Mental Health Services Act (MHSA) Steering Committee Meeting
Thursday, May 5, 2022 / 3:00 – 4:30 PM

MINUTES

1. **Welcome & Introductions**   5 min
   Jean Perry, MHSARC Commissioner & MHSA Steering Committee Co-Chairperson

2. **Logistics & Agenda Review** – *Doris Estremera, MHSA Manager*   5 min
   - Previous meeting minutes available on the MHSA website,
     www.smchealth.org/MHSA
   - Introductions public members (name, pronouns, affiliation) were shared
     via chat
   - Steering Committee members: Chris Rasmussan, Clarise Blanchard,
     Adriana Furuzawa, Juliana Fuerbringer, Kava Tulua, Mary Bier
     - New members: Eddie Flores, Peninsula HCD and Paul Nichols,
       MHSARC
   - Stipends available to clients and family members participating;
     information collected via chat
   - Notice that meeting was being recorded
   - For General Public Comments (non-agenda items) sign up via chat
   - Participation guidelines – enter questions in chat, will address those first,
     can also use raise hand button during question/answer and unmute when
     called on, share airtime, practice both/and thinking, be brief and
     meaningful

   - Quick Poll – participants reported demographics, there was an 74%
     response rate at the time the poll was launched:

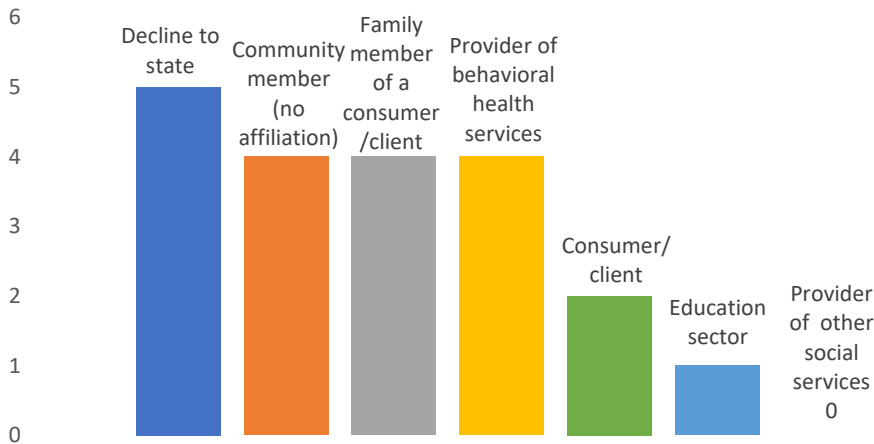| What is your age range?	
16-25	18%
26-59	24%
60+	59%

What is your gender identity?	
Female/Woman	59%
Male/Man	41%
Genderqueer/Gender Non-Conforming	0%
Another Gender Identity	0%

Race/Ethnicity
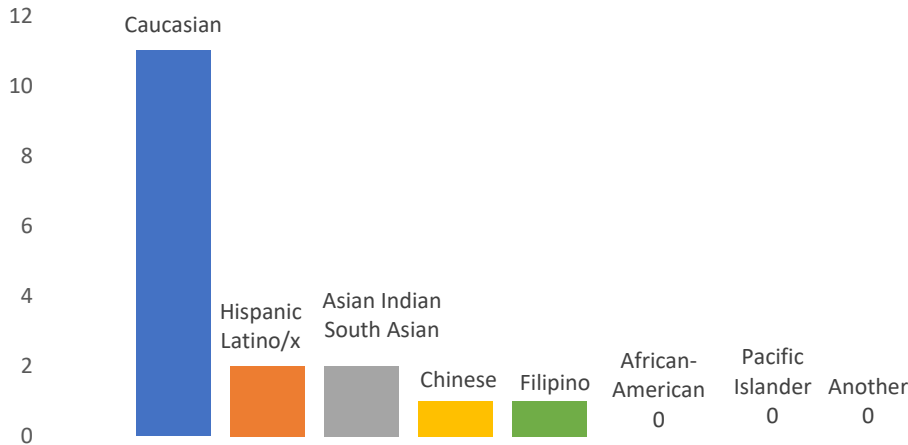
Stakeholder Group

What part of the county do you live in OR work in?	
Central County	29%
Coastside	0%
County-wide	12%
East Palo Alto/Belle Haven	0%
North County	35%
South County	24%

3. Announcements – *Jean Perry*   5 min
   - It is mental health month 2022! Visit www.smcmentalhealthmonth.org – click on "Attend an Even" to see all the exciting events (virtual and in-person)!

- o Innovation funding cycle opening June 1st – Visit www.smchealth.org/MHSA, under "Latest News" for the flyer and submission packet
- o Innovation workgroup developed a submission packet that will make it very simple to submit an idea, available in English, Spanish, and Chinese
- o In the meantime, Mark Your Calendars... there will be Info Sessions and Support Sessions available to help you complete the application packet and submit your ideas for funding.

4. **General Public Comment** *– Jean Perry*   10 min
   - For non-agenda items
   - Additional public comments can also be submitted via email to mhsa@smcgov.org.
     - o Juliana (California Clubhouse): Having their 7th Anniversary in Central Park in the City of San Mateo on May 25th!! Outside party with food should be fun, contact Clubhouse to get more info. https://smcmentalhealthmonth.org/events/clubhouse-7th-anniversary-celebrating-resiliency/?occurrence=2022-05-25

5. **Housing Navigator Program**

   – Judy Davila, Housing Consultant   40 min

   - Intro (Doris):
     - o Judy Davila has been a consultant with BHRS; she supported the MHSA Housing Taskforce work and continues to support the implementation of the recommendations that came out of the taskforce.   25 min
     - o Judy took a lot of the input from the taskforce participants to develop a scope for this new service (Housing Navigation and Retention services) and will present it today and open it up for final input and considerations
     - o The service will need to go through a Request for Proposal process to select the service provider.
     - o We are essentially still in the planning phase!
   - Judy: Housing Navigation and Retention Services
     - o The Housing Task Force prioritized certain goals, including housing navigation and retention, and key components to make this possible
     - o Conducted research and worked with Marianna Rocha, Clinical Services Manager and Karen Kran, Deputy Director of Adult and Older Adult Services
     - o The Housing Navigation and Retention Services will be a team of housing specialists who will provide both locator and retention services.

- Target populations: individuals with serious mental illnesses, their families, and families of children with serious emotional disturbance
- Access Points: BHRS Clinics, referrals from network of community-based providers and self-referrals. The team will alternate between the clinics and doing field work with individuals that have requested services.
- Staffing: 4 housing specialist, 4 peer navigators, 1 occupational therapist, 1 supervisor + administration
- 1 team (Housing Specialist and Peer Navigator) will be association with the three large regional clinics: north, central, south. 1 team will split their time between the two smaller regional clinics, East Palo Alto and Half Moon Bay
- The Occupational Therapist and Peer Navigator will be crucial in the retention phase working with individual on their independent living skills and develop a plan for them to remain housed
  o Housing Locator component:
    - Outreach to landlords, housing developers, property managers and housing community at large... establishing relationships
    - Partner with BHRS regional clinics, landlords, Housing Authority, and housing-based organizations.
    - Identify housing options that include Permanent Supportive Housing, Independent Housing, Shared Housing and Room and Board options.
    - Provide support to potential housing applicants including assistance with appointments and filling out the housing applications and acquiring funds to cover down payment and moving costs... we found that as we worked with new developments coming up, there is available space but, identifying individuals that are eligible and helping them complete all the tasks and show up to all appointments has been challenging, this will be a key component to this service.
    - Provide relocation services when needed... if someone needs to move they will have assistance and support
  o Housing Retention component: once individuals are housed...
    - Partner with BHRS clinics and provide outreach and education to clients and their families
    - Assess households for maintaining daily living skills and housing retention.
    - Provide WRAP (Wellness and Recovery Action Plan) for housing workshops... evolution taken place, recognizing that this is a key component of a WRAP plan but, needs more detail for the individual about what they need/want to do to maintain their housing

- Develop a hands-on education and coaching plan with each individual client
- Provide support for client with landlord/tenant issues... providing support to landlords who may need support in learning about the client issues and how to deal with them.
- Provide tenant eviction prevention through assessment, services to mitigate eviction and work with landlord to resolve... once the issue gets to an eviction action starting it moves to a legal realm, their should be a relationship with legal aide to get the client connected to legal services
- Assist tenant with annual housing authority recertification process... cumbersome for clients, who must keep their appointments with housing authority and allow them to enter their unit to verify the condition of the unit in order to not lose their voucher; we don't want this to happen!
- Provide annual follow up, reassessment and service if needed... at least ongoing regular contact with client; this is both for the clients and landlords, this is not short-term.
- Attend monthly BHRS Housing Operations and Planning (HOP) meeting... where a variety of partners come together to discuss housing issues and what's new.

- Public Input: What considerations do you want to see included and/or prioritized in this new service?
  - Melissa: Three questions – 1) how many clients will you expect to serve over a year or certain period of time and what if any kind of housing subsidies will be included, and 3) are you targeting people who are homeless?
    - Judy: How many people we might serve - we have danced around with understanding how many individuals are not stably housed and have no good data on this. For each clinic, ballpark, maybe 50-60/clinic?
    - Subsidies or vouchers - depending on what is currently available, there hasn't been discussion about using MHSA funding for individual subsidies
    - Targeting homeless: high priority, but not specifically, there are lots of individuals in a variety of housing situations. One of the key input from the housing taskforce was retention services for individuals that are housed; included but not exclusive.
  - Michael: Felton, early psychosis program; this would be really helpful for young people in our program as they move through recovery and are ready to be emancipated (most live with parents); finding alternative housing and the supports will be very important.
  - Jean: what tools will workers actually have? We recognize the magnitude of the need and wondering what tools will navigators have to do this huge job. 2) What does accountability? We've

looked into other programs where accountability was not written into the services. 3) What will be the roles for the workers and for the clients – they need to be carefully defined, specifically communicating with clients, families and care teams. Will they be empowered to do the work. 4) annual re-evaluation of services? We need guard rails so that the appropriate re-evaluation can be triggered by a client, family, landlord, clinician at any point in time. Assessments need to be done more than just yearly.

- Judy: you're right, it should be minimum just a year. The idea would be that the client and the team would work on a plan that will include frequency of visits or check-ins on the independent skills or other issues that may come up. If somebody doesn't want regular contact there would still be a minimum of annual and maybe 6 months.

o Yoko: 1) what about racial equity for homeless population – what is the % of young adults and language accessibility of case management. 2) training of agency that ends up with this service - have seen staff at serenity house that lacked training and caused system failures.

o Melissa: Without a minimum number of clients expected to be served it is very difficult if not impossible to respond appropriately especially since you are identifying the number of staff. What the staff client ratio should be, realistically. At least setting a minimum expectation. 2) HSA and DOH need to be involved so that we can have clear and open communication so that clients are not left out of getting subsidies or units that become available. The whole CES process has made our clients the lowest priority and yet they have the highest needs. We need a more open dialogue about the CES process and how our clients fit into this.

- Jean: what is the CES process? The Coordinated Entry System (CES) is required by HUD. So, all the funds that come into the County for subsidies require that clients get evaluated through CES where they take personal inventory based on self-report and individuals that are assessed as having the most vulnerability combined with longest period of homelessness get matched first to housing. We don't want our clients to live on the streets for over a year just to qualify for housing
- Judy: at BHRS, we also have a passion regarding this issue and the CES process. Subsidies is really important to address this; creating avenues for finding housing and supporting individuals that doesn't require the CES requirements is also important. We need coordinated avenues for accessing housing.

o Doris: my request to everyone is that as you are bringing up concerns I ask and encourage that you also share your opinion and

input on addressing these concerns. Jean, are there tools you would prioritize for peer support workers. Are there specific role responsibilities that you want included? Melissa: is there a staff/client ratio you would recommend

- Melissa: regarding staff/client ratio, it would depend on where a client is in the process.   In the initial stages it might be as low as 1:10 and once housed and stabilized it could increase to 1:50 depending on who else is involved with the individual for support. It's really critical to understand that caseloads will ebb and flow, so it is critical to have the number for the year so that it can be slotted accordingly.
- Mariana: timing is important; knowing when vouchers will expire or who has a little more time. Evaluating this components will come into play since things are time sensitive.
- Doris: lack of data is an issue and it does become a guessing game. We can do it where the first year we keep really close tracking and set a baseline after the first year of services.
- Melissa: I agree…we won't come up with a good number but, you need to have an expectation before putting out an RFP. Target something.
- Juliana: yeah I agree, without target numbers who knows who will bid on it? Set some target and guidelines to hit. No one will hold you to it, but there should be an estimate.
- Jean: tools these workers should have in their kit! Conflict resolution skills (training on a regular basis), case load consistent with the workload and acuity of need. We should regularly assess how much service a client need so we don't inadvertently burn out staff. Be realistic of how many clients a worker can serve at any time. And, peer navigators should have access as a full member of the client's care team.
- Mariana: I love these points Jean. We definitely want to support the staff and working collaboratively with the clients' team. There will be a supervisory component to it. The team could bring up issues related to caseload size or other issues we should consider. It's part of the ongoing assessment and evaluation. We just have to get the program up and going and see how we can improve it from there.

o Michael L.: thanks to Melissa for bringing up the issue with CES and the importance to connect with HSA/DOH – organization that supports entry into temporary assistance for needy family funds. It's not clear to me who helps clients with other services needed

(SSI, SSDI, care program from PG&E for subsidized billing) because every penny is needed to help them maintain their housing. Navigating all these applications is extremely tedious, and it is so difficult for anyone, especially BHRS clients. Our clients need help in application of all these benefits.

- o Michael K.: having a high level of coordination between navigators and occupational therapist will be important so that services are not duplicated with other agencies who are providing services.
- o Juliana: there should be a staff/client ratio recommendation given to bidding agencies in order to make their proposals more apples to apples
- o Jean: Will the RFP include data collection so that we learn what needs are?
- o Doris: this is not the last opportunity to provide input. The idea is to release this RFP in the upcoming fiscal year. We have other RFPs that need to be released first. Email mhsa@smchealth.org with any other input, it is still in planning phase!

6. **MHSA Prevention and Early Intervention – Prioritized Outcomes**

   –*Megan Drazek, RDA Consultant & Doris Estremera*

   - Doris: I had provided a "sneak peek" on this project at our previous MHSA Steering Committee meeting. Megan is joining me as a consultant from Resource Development Associates to share where we are with this project and offer an opportunity for input.
     - o MHSA Components: this slide includes general information about MHSA that I typically share and the legislative requirements for funding allocations. Today, we are focusing on the Prevention and Early Intervention (PEI) component of MHSA, which requires 19% of MHSA funding allocation.
     - o What is MHSA? This is how it is defined in the legislation.
       - PEI are interventions prior to the onset of mental illness with the exception of early onset of psychotic disorders.
       - The interventions are described further in the legislation as developing protective factors and reducing risk factors for developing a potentially serious mental illness. Often I get asked – what are we preventing? We are preventing the development of potentially serious mental illness and we do this by building protective factors and reducing risk factors.
       - These are very individual-level outcomes. Some examples of risk factors include, but are not limited to, adverse childhood experiences, severe trauma, poverty, experiences of racism and social inequality, prolonged isolation, suicide attempt. This is not an exhaustive list.

- On the other side of this, when we discuss protective factors… these could be things like having access to mental health services, knowledge, awareness, connectedness, skills, etc.
- So, that is primarily what MHSA programs are meant to do and you can see a full list of the MHSA funded PEI program on the MHSA website (www.smchealth.org/MHSA), under the tab "About MHSA" document titled MHSA Components and Program and this is also linked on today's slides.
  - To provide a bit more context before transitioning to Megan
    - In FY 18-19 the State came out with legislative guidelines for PEI data collection. Around that time, locally, the BHRS Office of Diversity and Equity led a community input process that focus on what impact we wanted to have in the community with PEI programming so, more community-level outcomes. We were able to incorporate this input.
    - In FY 19-20, BHRS released the first three-year PEI Report and a big finding was the need for aligning across individual level outcomes across programs. That is where Megan came in as a consultant. She has been working with the agencies that provide PEI programs and hearing from them on what outcomes they are providing
- Megan: will continue to discuss the process a bit more
  - We started engaging staff from several PEI programs, to learn more about the programs and the data collection processes that they already had in place.
  - We were able to identify common themes across outcomes and aligned with prioritized outcomes from the State and local stakeholders.
  - Various outcome domains were identified that led to a framework that could capture collective impact.
  - With the framework, we went back to programs to narrow in and identify the tools that would be needed to collect this data.
  - Led to tailored "crosswalks" so programs can report under standardized reporting templates that were created.
  - There are 4 key areas of data collection including 1) unduplicated clients served (in the core component of the program) and broad reach # of individuals served (workshops, families, etc.); 2) demographics – long and short surveys for the lighter touch program components; 3) referrals to mental health, substance use and social services including which programs; 4) individual level outcomes "domains"– these focus on the impact of program on clients – increased protective factors, decreased risk factors, improved recovery and decreased symptoms

- o This slide has both Outcome Domains and Programs that we worked with. Some program are missing from the list such as the Parent Project, Outreach Collaboratives and Suicide Prevention trainings… these program are lighter touch program that don't enroll clients in direct services and have data they are collecting that we can leverage. Next steps is to wrap them into this framework
  - o This chart is a great visual representation of the collective impact of PEI programs… it can help identify new outcome areas, where the gaps are, and inform decisions for the next funding cycle.
- Doris: The presented domains are aligned with the State requirements, community planning process priorities and with what our community-based agencies prioritized. The outcome list can grow, it is not the end. This is a tool and first steps to move forward in PEI programming as we move into a new 3-year planning phase

- Public Input - Your input can inform a) current data collection plans and b) future program prioritization. Question: Are there other individual-level outcomes you would want to see prioritized for PEI?
  - o Jean: not sure this falls under PEI but, under the domain "connections and support" maybe we are not doing the best we could to support families of individuals who have arrived at a diagnosis. Can we build more of that capacity in our system even if the client does not want the families involved or the family is so traumatized or don't have the capacity to support. Family support and engagement is crucial to recovery. Maybe teaching families skills for long-life connection, as an aftermath.
    - ▪ Michael K. : works in early psychosis. A lot of what we do is family and parental education! It is central to what we do even if participant doesn't want family involved. We can support families even if the clinician can't involve them in the client care. So important to have family outreach. Most of our clients are very resilient and don't have episodes. It's only a subset that for some reason don't have the resiliency in their emotional health to withstand the traumas they have experienced.
    - ▪ Megan: the framework we developed includes an additional outcome category where program can capture outcomes related to the impact on families or other broader reach.
  - o Juliana: the definition of PEI included "exception of early onset of psychotic disorders"- what does this mean?
    - ▪ Doris: this is part of the legislation definition to use PEI monies. Typically, PEI programs would provide service to individuals prior to the onset of mental illness so there would not be a diagnosis on any of these clients served, with the exception of early onset psychosis.

- o Doris: we will keep this notes and input in mind as we move into a three-year planning phase. We are required to have 19% of funding in PEI. So, as we increase services on the direct treatment side, we have to increase prevention and early intervention.
- o Michael K: school districts are the ones who have access to the children prior to onset of mental illness. Are school staff trained to identify early indicators then provide referrals? They should be…
- o Doris: we have a pilot program for five years, the Mental Health Student Services Act working in partnership with County Office of Education. The services offered include linkages and early assessment. Care Solace is helping with linkages, universal screeners and wellness counselors in high-risk schools, data is being collected and will definitely share in future meetings!
- o Michael K: how we traditionally think about high-risk schools is important, sometimes wealthy neighborhood students are under a lot of pressure to succeed, suicide statistics are relevant here.

7. Adjourn
   - Please complete the meeting survey:
     https://surveymonkey.com/r/MHSA_MtgFeedback

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide input. You can also submit questions and comments in the chat. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

*REMINDER – Please Complete the Steering Committee Feedback Survey

https://www.surveymonkey.com/r/MHSA_MtgFeedback

ATTENDANCE

There were up to 34 participants logged in to the Zoom app. Below is a list of attendee names as recorded from Zoom; call-in numbers are typically unidentifiable.

MHSA Steering Committee Co-Chairpersons
1. Jean Perry (she/her), MHSARC Commissioner

MHSA Steering Committee Members
2. Chris Rasmussan, MHSARC Vice-Chair
3. Eddie Flores (he/him), Director Youth Behavioral Health Programs, Peninsula Health Care District
4. Jairo Wilches
5. Juliana Fuerbringer, Family Member, California Clubhouse Board President
6. Kava Tulua (sher/her), One East Palo Alto
7. Melissa Platte (she/her), Mental Health Association
8. Michael Krechevsky, Felton Institute (re)MIND/BEAM
9. Michael Lim, MHSARC
10. Paul Nichols (he/his), MHSARC

BHRS Staff Supports
11. Doris Estremera (she/her) MHSA Manager, BHRS ODE
12. Sylvia Tang (she/her), BHRS ODE

Presenter(s)
13. Judy Davila
14. Mariana Rocha BHRS (she/her/hers)
15. Megan Drazek

Participants
16. Ann Wasson
17. Beverly Gerard, San Mateo County Board of Education Trustee
18. Branden Sarkissian(he/him), Affirmed Housing Group
19. Candice Hawley
20. Charo Martinez (ella,she,her)
21. Claire Radcliffe
22. Eloise Linero
23. Georgia Peterson
24. Gregory Aldip
25. Joseph C
26. Kate Phillips
27. Kira Donmoyer (she/her)
28. Lisa M
29. Megan Fletcher
30. Nelly Shu
31. Noreena Vannarat
32. Olivia Zagata
33. Ophelia Liang
34. Twila Dependahl
35. Yoko Ng (she/her/hers), MHSARC