



**Housing for California's
Mental Health Clients:
Bridging the Gap**



**California Mental Health Planning
Council
April 2003**

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**California Mental Health Planning Council
1600 9th Street, Room 350
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CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

HOUSING FOR CALIFORNIA'S MENTAL HEALTH CLIENTS: BRIDGING THE GAP

Executive Summary

In January 2001, the California Mental Health Planning Council (CMHPC) decided to focus on the issue of housing for persons with mental illness. This decision came as a result of public comments and correspondence that the CMHPC received from individuals and organizations regarding problems that contribute to the housing crisis in California.

Findings

Examination of housing issues affecting persons with mental illness revealed a number of problems that must be addressed:

- California has a serious shortage of acute care beds
- Counties are losing licensed residential care facility beds
- The community residential treatment system is underdeveloped
- More can be done to increase the effectiveness of supported housing
- The Supportive Housing Initiative Act needs to be saved from sunseting
- The Multifamily Housing Programs funded by Proposition 46 needs regulatory reform
- The Olmstead Act should address IMD transition planning

Conclusion

Our assessment of the issues presented in this report points to a number of actions needed to alleviate the shortage of housing options for persons with mental illness. Clearly, more normalized living environments, which are integrated into residential communities, are needed in order to reduce reliance on hospital and

other institutional-based care. The following actions will help to overcome barriers to acquiring, building, developing, and retaining housing that will complement all levels of the continuum of care for persons with mental illness:

- The regulations of the Multi-family Housing Program (MHP) should be modified to allow small developers to apply for funding for smaller shared housing projects that can be integrated into residential communities.
- Increased funding dedicated to the development of CRTS programs should be made available to expand the range of residential settings in the mental health system to help clients transition from an institutional dependency to the community.
- The law establishing the Supportive Housing Initiative Act (SHIA), which will sunset on January 1, 2004, should be extended so that this innovative program can continue when the fiscal climate in California improves.
- The Community Care Licensing Regulations should be examined to explore the feasibility of storing medications in a locked, central location. This measure would eliminate a major obstacle for clients to be able to live in unlicensed, supportive housing environments.
- The reported loss of licensed residential care facility beds for persons with mental illness should be studied more thoroughly. All stakeholders should be involved in crafting solutions to this problem.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

HOUSING FOR CALIFORNIA'S MENTAL HEALTH CLIENTS: BRIDGING THE GAP

In January 2001, the California Mental Health Planning Council (CMHPC) decided to focus on the issue of housing for persons with mental illness. This decision came as a result of public comments and correspondence that the CMHPC received from individuals and organizations regarding problems that contribute to the housing crisis in California.

An extreme shortage of affordable housing in California exists, particularly for low-income individuals, who must pay over half of their incomes in rent. In addition, there are over 360,000 homeless individuals in California, of which one-third of this population are families with children. California faces an urgent need to provide affordable housing to meet its increasingly unfulfilled housing needs.

California's housing crisis is especially significant for homeless, disabled, and low income populations. The problems faced by persons with mental illness are especially challenging. For example, persons with mental illness on the income support program, Supplemental Security Income/State Supplemental Payment (SSI/SSP) receive only \$757¹ per month to pay for rent, food, utilities, and other expenses. Given the cost of housing in most urban areas in California, persons with mental illness are priced out of the housing market.

Methodology

To study the housing issues, the CMHPC sponsored presentations from April 2001 through June 2002 on various housing issues. These presentations included overviews of the roles of the State Housing and Community Development Department, nonprofit housing agencies and

organizations, and models of housing programs. The CMHPC's Policy and System Development Committee held in-depth discussions of specific housing issues. A list of the presenters follows. More information on these presenters, including how to contact them and what resource material they have available, is included in the corresponding appendices.

Roles of Housing Agencies and Organizations and Available Resource Materials (Appendix I)

- State Department of Housing and Community Development
- Corporation for Supportive Housing
- State Department of Mental Health Supportive Housing Initiative Act (SHIA), Supportive Housing Program Council
- Local housing and community development agencies
- Successful Siting of Housing and Service Programs for Special Populations

Models of Housing Programs (Appendix II)

- Portals House, Los Angeles County
- Shelter Partnership, Inc., Los Angeles County
- Ford Street Project, Mendocino County
- Progress Foundation's Avenues and Ashbury House, San Francisco
- START Program, San Diego County
- Las Posadas, Ventura County

Findings

Examination of housing issues affecting persons with mental illness revealed a number of problems that must be addressed:

- California has a serious shortage of acute care beds

¹ For an individual, the amount of SSI per month is \$552, and the amount of SSP per month is \$205.

- Counties are losing licensed residential care facility beds
- The community residential treatment system is underdeveloped
- More can be done to increase the effectiveness of supported housing
- The Supportive Housing Initiative Act needs to be saved from sunseting
- The Multifamily Housing Programs funded by Proposition 46 needs regulatory reform
- The Olmstead Act should address IMD transition planning

1. Acute Care Bed Shortages

In May 2001, the California Healthcare Association asked the CMHPC and other organizations for assistance in helping to alleviate the shortage of community residential beds. Due to stringent Medi-Cal and private managed care utilization review policies, most hospitals that serve persons with mental illness in the public mental health system have evolved into providers of acute crisis stabilization services. Lengths of stay have been intentionally reduced with the goal of serving the individual in the least restrictive, most cost-effective community setting.

Although the use of acute hospital beds has been reduced statewide, sufficient community residential settings are not available for placing Medi-Cal patients who no longer meet the medical necessity criteria for acute inpatient treatment. As a result, clients must stay in acute settings because a residential treatment placement, such as crisis residential or transitional residential treatment, or appropriate supportive housing options or residential care is not available. Clients in this predicament are referred to as being on "administrative days." This outcome is neither therapeutic for the client nor is it cost-effective for the hospitals. If the client were able to move into a residential

program, he or she would be in a program geared more toward rehabilitation and community integration. Hospitals are adversely affected because the Medi-Cal administrative day rate is lower than the acute care rate and does not cover hospitals' costs of care. Thus, hospitals lose money in this situation. Some hospitals are closing acute care units as a result, which makes the acute care bed shortage even worse.

In response to these concerns, the California Institute for Mental Health conducted a study on this issue and produced a report in August 2001, entitled, "Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis." This report provides a preliminary evaluation of the problem, recommendations for immediate action, and recommendations for future assessment. The report found that reasons for this crisis include Medi-Cal consolidation and the incentive not to use hospitals; lack of federal reimbursement for some hospitals that are classified as "institutions for mental disease" (IMDs); lack of human resources; increases in clients with multiple diagnoses, especially those with substance abuse; and lack of alternative settings with placement needs varying widely by region.

Some of the strategies recommended in the report to address this problem include the following actions:

- Conduct an inventory of beds to assess and monitor the demand for acute beds and their numbers
- Identify steps to take immediately and in the long run to improve the availability of hospital beds
- Identify barriers to expansion of alternative services, such as crisis residential and crisis stabilization
- Assess the use of administrative day beds to determine the types of

alternatives needed to resolve placement needs

All the subsequent recommendations in this report would help ease the acute care bed shortage.

2. Reported Loss of Licensed Residential Care Facility Beds

Another issue that is contributing to the housing shortage is the gradual loss of licensed board and care beds in California. The CMHPC's Policy and System Development Committee conducted a brief survey of 16 counties from the five regions² to develop a better understanding of this issue (Appendix III). The purpose of the survey was to determine if the need for licensed board and care beds in these counties is being met, and if not, why not.

The responses to the survey questions varied significantly, making comparisons between counties or regions difficult. Some significant findings included the following points:

- 94 percent of the counties surveyed pay a county patch³ for some of their licensed board and care beds
- 81 percent of the counties surveyed have a supplemental rate program⁴; the rate varied per client per month, depending on the type of service provided

² These regions include the Superior Region, the Bay Area Region, the Central Region, the Southern Region, and Los Angeles County.

³ A county patch is an additional amount of money that is paid to a board and care operator to take a client. This patch may be paid due to special needs of the client, or it may be paid to compete with other disability groups who pay higher rates for their clients.

⁴ A supplemental rate program is similar to a county patch in that counties provide payment for extra services, such as medical services, that some of their clients may need.

- 50 percent of the counties surveyed make out-of-county placements because a specific type of care is not available in their counties or not enough beds are available in their counties
- Most of the counties surveyed lost more beds than they gained over a 5-year period
- 81 percent of the counties surveyed responded that they did not have an adequate number of beds in their counties

The survey counties provided the following general comments about the reasons for the lack of licensed board and care beds in their counties:

- The high cost of housing makes developing or maintaining these facilities difficult if not prohibitive
- Other disability groups, such as those serving persons with developmental disabilities and older adults, are able to pay facility operators a higher rate to house their clients
- The inadequate reimbursement rate under SSI/SSP makes the expense to run such a facility difficult. These expenses include providing quality care, hiring and retaining staff, and complying with the Department of Social Services Community Care Licensing (CCL) regulations.
- More clients have co-occurring medical issues, such as diabetes, which makes placement more difficult
- Communities are reluctant to accept facilities (NIMBYism)

Recommendation: The CMHPC should explore with other stakeholders an initiative on parity with residential care rates for persons with developmental disabilities.

Recommendation: The CMHPC should consult with consumer groups and other

mental health advocacy groups on residential care and how to improve it.

Recommendation: The mental health system should provide adequate support services to persons who are displaced by the loss of residential care and who may be moving to more independent housing.

Recommendation: The mental health stakeholders should collaborate to conduct a more extensive survey on the reported loss of licensed board and care beds.

3. Underdeveloped Community Residential Treatment System

A comprehensive residential treatment system should be a major component of a rehabilitation and recovery-oriented mental health system. Welfare and Institutions Code Sections 5670 et seq. describe the four types of community residential treatment programs:

- Crisis Residential Treatment (also known as acute alternatives to hospitalization), which provide a community-based alternative to acute care in a hospital (recommended length of stay -- short-term, up to 30 days)
- Transitional Residential Treatment, which provides a sub-acute level of care as an alternative to local inpatient or skilled nursing settings, as well as a rehabilitation-oriented alternative to licensed residential care facilities (recommended length of stay -- 3 to 12 months)
- Long-term Residential Treatment as an alternative to state hospital or skilled nursing care (recommended length of stay -- 1 to 2 years)
- Supportive Housing, which can utilize flexible staff available to provide varying levels of support for individuals who would otherwise require a 24-hour, more structured program

These four levels of care do not represent a mandated, linear progression of programs through which each client must move

toward community living. The levels of care represent a range of options so that clients, along with family members, referring agencies, or case managers can choose a setting that is most appropriate for an individual's needs at any particular time.

Community residential treatment system (CRTS) programs are certified by the State DMH and are licensed as "social rehabilitation" facilities by the Community Care Licensing Division of the State Department of Social Services. Social rehabilitation facilities have been in existence for over thirty years. The purpose of residential treatment programs within a system of mental health care is twofold:

- To provide a community-based treatment alternative for those individuals who would otherwise be admitted to, or remain in, acute and long-term hospitals or other institutional settings, including jails, due to the severity and seriousness of their disabilities
- To utilize a range of residential settings in the mental health system to transition from an institutional dependency to a community-based services capacity

When the CRTS was first developed, Medi-Cal operated under the "clinic option." Community residential treatment programs were not reimbursable under the clinic option and so these treatment options did not proliferate. California then changed to the "Rehabilitation Option," which allowed for federal reimbursement of community residential treatment programs. Unfortunately, at that time, the mental health system was suffering severe funding cuts. Providing new treatment options, although cost-effective and less restrictive, proved difficult for most counties. To date, only 15 counties operate community residential treatment programs.

Developing Crisis Residential Treatment Programs

In most mental health systems, crisis residential services are the first step towards reducing reliance on hospital and other institutional-based care. Crisis residential programs are provided in normalized living environments, which are integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

In order to develop community residential treatment programs, several factors must be addressed. One of the most critical factors is community acceptance. One of the presentations at the CMHPC was how to successfully site a residential treatment program. More information on sources for assistance in developing housing is contained in Appendix I, "Successful Siting of Housing and Service Programs for Special Populations." The following steps can increase success in siting a residential treatment program:

- Be an asset to the neighborhood. This step requires educating the community, working with government staff and officials, preparing for public hearings, becoming familiar with federal and state Fair Housing Acts, and cultivating the neighbors.
- Build an attractive project. The final project should make the neighborhood more appealing. The actual building should be more attractive than the existing structures. The project should be well-maintained.
- Acquire local municipality and county support. This step includes applying for fee waivers, applying for variances to allow parking waivers, asking for assistance in identifying suitable sites, seeking donations of land or long-term leases of land, seeking assistance with neighborhood acceptance, and seeking

funding through various grants and loan programs.

- Develop funding sources. These sources include the California Health Facilities Financing Authority, the California Housing Finance Agency, non-profit community development loan funds, county/city exclusionary housing funds, commercial loans, and grants and donations.

Recommendation: The CMHPC should advocate for legislation with a categorical appropriation to fund community residential treatment programs:

- a) The funds should be made available on a competitive basis
- b) The programs should be designed to provide both alternatives to hospital and institutional care, as well as rehabilitation services designed to promote recovery across multiple life domains such as independent living, work, and school
- c) Counties applying for these funds should demonstrate how they will use the funds to reduce dependence on hospital care and describe how reductions in acute care costs will be used to expand rehabilitation and recovery-oriented services
- d) Counties without crisis residential services would be required to either seek funding for such a program or demonstrate alternative means for reducing reliance on hospital care

4. Problems with Supportive Housing and Licensure

Chapter 428, Statutes of 2002 (AB 1425, Thomson) was passed to address the confusion that occurs when individuals with disabilities are receiving supportive living services (Appendix IV). Some individuals need a level of care and supervision that requires that they reside in a licensed facility. These residential facilities are licensed by the DSS

Community Care Licensing Division (CCL) and provide “care and supervision” to their residents. Care and supervision is defined by regulation as one or more activities provided by a person or licensed facility to meet the needs of clients, such as assisting in daily living activities and personal hygiene, storing and distributing medication, supervising clients’ schedules and activities, and monitoring food or diet. (22, CCR, Section 80001(c)(2)).

The new law clarifies that housing arrangements for individuals who live independently and receive “community living support services” are exempt from regulations related to care and supervision. Community living support services are defined as services that are voluntary and are chosen by persons with disabilities in accordance with their preferences and goals for independent living. (Health and Safety Code, Section 1504.5(c) et seq.) Examples of community living support services include education and training in meal planning and shopping, budgeting and managing finances, medication self-management, transportation, vocational and educational development, and use of community resources. Community living support services also include assistance with arrangements to meet basic needs, such as financial benefits, food, and clothing.

The new law also permits individuals with disabilities to contract for the provision of community living support services in their own homes as part of their service, care, or independent living plan. This provision allows clients to remain in independent housing and be free from unnecessary regulation. It also frees up more structured levels of care for clients who need that type of setting.

The sponsors of this legislation will be convening a work group to review Title 22, the Community Care Licensing Regulations, to make more legislative changes that will help to further define and support the

provision of supportive housing for mental health clients.

One area for potential change in regulations relates to storage of medications. Often, clients who would be able to live fairly independently in supportive housing must still reside in licensed residential care because they need supervision to take their medications. An innovative proposal is to store medications in a locked, central location onsite where the client resides. Then, mental health staff could provide medication management to these clients without having to house them in a licensed facility.

Recommendation: The CMHPC should work with the work group reviewing the Community Care Licensing regulations to explore the feasibility of storing medications in a locked, central location in unlicensed supportive housing residences.

5. Sunset of Supportive Housing Initiative Act

The Supportive Housing Initiative Act (SHIA) was enacted by Chapter 310, Statutes of 1998, and Chapter 667, Statutes of 2000. These statutes added Sections 53250 through 53315 to the Health and Safety Code, setting forth specific provisions for implementing supportive housing programs under SHIA. The intent of SHIA is to provide grants for supportive housing for very low income Californians with disabilities, including mental illness and substance abuse. The Department of Mental Health and the Department of Housing and Community Development have collaborated to provide grants to government and private, nonprofit agencies to provide supportive housing in their communities. In addition, the statute establishes a Supportive Housing Program Council consisting of representatives of those state agencies involved in this collaboration as well as consumer representatives from the target population.

Due to the fiscal crisis that California is facing, funding for the SHIA programs has been eliminated. To make matters worse, the law is due to sunset on January 1, 2004. Thus, DMH will lose the authority to administer and to continue to monitor these projects. Although an immediate remedy to the elimination of this funding to existing projects is unlikely, the statute should be preserved so that in better fiscal times, this program can again be funded.

Recommendation: In order to preserve the Supportive Housing Initiative Act and the Supportive Housing Program Council, the enabling language embodied in Health and Safety Code Sections 53250 through 53315 should be extended by adding another sunset provision of at least five years.

6. Regulatory Problems with the Housing and Emergency Shelter Trust Fund Act of 2002 (Proposition 46)

The Housing and Emergency Shelter Trust Fund Act of 2002 was enacted with the passage of Proposition 46 on the California ballot. This bond measure provides \$2.1 billion for housing for low-income individuals and families, including persons with mental disabilities. These funds will be managed by the Department of Housing and Community Development (HCD). Because of the large sum of money, the HCD is releasing the notices of funding availability (NOFAs) on a staggered basis over the next several years for the different loan programs.

Multi-Family Housing Program (MHP)

The Multi-Family Housing Program (MHP) is the source of funding that is used for developing housing for persons with mental disabilities. This loan program will receive a total of \$910 million from the bond. Problems exist, however, because the current MHP regulations discourage shared housing arrangements. In a shared housing arrangement, residents lease individual

locked bedrooms in a large house and share bathrooms, kitchens, and living areas. Each resident has a separate lease. Many small developers will convert single family homes with 2, 3, and 4 bedrooms into these single occupancy dwellings, which under the current regulations, cannot be funded. The current MHP regulations set the threshold for number of units in a project at 5 units. A conversion of a single family house to single resident occupancy (SRO) housing is not eligible for funding under current MHP regulations because the house, even if it will have more than 5 SRO units after conversion, still counts as one unit. These regulations favor larger housing projects, which are often not feasible for developers of housing for individuals with psychiatric disabilities. Shared housing projects are only possible if there are 5 or more units on a site. Currently, no known source of HCD funding exists for a project that will accommodate shared housing with fewer than 5 separate units.

Recommendation: The CMHPC should work with the HCD to revise the MHP regulations so that:

- a) The definition of "unit" will include SRO units, even if they are converted from a single family house
- b) Shared housing units where more than one resident shares a unit should be counted per resident if each resident separately leases the bedroom as an SRO

7. Implementation of the Olmstead Plan

In 1999 the United States Supreme Court issued a decision in Olmstead v. LC (119 S.Ct. 2176) in which the court concluded that states are required by the Americans with Disabilities Act (ADA) to place persons with disabilities in community settings rather than in institutions if determined appropriate.

The Supreme Court also gave states general guidance on how to demonstrate

compliance with the ADA, stating that a state can demonstrate compliance if it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings at a reasonable pace.

The California Health and Human Services Agency (CHHS) is developing a plan to implement the Olmstead decision. The CHHS convened a cross-disability work group to provide direct input into the content of California's Olmstead Plan. In light of the critical housing shortage, the success of California's Olmstead Plan hinges on the development of more housing to provide community placements for persons who are institutionalized.

Transitioning out of restrictive institutional settings, such as institutions for mental diseases (IMDs), should be the client's community placement goal. This goal should be identified at admission and be the organizing focus of treatment, rehabilitation, and support services. Discharge planning should identify treatment and recovery services and enlist the support of family and friends to ensure a successful transition to community placement.

Recommendation: The Olmstead Plan should facilitate transition out of restrictive institutional settings by helping to identify the client's community placement goal, which should be the organizing focus of treatment, rehabilitation, and support services. Discharge planning should identify treatment and recovery services and enlist the support of family and friends to ensure a successful transition to community placement.

Conclusion

Our assessment of the issues presented in this report points to a number of actions needed to alleviate the shortage of housing options for persons with mental illness. Clearly, more normalized living environments, which are integrated into

residential communities, are needed in order to reduce reliance on hospital and other institutional-based care. The following actions will help to overcome barriers to acquiring, building, developing, and retaining housing that will complement all levels of the continuum of care for persons with mental illness:

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- The law establishing the Supportive Housing Initiative Act (SHIA), which will sunset on January 1, 2004, should be extended so that this innovative program can continue when the fiscal climate in California improves.
- The Community Care Licensing Regulations should be examined to explore the feasibility of storing medications in a locked, central location. This measure would eliminate a major obstacle for clients to be able to live in unlicensed, supportive housing environments.
- The reported loss of licensed residential care facility beds for persons with mental illness should be studied more thoroughly. All stakeholders should be involved in crafting solutions to this problem.

APPENDIX I

Roles of Housing Agencies and Organizations and Available Resource Materials

1. State Department of Housing and Community Development (HCD)

1800 Third Street
Sacramento, CA 95814
(916) 445-4775
www.hcd.ca.gov

Mission

Provide leadership, policies, and programs to preserve and expand safe and affordable housing opportunities and promote strong communities for all Californians.

Major Activities

Award loans and grant to cities, counties, and private nonprofit and for-profit housing developers and service providers.

Loans and grants support construction, acquisition, rehabilitation, and preservation of affordable housing, child care facilities, shelters for the homeless, public infrastructure and facilities, and jobs for lower income workers.

Will begin issuing Notice of Funding Availability (NOFAs) for funds from Proposition 46, the Housing and Emergency Shelter Trust Fund Act, which was passed by the voters in November 2002.

Examples of Some of the Loan and Grant Programs Administered by HCD

- **Emergency Housing Assistance Program (EHAP):** Finances emergency shelters and supportive services for homeless individuals and families
- **HOME Investment Partnerships Program (HOME):** Assists cities, counties, and nonprofit community housing development organizations (CHDOs) to create and retain affordable housing
- **Multifamily Housing Program (MHP):** Assists in the new construction, rehabilitation, and preservation of permanent and transitional rental housing for lower income households
- **State Community Development Block Grant Program (CDBG):** Provide federal CDBG program benefits to non-entitlement cities and counties, 51 percent of which must be used for housing

2. Corporation for Supportive Housing (CSH), California Office

1330 Broadway, Suite 601
Oakland, CA 94612
(510) 251-1910
www.csh.org

Mission

Support the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance abuse, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy, and dignity and reach for their full potential.

Major Activities

Work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and be accountable to, the tenants of supportive housing.

- Help local organizations gain financial and technical assistance
- Create cutting-edge demonstration programs and new models to test new ideas
- Facilitate sharing of successful techniques and strategies throughout the industry; streamline and improve development and funding systems
- Provide public education and advocacy to increase resources for permanent supportive housing
- Evaluate the effectiveness and cost-effectiveness of supportive housing
- Document and disseminate effective approaches to housing and empowering homeless and disabled people
- Demonstrate the effectiveness of providing employment services to the tenants of supportive housing

3. State Department of Mental Health (DMH)

1600 9th Street, Room 130

Sacramento, CA 95814

(916) 654-6605

www.dmh.ca.gov

Supportive Housing Initiative Act (SHIA)

The Supportive Housing Initiative Act (SHIA) was created by Chapter 310, Statutes of 1998. DMH administers this program, which encourages the development of permanent, affordable housing with supportive services for low-income persons with disabilities by awarding grants for services and operating costs in supportive housing.

Supportive Housing Program Council

In order to promote interagency coordination and collaboration, SHIA also established the Supportive Housing Program Council (SHPC), an interagency council of state officials from the following agencies and departments: Health and Human Services Agency; Business, Transportation, and Housing Agency; DMH, Department of Developmental Services; Department of Social Services; Department of Health Services; Department of Aging; Department of Housing and Community Development; Department of Alcohol and Drug Programs; the California Housing and Finance Agency; Department of Rehabilitation; and the Employment Development Department. The SHPC also includes three consumer representatives. DMH is the lead agency.

4. Local Housing and Community Development Agencies and Funding Sources

Local Redevelopment Agencies

Local redevelopment agencies are advantageous as funding sources because they are flexible. Redevelopment agencies take a blighted area and freeze the tax base for a period of time. During this time, they start upgrading the community so that the area starts to generate more taxes, which are then reinvested into the community.

California law requires that 20 percent of these new taxes must be reinvested into housing development. The DHCD provides oversight of the redevelopment agencies.

Housing Trust Funds

Housing trust funds establish a local set-aside for housing development. These funds require a fee from developers that is set aside to develop a certain number of affordable housing units.

Community Development Block Grants

This program provides federal grants to cities and counties. The DHCD administers this program.

5. Successful Siting of Housing and Service Programs for Special Populations

The attached resource list, "Successful Siting of Housing and Service Programs for Special Populations," was prepared by Planning Council member Barbara Mitchell, MSW, Executive Director of Interim, Inc., a California Association of Social Rehabilitation Agencies (CASRA) agency.

APPENDIX IA

**Successful Siting of Housing
and Service Programs for Special Populations
Resource List**

Prepared by Barbara L. Mitchell, M.S.W.
Executive Director, Interim Incorporated
E-Mail: bmitchell@interiminc.org

NIMBY Web Resources:

- **Building Better Communities** www.bettercommunities.org The “Siting Tools” section of this website has essays and handbooks on building inclusive communities, names and contact information for experts in community building, links to websites providing information on building inclusive communities and books and articles related to Community Building.
Washington D.C. (202) 467-5730
- **The California Housing Law Project** www.housingadvocates.org This site has a thorough “Facts and Issues” section quoting specific laws that place limitations and obligations on local decision-makers in the area of affordable housing.
Sacramento, CA (800) 852-5711
- **HomeBase** <http://www.homebaseccc.org/> HomeBase is a public policy law firm on homelessness. The site provide a list of HomeBase publications and public policy briefs.
San Francisco, CA (415) 788-7961
- **The National Law Center on Homelessness and Poverty** <http://www.nlchp.org> This site contains articles, reports, fact sheets, studies, policy papers, and general information about homelessness and poverty.
Washington D.C. (202) 638-2535

NIMBY Text Resources:

- **Campaign for New Community A Series.** [InterFaith Conference of Metropolitan Washington](#), 1419 V. Street, NW Washington D.C. 20009 (202) 234-6300
- **Neighbors After All – Community Acceptance Strategies for Siting Housing and Services for Homeless People,** [HomeBase](#), 1535 Mission Street, San Francisco, Calif. 94103, (415) 788-7961
- **A Resource Manual for Siting Community Residential Treatment Programs,** [California Association of Social Rehabilitation Agencies](#), P.O. Box 388, Martinez, California, 94553-0038, (925) 229-2300, April 1988.
- **“Strategies for Responding to “Community Opposition in an Existing Group Home,”** [Psychosocial Rehabilitation Journal](#), Volume 15, Number 3, January 1992

Development Funding Web Resources:

* indicates funding for residential treatment facilities

- **California Health Facilities Financing Authority (CHFFA)**
www.treasurer.ca.gov/CHFFA , Sacramento, CA (916) 653-2799
 - **HELP II Program*** - The HELP II Loan program provides low interest (3%) loans of up to \$400,000.
 - **Pooled Bond Financing Program.** Borrowers with more modest financing needs are sometimes grouped or "pooled" by the Authority into a single bond financing, where bond issuance costs are shared by participants. This type of financing will generally allow a borrower to finance a loan for a minimum of \$500,000 for eligible projects.

- **California Department of Housing and Community Development** www.hcd.ca.gov
 Sacramento, CA (916) 445-4782
 - **Multi-Family Housing Program** - very low interest long-term loans for development of affordable housing. Must have five or more units
 - **State Community Development Block Grants (CDBG)*** - loans and grants

- **California Housing Finance Agency** www.chfa.ca.gov
 Sacramento, CA (916) 322-3991
 - **HELP Program** - Housing Enabled by Local Partnerships- short term loans at below market rate in partnerships with local government (Housing Authorities) for predevelopment costs
 - **Special Needs Affordable Housing Loan Program-** – Low interest loans for development of special needs housing with services, 3% or less, amortized over 30 years

- **Non-Profit Community Development Loan Funds**
 - **Low Income Housing Fund***
www.lihf.org Oakland, CA (510) 893-3811
 The Low Income Housing Fund is a steward for capital invested in housing, childcare, workforce development, education, and other community-building initiatives.
 - **Northern California Community Loan Fund***
www.ncclf.org San Francisco, CA (415) 392-8215
 The Northern California Community Loan Fund lends to nonprofit organizations which serve communities with limited access to financing from traditional lenders.

- **United States Department of Housing and Urban Development (HUD)** www.hud.gov
 Washington, DC (202) 708-1112
 - **HOME Program** - acquisition, rehab, new construction, rental assistance
 - **McKinney Supported Housing Program** limited to homeless, operating, rehab, limited new construction, can be used for transitional housing
 - **HUD 811 Supportive Housing for Persons with Disabilities**
 - **Shelter Plus Care** - rental assistance and supportive services, must be homeless

-
- **Community Development Block Grant Funds (CDBG)**– loans and grants, can also be used to develop residential treatment programs under the “community facilities” category **Other sources of funding:**
 - **Inclusionary Housing Funds** –developer fees set aside in a special fund and allocated by the County or City\
 - **California Housing Rehab Program**

APPENDIX II

Models of Housing Programs

1. **Portals House, Los Angeles County**
679 South New Hampshire Ave., 5th Floor
Los Angeles, CA 90005
(213) 387-1129
www.portalshouse.org

Background

Founded in 1955. Pioneer agency implementing and introducing unique, cutting edge programs. First organization to establish working with clients with a co-occurring substance abuse diagnosis.

Features

Operates eight "clubhouse" sites in Los Angeles County that provide residential services, homeless outreach, employment services, case management, housing to clients dual diagnoses, no-fail emergency centers, and housing services.

2. **Shelter Partnership, Inc.**
523 W. Sixth Street, Suite 616
Los Angeles, CA 90014
(213) 688-2188
www.shelterpartnership.org

Background

Nonprofit organization founded in 1985. Develops resources and housing for homeless families and individuals in Los Angeles County.

Features

Serves as a resource to public agencies, the business community, local and national media, and community members involved with issues of homelessness and the creation of permanent, affordable housing. Programs include technical assistance, shelter resource bank, public policy program, and donor assistance.

3. **The Ford Street Project**
139 Ford Street
Ukiah, CA 95482
(707) 462-1934
1 (800) 971-3673

Background

Founded in 1982. Provides all of the basic parts of the housing continuum, jobs, and treatment services.

Features

Provides shelter for homeless people, transitional housing, and long-term housing. Provides employment to supervised clients through a contract with the Department of Mental Health and the California Department of Transportation. Provides treatment services, including substance abuse treatment, detoxification treatment, and

outpatient counseling. Provides a residential recovery program for clients with co-occurring substance abuse diagnoses.

4. Progress Foundation

368 Fell Street

San Francisco, CA 94102

(415) 861-0828

www.progressfoundation.org

Background

Founded in 1969. Progress foundation is a non-profit agency dedicated to providing alternative community treatment options to seriously mentally disabled individuals. Pioneer in developing alternatives to institutional care for public mental health systems.

Features

Provides crisis residential, transitional residential, and supported living as well as training and consultation. Program staff is multidisciplinary and culturally competent. Two culturally competent models are Avenues, a crisis residential treatment program and Ashbury House, a transitional residential program.

Avenues

12-bed psychiatric crisis residential treatment program established in 2000. Emphasized service to the Asian community, with bi-cultural, bi-lingual staff available. Located in San Francisco's Sunset district.

Ashbury House

Transitional residential program for mothers and their children, established in 1995. Located in San Francisco's Haight-Ashbury district. Provides 24-hour treatment, rehabilitation, and parent education. Serves homeless women who are risk of losing custody of their children because of their mental disability, as well as women who have already lost their children due to their disability and who now need comprehensive mental health services and parent education in order to regain custody.

5. START Programs

Community Research Foundation

1202 Morena Blvd., Suite 300

San Diego, Ca 92110

(619) 275-0822

www.comresearch.org

Background

The Community Research Foundation founded the first Short-Term Acute Residential Treatment (START) program in 1980. Currently, six START programs in San Diego County. The START programs provide an effective acute care alternative to inpatient psychiatric hospitalization at a substantially lower cost.

Features

Located in predominantly residential neighborhoods. Each facility houses 11 to 16 residents. The main objective of the START programs is to assist residents in returning

to their highest level of functioning and stability in the shortest amount of time. Respect for the client is a core value, and all staff members share a commitment to the principles of psychosocial rehabilitation.

6. Las Posadas Service Center and Casa I, Casa II

1756 S. Lewis Road
Camarillo, CA 93012
(805) 383-3669
www.telecarecorp.com

Background

Las Posadas is a public/private partnership between Ventura County Behavioral Health Services, which coordinates system-wide program oversight and funding; the Area Housing Authority of Ventura County, which provides residential housing and support center facilities; the Telecare Corporation, which operates the necessary services and supports; consumers; and families.

Features

Located in a campus-like setting. Offers an array of residential mental health services and supports for adult residents with severe mental illness who might otherwise live in state hospitals or IMDs. Casa I and Casa II are each 15-bed duplexes, which are clustered near a community center. Each resident has a single occupancy bedroom with a half bath. Las Posadas operates on the principle of psychiatric rehabilitation with an emphasis on independence and recovery.

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**

1600 NINTH STREET, ROOM 350, SACRAMENTO, CA 95814
(916) 654-3585 FAX (916) 654-2739 www.dmh.ca.gov/MHPC

CHAIRPERSON

Darlene Prettyman, RNC

September 17, 2002

To: Policy and System Development Committee

From: Beverly Whitcomb
Deputy Executive Officer

Subject: **Preliminary Findings on Licensed Board and Care Survey**

During the PSDC's conference call to discuss the format and contents for the housing report, the committee decided to survey several counties in each region to address the gradual loss of licensed board and care beds in the State. The purpose of the attached survey was to determine if the need for licensed board and care beds in these counties is being met, and if not, why not. Responses to the survey questions have been compiled on the attached summary sheets.

Sixteen out of 20 counties¹ (80 percent) responded to the survey, with at least three counties responding from each region. However, the responses varied significantly from county to county, which makes comparisons among counties within regions or comparisons among regions difficult. A larger number of counties would need to be surveyed to determine any notable trends.

Many of the responses to the survey are incomplete and need additional information. In addition, Los Angeles County appears to be a complete outlier to the rest of the counties, having no patch at all in any of their facilities.

Based on the attached summary sheets for Questions 1 through 10, I have made the following general observations:

1. Questions 1 and 2: 94 percent of the counties (all of them except Los Angeles County) pay a patch for some of their beds. The amount of the patch varies. The percentage of beds that receive a patch in each county varies from 11 percent to 100 percent.

¹ Those counties that did not respond were Humboldt, San Mateo, Merced, and Riverside.

2. Questions 3 and 4: 81 percent of the counties (13 out of 16) have a supplemental rate program. However, the rate varies per client per month depending on the type of service provided. Types of services have been grouped together and listed by percentage of responses from highest to lowest:

31 percent:

- Social skills; socialization (5)

25 percent:

- Independent/daily living skills; taking care of oneself (4)
- Extra help with personal care and hygiene (4)
- Recreational activities/leisure time (4)
- Behavior management for difficult to handle clients (4)

13 percent:

- Medications administration/monitoring (2)
- Enhanced supervision (2)
- Transportation to appointments (2)
- Structure management (2)
- Day treatment (2)
- Payment to operators to take “difficult to handle” clients (2)
- Rehabilitation services (2)
- Increased staffing (2)
- Education/awareness regarding psychiatric disability/medications (2)

6 percent:

- 24-hour supervision (1)
- Basic first aid (1)
- Personal shopping (1)
- Crafts/hobbies (1)
- Training to use public transportation (1)
- CEUs (1)

3. Question 5: 50 percent (8 out of 16 counties) make out-of-county placements. Of those 8 counties that make out-of-county placements, 63 percent (5 counties) pay a patch. The level of the patch varies. Reasons for making out-of-county placements include the following responses, which have been grouped together and listed by percentage of responses from highest to lowest:

40 percent:

- Specialized care/specific services not available in-county (2)
- Not enough beds in-county (2)

20 percent:

- Offers a step down alternative to IMD (1)
- Not a large enough client group to be cost-effective for a local provider (1)
- Specific services not available in-county (1)

4. Question 6: The numbers of residential care beds lost or gained over one to five years was not answered by all 16 counties. In general, counties lost more beds than they gained.

- Beds lost in last year: eleven out of 16 counties answered this question. Of those 11 responses, 73 percent (8 out of 11 counties) lost beds.
- Beds gained in last year: six out of 16 counties answered this question. Of those 6 responses, 33 percent (2 out of 6 counties) gained beds.
- Beds lost in last 5 years: thirteen out of 16 counties answered this question. Of those 13 responses, 85 percent (11 out of 13 counties) lost beds.
- Beds gained in last 5 years: Six out of 16 counties answered this question. Of those 6 responses, 33 percent (2 out of 6 counties) gained beds.

5. Question 7: Most counties were unaware of the number of beds they would gain or lose during the fiscal year. Only 13 percent (2 out of 16) knew of beds they would lose and only 13 percent (2 out of 16) knew of beds they would gain.

6. Question 8: 81 percent (13 out of 16 counties) responded that they did not have adequate beds in their counties. These counties' estimates for how many more beds would be needed ranged from 15 to 200. The Southern Region and the Bay Area Region listed the largest number for how many more beds are needed.

7. Question 9: General comments about the availability of residential care beds.

Northern Region

- Not enough beds available
- Inadequate reimbursement rates

Bay Area Region

- High cost of housing
- Increasing numbers of older adults and clients with co-occurring disabilities
- Demand exceeds availability for certain levels of care

Central Region

- Lack of gender-specific and transition-age youth facilities
- Lack of quality and adequacy of care
- Lack of availability of RC beds with enhanced services
- Competition for existing beds has increased
- Inadequate and inconsistent monitoring and coordination

Los Angeles

- Not all facilities accept seriously and persistently mentally ill clients

Southern Region

- Lack of funds to pay for augmented RCFs
- Need higher SSI/SSP reimbursement
- Need to combat NIMBYism
- High cost of housing make BC development difficult
- Inconsistent monitoring by CCL

8. Question 10: All of the counties indicated that the board and care operators provide transportation to clients for appointments. (Two counties did not respond, due to use of a previous version of this survey.)

The committee needs to determine if this information has answered the question regarding whether the need for licensed board and care beds in these counties is being met, and if not, why not.

Attachments

**POLICY AND SYSTEM DEVELOPMENT COMMITTEE
TELEPHONE SURVEY ON LICENSED BOARD AND CARE BEDS**

Purpose: To determine if the need for licensed board and care beds in these counties is being met, and if not, why not

1. How many licensed board and care beds were available in your county for persons with mental illness, aged 18 to 59, as of June 30, 2002?
2. Does your county pay a patch/supplemental rate or augmentation for board and care beds for these persons placed by your county? If so, how much per bed for how many beds?
3. Does your county have a supplemental rate program? If so, how many persons are receiving services? How much money per month per client is provided? What types of services are included?
4. If your County pays a patch or supplemental rate, are you receiving extra services for that patch? If so, what services?
5. Does your county make board and care placements out-of-county? Why? Do you pay a patch for these beds? If so, how much?
6. On average, how many residential care beds for clients with mental illness has your county lost or gained in the last year? In the last 5 years?
7. Do you know of any beds your County will gain or lose in this fiscal year? If yes, how many?
8. Do you have an adequate number of residential care beds available to meet your County's needs? If no, how many more beds do you need in your County?
9. Do you have any general comments about the availability of residential care beds in your County to serve adults with psychiatric disabilities?
10. Do the board and care operators that your county contracts with provide transportation to clients for medical and other appointments?

Assembly Bill No. 1425

CHAPTER 428

An act to add Section 1504.5 to the Health and Safety Code, relating to health.

[Approved by Governor September 7, 2002. Filed with Secretary of State September 9, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1425, Thomson. Persons with disabilities: community living support services.

Existing law, the California Community Care Facilities Act, provides for the licensure and regulation of community care and residential facilities by the State Department of Social Services.

Existing law prohibits a community care facility that is unlicensed, is not exempt from licensure, and satisfies any one of several listed conditions from operating in the state. Among the listed conditions is if the facility is providing care or supervision, as defined by the act or rules and regulations adopted pursuant to the act.

This bill would exempt any supportive housing, as described, or independent living arrangement, for individuals with disabilities who are receiving community living support services, as described, from the application of the act. The bill would provide that community living support services do not constitute care or supervision.

This bill would permit counties to contract with agencies or individuals to assist persons with disabilities in securing their own homes, including supportive housing, and to provide persons with disabilities with the supports needed to live in their own homes.

The people of the State of California do enact as follows:

SECTION 1. Section 1504.5 is added to the Health and Safety Code, to read:

1504.5. (a) (1) This chapter does not apply to any independent living arrangement or supportive housing, described in paragraph (2) of subdivision (c), for individuals with disabilities who are receiving community living support services, as described in paragraph (1) of subdivision (c).

(2) This section does not affect the provisions of Section 1503.5 or 1505.

(3) Community living support services described in paragraph (1) of subdivision (c) do not constitute care or supervision.

(b) (1) The Legislature finds and declares that there is an urgent need to increase the access to supportive housing, as described in paragraph (2) of subdivision (c), and to foster community living support services, as described in paragraph (1) of subdivision (c), as an effective and cost-efficient method of serving persons with disabilities who wish to live independently.

(2) It is the intent of the Legislature that persons with disabilities be permitted to do both of the following:

(A) Receive one or more community living support services in the least restrictive setting possible, such as in a person's private home or supportive housing residence.

(B) Voluntarily choose to receive support services in obtaining and maintaining supportive housing.

(3) It is the intent of the Legislature that community living support services, as described in paragraph (1) of subdivision (c), enable persons with disabilities to live more independently in the community for long periods of time.

(c) (1) "Community living support services," for purposes of this section, are voluntary and chosen by persons with disabilities in accordance with their preferences and goals for independent living. "Community living support services" may include, but are not limited to, any of the following:

(A) Supports that are designed to develop and improve independent living and problemsolving skills.

(B) Education and training in meal planning and shopping, budgeting and managing finances, medication self-management, transportation, vocational and educational development, and the appropriate use of community resources and leisure activities.

(C) Assistance with arrangements to meet the individual's basic needs such as financial benefits, food, clothing, household goods, and housing, and locating and scheduling for appropriate medical, dental, and vision benefits and care.

(2) "Supportive housing," for purposes of this section, is rental housing that has all of the following characteristics:

(A) It is affordable to people with disabilities.

(B) It is independent housing in which each tenant meets all of the following conditions:

(i) Holds a lease or rental agreement in his or her own name and is responsible for paying his or her own rent.

(ii) Has his or her own room or apartment and is individually responsible for arranging any shared tenancy.



(C) It is permanent, wherein each tenant may stay as long as he or she pays his or her share of rent and complies with the terms of his or her lease.

(D) It is tenancy housing under which supportive housing providers are required to comply with applicable state and federal laws governing the landlord-tenant relationship.

(E) Participation in services or any particular type of service is not required as a condition of tenancy.

(d) Counties may contract with agencies or individuals to assist persons with disabilities in securing their own homes and to provide persons with disabilities with the supports needed to live in their own homes, including supportive housing.

(e) For purposes of this section and notwithstanding any other provision of law, an individual with disabilities may contract for the provision of any of the community support services specified in paragraph (1) of subdivision (c) in the individual's own home including supportive housing, as part of that individual's service, care, or independent living plan, only through a government funded program or a private health or disability insurance plan.

(f) An individual's receipt of community living support services as defined in paragraph (1) of subdivision (c) shall not be construed to mean that the individual requires care or supervision or is receiving care or supervision.

