Public Comments Received – for MHSARC Review

➢ MHSA Three-Year Plan, Fiscal Year 2020-23

1. **Comment:** I am health care professional within behavioral health. Health professionals, not police officers (alone) should respond when people with mental health and developmental disabilities or with substance use disorders are in crisis or in a mental health crisis emergency. How does the MHSA address improving the relationship between city Police Departments and crisis services? I believe we should consider supporting and expanding San Mateo's Psychiatric Emergency Response Team (PERT) to allow mental health professionals respond with law enforcement and be available 24 hours per day. Currently, the PERT team, per the brochure, https://www.smchealth.org/sites/main/files/file-attachments/pertbrochure.pdf?1556207937, do not provide co-responders nor do they service all cities. They function as a secondary response and it is unclear whether they are adequately funded.

   Response: Thank you for your comment. BHRS agrees with your sentiments on the importance of collaboration with law enforcement to improve mental health crisis response. The MHSA Three-Year Plan includes a $600,000 allocation to youth mental health crisis response team that would be available across the County to support police response. The crisis response team is in the planning stages, please see Appendix 7 of the plan for the current draft concept. PERT serves unincorporated areas and mostly adult clients. As part of our BHRS commitment to collaboration with law enforcement, we will continue to support our current work of providing Crisis Intervention Team (CIT) training, a specialized police curriculum that aims to train law enforcement to safely respond to encounters with people with mental illness.

2. **Comment:** Ranked # 1 was the Housing Continuum with 5 strategy recommendations. (really important that it is so highly ranked): Is there any provision/possibility that would be considered a part of the housing continuum among the 5 recommendations that patients being discharged from SMMC's 3AB acute psychiatric unit could access? That vital hospital unit has been impacted with patients that have no adequate efficacious therapeutic step-down place to be discharged to for continued care. These patients are generally BHRS clients....or future BHRS clients. They need a much higher level of care than the typical Board and Care.....a robust step-down place! Where can they be housed/cared for appropriately? They aren't acute but still very ill and in need of considerable care. As you probably know, the Commission at our January retreat made it our highest priority to maintain the number of licensed acute beds on 3AB vs. decreasing about half the beds. Patients who are no longer acute impact the acute beds because they have no place to go....this must be remedied.

   Response: Yes, there is still opportunity to include this and other gaps/needs. We will engage in a planning process with stakeholders to further develop the spectrum of strategies for the Housing Initiative with the goals of a) defining a continuum of services, b) identifying gaps at all levels of support or intensity in treatment, and c) articulating expected outcomes and identify the activities/strategies that will support a comprehensive continuum of services. Your feedback will be incorporated into that planning process, thank you.

Comment (cont'd): Ranked # 2 Crisis Diversion: Trained/certified peers providing peer and family crisis support services to assist clients transition from PES, hospital and incarceration into the community: Question: Doesn't the HOPE program already do most of this? Can it be enhanced, expanded?

Walk-in services for addressing immediate crisis needs in a less intensive setting than PES: Question: Couldn't the already existing Serenity House be the place for this? I believe that was what advocates originally proposed Serenity House to be.

Response: Yes, the HOPE program could be expanded. It was included as a strategy because stakeholder input identified this as an area needing additional support. Expansion of current services would absolutely be the way to approach this. When we begin planning for these services, your feedback will be incorporated into that planning process.

Yes, Serenity House could be an option. When we begin planning for these services, your feedback will be incorporated into that planning process.

3. **Comment:** Rank1 Housing: "Transitional housing that is designed for and specializes in the needs of transition age youth (16-25 years) with serious mental health challenges. "Transitional housing should be addressed for Transition Age Youth (TAY) even if their mental health (MH) challenges are not serious. Homelessness for this group directly affects the worsening of their MH. This affects all sorts of developments in their lives, most importantly, their academic ability. When (not if) than happens, it robs them the ability to develop into the best versions of themselves. Protecting our youth is the best insurance against future issues. It is the "low hanging fruit", the best return on our investment, and is the right thing to do. Additionally, I'd like to see a requirement of input from the TAY group on the development of this plan.

   Rank2 Crisis Diversion: In the previous MHSA planning cycle, a crisis management program for youth was approved. For various reasons, it has been delayed. Our County Office of Education (COE) has made a number of presentations the MHSA Steering Committee, the Children & Youth Services Committee, and others on the urgency of addressing this issue. Even a previous year's county Civil Grand Jury agrees with the urgency when they did a study on Teen Suicidality. The COE implemented a Post-vention procedure to help the community deal with the after affects of suicide. Let's make the investment today on Prevention, to eliminate the need for Post-vention.

   Rank3 Culturally Responsive and Trauma-Informed Systems: The 4 strategies listed are great. However, are we being culturally responsive to our Youth? Do we actively solicit input from our Youth? We have the Health Ambassador Program for Youth (HAP-Y) that educates them on MH topics. We provide input to their brains, but rarely prompt for an output. In the services we provide, I see Clinicians determining what's best for our Youth. But can we really say we fully understand their current stressors. The Youth "culture" has discernible shifts roughly every 5years, and it affects areas in fostering situations, poverty, schooling, substance use, etc. Look at the current times we live in. Does not the voices of our Youth today put a certain clarity on age old issues? To be fully culturally responsive & trauma-informed, I request that we invest in developing Youth leadership voices on MH. Perhaps a new Health Equity Initiative under the Office of Diversity & Equity, and charter them to address the Youth MH challenges of the day.

Response: Thank you so much for your comments across the top three prioritized initiatives, Housing, Crisis Diversion and Culturally Responsive and Trauma-Informed Systems. We appreciate your sentiments regarding prioritizing investments in youth strategies to prevent exacerbated mental health issues in the future. Your input will be incorporated into that planning processes for these initiatives when they being. The Youth Crisis Response and Prevention planning will continue as a priority through the MHSARC Youth Committee and we fully agree with your recommendation to include youth voice into our planning. The Office of Diversity and Equity is working closely with the Health Ambassador Program for Youth to begin connecting youth leaders to these opportunities.

4. **Comment:** Youth Crisis Response Team - County Council has been fielding a lot of questions from school boards and other regarding police response to a student's psychiatric issue (Suicide ideation, depression and anxiety/panic attacks). A lot of school districts are looking at ending contracts with the School Resource Officers due to the racial unrest in the county and the commitment for equity and to be more trauma Informed about the way the handle student mental health issues. If they no longer have SRO's it makes it difficult to 5150 a student that needs to be 5150'd. Often times parents won't take the children to PES for numerous reason (Stigma, costs, not believing the child, not wanting government involvement) and then the school needs to call the police to either take the student or call the police to have them go to the home for a welfare check since the parent's didn't take them. With schools doing distance learning, and continuing to do it next year, it puts the police as the only resource to check on a student at their house, since counselors cannot see them face to face.

   A lot of this seems to be able to be solved by the Youth Crisis Response Team (YCRT). Pediatric Psych beds are costly, and we only see about 2.5 kids a day county wide at PES, most of which never get sent to the hospital. We could avoid the need for this with the YCRT, they would act as triage and allow the student to be safe at home. Depending on the district the student is in the YCRT could even have Care Solace find them a provider for further treatment.

   School budgets are being cut, at a time where more mental health issues are going to come up. We will see huge fallout from this if we don't put into place what is needed. The priority #2 being Crisis Diversion, that is exactly what YCRT is. It diverts 0-25 year olds from PES and Jail, by giving the skills/safety plan and connecting them to care. In the adult population there seems to already be so many programs that assist in the aftercare from PES, 3AB or Jail. But unless you have Medi-cal as a youth there is nothing helping you when you leave PES or the hospital. The YCRT could be that for the non-medi-cal kids, which you know is the majority of this county and the majority of the student that need help, need treatment, don't get it, then become BHRS school based clients, or become YSC clients, or end up at IPRC needing residential placement at the expense of probation or school districts. I would really like to get a group together to figure out how to move YCRT to the top of the list, especially with how schools are starting back up in the fall. Kids are going to be home more, but parents will be at work. We need YCRT now.

   Response: Thank you so much for your comment and providing additional current context that is impacting school and law enforcement response to mental health crisis. We appreciate and agree with your sentiments that the planning and implementation of the Youth Crisis Response

Team must remain a priority. The planning for a Youth Crisis Response program was delayed due to needing to shift to COVID-19 response across all key stakeholders including schools, law enforcement and behavioral health providers. With facilitation support from the MHSA Manager and the BHRS Deputy Director of Youth Services, the MHSARC Youth Committee has been tasked with this effort. Appendix 7 of the MHSA Three-Year Plan has the current draft concept. These planning meetings are held on the third Wednesday of every month at 4pm, I will add you to the meeting notification.

5. **Comment:** Fiscal Priorities if Revenues Increase **-** Trained/certified peers providing peer and family crisis support to assist clients' transitions from psychiatric emergency, hospitalization, and incarceration into the community. Funding Stream: 0

   It seems inconceivable to me that this is only prioritized as an "if revenues increase". These individuals are among our most fragile mental health clients and it is proven that peer to peer support and encouragement, providing resources, facilitating, and simply listening are rated amongst mental health clients as extremely influential in their recovery. The identification of this high-risk population and services can lead to positive outcomes whereas the failure to provide such services can result in repeated mental health crises, recidivism, and recurrent hospitalizations.

   Response: Thank you so much for your comments. We appreciate and value your thoughts and suggestions. Yes, peer services to clients transitioning from psychiatric emergency, hospitalization, and incarceration is an important priority and was undeniably prioritized by the MHSA Steering Committee. Due to COVID-19 pandemic and subsequent recession, we anticipate reductions in funding over the next three years. To be able to fund a new direct treatment program, without new revenue, would require reallocation and funding cuts to another direct treatment program for clients. The MHSA legislation requires that 19% of funds be allocated to the important work of prevention and early intervention, including stigma discrimination and mental health awareness activities. Therefore, we cannot move monies from prevention to fund more direct treatment.

   As of January 1, 2018, under the Whole Person Care funding, Heart & Soul, Voice of Recovery, California Clubhouse and National Alliance for Mental Illness were contracted to provide the HOPE program which utilizes peer mentors and family partners to support individuals transitioning from locked facilities and other settings to the community. If MHSA funding becomes available, expansion of current services would be prioritized. In addition to the vital work that the aforementioned providers are doing, BHRS works diligently to connect individuals to our services or those of partnering agencies. We agree that this work is critical and will continue to work to strengthen these connections between those that need support and those that are providing care.

   Comment (cont'd): Digital Storytelling and Photo Voice - Funding Stream: 50 people served at the cost of $56,289

The cost per individual served, with only 50 clients served, equates to $1,125.78. Given our dire needs in direct services, I feel a portion of this funding should be diverted to serve a great number of individuals with direct services that will have a greater overall impact. While I applaud Photo Voice and Digital Storytelling, the service of the mental health community would be far greater impacted by shifting half of this budget, or $28,144.45 to direct services aimed at helping the much larger community in need. I would transfer this money to the unfunded peer outreach program discussed in item one. While photovoice and digital story telling may impact the individual participating in learning to tell their story in this medium, the reality of our county is that not many clients utilize the; websites and online information provided by BHRS as is currently exists. I think a clear choice needs to be made between saving lives and benefitting consumers, especially, as argued above those most at risk rather than an expensive program aimed at a much smaller group. Our world is topsy turvy right now and without support I believe many of the consumers will not thrive. We are already large increases in substance abuse among co-occurring clients, elevated depression, isolation, feelings of hopelessness and failure to have a viable support network. We also have in place the Lived Experience Academy which teaches storytelling, NAMI provides similar training as does of Voices of Recovery. While this is not inclusive of video and the digital medium, I feel its far reaching effects are far outweighed by the one on one support of a fragile client.

Suicide Prevention and Be The One Campaign - Funding Stream: $113,522 with a projected 3000 people served

While Suicide Prevention was one of the top choices for funding in the BHRS focus groups, I question whether a "Campaign" particularly given our lack of diverse online zoom meetings and training will come no where to close to reaching 3000 people. Further, I would like to know what definition of "serve" you are using in the capacity to project this number. I am certainly not advocating for this campaign not to be funded, as the recognition, empowerment, and education of individuals to identify and take appropriate steps is a must needed tool.

However, in addition to this training, which is also offered through Mental Health First Aid, and Wellness programs in the county, one cry I heard over and over was the lack of support upon transition out of hospitalization and no follow up leaving consumers at risk for a second attempt. The per person costs of the current budget at 300 served is $37.84. Reducing the Served pool to 2, 225, frees up $29,328 which could be utilized in direct services to those in suicidal crisis, following attempts, and allocating more money to aftercare. We heard in the focus groups of individuals who received a small amount of after-care but then, in their opinion, were abandoned. Since life is out most commodity and BHRS owes of a duty of care to this fragile population, in my opinion, action steps to help insure no further attempts as in a state of abandonment and neglect we lose lives. I believe this almost 30,00, a small reduction in the overall allotted funds, will still live the campaign with $84,194 dollars.

I will again reiterate the lack of consumer participation online as seen in BHRS own survey asking what is important to the client. Many clients do not know how to set up email much less have the savvy to zoom for a Be the One Workshop.

Response: MHSA legislation requires that 19% of funds be allocated to prevention and early intervention, including stigma discrimination and mental health awareness and suicide prevention activities. We cannot move monies from prevention to fund direct treatment. We do appreciate your recommendation and due diligence in identifying funding for much needed direct services to clients transitioning from psychiatric emergency, hospitalization, and incarceration. We will continue to work with the MHSA Steering Committee and stakeholders to bring your perspective into the Housing strategic planning process, which includes the recommendation to connect peers to homeless engagement activities.

More specifically, in terms of the $56,289, this funds 50% of a program coordinator position in BHRS that oversees Digital Storytelling, Photo Voice and other stigma reduction work under the Office of Diversity and Equity. The impact of this storytelling program is beyond the 50 clients that have participated directly in workshops to share their stories of recovery and wellness to heal and to address issues within their communities. The impact of this program has been well documented in the MHSA annual reports and includes topics related to recovery in jails, substance use and suicide, spirituality in recovery and housing.

Storytelling is used not only to support the recovery of the 50 clients but to reduce stigma, bring awareness, education and advocacy on important topics countywide, impacting thousands. These are some of the limitations with reporting quantitative data and why we include qualitative impact in all MHSA annual reports. As one example, housing advocacy using storytelling led to the mapping of the housing system to identify the most effective advocacy points which included leaders of homeless shelters (or those who make decisions about the shelters and landlords (to challenge the stigma about people who are formerly unhoused or struggle with substance abuse to be risky or 'bad' tenants).

The $113,522 funds a full-time position that oversee Mental Health Awareness activities, Mental Health First Aid contracts, Suicide Prevention activities and the Be the One Campaign. The campaign is only a small portion of the activities to bring recognition and education around mental health, stigma and discrimination reduction. 3,000 is an estimated number of people reached via the many activities (workshops, online marketing, educational series) during Mental Health Awareness Month, Suicide Prevention Week and Be the One Campaign. We will continue to work with the Office of Consumer and Family Affairs strengthen the supports to clients given the challenges you bring up related to online participation in these sorts of activities.

6. **Comment:** Our NAMI National 5 year plan identifies 3 critical areas where we feel we can have the greatest possible impact in the lives of the individuals and families we serve: Getting people help earlier;

   ensuring people have access to the best possible care; and diverting people with mental health conditions away from the criminal justice system. All of these align closely with MHSA's stated goals.

   NAMI can provide training and support to both peers and family members to help implement Children & Youth and TAY full service partnerships. NAMI's mission of support, education and

advocacy in targeting young people and their families is in keeping with these goals. We can partner with you in these prevention and early intervention efforts.

Intervening early with the youngest population involves providing education and support (now virtually) for parents, caregivers and other family members along with addressing the issues of the young person experiencing mental health difficulties. Having been conceived and developed by families 45 years ago, NAMI's existing programs uniquely focus on the family as the primary support system.

Our growing outreach efforts targeting schools, businesses, and other community resources provide a forum for beginning a dialogue about mental illness, addressing stigma and myths about these illnesses, and advocacy for change. Our efforts to train and work closely with law enforcement and health professionals engaged in early crisis intervention can be effective in diverting people from the criminal justice system and getting appropriate and effective treatments from day one.

No one should face mental illness alone, and our community will be most effective when we partner to address our common goals and priorities, together.

Response: Thank you so much for your public comment on behalf of NAMI SMC.

We appreciate the opportunity for partnership and agree with your sentiments regarding the importance of intervening early and training peers and family members to support FSPs. This work is definitely a big lift and we appreciate NAMI's partnerships and outreach efforts to-date. We look forward to growing our collaborative efforts with agencies like NAMI.

I will be sharing your comment with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review. Your comment will be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisor and the State.

COMMISSION ON DISABILITIES

June 25, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

To the members of the Mental Health and Substance Abuse Recovery Commission,

The San Mateo County Commission on Disabilities (CoD) would like to submit the following public comments as suggestions and changes for the Mental Health Services Act 3-Year Plan Update, which many County residents with disabilities and/or aging related issues rely on:

1. There should be representatives from the disabilities community on the MHSA Steering Committee, so we request that if applications are not received from a range of persons with disabilities or any liaison agencies or organizations (such as the Center for Independence of Individuals with Disabilities) that the MHSA Director take affirmative steps to seek such representatives to serve on the Steering Committee.
2. We request that the innovation funds and related projects and ideas be shared with the CoD as they are being considered, as well as the protocols for submissions, as this may be a wonderful opportunity for collaboration between BHRS and the often unfunded, innovative projects of the CoD's various Committees, which frequently have a connection or co-occurrence with mental health.
3. We request that actions/resources/training be prioritized in the furtherance of fostering cultural sensitivity to the disabilities community, in partnership with the work of the CoD, as well as of the Office of Diversity and Equity, the Health Equity Initiative, and the NEW Office of Equity and Social Justice.
4. There was a high need for focus on youth mental health crisis supports, including for children (pre-adolescent/Age 12 and below) diagnosed with psychiatric disabilities, pre-COVID-19. There have been recent statements from BHRS (6/3/20 Commission Meeting) that since schools are not currently in session, this priority was being delayed. Now, with the effects of COVID-19, this is not the time to delay such focus. It has become even more important with the anxiety, depression, and mental health impacts on families and children.
5. The County should prioritize supports for children with mental health and psychiatric disabilities and their families, by:
    a. Having pediatric psychiatric ER beds in San Mateo County (which are currently nonexistent) so that families will not be displaced out-of-county in the middle of psychiatric crises that require children to be put on 5150 holds;
    b. Providing more readily accessible psychiatric crisis supports for children, rather than the default to call 911, which is not always safe for children given the variance of officer responses to sometimes atypical responses of persons with disabilities to their authority; and
    c. Assisting schools with early mental health supports for children through a much stronger partnership with the SMCOE and local School Districts to support their identification and service to children through Educationally Related Mental Health Services (ERMHS), consistent with AB 114 (2011). These supports are lacking in many respects (as many schools and staff often do not

understand their role and responsibility concerting mental health supports for their young students), resulting in delayed or nonexistent services. For instance, most families are unaware of the opportunity for Districts to make ERMHS referrals to the SELPA or through the County's Clinics for consideration in obtaining access to the BHRS-contracted Full-Service Partnerships (such as the Youth/Family FSP at Edgewood Center), and better attention, training, understanding of the available resources would likely result in a significant decrease in extreme crisis events for children and families throughout San Mateo County.

The Commission on Disabilities requests that these suggestions and changes be strongly considered in the plan's update. We hope this will result in creating additional opportunities for the two Commissions to partner in making positive improvements in the quality of life for our residents in the County.

Sincerely,

San Mateo County Commission on Disabilities

Robert G. Hall, President
San Mateo County Commission on Disabilities (CoD)

Chelsea Bonini, Chair
CoD Youth and Family Committee

Cc: Honorable Carole Groom, Member, San Mateo County Board of Supervisors
Lisa Mancini, Director, Aging and Adult Services

Response to Letter from the Commission on Disabilities

Thank you to the Commission on Disabilities (CoD) for taking the time to write this letter and provide such important feedback for the MHSA Three-Year Plan. I have cc'd the relevant BHRS Directors in this email who may also provide additional response and relevant action items.

Additionally, I will be sharing your letter with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) to discuss any relevant changes to the MHSA Three-Year Plan, at the next MHSARC meeting on July 1st. The letter and the response will be included with the Three-Year Plan as an attachment and submitted to the State as formal public comment.

Regarding the specific recommendations, I wanted to take the time to formally respond to some of your comments. Again, the MHSARC, Directors and other stakeholders may also provide additional recommendations.

1. I appreciate the feedback regarding stakeholder engagement as this is directly related to my role as the MHSA Manager. I will commit to taking more affirmative steps as you pointed out to ensure there is representation from the disabilities community. Having diverse stakeholder engagement is something that is very important to BHRS and I've always held MHSA in San Mateo County to a high standard of ensuring diverse voices are represented. I will make sure the disabilities community continuous to be heard and appreciate you reaching out and holding us accountable.

2. Throughout the year, we conduct broad outreach and communications to inform stakeholders about innovation funds and other planning and funding opportunities as they present. The last innovation funding cycle resulted in over 35 proposals being submitted for consideration across diverse agencies and interests. I will commit to ensuring announcements are forwarded to CoD at all times to support and improve ongoing representation. I also encourage folks to subscribe to the MHSA list serve if you haven't already, www.smchealth.org/MHSA. I provide regular announcements and information via this MHSA website and list serve.

3. Thank you for your important perspective on fostering cultural sensitivity to the disabilities community. The Director of the Office of Diversity and Equity, who also oversees the Diversity and Equity Council and the Health Equity Initiative, has direct oversight of MHSA community and stakeholder engagement and prevention and early intervention. We look forward to partnering with the CoD to ensure cultural sensitivity work moving forward includes the disabilities community.

4. Youth crisis prevention and response continues to be a priority for BHRS, MHSA Stakeholders and the MHSARC. The planning for a Youth Crisis Response program was delayed due to needing to shift to COVID-19 response across all key stakeholders including schools, law enforcement and behavioral health providers. We appreciate and agree with your sentiments that the planning and implementation of these efforts must remain a priority. With facilitation support from the MHSA Manager and the BHRS Deputy Director of Youth Services, the MHSARC Youth Committee has been tasked with this effort. Appendix 7 of the MHSA Three-Year Plan has the current draft concept. These planning meetings are held on the third Wednesday of every month at 4pm and open to anyone who wants to join. To be added to the email list for the MHSARC Youth Committee, please contact Nicola Freeman at nfreeman@smcgov.org.

5. Thank you so much for this feedback regarding children with mental health and psychiatric disabilities. I will be bringing this forward to the MHSARC, our BHRS Director and the Deputy Director of Youth Services for further comments. The Youth Crisis Response program mentioned above is a way to address the community response along with law enforcement to ensure a more sensitive and appropriate response to children with disabilities. As part of our BHRS commitment to collaboration with law enforcement, we will also continue to support our current work of providing Crisis Intervention Team (CIT) training, a specialized police curriculum that aims to train law enforcement to safely respond to encounters with people with mental illness.

   With regards to your comment on assisting schools with early mental health supports, The Children and Youth System of Care (CYSOC) committee, is an inter-agency collaboration between BHRS, SMCOE, Probation, Human Services Agency/Children and Family Services and the Special Education Local Plan Area (SELPA) District that meets monthly to coordinate prevention, early intervention and treatment capacity so that children and youth have the best opportunity to succeed in school and achieve optimal mental health. Your feedback will be forwarded to the group and I have included the BHRS Deputy Director of Youth Services in this email to facilitate that dialogue.

Again, huge appreciation to the Commission on Disabilities for taking the time to provide such thoughtful feedback. BHRS looks forward to facilitating increased partnerships in this important work.

SOLUTIONS for Supportive Homes
1161 Granada Street
Belmont, CA 94002

June 30, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

Response to 30 Day Open Public Comment to MHSA 3 year Plan, 20-23

To the MHSA Commission:

Solutions for Supportive Homes strongly recommends language in the MHSA 3 year plan that names discrepancies or problems, links strategies to the problems and describes outcome or goals of intervention/strategies. A clear statement of priority of funding is needed. The Plan needs to reflect a change in both delivery of services and a change in services.

- We are not satisfied with reiteration of past plans.
- We are not satisfied with the results of past plans.
- The lack of change in response to direct community stakeholder request is disheartening.
- We are not satisfied with a promise of involvement as stakeholders in future planning.

Urgent issues span the whole continuum of care, including, most markedly, the housing continuum. There is a need for **Supported Housing**, and a clear definition of Supported Housing.

- The first point of scarcity is about to be exacerbated: limited acute psychiatric beds. Because of scarcity of stepdown care, clients remain on 3AB beyond the acute stage of their illness. Clients needing acute psychiatric care experience extended traumatic stays in PES. We strongly recommend conducting needed structural modifications to 3AB and resuming present bed count.
- Clients need different levels of and types of support during recovery. Contractors providing Full Service Partnership care need to be adequately funded to do so. Intermediate levels of care need to be available for non-FSP clients.
- BHRS and its contractors, with MHSA support, need to make movement toward a level of staffing with the range of needed professionals, including

peers, and appropriate intervals of reassessment, to make the care congruent with client needs.

- All programing needs to be based on recovery-oriented, whole person, evidence based practices. This support needs to be brought to where the client is. Consider providing higher intensity services by BHRS/contractor staff in settings such as board and cares, as well as already "supported" settings when client need increases.
- On-site support in housing is needed for both assistance in independent living skills and acting as liaison to the individual's support services or emergency services as needs arise.
- Current client/support staff ratios are inadequate for real-time benefit.
- Finally, it is not realistic or fair to prioritize services away from clients whose family and community are currently providing sufficient support to keep the client out of PES or incarceration, but not prosper. An actual strength (family and community support) ends up hindering recovery in the present system.

In closing, there are several models of supportive homes: multi-unit buildings with on-site health and social services, shared cooperative houses, groups of units set aside in large affordable housing developments linked to local health and social service, tiny home villages and mini therapeutic communities with on-site employment opportunities. These are strategies that not only prevent homelessness, they can be life-saving and ultimately cost saving.

No single investment of MHSA funds can do more good than investment in quality supportive homes. Please help make supportive homes a reality.

Submitted by

SOLUTIONS for Supportive Homes
Inclusive living environments for adults with mental health and cognitive disabilities

Carolyn Shepard – J092048@aol.com, (650) 595-5635

Melinda Henning	Joan Dower-Wilson	Tanya Frank
Karen Shea	Linder Allen	Dorothy Christian
Helene Zimmerman	Jean Perry	Jem Quesinberry
Mary Beaudry	Fara Presto Chan	Michael Lim

Response to Letter from SOLUTIONS for Supportive Homes

Dear Carolyn,

Thank you so much for taking the time to submit a thoughtful public comment on behalf of SOLUTIONS for Supportive Homes for the MHSA Three-Year Plan. The MHSA Steering Committee, the Mental Health and Substance Use Recovery Commission and stakeholders agree with your sentiments regarding the urgency of having a continuum of care in relation housing services. Housing was the initiative prioritized in the MHSA Three-Year Plan for strategic planning investment. While the MHSA Three-Year Plan is not this strategic plan, it is intended to identify gaps in services, identify potential solutions and strategies and prioritize these strategies for funding as it becomes available.

We engaged over 400 individuals in this process via online surveys (329 respondents) and 28 targeted and geographically-based input sessions. Through this process we distributed 57 stipends to clients and family members that participated in providing input. Having diverse stakeholder participation is something that is very important to BHRS and we've held MHSA in San Mateo County to a high standard of ensuring diverse voices are represented. I can assure you that stakeholders will be involved in the strategic planning for a continuum of housing services. Your feedback will be incorporated into that planning process and I look forward to working with SOLUTIONS for Supportive Homes on this effort.

In the meantime, I will be sharing your comments with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review and consideration of changes to the Three-Year Plan. Your comment will be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisors and the State Mental Health Services Oversight Commission and the Department of Health Care Services as formal public comment.

Thank you again for taking the time to submit this very important perspective!

July 20, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

To the members of the Mental Health and Substance Abuse Recovery Commission,

The MHSA Commission is designed to play an important role in crafting how BHRS and our county approach the complex challenges of serving our citizens who struggle with a wide range of challenges, including those related to mental health and substance addiction.

We have noticed over the years that while community input has evolved, the basic tools used by the county to address these complex needs have remained the same. There have been positive improvements, especially including peer and family support team members. However, the basic "business model" used to work with non-profit community-based organizations and the community in general has stayed the same.

We believe that this basic model is unable to provide stable, sustainable services over the lifetime of needs experienced by our citizens. Our non-profits are tied to three-year county-funded contracts that typically don't provide sufficient funding to fully support a team of well trained, experienced care providers who are paid enough to live in our county. And of course the county budget is tied to the macro-economic tides impacting the state budget and the federal budget.

The most experienced team members are often syphoned off into county or other programs – or other counties - that can provide a more livable wage and benefits. The constant turnover is hard on clients, their families, and the remaining team members. Even the non-profits themselves are challenged to sustain their presence in our county because of the cost of office space and living.

The structure of the county contracts can leave little room to integrate "lessons learned" and can stifle synergy between groups.

Some of our most effective non-profit services, such as Edgewood's Transition Age Youth program, provide an array of holistic well-being supports and services that don't typically exist in the "for-profit" arena. Our county is home to many high-income citizens whose families would benefit from these services, and who probably don't even know they exist.

We would like to urge BHRS and the county Board of Supervisors to explore directly how our diverse community can collaborate to create new business models for

integrated care, and new funding models beyond the basic "ask the county and a few donors to pay for it" approach.

Think of it as working toward a sustainable ecosystem that will support and nurture the long-term evolution and survival of truly effective, integrated care for our citizens.

San Mateo County is home to a large number of companies, including non-profits, that were created around novel business models. We have a well-established biomedical industry that evolved from a hardy band of startups back in the early 1980s. We have a thriving and diverse population of companies exploiting information technology and engineering. We have companies that have merged several new areas together in unexpected ways to create better approaches to the challenges we all face.

We have many entrepreneurs who are experienced in looking beyond the usual way of doing business. And many of these people are directly impacted by mental health/substance addiction challenges - in their own families and close friends or affecting key employees in their companies.

The huge impact on quality of life and costs has caught the attention of companies that employ large workforces. These companies are highly motivated to find ways to bring better health care to their employees.

We challenge BHRS and the county Board of Supervisors to proactively pursue collaborations to explore creating new business approaches that can couple the impressive experience and knowledge existing in many non-profits with the entrepreneurial ideas and networks existing in our county's private and corporate citizens.

Sincerely,

Cynthia Robbins-Roth*
Jean Perry Verley**

*CRR came to the Bay Area in 1981 as a research scientist at Genentech. She worked in business development before becoming an industry consultant and journalist/founding editor of BioVenture View, BioWorld, and BioPeople Magazine.

Following a serious accident, CRR and her family gained first-hand experience in searching for effective mental health and family supports in San Mateo county, and dealing with the huge impact of serious illness. CRR worked as a Family Partner and manager at Edgewood Center for 11 years before retiring.

**JPV came to the Bay Area in 1978 as a graduate student at UCSF. During her career as an Advanced Practice Nurse she provided direct care in community clinics and contributed to translational research in women's health.

During her unintentional career as a family member with lived experience, she and her family have benefitted from Full Partnership Services from Edgewood Center for Children and Families, NAMI support and educational services and BHRS's Lived Experience Education Workgroup.

Cc: Scott Gilman, director, San Mateo County Behavioral Health, San Mateo County Board of Supervisors

Response to Letter

Dear Jean and Cynthia,
Thank you so much for providing such a thoughtful public comment about the current County business-model used to work with agencies to provide high quality, stable and sustainable behavioral health services and the recommendation to considering doing things differently, especially given the entrepreneurial resources in San Mateo County.

I will be sharing your comment with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review and consideration. Your comment will also be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisors and the State Mental Health Services Oversight Commission and the Department of Health Care Services as formal public comment.

Thank you again for taking the time to submit this very important perspective!