

**Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process**

**CAPITAL FACILITIES WORKGROUP
JUNE 23, 2005 - SACRAMENTO**

**Meeting Summary
For Discussion Only**

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I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's (DMH) *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

This series of two workgroup meetings addresses Capital Facilities. This first meeting focused on the basic issues of housing and facilities planning and community collaboration. The second meeting to be held September 12, 2005 will discuss Capital Facilities and IT. Approximately \$325 million will be available for "capital facilities and technological needs" to implement plans for mental health services over four years, from FY 2004-05 to FY 2007-08. Proposed capital facilities costs may include:

- Purchasing land or buildings
- Construction or rehabilitation costs for buildings or office and meeting spaces
- Adequate reserves for projects to cover gaps in operating costs in future years
- Related "soft" costs for development including strategies to build community acceptance for projects

Decisions about how to use MHSA funds for capital facilities will be guided by the MHSA Vision and Guiding Principles.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the afternoon workgroup session purpose, review the workgroup agenda, provide feedback and network with each other. The workgroup was held from 1:00 – 4:00 p.m.

Forty-two (42) people attended the combined Capital Facilities and Performance Measurement and IT morning CFM pre-meeting and 35 people attended the afternoon Capital Facilities workgroup meeting. The summary of the Performance Measurements and IT workgroup can also be found on the DMH website.

A. Meeting Purpose

The outcomes of the workgroup meeting were:

- To identify a range of appropriate uses for MHSA funds that will be available for capital facilities
- To identify principles to guide the use of the MHSA funds
- To provide definitions and important information to help guide the use of MHSA capital funds to expand housing options for consumers
- To stimulate discussion and obtain feedback from stakeholders

B. Schedule of Meetings

All previously scheduled workgroup meetings in July have been postponed until the fall. DMH will post new dates by July 1, 2005 on its website.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 a.m.)

Forty-two (42) people attended the combined Capital Facilities and Performance Measurement and IT morning CFM pre-meeting.

A. Welcome, Introductions and Purpose of Today's Meetings

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the client and family member session by informing participants that the dates for the MHSA workgroups in July have been postponed until the fall.

Ms. Wunsch introduced Carol Wilkins, Director of Intergovernmental Policy for the Corporation for Supportive Housing (CSH). CSH is a nonprofit organization that works to end homelessness by bringing together people, skills and resources; providing quality advice and development expertise; making loans and grants to supportive housing sponsors; strengthening the supportive housing industry; and working to reform policies to make it easier to create and operate supportive housing. CSH works with nonprofit providers, counties, states and local governments to help provide housing alternatives for people with disabilities and for those at risk for homelessness. Ms. Wilkins then introduced Liz Orlin, Associate Director of CSH's California program, who directed the focus groups that helped guide the MHSA paper, *Mental Health Services Act Capital Facilities Draft, June 13, 2005*.

Ms. Wunsch reviewed the agenda for the afternoon workgroup meeting. Ms Wilkins gave a brief overview of the presentation scheduled for the afternoon workgroup.

Client and Family Member Questions and Comments

- Please do not have workgroup meetings on capital facilities that overlap with IT or other topics. There are a few clients who can provide expertise on these topics.
- For clients and family members traveling long distances, it is important to be able to have access to complete information on all of the topics. Do not overlap meetings.
- If it is necessary to overlap meetings, cancel the CFM Pre-Meeting and hold one workgroup in the morning and one in the afternoon. It is more important for clients and families to be able to hear everything than to have the pre-meeting.
 - **Pacific Health Consulting Group Response (PHCG):** This is important feedback. This concurrent scheduling was an attempt to address several different topics as quickly as possible. Many topics originally scheduled for July have been postponed to the fall. The new schedule will be posted on the website.

B. Key Issues in Capital Facilities

The next part of the meeting was comprised of three separate discussions on performance measurement, IT and capital facilities. Each small discussion group discussed one or two questions and then was able to ask questions of the subject matter experts. The structure and timing of this process allowed for each participant to attend two of the three small discussion groups. Before starting the discussion, Ms. Wilkins defined Capital Facilities:

Capital Facilities addresses long-term investments. This includes buildings that are purchased, renovated or constructed and things that go inside that building, such as furnishings, wiring, improvements, etc. This can include “soft” costs, such as the costs related to obtaining financing, community approvals, appraisals, environmental review of the site, initial architectural drawings, etc. Capital Facilities could also include capitalizing a reserve to cover some future operating costs of the facilities (for example in a housing project the reserve would be calculated based on an expected gap between tenants’ ability to pay rent and the operating costs of the housing project. This can be important for securing other capital financing when other sources of rent subsidies are uncertain.)

The questions for and feedback from the Capital Facilities small discussion group follows:

What are the most important capital facilities needs by age groups?

Age Groups

- All facilities must be compliant with the Americans with Disabilities Act (ADA) for all age groups.
- More consumer-operated facilities and programs for all age groups together or separate, as appropriate. Existing peer-run programs are overcrowded.

- Consumer-operated facilities are not to be run by young children. Discussion about consumers usually refers to the family and the support system as well as the identified client, so children as an age group would be included through family-member involvement. A family member of a child has very different needs from the needs of an adult consumer or the family member of an adult consumer.
- In many communities, people have to work to pay the rent and cannot take care of their small children with SED. Create a housing program for low-income parents of children with severe emotional problems. Parents cannot take care of their children and often have to put them in institutions so they can go to work.
- A Drop-in Recovery Center for transition-age youth, adults and older adults that provides tools and skills to teach people about the recovery process.
- Transition-age youth have specialized needs. It is always difficult to focus on permanent options for them, because those between the ages of 18 and 21 are in transition.
- For older adults, include space for medical services either nearby or on-site.

Multi-Use Facilities

- Multi-use facilities that combine housing and other resources in one facility, serve all ages, are family-oriented and include culturally competent components, such as a skills center, family treatment, etc.
- Multi-service consumer-run center. It must be local with easy access. These services must be available in a central location as well as be accessible to those in outlying areas. This type of center would serve a range of needs from transition housing to supportive housing to independent living.
- A wellness center that is an integrated drop-in center with a variety of supports, including computers and Internet access, training, and employment services, etc.
- An employment and training center where consumers and family members can gain computer expertise and other employment skills, for both those who are unemployed and for those who are employed and need technical assistance.
- Many counties cannot afford to place facilities in all population centers, but it is important to have facilities that are centralized to a community and services that can be delivered with a mobile clinic or mobile office.
- Space for trainings, meetings, supplies and record keeping for peer outreach teams and peer advocates.
- MHSA-centralized ongoing conference and training facility where workgroups like these can occur without having to secure an outside conference facility. It would have a resource library, referral services, etc.
- In-home day care.
- Ed Roberts Campus in Berkeley has many of these supports for persons with disabilities. The mental health community needs a facility like this. It is located in Berkeley adjacent to BART and is totally accessible. It is a good model to replicate.

Other Location Issues

- Reasonably and centrally located.
- Located for easy access to transportation.

- It is not possible to put up buildings in every small town. Provide mobile services to the outlying communities. The services could operate, for example, for a half-day once or twice per week.
- Broadband Internet wiring and cable access in each room.
- Non-institutional facilities that are effectively incorporated into the community.

Transitional/Re-Entry Housing

- Diversified re-entry approaches specific to each age group, for people transitioning from institutions for mental disease (IMDs) to re-enter the community.
- A step-down transitional facility for youth who have been in a locked facility. Transition-age youth tend to sabotage their independent living due to an inability to deal with being in the community. They need to learn survival skills to remain in the community.
- Transitional housing for re-entry for people transitioning back into the community from IMDs. A wide range of populations would benefit from this, especially mothers with children.
- Combined re-entry housing. Clients would transition to an apartment with supportive services. It could operate like the Individual Education Plan (IEP) for children who qualify for special education services. When coming out of IMDs, for example, clients need intensive services, while later less intensive services are needed. A person who had already completed this process could peer-counsel others entering the supportive housing program.
 - **CSH Response:** Often people talk about "transitional housing" when they mean housing with supports. It's important to think about when a need for housing is really transitional because people are expected to move, or when people need housing where they can stay while getting supports that can be transitional.

Crisis Housing

- Crisis residential not as a substitute for housing, but as a substitute for inpatient options for all age groups.
- Crisis drop-in for stabilization during a crisis, including respite for family members and clients for all age groups.
- Emergency short-term housing for all ages including families.

Types of Housing

- Single-occupancy housing.
- Shared housing, in which people can be matched with people of similar interests and similar cultural backgrounds, etc.
- Housing that is pet-friendly for all age groups.

Special Populations

- A facility for single mothers with day care capability including crisis intervention, a resource center, on-site training programs, etc.
- An Indian Center in rural counties that could provide a range of supports including food, help, a place to live, etc. It has to be all-inclusive, not controlled by one group or tribe. Capital Facilities funding could be used to address this need.

Involuntary Services

- Children's inpatient unit
- A child inpatient unit is very involuntary in nature and should not be funded by MHSA
 - **CSH Response:** DMH is working on the issue of reduction in involuntary services. People are looking very closely at this issue.

Client and Family Member Involvement

- Convert buildings in good condition in a central location into duplexes, etc., for independent living. Consumers can be a part of the work to renovate the space. If a mental health consumer can only lift a hammer, s/he can be involved in creating his or her own space and be responsible for maintaining the property. This way, clients gain skills and confidence. More technical people could oversee the details while the consumer does as much of the work as possible.

Staffing and Training

- Consumer employees and appropriate staff for the different facilities, including culturally competent staff.
- Internships to train bilingual people to work with monolingual, non-English speakers about family rights.
- There should be better translations in multiple languages to aid understanding of the new terminology.
- Provide more training to people about capital and capital facilities. Consumers need to have much more education about this.

Client and Family Member Questions

Carol Wilkins and Liz Orlin of CSH discussed Capital Facilities with participants, provided clarifications and answered questions.

Uses and Limits of Capital Facilities Funding

- In developing housing that includes community involvement, through someone who wants to contribute land or a home, what kind of support could be given from Capital Facilities that would not be affected by supplantation?
 - **CSH Response:** The supplantation question still needs some study. The support depends generally on who would eventually own the building. The Capital Facilities funding would go to the non-profit organization that would use the funds to pay for improvements. A key consideration is to ensure that it will be available for the benefit of consumers and family members for a long time to come – 30 to 50 years.
- Can Capital Facilities funding be used to upgrade facilities to comply with ADA?
 - **CSH Response:** Yes. Ease of access to the location as well as ADA facility considerations both play a part in Capital Facilities.
- In Los Angeles, a children's center has been closed. The place is beautiful: park-like with a swimming pool, classrooms, a playground, etc. Can Capital Facilities funding be used to obtain and rebuild facilities like this, for example, for transition-

age youth, or for resource centers to provide peer support to parents and their children? Instead of just building more buildings, people should look at renovating vacant older buildings. People live on the streets in worse environments than can be found in these buildings.

- **CSH Response:** In general (without having enough information to respond about specific site described), yes. It is acceptable to use funds to rescue or change ways a community uses property or facilities, by taking over and redeveloping the land to renovate or construct new facilities that fit the identified needs. For example, a project that includes housing for clients and their families (with MHSA Capital Facilities funds) as part of a larger development that includes affordable housing for people without disabilities might be one way to reduce stigma associated with a site that is being converted to new uses.
- **CFM Response:** The idea is not to turn them into long-term affordable housing rentals but to make them available for young people or parents who need just a little help, such as a resource center for technical support while parents or families get back on their feet.
- **CSH Response:** CSH experience shows that it is critical to bring together the consumers who are likely to use the project during the planning and design phase. The focus groups have heard from youth with serious mental illness that they want a place of their own. The term “transitional housing” has been replaced with "permanent housing" to confirm that people have a choice to come and go, to stay or move on.
- Can Capital Facilities money be used for programs other than purchasing a building?
 - **CSH Response:** Capital Facilities dollars are about buildings. The issues are not what programs but what kind of building can the programs go into? It is important to establish the building needs early on. This is about defining the physical structure for the programs. If an agency owns the building, it is not taking money out of its budget to pay rent.
- What are the limitations for the MHSA Capital Facility funding in terms of nonprofit agencies?
 - **CSH Response:** MHSA Capital Facilities funds may be used for capital costs and/or for capitalized reserve for operating costs of capital projects. MHSA CSS funds may be used for operating costs and/or services. Some examples are: Capital Facilities funding can fund supportive independent living or residence clubs, where a person has his or her own room, but might share living space. MHSA Capital Facilities funds can also be used by a nonprofit developer who is creating some units set-aside for mental health clients within a larger development that provides affordable housing for other populations in a single building or apartment complex.
 - **CSH Response:** The money available for a new development through Capital Facilities includes large amounts of initial funding for capital for the first three years. Organizations can use MHSA Capital Facilities money as an operating reserve. They could make affordable units even more affordable by setting aside a reserve, either through Capital Facilities or CSS, that can be accessed over time.

Not in My Backyard–NIMBYism

- An important part of an existing program is its consumer drop-in. With rents going up and addressing NIMBY issues, is this an opportunity to purchase the building?
 - **CSH Response:** Yes.
- How can MHSA programs educate about stigma to overcome possible NIMBYism? There are people who would object to a mental health center in their community. Because of the stereotypes, the public would be concerned about criminals including sex offenders, etc. But consumers need a secure place free of crime.
 - **CSH Response:** This is a very important concern. People bring their ignorance and fear to this discussion. CSH has heard a variety of needs and desires from consumers: some prefer to live in their own unit; integrated with the larger community, others want to live near or with consumer peers. To avert NIMBY problems is a matter of “selling” the project when speaking to the community.
- One county has received surprising support from some of the most conservative community members, because the mental health services are integrated into the community. The community seems to understand the need.

Leveraging

- Please say more about leveraging funds.
 - **CSH Response:** The paper on Capital Facilities talks about this and CSH expects to expand on this information. CSH will make the MHSA Housing Tool Kit available soon. It will have more ideas for leveraging funds. The MHSA Housing Tool Kit will answer a lot of questions and eliminate some confusion.
- What is the most economically realistic way to solve the housing problem so people do not have to live in board and care facilities?
 - **CSH Response:** One of the ways is to make sure to use these dollars to leverage other dollars. There are several ways in California to create affordable housing (e.g., low-income housing tax credits; Prop 46; resources tied to local Ten-Year Plans for Ending Homelessness, etc.), but a lot of the “affordable housing” that is being developed for low or moderate income workers is not affordable enough for people living on SSI, etc. MHSA funds can be used to make it more feasible for non-profit developers who have access to these other sources of funding to develop more units of housing for mental health clients who need affordable housing and services. For example they can use MHSA dollars to set aside (or reserve) some of these units. In some communities this will not work because there may not be enough experienced non-profit housing developers who know how to tap these other sources, but in most places, MHSA dollars can be used along with other capital and operating dollars. CSH will offer training about how to best do this.
- Every issue discussed here involves a facility for programs. It is essential to leverage monies for social resources, not just capital resources.

Supportive Housing

- Not all facilities should be clean and sober. While they have a place, they cannot be allowed to continue under MHSA.

- The flip side of NIMBYism is also a concern. Some “supportive” housing operates like a jail, with multiple kinds of identity checks, security desk clerks, etc. They use safety as justification against having visitors. Security funding may be included in Capital Facilities but surveillance cameras, bars, showing identification, etc., should not be part of it.
 - **CSH Response:** Regarding supportive housing: balancing safety with dignity and autonomy is difficult. Often there are different perspectives on these issues with some tenants who want a lot of rules governing the behavior of tenants or policies about guests in a building vs. other tenants who want fewer controls. The MHSA Housing Tool Kit will address fair housing issues. The tool kit touches on how housing sponsors cannot make different rules for tenants depending on whether or not they have disabilities. Housing sponsors need to learn how to put rules in place to make sure tenants can live in the quiet of their own homes, but not be restricted or discriminated against.
- There is a need for any building serving housing needs of consumers, whether large facilities or independent residential units, to have a service center within the building or close by. It should include vocational rehabilitation, training and language assistance. Many people are happy about MHSA funding and opportunities, but are concerned about language barriers which will prevent some consumers and family members from knowing how to access services or how to get the information when they are in need of services. It is important that people who speak languages other than English can receive services near their home and at their own pace.

Master Lease

- It is possible to maximize facility money by using master leases. Would a county or a consumer-run agency that has a master lease qualify for Capital Facilities funding?
 - **CSH Response:** Master-leasing usually involves a whole building. The question is how far can a project go without building a new building? Some organizations have master leases for decades. In considering a master-lease arrangement as a Capital Facilities cost, there would probably be a legal question regarding whether lease payments could be considered a capital facilities cost and if so, how long the lease would be in place. From the perspective of the organization entering into that lease, there is need to understand the financial issues and implications of the arrangement. Look at whether it makes sense financially to buy outright rather than to make lease payments over 20 years. DMH will need to get legal advice to figure out if and how leasing costs will be considered as capital facilities costs. A master-lease will be fine for Community Services and Support (CSS) money.
 - **CFM Response:** In this case, it is an agreement between an agency and a landlord.
 - **CSH Response:** Most likely, individual leases would more appropriately be funded through CSS funds.
- It might make master leases more affordable if an option to buy were built into the lease.

Consumer and Family Member Involvement

- It seems unlikely that counties will give Capital Facilities funding to consumers to purchase buildings.
 - **CFM Response:** Some counties will. It has happened in Los Angeles already.
- Can organizations require a resident council in a building so that residents make the decisions rather than the developers?
 - **CSH Response:** It will be helpful to ask developers how consumers and family members will be involved in the design. There may also be some employment opportunities.

Questions for Later Consideration

Participants submitted additional questions to be recorded for discussion at a later time.

- How is Capital Facilities money to be allocated: by a formula or equally to all counties?
- Is there a way to facilitate a linkage between the use of Capital Facilities money and funding for programs?
- Will Capital Facilities finance children's group homes at the Rate Classification Level (RCL) 12 to 14?
- Please provide examples of model programs that have peer support as part of the housing model.

III. Workgroup on Capital Facilities (1:00 – 4:00 p.m.)

Thirty-five (35) people participated in the afternoon workgroup meeting.

A. Welcome, Introduction and Purpose of the Workgroup Meeting

Babs Kavanaugh, Pacific Health Consulting Group, welcomed the participants. She reminded participants of the purpose of workgroup sessions: to focus on a specific topic and provide feedback to DMH. After a presentation by Carol Wilkins, Director of Intergovernmental Policy for the Corporation for Supportive Housing (CSH), participants would have the opportunity to ask questions and discuss issues raised by the presentation. Later, in order to obtain feedback from everyone, the group would divide into small groups for additional discussion and feedback.

B. Scope of MHSA Capital Facilities

Carol Wilkins introduced the key issues for the Capital Facilities component of MHSA.

Investments in capital facilities should help achieve the desired outcomes of MHSA.

- Safe and adequate housing and a reduction in homelessness
- Timely access to needed help, including in times of crisis

- Reduction in involuntary services and incarceration

A county's proposed uses of these funds must be aligned with planning for Community Services and Supports (CSS).

- Meet identified mental health needs in the community
- Focus on unserved and underserved individuals and reducing racial and ethnic disparities
- Support implementation of identified strategies

Capital Facilities investments should:

- Produce long-term impacts with lasting benefits for clients, such as reduction in hospitalization, incarceration and the use of involuntary services, and increase in housing stability
- Increase the number and variety of community-based facilities supporting integrated service experiences for clients and their families
- Support a range of options that promote consumer choice and preferences, independence and community integration
- Invest in options that will be available for the long-term, such as housing that will be affordable and dedicated to consumers for many years
- Leverage additional funding from other local, state and federal sources and support projects that are financially viable

Capital Facilities needs most frequently identified in focus groups

Purchase, construction, acquisition and/or rehabilitation costs for community-based facilities that provide:

- Consumer/peer-operated wellness and recovery support centers
- Family Resource Centers: multi-service facilities that are sensitive to the needs of communities with multi-cultural backgrounds, designed in ways that are sensitive to the needs of tribal communities, for example
- Crisis stabilization and residential care as alternatives to hospitalization
- Mental health services co-located with community-based services including schools and primary care clinics
- Affordable and supportive housing

Important considerations

- Separate facilities may be needed for adults, youth and young adults, and children, even when addressing similar needs for services and supports.
- Facilities that provide opportunities for inter-generational services and supports for families can reduce out-of-home placements for children and facilitate family reunification.
- Co-location with other community services and supports can reduce stigma and improve access, facilitate community collaboration and provide an integrated service experience for clients and their families. What portion of these costs should be paid by MHSAs?
- De-centralized facilities can offer services in locations that are more accessible to clients and their families.

Affordable & supportive housing

- There is substantial agreement among consumers and family members, county mental health directors and other stakeholders.
 - Safe, affordable stable housing is a foundation for recovery, resiliency and wellness.
 - Reducing homelessness is a major focus of MHSAs implementation.
 - Consumers and families need a range of housing options.

Client and family member preferences

- Most adults and transition-aged youths want their own apartment without roommates.
- Some clients and family members want to live in buildings with others who have similar needs. Others prefer to live in buildings without other clients or with a mix of tenants.
- The majority of consumers do not want the structure and rules associated with "clean and sober" housing, but program staff think consumers need a mix of housing models (including "clean and sober" and "low demand" housing (i.e., tenants are not under demand for treatment and other)).

Priority populations for housing

- Adults with serious mental illness who are homeless or inappropriately housed in restrictive settings
- Youth and young adults diagnosed with SED who are at risk of homelessness

- Families with children/youth diagnosed with SED who are experiencing housing instability or homelessness that interferes with treatment and recovery/resiliency

Defining Supportive Housing

- Permanent affordable housing with combined supports for independent living:
 - Housing is permanent, meaning each tenant may stay as long as he or she pays rent and complies with terms of lease or rental agreement.
 - Housing is affordable, meaning each tenant pays no more than 30% to 50% of household income.
 - Tenants have access to an array of support services that are intended to support housing stability, recovery and resiliency, but participation in support services is not a requirement for tenancy.
 - May be site-based or scattered site.
 - Options are available for adults who are single, those who choose to share housing and families with children.

Who is Supportive Housing for?

People who are homeless or at risk for homelessness and face persistent obstacles to maintaining housing, such as mental health issues and other challenges.

Supportive Housing is for people who:

- But for housing, cannot access and make effective use of treatment and supportive services in the community
- But for supportive services, cannot access and maintain stable housing in the community

What is Supportive Housing? Six Dimensions of Best Practice

1. Housing choice (not one-site-fits-all)
2. Housing and services roles are distinct
3. Housing affordability
4. Integration (maximize the opportunity to integrate into the community)
5. Tenancy rights/permanent housing
6. Services are recovery-oriented and adapted to the needs of individuals

Major findings from AB 2034-housing is really important!

When consumers have housing, they are much more likely to stay enrolled in the program.

Housing outcomes

- "Housing readiness" is not a good predictor of housing outcomes.
- Programs that enroll "more challenging" consumers (those who have had longer histories of homelessness or more barriers to housing stability) are not getting worse results in terms of housing outcomes; in fact sometimes the results are better.

Housing makes a very big difference

- There is wide variation among counties/programs in the proportion of ever-enrolled consumers who are now in stable housing. The range is 11% to 62%.
- There is a very strong correlation between having a high proportion of ever-enrolled consumers who are in housing and having a very low proportion of consumers who disenroll.

What is most needed?

- More affordable housing
- Permanent supportive housing
- Landlords and property managers who are tolerant and understanding of consumers
- "Wet/Damp" and "Harm Reduction" housing models for people with substance use problems
- Support for both landlords and tenants
- Wide range of housing options

Strategies for creating more housing options for consumers

- Development of new buildings
- Acquisition and renovation of existing buildings
- Long-term lease agreements with private landlords for single units or entire apartment buildings (master-leasing)
- Identifying private landlords who rent directly to consumers

Three types of financing for Supportive Housing costs

- Capital (land or buildings)
- Operating costs (or rent subsidies)
- Services

MHSA Capital Facilities funds may be used for capital costs and/or for capitalized reserve for operating costs of capital projects. MHSA CSS funds may be used for operating costs and/or services.

Carol Wilkins added several ideas that were discussed during the client and family member pre-meeting. These included the need for facilities for training, employment opportunities for consumers and fully accessible facilities that meet ADA requirements. One suggestion is that some funds might be used to renovate older facilities and bring them into ADA compliance. She noted that it is essential that people who will be served by a facility be able to provide input into developing or reviewing the proposals.

Stakeholder Comments and Questions

Consumer Choice and Independent Living

- There is concern about the potential constraints placed on clients. Sometimes the authorities say a client is obligated to take medications just to obtain affordable housing.
 - **CSH Response:** That is not right. CSH is in the process of preparing the MHSA Housing Tool Kit to help everyone understand issues around fair housing. Housing managers cannot require people to take medications to qualify for affordable housing. Housing managers cannot treat someone with a physical illness differently from someone with a mental illness. A landlord can require certain standards of behavior. A landlord cannot set requirements that are different from requirements for other tenants.
- The biggest concern is when a landlord is also the service provider. It is important that there are guidelines established to address potential conflicts of interest.
- In some supportive housing programs, the property management and the case management are part of the same non-profit organization. Sometimes the result is that tenants' rights are not always respected. They are not able to make their own decisions. Consequently, some people are forced to sleep outside. Tenant oversight must be built-in and required by MHSA funding. The organizational structure should be chosen/elected by tenants. The rules need not discriminate against people who want to live independently.
- Housing developers are being challenged to adequately meet the needs of more and more people with the most severe mental illnesses, the most challenging consumers. There are no good models for transition-age youth, who by nature are in transition and need some sort of support. The lack of these successful models makes the construction of buildings at this stage problematic. The consumers in this room are doing well. Those consumers who are not doing as well are the ones needing services.
 - **CSH Response:** There is a difference between residential facilities and supportive and independent housing. The paper on MHSA Capital Facilities recognizes there is a need for both housing and other types of residential programs and facilities for services, and includes a list of facilities that is not limited to housing. There is need for residential treatment, including crisis

residential programs that would provide a lot more structure and program rules than supportive housing, which would have few restrictions.

- Regarding the comment that people in this room are doing well, most consumers here were not doing well. The problem is that people are left in board and care facilities because there is not enough housing available. People are in supervised housing who do not need to be supervised.
- Transition-age youth with or without a psychiatric diagnosis have transition issues. Many times transition-age youth are those who have not ever had a place of their own (foster children, etc.). In discussing this age group, it is important to think about housing not related to being transitional. Transition-age youth need housing they can call their own as long as they need it but that they are also free to leave.
- Some participants attend these meetings because of their concern that transition-age youth will have their rights taken away because they are not here to speak for themselves. They deserve the same freedoms to be offered to all of them.

Types of Housing

- Does the definition of supportive housing included in the Capital Facilities paper include room and board (board and care) facilities?
 - **CSH Response:** This is a policy decision for DMH based on the principles articulated. Stakeholder input on this is welcomed.
- Most of the consumers' experiences do not relate to these housing descriptions. In many rural counties, there are just no places for people to live. Let's talk about portable housing like tents and trailers.

Pets and Housing

- People need housing where they have the right to have animals. People need pet recovery facilities, a place for their pets to be safe. The people on the railroad tracks find housing and their pet is just left on the street.

C. Small Group Discussions on Community Collaborations and Facilities Needs

Participants selected one of two topics for their small group discussion: community collaboration and housing/facilities needs. Their discussions are summarized below.

1. Community Collaboration

C.1.a. What other local collaborative planning processes are underway that should be coordinated with investments of MHSA funds for Capital Facilities?

Groups or Agencies to Collaborate With

- Hold discussions with health centers about co-locating services, and combining funding to create facilities.
- Participate in local "ending homelessness" initiatives, e.g. Prop. 46. Leverage MHSA funds with these funds and combine the implementation processes.
- Participate in planning with local housing authorities.

- Collaborate with local redevelopment agency proposals.
- Reach out to developers and participate in funding facilities.

Ways to Collaborate

- Let county-level planning drive the determination of funding choices between capital for facilities and for IT.
- Provide education to counties about how to deal with potential neighbors.
- State could provide lists of others with whom counties or agencies could partner.
- Support maximum flexibility in the kinds of relationships that can be established to develop facilities.
- Put accountability focus on set-up, how the services or housing works.

Specific Examples of Collaboration

- U.S. Housing and Urban Development (HUD)
- Habitat for Humanity

C.1.b. How can coordination with other local efforts help achieve cultural competency and reduction of racial and ethnic mental health disparities?

Education and Support

- Provide referrals to legal services or provide training for individuals accessing public services who are concerned about the impact on immigration status. Help ethnic communities “grow their own” buildings, staff, and programs.
- Individuals leading the process need to be culturally sensitive.
- Engage individuals from ethnic communities to participate in planning and/or giving input.
- Locate facilities in places where ethnic groups will naturally access services. Think about who will staff the facilities, focusing on individuals trusted by the community.

Build Collaborations

- Partner with Latino and other ethnic 501(c)(3) organizations to provide mental health services to their constituency in their agency sites.
- Collaborate with groups that work on increasing access in their outreach efforts, to enhance communication with people speaking other languages.
- Build collaborations between advocates and users of harm reduction services and tenants and disability rights organizations by and for communities of color.

C.1.c. How should MHSA capital investments be coordinated with local activities for neighborhood revitalization, ending homelessness and school or community safety improvements?

Inclusion of Mental Health Advocates in Planning Processes

- Plan requirements should encourage collaboration with organizations that share the same focus.
- Where possible, try coordination, but don't be governed by that.

- Participate in meetings of these groups, but also meet and form community collaborations outside of government-funded agencies such as redevelopment agencies and neighborhood safety projects. There are trust issues with these organizations because of past experiences by consumers and family members.
- Make certain that mental health people are not left out.

Factors to Consider

- DMH should lobby oversight organizations to encourage flexibility in working with MHSA.
- Focus on permanence. Advise counties about pitfalls that could lead to loss of housing, such as the sale of a facility in which clients are placed.
- Make sure facilities are appropriate for supported independent living, including having peer support to teach “living” skills.

2. Housing/Facility Needs

C.2.a. What is missing from the draft document? Does it include the right types of housing and other buildings/facilities that are important to consumers and their families and needed to implement the community services and supports that are planned for all age groups?

Children and Youth

- An alternative resource site to provide services in the community that youth would otherwise have to be in a hospital to receive
- Treatment facilities for children
- Facilities that will allow children to stay in California or be diverted from Juvenile Justice
- Child/family recovery centers: families need support too. It could be a place that is focused on mental health or a family resource center that meets multiple family needs.
- Something in between home with wraparound services and hospitalization, with a place for the child and family
- Places for a family with a troubled child

Transition-Age Youth

- Need successful model for services before assessing bricks and mortar needs.
- Need tents, bicycle-pulled trailers, camps, boy scouts, pet care homes, a room of one’s own, friends, something meaningful to do, a social life and the choice to have a setting one wants and changes that are healthy, chosen and help one to mature.

Adults

- Drop-in center
- Wellness center
- Crisis house

Older Adults

- Senior community center
- Facilities that are respectful and supportive of residents
- Education, adult education, community education, arts and recreation, health and recreation. People want and need different things at different times and want to choose for themselves.

All Age Groups

- Crisis stabilization and crisis residential should be high priority
- Have capital facilities with “full service” capacity
- “Urgent Care Centers” like those in Los Angeles County
- Ensure housing is supportive, not punitive
- Safe houses
- Focus on scattered site housing, using Capital Facilities funds for those costs
- It would be interesting to learn how people really feel about where they want to live: independent or group or supportive housing?
- How about small dwellings near shopping areas?
- Pet care/respice/adoption live-in care communities

Other Concerns

- Require that all facilities are ADA-compliant
- Translate all documents into multiple languages
- Answer liability questions
- It seems almost impossible to use Capital Facilities funds for anything but housing based on the guidelines
- Concern about the inability to use Capital Facilities funding to support leasing buildings for client-driven service centers, drop-in centers, wellness centers. Can CSH help with this?

C.2.b. Some of the facility needs that have been identified include facilities that will be co-located with or in settings that offer a wide range of services to clients and their families. How should counties determine what portion of the costs for these facilities should be covered by MHSA funds?

Potential Determining Factors

- Use “allocation of space” formula to determine MHSA share
- Determine percent of cost of new space assigned for mental health services
- This should be negotiated locally

C.2.c. Some facilities will serve both clients with identified needs for mental health services and other members of their families. What considerations should guide the use of MHSA funds to serve family members who are not identified clients?

Considerations

- Is the person (parent, significant other, friend, roommate, etc.) important to the client's well being?
- Are the services provided to the person (parent, significant other, friend, roommate, etc.) beneficial to the client?
- As people recover, their needs change. They may initially need to be around other consumers and later want to be around non-consumers.

Services

- Serves whole family as well as pets
- Respite care centers
- Transportation and child care

D. Lessons Learned and Challenges Looking Forward

Ms. Wilkins presented information based on the PowerPoint presentation *Looking Forward: Lessons Learned & Strategies for Meeting the Challenges*, June 23, 2005.

Key challenges to using MHSA Capital Facilities funding:

- NIMBY, community acceptance and fair housing
- Timelines for developing housing or other facilities
- Risks related to future costs to sustain new facilities
- Partnerships that effectively leverage resources, skills and experience of different organizations and public agencies

Solutions will require changing the system:

- "Any door" leads to effective bundle of housing and services to support recovery and resiliency for clients and their families.
- Funding for capital facilities and services are allocated in a single or coordinated process, timed as needed for project implementation.
- Rules for project approvals and funding are not improvised project-by-project, or on exceptional basis, but established in routine practice.

The indicators of a changed system are power, money, habits, technology and skills, and ideas and values, all linked together to achieve the mission. When there are changes in power:

- Duties and authority are re-arranged

- Designated staff are given formal authority and responsibility for managing investments in supportive housing and other facilities needed for implementation of community services and supports
- Stakeholders who have not been heard or involved assume new or different roles and have a real impact on decisions

Changes in the system can come about through changes in money:

- New money (e.g. MHSA) is used as a catalyst for change
- Old money (“existing resources”) used in new ways through targeting, eligibility changes, technical solutions, incentives
- Funding for all components of supportive housing and other facilities projects (capital, operating and supportive services) is available and reliable – and coordinated

Changes can also lead to changes in habit:

- People and organizations interact with each other to create and sustain integrated solutions (e.g. housing and more effective services) for clients and their families as part of their normal ongoing routines and core work activities.
- Requires new understanding and skills for working in a “multi-cultural” environment.

Changes come in technology and skills

Skilled practitioners can effectively deliver results:

- Direct services are delivered in home and community settings based on promising practices.
- Organizations have the capacity to engage in new activities (e.g. housing) or partnerships and to use new financing strategies.
- New procedures and systems and cross-training for government agencies to implement, monitor and evaluate new program activities.

Changes in ideas and values can result in the following:

- A new understanding of the problems to be solved
- Re-examination of traditional definitions of success
- Re-definition of target populations based on shared priorities
- Widely shared new performance expectations and definitions of success

The art of system change is also based on the notion that systems deal with behavior: habits, ideas and relationships. Behavior change can be made through persuasion,

incentives, trust and practice. Effective systems change requires persistent pressure on most or all of the key elements over a sustained period of time. This takes years, not months of effort. It often begins with persuasive short-term accomplishments and producing a new product or service by extraordinary means, just to show it can be done and is worth replicating.

Important building blocks include:

- Collaborative planning
- Investment and leveraging resources
- Coordination, streamlining and integration of funding
- Building provider capacity

Resistance should be expected. The tools of system change are meant to unsettle old systems while building new ones. Old systems will resist: they exist because they have survived pressures and onslaughts before. Services and housing are not just separate systems, but (many) separate cultures, disciplines and sets of values.

Stakeholder Questions and Comments

MHSA Vision

- A lot of the community collaborations are run by government agencies (i.e., HUD, Ten-Year Homeless, etc.) at the expense of many homeless people. There are potential opportunities to leverage MHSA money for collaborations. But what if this fails? The same applies to neighborhood safety and other issues. Many programs have specifically displaced mental health consumers, immigrants, children and youth, seniors, people of color and others. Do not let the most privileged citizens and the government agencies direct the programs.
- Some counties will never be moved toward transformation, because the leadership is not committed to the vision of MHSA. Capital outlay has to be built on the philosophy of MHSA. How can any county department assure there are no services offered that are not true to the MHSA vision? There will be two systems. Even with staff, buildings and support for the system in place, unless Medi-Cal changes, there will be no real transformation. The division between the staff/administration and consumers will remain because money drives the system and the bulk of the money comes from an illness perspective.
 - **CSH Response:** Another way people talk about change is to build to a tipping point. The struggle over the next few years is with these tensions, especially with Medi-Cal. CSH hopes that all the efforts related to MHSA implementation will build to the tipping point, where people change their ideals and values.

Combining with CSS

- What if a county uses its limited funds to build a beautiful housing project? Will there be additional funding for the necessary wraparound services?

- **CSH Response:** The Capital Facilities dollars build the building and the CSS dollars fund the ongoing services.
- A county supervisor talking about AB 2034 expansion spoke as if MHSA were responsible to care for all the homeless in the cities. Knowing housing is an issue and that CSS is for ongoing expenses, care must be taken to address the naysayers' concerns for ensuring that a building project includes funding for ongoing services. If the services that go with the building were not funded, the whole housing issue would turn to disaster.
 - **CSH Response:** Planning for capital facilities has to dovetail with CSS plans.

Leveraging

- Already the MHSA has had an impact on housing funds. \$40 million out of Prop. 46 dollars are allocated to MHSA projects. Just because MHSA cannot solve all the problems does not mean it cannot impact them.
- There are probably ways that CSS can leverage resources as well. There may be smarter ways to do it. There have been great ideas about housing and capital expenses. How should these all come together?
 - **CSH Response:** DMH is still considering how the money will flow from the State to the projects. When that initial decision is made, there will be a process similar to the other MHSA planning processes: criteria put forward, a draft proposal, etc. It is clear that training will be necessary to help people determine how to best use these funds. DMH is looking at what training to provide, how to train stakeholders and how to invest in that training.
 - **DMH Response:** The requirements process will be similar to that of the CSS input process. The process is being initiated today. At some point, training will be provided to the counties. DMH is trying to come up with an effective way to accomplish this. The CSH training was very effective and generated a list of all the things the communities are asking for. The next step is to figure out how to meet that need. DMH, the counties, consumers and family members can work together to develop and disseminate the training to meet these training needs. It is the Department's hope that by early July at least part of the process will be ready to disseminate.

Funding and Funding Limitations

- The guidelines must be specific and care must be taken for the allocation of the money. What is the \$325 million over the next three years for?
 - **CSH Response:** The approximately \$325 million over the first four years represents 10% annually of the overall MHSA funding dedicated for both Capital Facilities and IT. It is not always clear what is a Capital Facilities or an IT expense. For example, will Internet wiring be Capital or IT?
- There are grave concerns about the limited money and the high costs of building. \$325 million builds only about 325 houses in California. Capital Facilities funding must be used cost-efficiently to put people in facilities where they are not over-supervised because ongoing supervision costs money. The Capital Facilities funding cannot solve homelessness. There is not enough money to solve the problem in one county, let alone the whole state.

- **CSH Response:** Capital Facilities funding is not enough. At the same time, these dollars can be used to leverage other program dollars. This can make it easier for a developer to obtain funds for other programs. CSH wants to provide guidelines that create a framework for people to make broad decisions, rather than case-by-case or project-by-project decisions. Funding is key to make those projects work. Certainly this is not enough funding to solve all the housing problems. But it can have a huge impact.
- **CSH Response:** Costs per unit are high but no one is suggesting spending \$1 million per unit. CSH has not seen anything over \$250 thousand per unit, which was by far the highest in any county CSH has experience with.