

Transformational Treatment: *Mental Health Care Delivery in Texas*



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Transformational Treatment: *Mental Health Care Delivery in Texas*

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Introduction—A Profile in Transformation

John (not his real name) struggled with alcoholism for 20 years, cocaine addiction for 10 years, and chronic major depression throughout his life. He eventually landed in jail for possession of drugs.

Throughout his journey to recovery, John tried to quit taking his meds whenever he began to feel better. Instead, he turned to self-medication. Unable to quit using drugs on his own, his probation was revoked. He wondered where 20 years of work had got him. He attempted suicide by overdose.

He closed his eyes and waited for death—but it didn't come. He awoke in a hospital, where he spent four days before he was transferred to a psychiatric unit. After this ordeal, he decided on sobriety. For nine months, he rotated between jail and medical rehabilitation and then moved in with his brother. But the burden on his sibling's young family was too great. An argument erupted, and he became homeless.

Then John found a place to go to receive the support he needed to transform his life—Haven for Hope in San Antonio. Thousands like John can credit personal case management and counseling from Haven for Hope as the keys to their recovery. The next-door medical facility also helps people achieve stability with medication. Haven for Hope also has opportunities to advance their education or career.

Some, like John, even go back to become peer specialists at Haven for Hope where they work to help those with similar mental health disorders. John said he felt encouraged and supported by the many volunteer groups associated with Haven for Hope. He had the opportunity to pursue recovery, which has helped him remain sober, drug-free, employed, and optimistic about his future. He truly believes that Haven for Hope changed his life.¹

Integrating Mental Health Delivery

Any taxpayer investment in mental health delivery should be in recovery-oriented care, as it is more likely to have a lasting effect on the people receiving services. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.² Too often, people experiencing mental illness, substance use disorders, or homelessness wind up cycling through expensive government institutions like jails and hospitals; they become dependent on expensive government entitlement programs. Mental illness pervades the lives of many socially disenfranchised people.³ Whether people living in poverty disproportionately experience mental illness because of psycho-social impairments or greater exposure to adverse life events is unclear.⁴ Similarly, homelessness often correlates to unemployment, mental illness, substance abuse, domestic violence, lack of affordable housing, and limited life skills.⁵ Both homelessness and mental illness are complex problems. People experiencing these conditions need flexible programs that can adapt to individual needs and ultimately help each complex person live out his or her life to its greatest potential.

Integrated, transformational programs like Haven for Hope teach people how to become and remain self-sufficient rather than continue to rely on government care. Any program designed to serve people with mental illness should help individuals seeking recovery move into a life full of meaning and dignity. Many current government programs lack the flexibility to help individuals transition into lives in recovery. Haven for Hope is an example of private organizations joining with the government to fight the root causes of a specific problem—homelessness. Mental health care would benefit from similar integrated, transformational programs. Lives begin to change with choice: the choice to seek help, the choice of treatment, and the choice to pursue life. People with mental illness need options that will support them in their choice

to pursue life. Haven for Hope's flexible program allows individuals to tailor services to achieve personal goals, and ultimately a life of meaning and self-sufficiency. Mental health care should include similar flexibility and support for those seeking better lives.

Definition of Homelessness and Mental Health

For the purposes of this paper, homelessness will refer to people meeting the criteria for being homeless as defined by the United States Department of Housing and Urban Development: (1) individuals and families who lack "a fixed, regular, and adequate nighttime residence;" (2) individuals or families "who will imminently lose their primary nighttime residence;" (3) "unaccompanied youth and homeless families with children and youth . . . who . . . have not had a lease, ownership interest, or occupancy agreement in permanent housing at anytime during the 91 days preceding the application for homeless assistance; have experienced persistent instability as measured by three moves or more during the 90-day period immediately before applying for homeless assistance; and can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration, and a history of unstable employment;" and (4) individuals or families "fleeing, or . . . attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions" who lack an alternative residence.⁶ Chronically homeless people have been homeless for a year or longer or have experienced at least four episodes of homelessness in the last three years and have a disability.⁷

Most criminal justice and public mental health interventions rely on the DSM-5 for diagnosis. This paper will define mental illness as mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which some mental health professionals believe expands, "the purview of mental disorder to include normative reactions to life events"⁸ resulting in overdiagnosis. However, as this paper focuses on homelessness, more likely than not the policies discussed will target only people who have a serious, disabling mental illness. Serious mental illness is a "mental,

behavioral, or emotional disorder" that results in "serious functional impairment, which substantially interferes with or limits one or more major life activities,"⁹ such as housing or employment.

Unfortunately, homelessness and mental illness are problems neither the government nor the private sector will ever "fix." We live in a world where people have real, complex problems that have no easy solution.

Cost of Reacting to People in Crisis in Texas

Transient and homeless people can be found in every major city in Texas. In 2011, Point in Time (PIT) data^{*} found 36,911 individuals were either sleeping on the streets (17,929), in an emergency shelter (10,010), or in transitional housing (8,962). National data, at the time, suggested that 90,000 Texans could be in one of these categories of homelessness for at least one night throughout the year.¹⁰ PIT data for 2014 showed 28,495 people experiencing homelessness in Texas.¹¹ Since 2007, Texas has seen one of the largest declines in its overall homeless population—28 percent, a decrease of 11,293 people.¹² Although Texas does appear to be making significant progress in addressing homelessness, there are still challenges, especially with Texas' chronically homeless population, which according to the National Alliance to End Homelessness increased by 3.8 percent from 2013 to 2014. It is also noteworthy that 63 percent of chronically homeless individuals in the U.S. were unsheltered.¹³

Without stable housing or employment, and living with a disability, the chronically homeless population often cycles through prisons, hospital emergency rooms, and shelters at considerable cost to taxpayers. The City of Fort Worth, for example, found that the 20 most expensive homeless people who entered the emergency room (ER) cost \$48,736 per person per year in 2007.¹⁴ The University of Texas estimates the cost of health care to be at least \$23,223 per homeless person per year in 2010 dollars.¹⁵

In addition to ER costs, homeless people consume significant taxpayer resources through the criminal justice system.¹⁶ People experiencing homelessness are often placed in jail for violating laws against trespassing, loitering, sleeping in public places, and panhandling.¹⁷ It is hard to get a clear picture of the extent of the problem because homelessness information is not collected or analyzed at jails or prisons. However, in 2014 in Salt Lake City, Utah, 73 percent of people experiencing homelessness reported a previous jail stay.¹⁸ In 2009, the Urban Institute suggested that incarcerating homeless people continues to cost Texas taxpayers

* PIT data is a headcount of people without a home on a single night in January. This data is collected annually.

significant sums. For one example, a study of the Travis County Jail population “found that there were 6,473 unique homeless persons booked into jail 15,813 times utilizing 284,719 jail bed days between October 2006 and June 2009 that cost the jail \$4,133,787.”¹⁹

Like those experiencing homelessness, people with behavioral health problems—mental illness and substance abuse disorders—also incur high hospital and criminal justice system costs.²⁰ Both populations tend to overuse emergency services, crisis services, and public safety systems. These populations also have significant overlap. Of course, not all people who are homeless have behavioral health problems (and vice versa). But mental illness and substance use disorders are far more prevalent among the homeless population than the general public. Although precise figures are difficult to calculate, it is estimated that more than 60 percent of chronically homeless adults suffer from mental illness, while 80 percent have a substance use disorder.²¹ Indeed, mental illness and substance use disorders often go hand-in-hand. Among an estimated 9 million U.S. adults aged 18 or older diagnosed with a serious mental illness, nearly 24 percent meet the criteria for substance use disorder; the rate for those with any mental illness is 16.5 percent.²²

Mental illness is more pervasive than homelessness. An estimated 488,520 adults and 154,724 children have a serious, persistent mental illness.²³

Since deinstitutionalization began in the 1960s, increasingly more people with mental illness have been coming in contact with the criminal justice system. A report on deinstitutionalization from 1971–1996 showed that people with mental illness who were discharged from state hospitals accounted for 4.5 to 14 percent of the expansion in the incarcerated population during that period.²⁴ In 2006, the Bureau of Justice Statistics estimated that “705,600 mentally ill adults were incarcerated in State prisons, 78,800 in Federal prisons and 479,900 in local jails.”²⁵

Texas county jails house around 60,000 to 70,000 inmates per day. On September 1, 2015, the Texas Commission on Jail Standards reports that 65,810 people were in county jail.²⁶ A 2009 study of U.S. jails found that 14.5 percent of adults entering jails met the criteria for serious mental illness.²⁷ If this holds true in Texas, county jails held about 9,542 people with serious mental health issues every day. With counties in Texas spending an average of \$59.65 per inmate per day,²⁸ this suggests an annual cost of about \$207.8 million for inmates with mental illness in county jails, not including cost of treatment or other extraordinary costs often associated with mental illness.

The Texas state jail and prison system had 150,361 people on hand on August 31, 2014 (136,460 in prison and 10,524 in state jail).²⁹ An average prison bed costs \$51 per day.³⁰ State Jail beds cost \$43 per day.³¹ Sixteen percent of these individuals are estimated to have a mental illness.³² By the logic described above, inmates with mental illness cost Texans about \$406.4 million for state prisoners and \$26.4 million for state jail inmates for an estimated total of more than \$432.8 million dollars each year. The remaining on hand state inmates are in Substance Abuse Felony Punishment Facilities and are all receiving behavioral health services. The 2014 budget for these facilities was \$57.4 million.³³ That adds up to well over \$500 million in cost for behavioral health services for people in Texas Department of Criminal Justice’s custody.

In 2013 over the course of the year, 51,901 people received mental health crisis services (this includes psychiatric hospitalization).³⁴ On a daily basis in the same year, about 40,000 people in the criminal justice system needed mental health services based on the estimates described above. These numbers support the commonly reported assertion that Texas’ jails and prisons have become de facto psychiatric hospitals.

People with mental illness draw higher costs while in prison and run a significantly greater risk of re-entering the prison system without ongoing treatment after release. A 2015 report found that only 11.2 percent of individuals with mental illness returned to jail after three years if they had more than a year of case management with the Texas Correctional Office of Offenders with Medical or Mental Impairments compared to 22.6 percent who fell back into the prison system within the same three year time-frame without case management.³⁵

Many people with mental illness who cycle through the criminal justice system also overuse emergency rooms.³⁶ People with mental illness tend to stay in the ER longer, which decreases access for others with medical emergencies.³⁷ In 2011, every time an uninsured person visits the emergency room (regardless of their mental health), it costs an average of \$986.³⁸ A more recent NIH study of ER costs for all diagnoses published in 2013 found that the median ER cost was \$1233, regardless of their insurance enrollment.³⁹ Although the ER cost estimates described in the preceding sentences are not specific to people with mental illness, emergency care for people with mental illness likely comes at a comparable price.

State Funding for Mental Health

The increasing use of prisons as mental health treatment facilities has captured legislative interest over the past two decades, illustrated by the \$82 million appropriated to the Department of State Health Services (DSHS) in 2007 to improve the state's delivery of mental health and substance abuse services.⁴⁰ The goal of the redesign was to cut costs and increase care by shifting mental health crisis delivery away from costly emergency rooms, prisons, and state hospitals. The costs of incarceration and ERs is discussed previously. But state hospitals cost nearly as much as emergency rooms and cost significantly more than incarceration. In 2014, the cost of a state hospital bed was between \$560 and \$955 per bed per day; contracted community hospitals and contracted private or university hospitals cost \$337-\$591 and \$449-\$605, respectively.⁴¹

Between 2006 and 2008, diversion of some patients away from state hospitals to community-based treatment alternatives resulted in a 20 percent overall program cost reduction of \$9.5 million—this does not include new capital costs.⁴² Yet the costs of treating people with mental illness remains high. According to a survey included in the report, 93 percent of Local Mental Health Authorities (LMHAs) indicated that so-called “crisis cyclers”—those who continually suffer mental health breakdowns without effective long term treatment—are an expensive burden on the state.⁴³ Texas needs to shift care from expensive institutional settings to more effective community-based care that will improve individual outcomes and be more fiscally sustainable.

In 2013, Texas' 83rd Legislature allocated an additional \$312.4 million to fund the expansion of mental health services.⁴⁴ “Appropriations were included to eliminate the waiting list for people seeking community-based mental health services and supportive housing programs, create a public awareness campaign, assist Texas veterans, expand the Youth Empowerment Services waiver statewide, establish a jail-diversion pilot program in Harris County, create a grant program for local collaborative projects, and to support other programs to strengthen the provision of state mental health services.”⁴⁵

Despite the Legislature's efforts to improve Texas' public mental health care system by boosting appropriations, the areas that received additional funding do not adequately address fundamental flaws in the current system, which over-relies on intermittent treatment, overlapping services, and inflexible treatment programs as compared to public-

private partnerships. Although funding grants for public-private partnerships that serve people who are homeless in the state's largest metro areas was a step in the right direction, state hospitals still consume nearly a third of the DSHS budget. For example, the appropriation of \$20 million was used to repair state psychiatric hospitals and \$10 million in bonds was used to renovate aging state hospitals.⁴⁶

Texas is consistently criticized for spending less on mental health care than other states,⁴⁷ but simply pouring additional funding into the existing mental health care infrastructure, or spending more on state prisons and county jails to treat people with mental illness, is not the solution. The problems that plague the current system do not arise from a lack of funding but from a flawed approach in the delivery of care. When problems like those associated with mental illness capture public attention, the default response is to expand government funding to correct the perceived market failures. But inflexible government policies are often the cause of the problem. This is nowhere more apparent than in the delivery of services to people with mental illness and people who are homeless.

A Better Response to Complex, Systemic Problems

Government failure in mental health care delivery is apparent in Texas. Bureaucratic legislation has resulted in inflexible systems of care that cannot adequately address complex individual needs. In cities with a diversity of programs related to mental illness or homelessness, quality of service and efficient delivery would improve if government oversight and regulation gave way to public-private partnerships or private organizations that are more flexible and responsive to individual needs.

For many years, Texas has focused on the most impaired when prioritizing treatment. The three major mental illnesses that Texas prioritizes are clinical depression, schizophrenia, and bipolar disorder. Through the lens of the medical model,* the “Big 3” often require more than merely short-term or episodic medication for effective treatment. According to the National Institute of Mental Health, depression is a disorder of the brain most likely caused by a combination of genetic, biological, environmental, and psychological factors that is experienced by 6.7 percent of the population each year. Many people who experience depression never seek treatment, but treatment generally consists of medication or psychotherapy and has varying results.⁴⁸ Schizophrenia affects about one percent of the population. Its causes

* The medical model is an approach to treatment that defines recovery from a mental illness as symptom reduction and reduced need for treatment. In contrast, the recovery model is an approach to treatment that defines recovery from a mental illness as the improvement of a person's quality of life and level of function despite the illness.

are unknown, so only the symptoms can be treated. Typical treatment requires long-term use of powerful antipsychotic medications that often compound the illness with resulting co-morbid mental health and substance abuse problems.⁴⁹ Scientists have yet to discover an effective cure for bipolar disorder—an ailment that can only be rendered less destructive through long-term treatment, including medication and psychotherapy.⁵⁰ Treatment for such mental illnesses becomes increasingly difficult if they remain untreated or undiagnosed. Because treatment is complex and requires flexibility, people would receive higher quality, more tailored services if providers were not bogged down by government bureaucracy.

Mental illness can be debilitating and it may require intensive and collaborative medication regimes, consistent therapy, community support, faith-based intervention and, above all, time. The Texas model is based largely on the medical model of mental illness. But in recent history, nationwide more providers, advocates, and policymakers are shifting toward a system designed around the recovery model. The recovery model is based on the notion that people can and do recover from mental illness and substance abuse and deserve to live meaningful lives in the community. Haven for Hope, described below is such a system. And though it was designed to help people transition out of homelessness, the model has broader implications for helping people with serious mental illness or substance use disorders get a second chance at life.

However, chronically homeless individuals only comprise about 15 percent of the homeless population nationwide and 17.4 (4,952/28,495) percent in Texas.⁵¹ Solutions that might help people who are chronically homeless, might not help most people who are homeless or might help this subpopulation to the detriment of others. And similarly, solutions for people with serious mental illness, who comprise about 4.2 percent of the U.S. population,⁵² solutions for people with the most serious mental illness may not be appropriate for people with less serious disorders or co-occurring disorders. Chronic homelessness and mental illness are both complex problems affecting some of the most vulnerable members of our society. Although these groups are small portions of our population, the people matter and deserve hope and dignity. These small populations also tend to effect society because they consume many public resources provided by the government and give rise to occasional public safety concerns.

Our policies should treat people experiencing these problems like people, which does not mean abolishing poverty or homelessness or mental illness—that would be impossible.

But we should be looking for ways to help as many people out of those problems as possible, not by perpetuating dependence on government resources and government programs, but by giving people a chance to take responsibility for themselves, and learn and grow and thrive.

Our policies should treat people experiencing these problems like people, which does not mean abolishing poverty or homelessness or mental illness—that would be impossible.

House Bill 3793 Advisory Panel

The 83rd Texas Legislature passed House Bill 3793 to help DSHS make a long-term plan for the proper allocation of outpatient community-based services and state hospital beds.⁵³ The advisory panel met at least monthly to develop a plan that they must update the plan biennially.⁵⁴

The HB 3793 Advisory Panel strategized ways to “provide timely access to appropriate care at the local level.”⁵⁵ The panel was directed to develop a system that maximizes the use of community-based alternatives to state psychiatric hospitals.⁵⁶ Hospitalization is expensive, and hospitals have limited capacity.⁵⁷ Only people clinically or legally necessitating hospitalization should be receiving such intensive care.⁵⁸ Others should be treated in the community or discharged to community-based programs once they are stable.⁵⁹

In fact, the American Disabilities Act (ADA), created a positive right to community-based care when appropriate. In *Olmstead v. L.C.*, the U.S. Supreme Court reinforced this right in 1999 holding that “unjustified isolation” of people with mental illness is discrimination based on disability. The Court reasoned that “[i]nstitutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Additionally, community-based care is generally cheaper and more effective than institutional care when possible.

Although the panel’s objective was to find ways to increase community capacity and national law dictates that care must be provided in communities when appropriate, the panel resorted to a quick fix to address “urgent needs” and recommended additional hospital beds, thereby increasing institutional care rather than community-based care.

Merely ramping up state hospital capacity in lieu of expanding community-based services will not help individuals move into recovery or alleviate the extrinsic burdens on society. Texas instead must improve management of existing capacity and attempt to close state hospitals. People should be hospitalized only out of clinical necessity or legal mandate, and community-based alternatives should be used whenever possible. This approach will save taxpayer dollars. Every acute care admission avoided saves the state \$200,000 annually; reducing average acute care length-of-stay by one day saves the state \$1.6 million annually.⁶⁰ Incentivizing community-based alternatives also helps the system better balance quality, cost, and value by keeping people out of hospitals when they are safe and stable and allowing them to pursue recovery in the community.

Consumers should have a more active role in their health care because more active consumers have better outcomes over time.

The panel made its recommendations based on consultants who suggested that Texas needs about 4,400 beds and 50 new beds per year to account for population growth.⁶¹ Currently, DSHS funds about 2,900 psychiatric beds in Texas, including state hospital and community beds.⁶² If DSHS purchases 1,500 beds at the current average cost for state hospital beds, it would cost over \$300 million annually.⁶³ But adding state hospital beds is not the answer. Instead of spending money on state hospital beds, we should focus on developing capacity within communities based upon regional needs, leveraging public-private partnerships for the delivery of care, and ultimately helping people move away from government assistance. Until people are able to live independently, community care, is generally cheaper and provides more effective treatment than state hospital beds.

SB 58 Behavioral Health Integration Advisory Committee (BHIAC)

Texas' 83rd Legislature passed Senate Bill 58 in 2013, which created the BHIAC to provide formal recommendations to the Health and Human Services Commission regarding planning and development needs of integrating Medicaid behavioral health services, including targeted case management, mental health rehabilitative services and physical health services into Medicaid managed care, by September 1, 2014. Although focused on Medicaid programs, BHIAC's recommendations are relevant to health care integration in all state-run programs.

Comprehensive treatment is necessary because a person's behavioral health conditions do not exist in a vacuum. Physical health conditions can exacerbate behavioral health conditions and vice versa. Integrating behavioral and physical health should improve quality of care and help control the overall cost of health care. Fifty-eight percent of Texas' adult population has a medical condition,⁶⁴ and 25 percent have a mental illness.⁶⁵ These two groups overlap significantly: 68 percent of adults with mental disorders have medical conditions, and 29 percent of adults with medical conditions have mental disorders.⁶⁶

People with co-occurring conditions tend to be more expensive.⁶⁷ Eight-seven percent of years of life lost in Texas are due to a physical illness, yet⁶⁸ treatment compliance is more difficult for people with mental illness.⁶⁹ For example, the non-compliance rate for depressed patients is three times higher than for non-depressed patients.⁷⁰ These non-compliance issues significantly contribute to the lower life expectancy of people with mental illness.⁷¹ On average, people with mental illness die 25 years younger than those without.⁷²

Consumers should have a more active role in their health care because more active consumers have better outcomes over time.⁷³ Research shows that 80 percent forget what providers say, 33 percent are unable to read provided health material, almost 50 percent of what patients remember from a health care appointment is incorrect, and 26 percent cannot understand information on appointment slips.⁷⁴ Because health care providers are not available to make decisions for their patients on a day-to-day basis, educating patients on and including patients in decision-making is essential to improving quality of care.⁷⁵

Increasing provider choice by increasing private sector participation is vital to improving behavioral health services. Provider networks should include a wide array of community-based treatments that meet individual needs.⁷⁶ Some of these treatments might include peer services, crisis respite, crisis observation, crisis residential, intensive outpatient care, and partial hospitalization.⁷⁷ Community based behavioral health services are more cost-effective than hospitalization. The average cost per day for community-based services is \$12 for adults whereas⁷⁸ state hospital beds cost \$401, jails cost \$137 for an inmate with mental illness, and emergency room visits cost \$896.⁷⁹ In addition to cost, these services are less restrictive for individuals and often more effective.⁸⁰

Texas has a shortage of behavioral health professionals, which contributes to endemic problems patients face with access to care.⁸¹ Low Medicaid reimbursement rates are not the only reason provider networks lack adequacy. Adminis-

trative complexity also deters providers from participating in MCOs' networks.⁸² Simplifying the administrative processes for providers should increase provider choice and access.⁸³

Oversight is also critical. HHSC has a responsibility to oversee operations and to have processes in place to assist patients, providers and advocates with a complex system. The state's most important responsibility is to ensure transparency and accountability in the system.⁸⁴

Haven for Hope

In 2005, San Antonio businessman Bill Greehey began researching models and best practices nationwide to address the growing homeless population in Bexar County. He found that continuity of care was vital, a campus-style environment is most effective, and the facility must be managed by an independent board of directors rather than the government. With Mr. Greehey's leadership and the support of private and public (local, state, and federal) funds, Haven for Hope opened in downtown San Antonio in 2010, providing a residential and service space for the homeless of Bexar County.

The center employs a unique incentive system: newcomers start out by sleeping in an outdoor courtyard, and they earn more personal space and belongings as they progress through treatment. When individuals are brought in by local law enforcement as an alternative to incarceration, they are given a chance to enter voluntary treatment through the Restoration Center, a substance abuse and detox center led by Leon Evans and the Center for Health Care Services that works in conjunction with Haven for Hope. Working with a host of local partners, Haven for Hope offers comprehensive health care, including a medical clinic, dental clinic, vision clinic, podiatry clinic, immunizations, as well as mental health and substance abuse treatment programs.

Although no academic or government studies have analyzed Haven for Hope's outcomes, undocumented self-reports indicate positive, dramatic results from Haven for Hope's incentive-based, continuum-of-care approach. These reports claim thousands of people have been served at Haven for Hope. They also assert that the homeless population has decreased significantly in downtown San Antonio along with crime and recidivism rates.⁸⁵ Haven for Hope attributes \$50 million in savings or cost avoidance to these reported successes,⁸⁶ claiming the Restoration Center alone saves more than \$10 million every year.⁸⁷

Many of the benefits of the program are the result of diversion efforts by local law enforcement. Officers are trained to bring public intoxicants to the Restoration Center rather than placing them in costly jail cells or emergency rooms.

Haven for Hope officials then engage every individual with "motivational interviewing" and offer them voluntary admission into the Haven's substance abuse treatment program.⁸⁸

A key to the program's success has been to focus resources on treating the root causes of homelessness through job training and employment readiness, education, behavioral health services, spiritual services, and more. Among Haven for Hope's seven guiding principles are: reward positive behavior, impose consequences for negative behavior, and prohibit panhandling. Perhaps most important is the first principle: "Move to a Culture of Transformation (versus the Old Culture of Warehousing)." The idea behind Haven for Hope is to equip people with the skills needed to change their life, so they can go on to lead happy, independent lives rather than rely on handouts from panhandling or the government. It's designed to give people purpose and dignity and a real second chance instead of perpetuating dependence.

This experiment in addressing the root causes of homelessness has been hailed as largely successful. Since opening in 2010, Haven for Hope's sprawling, 37-acre facility has been visited by some two hundred cities from forty-four states, as well as former U.S. Secretary of Health and Human Services Kathleen Sebelius, confirming its recognition as a model for mental health delivery reform—not only in Texas, but nationwide.

Haven for Hope has also benefited the county's Crisis Care Center. Thanks to cooperation between law enforcement and the local Center for Health Care Services, San Antonio police officers are now trained to recognize signs of psychological disorders and engage in crisis intervention during response calls.⁸⁹ Because of the Crisis Care Center, police officers can offer uncooperative individuals treatment in a clinical setting rather than sending them to the city or county jail. Not only is it less expensive, but such treatment centers do the utmost to address and resolve the root causes of the physical and mental health problems that many homeless people face, which often involve mental illness, substance abuse, or both.

Haven for Hope uses integrated health that entails closing the medical gap between mental and physical health, recognizing the connection between mind and body. Although considerable barriers to integrated health still exist in Texas, such as a lack of psychiatric training for chronically overworked physicians,⁹⁰ Haven for Hope provides case management and co-located mental and physical health facilities to accelerate recovery.

Much of this innovation is possible because Haven for Hope is a private entity funded by a combination of public and

private dollars and run by an independent board that in some instances can circumvent government inefficiencies. More efficient care allows for more innovation, which could further improve the quality of care. Its FY 2013 operating budget was \$15.5 million—23 percent from the City of San Antonio, 23 percent from combined state, county, and federal government sources, and 54 percent from private donations and grants.⁹¹

The passage of Senate Bill 58 by the 83rd Texas Legislature allowed the establishment of up to five community collaboration grants in the state's most populous municipalities. The funds are designed to encourage public-private partnerships that provide services to the mentally ill homeless, and come in the form of matching-funds grants (contributions from public-private partnerships must equal the amount of the state grant). This approach could encourage counties and municipalities, along with interested parties in the private sector, to create programs like Haven for Hope in Texas.

Haven for Hope as a Model

Texas government does not have enough money fix the problems surrounding mental illness. Currently, about 80,000 people receive community mental health services each month.⁹² With around 1 million people receiving state-funded mental health services each year we need a better solution.⁹³ Texas has many charities and private sector participants that provide mental health services. But these private sector organizations do not currently have the infrastructure to meet the high demand for services. Texas should examine ways to expand both private and public-private and secular-sacred partnerships to meet the vast need for behavioral health care.

As more counties begin to make changes in mental health care delivery through jail diversion and other programs, Haven for Hope can serve as a model. Haven for Hope is guided by seven principles of transformation: (1) move to a culture of transformation, (2) co-locate and integrate as many services as possible, (3) possess a master case management system that is customized, (4) reward positive behavior, (5) impose consequences for negative behavior, (6) redirect activities that enable homelessness, and (7) stop panhandling.

Moving to a culture of transformation requires engaging program participants in productive activities. At Haven for Hope, 78 nonprofit, faith-based, and governmental partner agencies provide a wide-array for critical services to the homeless and surrounding community. In addition to providing basic food and shelter, health care services, including medical, dental, vision, mental health, substance abuse detoxification and drug treatment, hospice, nutrition, immu-

nization, and other preventative health care, are available.⁹⁴ Other services include job training and job search support; education opportunities; financial counseling; legal services; spiritual care; specialized services for veterans, sexual violence victims, HIV/AIDS patients, ex-offenders, pregnant teens, disabled people, and pet owners; childcare; barber services; exercise; and more, are also available.⁹⁵ Many services are also available to qualifying individuals who are not homeless.⁹⁶ These different services all work together to help homeless individuals gain self-sufficiency.

Having a one-stop shop of supportive services promotes efficiency and effectiveness in delivery of care.⁹⁷ To ensure coordinated and comprehensive service, Haven for Hope uses the Case Management Tracking System.⁹⁸ This software tracks the services provided to homeless people to monitor effectiveness.⁹⁹ This system also helps case managers customize services to provide the most effective care for unique individuals.¹⁰⁰ Additionally, having a single integrated location has reduced rent and overhead cost, expanded service capacity, increased resources for services providers.¹⁰¹ Better coordination among these providers has also made service more effective.¹⁰²

A program designed to help people with mental illness should be person-centered and recovery-oriented. Like Haven for Hope's shift to a culture of transformation, recovery-oriented care would help people discover a fun, fulfilling life.

A program designed to help people living with mental illness should be person-centered and recovery-oriented. Like Haven for Hope's shift to a culture of transformation, recovery-oriented care would help people discover a fulfilling life. Currently many people with mental illness are expected to live out their lives on benefits checks.¹⁰³ Billions of taxpayer dollars are spent every year on programs designed to help people living with mental health challenges. Unfortunately, these programs often do not help people with mental illness regain self-sufficiency and dignity.^{104*} Many people recover from serious mental illness over time, and others can learn how to manage their disorder.¹⁰⁵ Being in recovery from mental illness means learning how to live a safe, dignified, and gratifying life in the face of enduring disability.¹⁰⁶ Hence, the goal of any program should be to help people with mental illness return to a productive life in the community.

Recovery, moreover, is the responsibility of the individual with mental illness, not something that can be done to or for people. Any care provided to people with mental illness should be geared toward helping individuals pursue their own life, liberty, and happiness.

The Restoration Center, which is a partner organization in Haven for Hope and co-located on the campus, offers many of the recovery-oriented services discussed above specifically for people with mental illness and substance use disorders. The center has a 48-hour inpatient psychiatric unit, outpatient services for psychiatric care, drug and alcohol detoxification treatment, and a 90-day recovery program for substance abuse. These programs help people with acute needs. The Restoration Center also has a full range of mental and physical health services, housing for people with mental illnesses, and job training to help people manage their illnesses and stay out of jails and hospitals.

Haven for Hope also works to stop societal behaviors that enable homelessness like panhandling. A program that focused primarily on mental health could focus on reducing stigma, which often discourages people from seeking service and could limit opportunities to work or find housing.

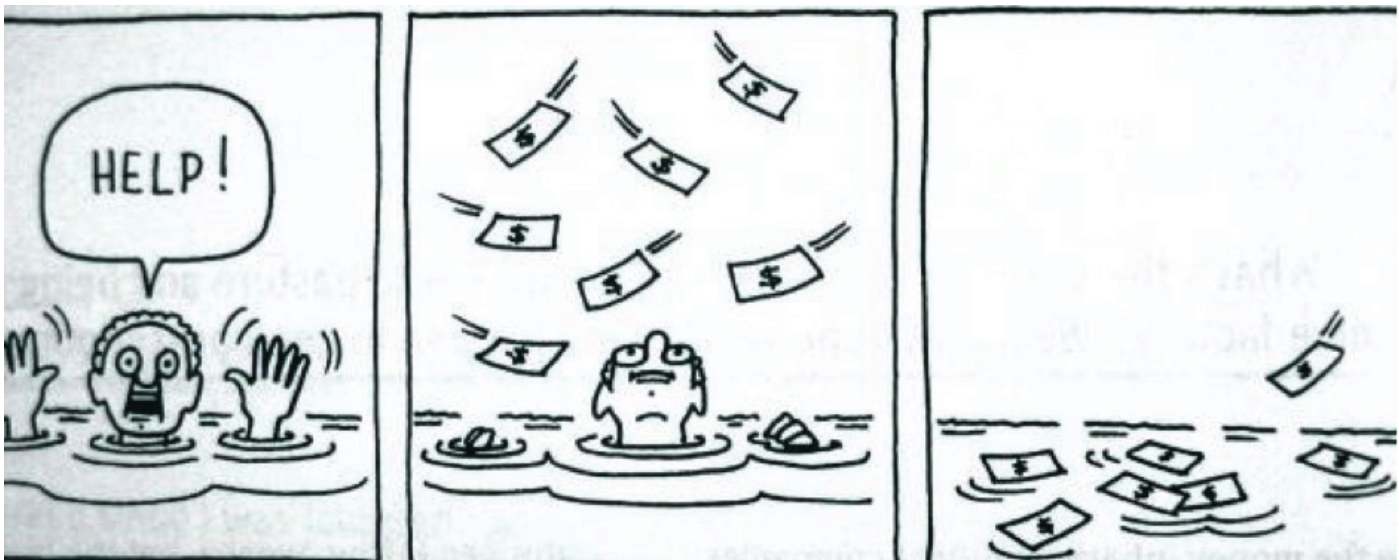
In addition to these seven principles, Haven for Hope determined that the facility should be managed by an independent board. Independent management allows Haven for Hope to be free of political influence and red tape. The creators of Haven for Hope found this autonomy essential to the effective and efficient delivery of services.¹⁰⁷ This element could easily be replicated in other programs and should be. Government-only solutions are inflexible. Lasting, effective reform requires a greater role for private

organizations free from the distortions of government micromanagement. The current philosophy of spending more does not mean providing more quality care. Private-sector involvement, as seen with Haven for Hope, has led more effective care than government-centered solutions.

Programs designed to assist people with mental illness should consider how contingencies could be used to promote recovery. Contingency management techniques reward good behavior (i.e., adherence to treatment and abstinence from substance use) and impose consequences for bad behavior. These techniques have been successful at Haven for Hope where many of the homeless people served experience mental health challenges and substance use disorders. Some studies show that participants in treatment with contingencies were more likely to abstain from drugs, obtain stable housing, and gain employment.¹⁰⁸ And perhaps most importantly, Haven for Hope participants pledge sobriety and pledge to avoid welfare services and government welfare for two years as they move from their lives on Haven for Hope's campus into a new beginning full of hope and free of government assistance.

Housing First

“Housing First,” also called “Permanent Supportive Housing,” has been touted as the solution to chronic homelessness. Under this model, housing is permanent because it is not time-limited or contingency-based, meaning the person receiving supportive housing can stay as long as they need and is not required to be sober or to participate in treatment, job training, or any other activities unless they want to. Housing is supportive because a case management team encourages treatment and other supportive services,



* Patricia E. Deegan, [Silence: What We Don't Talk About in Rehabilitation \(June 14, 2005\)](#)

and such services are available to housing recipients if they choose to pursue them.

Housing First propagates the notion that housing is a human or civil right. Indeed, some believe that homelessness is the most egregious human or civil rights violation in the United States today,¹⁰⁹ and that all people should be in a home of their choosing with support for a disability if necessary. Housing First proponents further believe that each person should be in scattered housing (meaning no group homes, congregate arrangements, multi-unit buildings or complexes primarily for people with disabilities), and housing should not be conditioned on compliance with a service plan.

This policy has some limited benefit. It has been proven effective for housing retention and cost savings in a number of studies and seems to be an especially useful intervention for people with mental illness but no substance abuse problems. Utah's adoption of Housing First is an example of how this approach can work. The state has reduced homelessness by 72 percent since 2005 and has nearly eliminated chronic homelessness and veteran homelessness.¹¹⁰ And a plurality of people without homes in Utah are utilizing permanent supportive housing services.¹¹¹ Utah focused on chronic homelessness—even though this group comprises less than 5 percent of Utah's homeless population—for three reasons: (1) they are the most vulnerable, (2) they present the greatest opportunity for cost savings, and (3) they use the most resources.¹¹² State officials estimate that for each chronically homeless person housed, the state saves \$8,000 across community systems and is able to serve an additional 2.4 temporarily homeless individuals.¹¹³ They also believe that coordination and planning has improved because this group is easily identifiable and crosses many services systems including emergency rooms, hospitals, and jails.¹¹⁴

Utah's permanent supportive housing, like other housing first solutions, focuses on strategic planning, housing, supportive services, emergency services, and discharge planning.¹¹⁵ However, strategic planning is likely the most significant piece of the puzzle. Strategic planning includes better coordination of providers across systems and resources as well as system change based on performance measures. The measures of success Utah uses are: increased tenure in housing, increased employment, increased access to mainstream benefits, and reduced episodes and length of homelessness.¹¹⁶ No one would argue that increased housing retention and employment are solid outcome measures. But Utah's system is flawed in recognizing increased access

to government benefits as a positive performance measure. This measurement views dependence on government services as a desirable outcome.

If the policy goal is simply to get people off the street and get them government benefits, Housing First works, as demonstrated in Utah. But if the goal is to help people experiencing homelessness take responsibility for themselves and become self-sustaining and free from government welfare, Housing First fails. A "linear approach" like Haven for Hope, which requires sobriety and independence, is a more effective policy for reducing both homelessness and dependence on government welfare. Linear approaches are based on theories of human behavior change and assume individuals are capable of returning to independent, long-term, stable housing. Such an approach requires behavioral self-regulation, or personal responsibility for actions and choices, to reach this goal.

If an individual's mental illness is so severe that it makes personal responsibility impossible, Housing First could be a good solution. But a growing body of research suggests that people with mental illness are more fully capable of making wise decisions that will help them achieve recovery than was previously thought.¹¹⁷ In fact, Housing First is premised on the idea that if basic needs (housing, food, etc.) are met then people will make the choice to seek recovery. Undoubtedly, a linear approach to housing is difficult. Not all people will choose treatment, and not all people will succeed in a linear model even if they choose treatment. Failure is unfortunate, but also part of life. Being given the dignity to fail is not only part of pursuing a meaningful life, it is absolutely necessary.

Although a linear approach makes long-term housing success less likely, it does not preclude such success. Additionally, a linear approach may do more to help an individual live a life free from government intervention, interference, and dependence. Studies have shown that certain linear models reduce psychiatric impairment, reduce substance use, improve employment opportunities, and improve housing outcomes.¹¹⁸ Two models in particular stand out. The first is a therapeutic community, the second is the Birmingham model. Oxford House is like the therapeutic community model. These programs offer social treatment for substance use disorders in a residential setting.¹¹⁹ In this model, people learn how to correct antisocial behavior through structured, sober, group living.¹²⁰ Haven for Hope is like the Birmingham model, or abstinence-contingent housing. In this model, people re-

ceive housing in exchange for treatment compliance and/or employment.¹²¹ It is based on the idea that incentives drive behavioral change. There must be consequences for choosing substance use or making other harmful decisions. People are rewarded for making wise decisions that further their recovery effort and lose opportunities when they make poor decisions. This is not easy, but it helps people learn to take responsibility for their choices and increases the likelihood that recovery and independence will be long-term.

The policy goal of any housing or treatment program should be independence. Housing First, like many government welfare programs, fosters a culture of dependence. It might move people off the street, but the now-sheltered individuals often face the same substance use and mental health problems, only without accountability for treatment or recovery. It does not fix their problems or give them a chance at an independent life. Instead, it hides them from public view and teaches them to continue to rely on government services. Taxpayers should not be subsidizing housing for those who choose substance abuse and fail to comply with treatment and employment programs. Addiction behind closed doors is still addiction. It may be less expensive for taxpayers because those experiencing addiction are shielded from jail and emergency services. But if individuals refuse treatment in a Housing First program, should taxpayers continue to pay for their harmful choices?

A model like Haven for Hope is more effective. Participants do not have to prove housing readiness, but are rewarded for progress and treatment compliance, and there are consequences for poor decisions—just like in real life. The policy goal has to be more than just getting people off the street into a more stable environment. Housing First participants use substance use and psychiatric services less than those with linear interventions, and housing retention is better, so it is called a success. But it is only a success according to the narrow terms of the goals underlying the policy, one of which is to promote dependence on public benefits, albeit at a lower cost than services provided in an institutional or emergency setting.

Conclusion

Funding for mental health should encourage innovative, successful treatment facilities and integrated programs that result in substantial taxpayer savings by diverting individuals in need of care away from expensive state hospitals, corrections facilities, and government welfare. For the homeless population, independently run campus-style facilities that coordinate mental illness and substance abuse treatment, support, and other services in a residential, community setting are more effective at addressing the root causes of homelessness and thus empowering homeless people to achieve self-sufficiency. For people with mental illness, a similar model that helps coordinate inpatient and outpatient mental health care could be effective.

Haven for Hope—a privately operated program funded with more than 50 percent private dollars—is a model for an effective system of care. This public-private partnership works closely with local law enforcement and social service agencies. Haven for Hope has brought public and private services to provide a unique, extensive system of care.

This integration of social services, housing and shelter, treatment and counseling, together with Haven for Hope's conceptual framework to treat the root causes of homelessness—including its willingness to reward positive behavior and impose consequences for negative behavior—constitute an approach to homelessness that is able to transform lives. A similar integrated, transformational system could benefit people with mental illness across the state.

As Texas works to efficiently direct mental health funding and delivery, lawmakers must find ways to move away from institutionalization—whether in state hospitals or county jails—and instead encourage the creation of local, private programs that are able to integrate existing public services and mental health providers into a holistic, principled approach to homelessness, mental illness, and substance abuse. Such programs work—just ask any of the thousands who have turned their lives around at Haven for Hope. ★

Endnotes

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