MHSA Housing Initiative Taskforce

Outcomes Review Optional Meeting – 4/22/21

(Edits provided by Taskforce participants via email and during the meeting are in red)

During the April 7, 2021 Housing Initiative Taskforce meeting, participants brainstormed broad outcomes in response to the question: What is the impact we want to see on the health, wellbeing and lives of clients, family members and communities? A set of outcomes were developed by incorporating input from stakeholders received during the brainstorming and previous community planning processes. Members of the MHSA Housing Initiative Taskforce were then asked to provide comments to these outcomes via email. The following includes a synopsis of those comments.

Themes:

- The outcomes are presented as broad, value-based vision statements for housing-related priorities… they are not measurable outcomes at this point and not tied to any specific strategy. The intent was to begin narrowing down the focus of the Taskforce as we prepare for identifying best practice strategies to recommend for funding.

- The word "adequate" is used to describe services that are appropriate in quality and the intensity is adjusted for the individual's needs at any point in time. Defining what these adequate services are (e.g. housing that is located close to amenities, services based on level of support needed, etc.), will happen during the planning phase once decisions are made about what to fund.

- The word "clients" is used for all individuals living with a serious mental illness, which includes peers. Currently, MHSA legislation requires that funding used for housing developments serve 1) individual with serious mental illness and 2) individuals that are homeless or at-risk of homelessness. There may be some flexibilities with defining "at-risk of homelessness" and we have reached out to appropriate State entities for guidance.

Guiding Principles:

There are MHSA-required and locally-defined guiding principles and values. All MHSA funded programs, services and strategies will be:

- Client-focused, client and family-driven
- Collaborative and coordinated across systems in planning and service delivery
- Co-occurring substance use and mental health capable
- Culturally responsive and welcoming
- Peer integrated
- Trauma-informed

Updated Outcomes (Vision Statements):

1. Clients have sufficient, safe, adequate and affordable housing that meets their evolving level of need.
2. Clients have simplified, easy to access (e.g. no wrong door, single-point of entry) supports for finding and securing appropriate housing.
3. Clients have the adequate, ongoing, long-term supports and resources to help them maintain their housing through all phases of recovery, including relapse.
4. Clients meaningfully engage and are connected with the community via occupational, volunteer and/or educational opportunities, etc.
5. Clients' recovery and self-actualization is supported and enhanced at every stage to improve their independence and quality of life.
6. Community crisis and need for emergency services is decreased.
7. Community is welcoming and supportive of safe and stable homes for clients
8. Clients receive quality, integrated supports and services; both clients and families report satisfaction with housing and the services provided.

Email Comments:

- Support staff functions as an integrated client-focused wellness team
- Also, I notice that the word "adequate" appears in some of the important outcomes. Words matter and can be an important driver of outcomes. Could it be useful for us to agree on the definition of adequate so we're all on the same page?
- One of the outcomes I did not see on here is my input regarding housing for individuals with lived experience who are now working the front lines with clients who have mental health and substance use disorders like myself. My peers in this field (peer counselors, recovery coaches and certified aod counselors) all have expressed to me, and I have experience presently with this myself, not being able to afford housing in San Mateo County. Most non profits pay between 19 - 25 per hour in this field which is far below the approximately 40.00 per hour needed to be considered to be a living wage. San Mateo County is the most expensive county in the nation to live in. Google reflects a single person living in this county needs to make 6300.00 per month to support themselves. My peers and myself need to have a serene place to go home to at night to re-group, re-center and refuel ourselves so we can pour into our clients the next day. It is difficult to do when we go home at night to unstable living environments. Most of my peers have to live with family, friends, rent a room, are considered homeless because they live in a Sober Living Environment or a Transitional House (like myself), live out of their cars or have to move out of the area entirely, meaning this county loses quality, well trained AOD workers to other counties. AOD workers who are trained with co-occurring disorders, who work on the front lines in this county and help to reduce recidivism to the emergency rooms, ambulance calls, police calls, and fire dept. calls

saving the county thousands if not millions of dollars. Some individuals, who are in programs and think they would love to work in this field get discouraged after investigating the pay rates in this field and ultimately choose another field making us lose even more qualified lived experience people. San Mateo County prides itself on leading the state and the nation with programs available to it's citizens, to it's employees through contracts with non profits. Please consider being trailblazers in the state and making a way for my peers and myself to have access to affordable housing through a voucher, a grant, or some kind of funding, where we can go home every night to a peaceful serene environment and take care of ourselves as much as we give to others.

- As I review the notes, I'm thinking whether it might be appropriate to have an outcome tied to system efficiency – this can be phrased from the client perspective i.e. it is easy to navigate the myriad of available services" but it can also be stated from the side of the care delivery system, i.e. "services, particularly if they are new, leverage and mindfully augment the existing service delivery infrastructure". This is really stemming from the feeling that there are a lot of funding sources at the moment for behavioral health for people experiencing homelessness, and wanting to be very strategic how each funding pool is used so we can do the best by the clients!
- The 8 bullet points in the 'draft' of outcomes do resonate and seem to be as inclusive as the committee suggested. You captured the essence of the meeting and the various comments folks made. I do have one minor suggestion: On the 2nd bullet: Clients have simplified, easy to access supports for finding and securing appropriate housing. **Can something be added to call out that it would be via single point of access?**
- Thank you for your continued dedication to this really important taskforce project. am in agreement with the outcomes listed but want to suggest that the biggest outcome all of us want to see is an INCREASE in available housing. Perhaps some type of target in a certain period of time? Say 10% in 3 years?
- I think the outcomes listed resonate as needing further discussion. Without discussion re what programs or activities look like or will be expected/undertaken I don't think I would endorse these as actual outcomes. I am open to another meeting but I appreciated the original vision you and Judy had for this as I am not sure what the purpose would be at this stage of the game.
- My only comment is for this bullet "Clients meaningfully engage and are connected with the community via occupational, volunteer, education, etc.", I think that maybe it might wound better with the addition of opportunities or a word like that so it reads: "Clients meaningfully engage and are connected with the community via occupational, volunteer, education opportunities etc."
- I see a black and white approach in responding to symptoms related to "relapse". If yes, hospitalization, with cascade of loss of housing, social supports, other things important to recovery. If no, larger intervals between episodes of client/team interaction. No crisis results in less support, when reality is the type of support needed changes. Current

structure has little safety net before calling 911. Ideal team would have better inter-team communication (including family members that client identifies) as well as uncomplicated route to intermediate responses like Serenity House, adjustable peer support, support in resolving inter-neighbor disputes. Team would have tool boxes full of options, so clients will have choices. Caseloads that are realistic to accommodate changes in level of function with adjustable levels of support.

- Definition of “adequate” in relation to housing, services, important outcomes, needs precision.
- Please add these outcomes:
    - Clients report they are happy with their supportive homes and the services provided.
    - Clients have assurance they will have their home to return to in case of symptom relapse requiring hospitalization.