Community Mental Health

House of Hope

Melissa R. Olson

Department of Psychology,

Mount Saint Mary's University

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Dr. P. Heul-Brown, PhD

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The House of Hope is a women's addiction treatment center located in San Pedro, California. Originally the House of Hope was established in Long Beach, California in 1955, but in 1971 after funds were raised; Helen Gilbert acquired the House of Hope that is now the main "House" used for inpatient care. In addition to inpatient care, House of Hope also provides care settings and services which include Recovery Bridge Housing (RBH), outpatient services, independent living, and sober living to the population focus of women within the community, court ordered, and homeless population of women. House of Hope (HOH) offers a variety of treatment plans for both adult and young adult programs that treat alcoholism, opioid addition, mental health, and substance abuse. Overall, there are 86 beds. HOH aims to create a supportive, welcoming, and nurturing environment upon which each of the women's journey to recovery begins.

To receive services at HOH, clients have the option to self-pay, receive financial aid to cover charges, Medicaid, private insurance, or monthly cash pay for $2,700. The House of Hope is a non-profit organization. Funding to maintain this organization is received is by grants, charity donations (Tax ID 95-1868767), and fund raising. Since the initial main house was acquired in 1971, they expanded their services provided RBH, a building for outpatient services with additional beds, and sober living housing for the women which span in development from 1996-2019. The progression to acquire this multi-level treatment center by means of identifying as a non-profit is quite remarkable and is apparent of the successes within the small city of San Pedro. It began to expand in 1996, a house later named the Welborn House on 9th street (two streets from the main "House") and is used for Independent Living for the HOH gradates and was acquired from a women named Dortha who later was appointed as Board Member Emeritus in 1999. The following year, in 1997 the HOH was able to purchase its first property which was

became a Sober Living Facility located on 10th St. (three streets from the main "House"). It later became known as the McMillian House. Two years later in 1999, joint efforts of the Adams Foundation and Bill Johnson, HOH acquired another property adjacent to the main "House" and after a team of volunteers converted the liquor store building into an office space for computer labs, executive offices, rooms for classroom and meetings, it later became known as the Adam's Center. In 2019, through the generosity of the Manillian Foundation, HOH acquired another property later named the Bobbi House and was able to provide a Recovery Bridge Housing Program, which houses homeless women that are in this specific three-to-six-month program. And most recently in 2000, HOH purchased their second property known today as the Mary Lou House which is used to house Sober Living and Primary Phase II in the program.

The House of Hope's mission is *"to help women to regain their dignity and learn how to live without alcohol and drugs. We at the House of Hope know that substance abuse, the interactive disease of alcoholism and drug addiction, can never be cured. We know that the disease can be arrested, given time with an encouraging environment, educational tools, knowledgeable support groups and, most importantly, the women's sincere desire to change their life"* and a chance to learn about the disease of addiction, to find their strengths, regain dignity, and once again live a meaningful life filled with purpose. HOH is proud to offer life changing and lifesaving treatment that is within your means (https://houseofhopesp.org/).

Goals of HOH varies of the level of treatment plan you are receiving. For Inpatient, the team focuses on providing a foundation for the women that include coping skills, individual and group therapy, life skills, peer support, and a sense of community in their path to recovery. They mention that the best way to achieve recovery is in a structured, comfortable, respectful environment, and in addition to a substance free living environment that includes 12-step

activities. The program at HOH can last up to ninety days, and the first two weeks the clients are placed on a restriction which mean no visitors nor phone calls for them to detox, refocus, and ground themselves in their treatment plan.

The Program's success' is that the HOH is listed with The Substance Abuse and Mental Health Services Administration (SAMHSA), which is a branch of the U.S. Department of Health and Human Services. The HOH has not failed a county nor state licensure inspection. I had asked Adara (the therapist whom I interviewed at this site), if other facilities have; and she mentioned some have and have been closed as a result. HOH is Accredited by DHCS (California Department of Health Care Services), GuideStar Exchange GOLD Participant, County of Los Angeles, CARF Accredited ASPIRE to Excellence House of Hope has been awarded a third three-year accreditation by CARF International for Intensive Outpatient Treatment: Alcohol and Other Drugs, Addictions (Adults); Outpatient Treatment: Alcohol and Other Drugs Addictions (Adults); Residential Treatment: Alcohol and Other Drugs / Addictions (Adults). CARF accreditation demonstrates House of Hope's quality, accountability, and commitment to the satisfaction of the population they serve within the community. CARF (Commission on Accreditation of Rehabilitation Facilities) International is an independent, nonprofit accreditor of health and human services providers in the areas of Aging Services, Behavioral Health, Child and Youth Services, Durable Medical Equipment, Employment and Community Services, Medical Rehabilitation, Opioid Treatment Programs, and Vision Rehabilitation Services (www.carf.org.).

Ways that HOH is affecting the community in a positive way, the HOH has remained in the community for many years and is well established. HOH has remained a non-profit organization, HOH is community orientated, very strong outside relationships and bonds,

strong alumni support network, and many say that it feels different here (the vibe is much different than most treatment facilities that they have experienced).

When I asked Adara how she felt ways that HOH was affecting the community in a negative way; she hesitated at first because factually there is not a response that HOH is having a negative impact. But she did mention stigma. She said there is always going to be people in the community that view addiction and substance abuse treatment facilities in a negative way, and especially since of HOH's properties are residential in appearance, they come with the stigma of drug users, homeless populations, and a slew of words that are stigmatized to this population. She mentions they try to remain involved in the community to be transparent and help to be a positive and have to women give back at volunteer events while in treatment if an event arises.

The following are the evidence-based treatment interventions that have been effective in the treatment plans and recovery of the population served at HOH. First is Cognitive Behavioral Therapy (CBT). Adara finds this therapy modality useful in this population as this helps the women to be able to identify their thoughts, feeling, and behaviors they are experiencing. She helps them to replace their unhealthy responses to what they identify with teaching them what healthy response look like and to be able to practice theses skills in a safe and supportive space. By doing this they can slowly be able to self-regulate and gain self-awareness. Group therapy is used often with specific aims of modalities throughout the day. It depends of the level of education or experience of the counselor who is leading the group as to which group therapy modality will be led. But it is a good way to have the women share their experiences and relate to one another, especially when it involves processing between the women. Life skills is another form of therapy that helps train the women in developing these skills. This therapy modality is used in the group therapy setting and teaching the women how to improve their communication

skills, better manage their time, bring out their positives in how they would focus those skills into a career after treatment, parenting skills, and financial management. It is essential the women learn these skills, as unfortunately many have not learned these skills; having strength in this plays an important role in their sobriety.

Trauma therapy is individual therapy with the client. Adara explores past traumas with the client to identify the root of the trauma and the relationship with the trigger and the addiction. Many times, it is from childhood traumas such as sexual, physical, or emotional abuse. Most times clients are victims of domestic violence or have been in the past. In the homeless population the women have experienced human trafficking which many times is what led them to their addictions due to their abuser consistently drug inducing them. In addition, they also are very paranoid and have developed co-occurring disorders as well. Overall, the aim for her working with the women using this modality is to process their trauma in a safe space and to be able to move past it with the help of her by providing compassion to each of the women. She mentions couples and family therapy as she feels this is such an important aspect within the client's treatment and recovery. But she finds it difficult at the inpatient level to have full participation of families and partners of the women. She did explain that when she is able to work within a family setting it helps to educate the family and by involving them and it makes a huge difference in the client's recovery outcomes. And when having the children present during the therapy, she like to use play therapy, as this gives a chance for the children to have a safe place to express emotions and build back the relationships. In the last couple years, she began implementing Eye Movement Desensitization and Reprocessing (EMDR). She finds that in this population it renders positive results. Specifically, since many women at HOH have complex traumas, it helps them to reprocess the traumatic experiences and the emotional stress associated

with, and along with other skills they are learning the help regulate and process their emotions it is another safe place having them here to explore and process through past traumas. And every week the women attend Zoom meeting for NA and AA and participate in The Twelve Step program, as well have an outside sponsor that each visit with. Adara also mentioned some other common therapies such as motivational interviewing, but I was most interested in listening and learning of her experiences and insight regarding the women's traumas and SMI's. Overall, the therapies that Adara and the other counselors work with the women and teach them what it looks like to manage their addiction and most times the co-occurring SMI, it helps to show them how to manage daily life day by day so that they will be prepared for when they complete the treatment plan and move onto the next step.

The overall expectations of clinicians in this position are that Adara oversees all inpatient therapy, provides individual therapy, interdisciplinary team meetings, reviews client charts, and ensures inpatient staff side of HOH is following regulations. Dr. Marick, MD is the HOH designated medical doctor who sees the women upon admittance at his office to perform a medical physical to address health concerns. HOH has a Director that is onsite on the inpatient side that works along with the CEO of HOH. There are five support staff members on the inpatient side, one cook, three substance abuse counselors, Adara (LMFT), and Barbara (LMFT) who is the therapist on the inpatient side and outpatient side as well. Every Wednesday is the interdisciplinary team meets, as Adara mentions "it's all hands-on deck"; which they discuss in length of client concerns and progress of treatment plan. In the executive building, the CEO Maricela oversees the entire operation and visits sites daily, there is a compliance officer Coco that also handles the billing, and Ana who oversees Intake at all facilities, schedules appointments, screens over phone to see if clients qualify to receive services through HOH.

HOH staff and executive team is culturally competent Adara strongly agrees when I asked this question. They can meet and exceed the unique and diverse needs of each of the women that are receiving treatment. Many times, they have women experiencing psychosis, women that have just been in prison, women form a domestic violent partnership, women homeless that are detoxing, and she prides in that her, and her team are competent that they can provide a safe environment to meet the needs of each of the women and to also keep harmony with the women in the House to all that is taking place around them. The women often mention it feels like a family and is inviting and very welcoming when they arrive. And much of the feedback and results they see from the women's success in recovery after reflecting the ability in their cultural competence working with such a diverse group and population of women.

Adara favorite aspects of her job is she's passionate about helping the clients at House of Hope, her most favorite aspect is being able to help the women in whichever way she can and to make a positive difference. There is not one day she mentions that is not like the previous day, it is always exciting and always learning something new in the field. She especially takes interests in being able to work with the women experience co-occurring disorders because she loves challenges, and this is where she can truly see the rewarding work taking place by the recovery progress.

Some of the hardships with working within this populations and within a non-profit organization working in a community mental health setting is very rewarding overall. There are commonalities within most CMH with hardships one experiences, and I learned a greater insight into addiction CMH specific hardships. There are various forms of burnout. Burnout that is felt often, the burnout rate in the field, and burnout in general. Adara described a lack of selfcare. Though we each are aware of the need for and importance of selfcare, she mentioned that many

times during the day, the case load is quite busy and often you find yourself working through your lunch, not eating healthy, or after work you feel fatigue and rather skip taking time for a workout. Many times, it's difficult to balance the stress and a selfcare routine. Next, as I was aware of is the pay. She mentioned that if you are looking to make a high salary, CMH is not the setting. Explained more in detail is that as soon as you walk into the office and often you leave later than anticipated, its nonstop demands of the job; and for that and the dedication and time you put into your work, the pay is not equivalent.

Another hardship is when it comes to clients that are nearing the end of treatment and deciding to return to their homes with their families. She faces many barriers in terms of trying to set the clients up for a successful transition. Meaning that it's difficult to do with the resources that are readily or made available to you so they can continue and follow up and maintain their treatment care plan. If it is not set up for them before they leave, most times the clients will not set up their appointments and attend on their own after they leave. This also includes their medical appointments as well. Most women are still in the process of receiving medical care treatments; since when they first arrive the women are given exams that include mental health, medical, and dental and are addressed. It is quite common with their homeless population that if these follow-up appointments and medication refills are not set-up, they will not follow through afterwards.

As we began discussing further, I asked what changes she would make to elevate and improve patient care. She mentioned immediately a nurse practitioner and a clinical psychologist onsite. She expressed is difficult to manage the client's medication since they are not authorized to handle nor give advice regarding this. It takes a great deal of time away from the staff, time away from the other clients when they have a client that needs to see a doctor regarding

medication, transportation to get to the doctor's office at the urgent care to receive the care and then to the pharmacy to pick up the medication. Having a nurse practitioner would alleviate much stress and time in all aspects. Also having a clinical psychologist onsite aligns similar with the above concerns. It comes down to transportation, time, taking away from other client care, staff away from the office, and if they had a clinical psychologist onsite, they would know more so of the case and would be involved in the interdisciplinary team and be able to closely monitor and diagnosis accurately verses how the system is setup currently. The next response was an eye-opener, which its responses as this as to why I will be working in the CMH setting. Drug and Alcohol counselors need more educations for the duties and responsibilities they are required to perform. She notes that majority in the field have also been working for years and are not up to date with new trends in the field also. Overall, the counselors do not have sufficient qualifications to have the level of severe mental illnesses the clientele they are now serving because the street drugs are no longer the same. They are very limited in their training with handling severe mentally ill clients and when they experience psychosis. She stressed that we need more money in this field. Not just for pay, but for office supplies, transportation of clients, more aftercare, art supplies for art therapy, housekeeping items, and additional funds for upgrades to the kitchen.

When asked of the hardships and challenges, some of the responses provided by Adara I almost felt need to be investigated further as there needs to be a call to attention as there's so depth to what she had to say. A hardship is the influx of psychosis. They lack the staffing abilities to handle the amount of psychosis as a result in the change in street drugs they have seen over the last few years. Example made was, a woman a few years ago came in for methamphetamine addiction. The woman went through treatment and recovered. Recently the

women returned to inpatient, and it is very distinct that the women from a few years ago that return to inpatient a greatly impacted by the change and severity of what is now in the street drugs. Many times, some feel they are being filled on a reality television series, many are now schizophrenic, and recently in the past year they are seeing marijuana addictions with related psychosis to the synthetic marijuana. And lastly another hardship in this field is treating the homeless population. Many times, in the jails they behave a certain way to be placed in the psychiatric section of the prison. In prisons, she explains that they give inmates strong medications which places them in a "fog", and they have no concept of what is taking place around them. It is difficult to have an accurate diagnosis when a client is homeless, their files are inconsistent with many past psychiatrists and psychologists with various diagnosis'. It will take about 30-60 days before reaching an accurate diagnosis and that still does not give much time to monitor medication before they need to be discharged. They also receive many referrals from outside sources with limited number of beds, which makes it difficult not to be able to help every client in need of treatment. And advice she gave to be aware of is that many of these women fake their own suicides to get off the streets and have somewhere to live. They are extremely good at manipulating, so to make sure to learn how to read between the lines very well and to always research past reports on the clients, as well as if they have family members to reach out to ensure they are being accurate.

I enjoyed visiting the clinic, though I knew they had a residential treatment center in addition to the main "House", it was interesting to learn the systematic process of how the House of Hope operates and how it is broken down. It is a huge operation, more than I thought it was. And grateful for the time Adara took to show and explain in detail to me from each building to licensure, roles, responsibilities, and financials.

It was grateful for the time Adara set aside to meet in-person with me. I understand the high demands and her busy schedule. Initially I had requested an hour to meet and suprising the hour somehow evolved into a few hours. I feel I went in to meet with her at the perfect time. With the material we had covered in our course. I was familiar, fluent, and current when speaking with her. Which provided for our lengthy meeting. It was refreshing to understand what I have researched, experienced, learned, and we discussed in class aligned to Adara's responses. In addition, she brought up many other talking points and areas of interest that I was not aware of. It was quite thought provoking. It seemed like every day is something new and no two days were alike in this field. Which is something that draws me to this CMH. There's so much to learn when talking to someone with first-hand experience and that oversees the inpatient side of the organization. I was amazed and intrigued of the many stories she shared. And was also surprised of the many new trends that addictions and street drugs are new experiencing. It was also nice how she shared ways she connected with clients and their families, and ways she found to make therapy more effective within family systems, which much of what she said was thought provoking and got me to thinking how I would apply this in the future when I begin in the field.

I am committed to serving within a community mental health setting as I feel this is the area in which my experience, skills, and time would be most effectively useful. In this short time, I can feel the passion within myself when I am in this setting verses other clinical settings. As a scholar practitioner I will continue to research, and there is much to learn from the populations with this setting. There are many improvements systematically that I can already identify, and I am sure as I immerse myself further as a professional, I will be able to navigate and change policy to better in the way we manage and provide care in the community. I not only want to solely focus on the clients, but also on the support staff to improve trainings and work on ways to

help increase the support they need to provide better care for the clients. I feel privileged that I will be in a position where I have an advantage to see the full picture and capable to make changes as necessary to try improving the interdisciplinary treatment care team to ensure the clients continued outcome success goals are met. And this also includes advocacy and destigmatizing within the community I am working in.

References

https://houseofhopesp.org/

httpss://carf.org