- Crisis Residential Facilities, Hope House, Nevin House, Nierika House
- Federally Qualified Health Centers
- Regional Specialty Mental Health Clinics
- AOT/ACT Fidelity Model, Mental Health Systems Provider
- FSP partial ACT programs, Hume Center, Mental Health Systems, Familias Unidas
- Putnam Clubhouse
- RI/Wellness Cities
- NAMI Contra Costa Voluntary Family Support Network
- Coordinated Entry System through a separate Housing, Homelessness and Health Division

While this is not an exhaustive list, it is reflective of what many SMI advocates consider the gold standard. However, even with this robust system of care, we assume that the largest psychiatric facility in Contra Costa County is still its Detention Facilities. And, we know that we have many people in out of county placements in locked IMD facilities that are not brought home because there is insufficient capacity in lower levels of appropriate care because all appropriate housing placements are full.

When we returned to Contra Costa from Santa Ana, we created a road map for the programs that we wanted to visit both in and outside of our county. We intentionally set out to visit a variety of housing programs. We knew that there was going to be a new wave of funding and focus on housing in 2019 because of the NPLH[80] initiative. We knew that initiative was going to be focused on a Housing First model to address our county's "homelessness" crisis. We feared that the new planning might leave out those with SMI who were at risk of homelessness, stuck in a county jail, in an unlicensed or unregulated board and care or an out of county placement. This is the population who are often forgotten because they are currently "housed" or they have a negative clinical history that prevents access to some programs.

Heart Note from Teresa

My son's only "Housing First" independent living situation was following six weeks of being homeless. Upon renewal of his LPS Conservatorship, the judge agreed to allow him to live in a duplex with his girlfriend who was in an FSP. It was not a safe neighborhood. The "whatever it takes" services were inadequate for their level of need. Within 3 weeks my son was off his meds and suicidal. His girlfriend called the FSP 24/7 phone line for help but nobody answered. So she called me and told me that my son was carving on his own throat. I called 911. By the time I arrived, the ambulance was pulling away and I was assured he was okay. I went inside to speak to his girlfriend and introduced myself to the Richmond Police Officer. The officer told me that when they arrived, Danny tried to run out of the house and was cornered in the back of house. He wrestled with an officer and had to be tasered. I apologized to the officer and explained the efforts we had made to support our son and the placement. I knew we were lucky that he was on his way to a hospital instead of jail or the morgue. So, this "Housing First" experiment resulted in a system failing for my son again. He returned to live in a locked facility for several months.

Heart Note from Lauren

My son's many "Housing First" attempts have all ended the same way; the police have had to intervene with a 5150. These events have traumatized our entire family. Our family was in shock when we saw the words "cremate me" written on his refrigerator and learned of his being delivered to a hospital emergency department in a comatose state. However, the saddest thing was to learn that a Hearing Officer, after our son was an inpatient for less than one week, had deemed our son no longer a danger to himself or others and released him.

[80] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1206

Our mission was to ensure that all of the SMI specialty mental health population's housing needs would be considered in all housing priority discussions. We knew that our sons would not show up on a *point-in-time count*[81] but we wanted them to count. And, we knew that the Housing First model had not been successful for our sons.

We have already described our site visits in detail in the first part of this paper. Now we will apply the criteria that we would use as moms in search of Housing That Heals for our sons to the following Contra Costa County programs and include suggested solutions for improvement:

1. ***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.

   Solutions

   - A nonprofit housing corporation or developer should be identified who could start development on a permanent supported housing community like Kirker Court. Master leases with the treatment provider would ensure the owner of the property a secured revenue flow and would allow people with poor financial and criminal justice history to acquire housing.
   - Contra Costa County needs to work with a provider to secure a braided funding stream[82] that could build a complex that contains the 4-plex model outlined in the NPLH.[83]

2. ***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.

[81] https://cchealth.org/h3/coc/pdf/PIT-report-2019.pdf
[82] https://www.tfah.org/wp-content/uploads/2018/01/TFAH-Braiding-Blending-Compendium-FINAL.pdf
[83] https://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

Solutions

- 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.

3. ***Mental Health Systems (MHS)*** has used master leasing to supply Temporary Supported Housing to their AOT clients. The homes are owned by private investors who then lease the homes to MHS. Master leasing is important in that it secures a placement for an AOT client who would not be able to secure a lease. At the Antioch house, the neighborhood was **safe** and secure. The house in Pittsburg did not seem to be in as safe of a location. Residents in that home would have to be street savvy; however, many of the Pittsburg home's residents were from this area originally.

   MHS secures a monthly allotment from each of the AOT residents. This allotment, in most cases, is a portion of the AOT residents' SSI. This also includes food, housekeeping, and direction on life skills. This is both an **effective** and **efficient** manner to encourage AOT clients to gain the skills needed to re-enter the community. The AOT staff hold **patient-centered** support groups at the homes.

   Solutions

   - In order to ensure that the houses will always be available to the AOT program, an entity – either MHS or another nonprofit housing corporation – should be the owner of these homes. The County should work with the Planning Commission, the Department of Conservation and Development, and the AOT Provider to ensure that this housing is financed in a manner that secures housing for the sole use of those with a serious mental illness. Master leasing, where the owner of the property has a commitment to the SMI population, is essential.

   - AOT and FSP providers need to have their housing located in a contained area within the greater community. An ideal set up would mirror the Garden Park Apartments where a Community Center provided access to the therapeutic supports needed. Clinical counseling supports, life skill training, and meaningful daily activity supports will always be accessed easily by the residents, and the AOT and FSP providers would also have a consistent open line of communication with their clients.

4. ***Crestwood Pleasant Hill*** has partnered with CCCBHS to serve individuals who are affected with severe mental illness. The location of the program and facility within the county allows those living there to be located near their **families** and enjoy access to the vibrant **community** that surrounds the facility. Poets' Corner is one of the most sought-after communities because of the **safety** and **security** it provides along with the opportunity for individuals to engage in **cultural**, **social**, and **educational opportunities embedded** in this community. Residents have the opportunity to complete their high school requirements, enroll in the nearby Community College, and seek employment opportunities in the neighborhood. This stable living environment is not always available to those who might benefit from it because it is full. Others may not fit the profile of a client that is accepted because of their past diagnosis or history.

Solutions

- Both families and consumers had to stage a massive resistance to the Nimbyism the community presented when Crestwood sought a Use Permit. There is still this archaic belief within Contra Costa communities that those living with a serious mental illness will create an unsafe environment in their neighborhood. Nimbyism must be eradicated and the benefits of having neighbors who are facing the challenges presented by serious mental illness must be understood and championed. There is a large population of people receiving treatment for serious mental illness at our County clinics and in privately insured clinics that would benefit from programs and housing opportunities like those provided at Crestwood Pleasant Hill.

5. ***Family Courtyard*** is a licensed board and care provider, contracted by the County, to care for adults 60 years and older. Many of the residents are very frail because of additional medical issues and needs. This facility is tucked away off of a busy business corridor next to a private high school and allows residents to have their care needs met within the community. The facility does provide a **safe** environment that is clean, comfortable, and **secure**. When family advocates pointed out a lack of social rehabilitation and supportive services, the County did step in to provide additional opportunities to participate in meaningful activities by providing classes led by trained county staff.

   Solutions

   - For the older adult population social rehabilitation is especially necessary. It is good that the CCCBH provides additional staff to conduct group activities that prevent loneliness and inhibit the onset of depression. These group classes such as craft and art therapy need to be a daily activity. The staff of Family Courtyard needs to be supplemented by staff who are well trained in providing the needed rehabilitative supports.

   - Older adults who have had more than one stay at the county shelter system need to be provided an opportunity to live in an assisted living community where supportive services are available to meet their mental health needs.

   - Older adults who live in locked settings should be evaluated to see if their mental health needs could be met in an assisted living community dedicated to seniors where supportive services are provided every day.

6. ***Oxford House***, also contracted by the County, is a room and board that is democratically run by the residents in each house. Each house represents a remarkably effective and low cost method of preventing relapse. The homes are located in **safe** neighborhoods in the central Concord area. Residents in the home are committed to living in a **secure** environment, free of addictive substances. Residents enter the home with an emergency exit plan that ensures if they relapse an **effective** rehabilitative plan is in place. The goal of Oxford House is to replicate itself once there becomes a wait list for placement. Residents may choose to stay for a limited amount of time or for a lifetime; however, each house council may ask a house member to leave if they are a disruptive member of the house community.

To sustain growth and to ensure that all houses stay on track, Oxford House World Services organize houses into mutually supportive local chapters and state associations – all democratically self-run and self-supported. To date there are over 2,400 houses.

Solutions

- CCCBHS must encourage Oxford House to expand in each area of the county. People with SMI and a co-occurring SUD need to have a placement available where substance abuse is not tolerated as it is in the "Housing First" model and the "harm reduction" philosophy which allows residents to stay in their housing while using addictive substances.