Housing Initiative Taskforce Meeting #3
MHSARC Older Adult Committee Meeting – 5/5/21

Question & Answer

1. **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. Is there flexibility with defining "at-risk of homelessness" for San Mateo County?**

   A: Yes, there is flexibility, and this will be decided for San Mateo County once we are ready to roll-out implementation of new MHSA-funded housing. Currently, there are three definitions (attached) that have been used by different housing programs including the San Mateo County Office of Homeless, the MHSA Housing Program, and the No Place Like Home.

2. **Department of Housing already has a housing service available would it make sense to work with the existing program rather than duplicate services?**

   A: Yes, this is a Guiding Principle to build off of what is already available and not build anything new. The DoH is funding a housing portal and we will see if there is a way to build off of it.

3. **Is the housing portal going to integrate all the other housing portals or a separate point of entry? Does it address the easy access, one point of entry outcome?**

   A: This would not be a stand-alone portal, it will be for any individual with serious mental illness to be able to get information on all housing availability.

4. **Will this portal require that someone have a diagnosis to be able to receive services?**

   A: No, the priority will be to build off of current portals available via the DoH and to be supported by housing navigators that are familiar with the nuances of different eligibilities and supports for individuals with mental health challenges.

5. **I had success using the housing portal to locate housing but was given 5 days to get the unit and no moving support or support to get paperwork together. Will there be support for individuals to maintain their housing?**

   A: Peer navigator services is a funding recommendation for the ongoing MHSA budget that could support clients after identifying housing.

6. **Will these housing navigators be embedded into existing teams that are already doing some of this work to expand and improve vs. separate team?**

   A: These are the types of considerations we would like input on to inform the design of the services so that it is most effective.

7. **What will be the outcome of the portal for a client, what will that person get?**

   A: It would be a starting point to gather information and be linked to resources and housing navigators to get clear instructions on the processes for what is available and how to apply. A client and a case manager can go through the information together and develop next steps as a joint effort but, having one place to go to for individuals with mental health challenges, is currently not available. It will need to be a collaborative effort with Department of Housing.

8. **How is this portal envisioned? Is it interactive, question and answer forms?**

   A: Other than a basic concept, the portal is not designed yet. This will be part of the planning process; which can take a look at what could be included and other models.

9. **Regarding mental health supportive housing has any thought been given to surveying existing tenants for satisfaction?**

   A: Currently, we have a statewide Multi-County Full Service Partnership Project looking into the standards, quality and outcome reporting to make recommendations for FSP improvements. This process is being informed by FSP clients and family members via focus groups and interviews. A Progress Report of this project can be found here, https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf

10. **Is there an "easy" process for providers of clients who have "graduated" from FSP, to re-enter, to re-engage in some or all of the services?**

    A: Referral to and participation in FSP is based on an individual's level of functioning in the community at the time of referral. They would start at the highest level of service. As their functioning improves and their service needs lessen, they would step down into a lower level of care provided by the FSP. If they reach a level of independence that would make them eligible for "graduation" their care and case management would be provided by the regional clinic. Should there be a need to return to an FSP level of care, the case manager would make a new referral. Timing of re-enrollment would depend on the availability of FSP slots. However, some of the services might be available through other means without the FSP. The individual should work with the case manager to secure the needed services.

11. **When clients are no longer in FSP what are the menu of services that these clients have access to? How can we address this gap? What is the safety net and intentional ongoing support after making progress and graduate?**

    A: Right now, if a client step-down from FSP they are supported by the regional clinics unless they qualify for a specialty program like OASIS for older adults that are homebound. It depends on the client's individual situation, what they qualify for and what they are interested in. Most of the time they move into a wellness tier within FSP where they continue to stay in the program so that they are monitored before they're fully exited.

    There is a recognition that stable housing is a contributor to an FSP participant's progress so separating a client from housing without supports is detrimental.

MHSA Housing Initiative Taskforce

Definitions of At-Risk of Homelessness

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 is flexibility with how we define "at-risk of homelessness" locally this will be decided for San Mateo County once we are ready to roll-out implementation of new MHSA-funded housing. Following are three definitions for at-risk of homelessness currently used by different housing programs:

1. San Mateo County Office of Homelessness

Mckinney- Vento Act CFR 578.3 - At risk of homelessness.

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, ***e.g.,*** family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan

2. MHSA Housing Program

At risk of homelessness includes the following:

- transition-age youth as defined in Welfare and Institutions Code Section 5847(c), and in Title 9, California Code of Regulations, Section 3200.80) exiting the child welfare or juvenile justice systems
- individuals discharged from:
    - hospital, including acute psychiatric hospitals, psychiatric health facilities (PHF);
    - skilled nursing facilities (SNF) with a certified special treatment program (STP) for the mentally disordered;
    - mental health rehabilitation centers (MHRC)
    - crisis and transitional residential settings; and
    - city and county jails.
- Individuals temporarily placed in a Residential Care Facility upon discharge from one of the above.
- Individuals who have been assessed and are receiving services at the County Mental Health Department, and who have been deemed to be at imminent risk of homelessness, as certified by the County Mental Health Director

3. No Place Like Home (NPLH)

"At-Risk of Chronic Homelessness" for this Program means an adult or older adult with a Serious Mental Disorder or Seriously Emotionally Disturbed Children or Adolescents who meet one or more of the criteria below. All persons qualifying under this definition must be prioritized for available housing by using a standardized assessment tool that ensures that those with the greatest need for Permanent Supportive Housing and the most barriers to housing retention are prioritized for the Assisted Units available to persons At Risk of Chronic Homelessness pursuant to the terms of the Project regulatory agreement. Qualification under this definition can be done in accordance with established protocols of the Coordinated Entry System, or other alternate system used to prioritize those with the greatest needs among those At-Risk of Chronic Homelessness for referral to available Assisted Units, that meet the requirements of these Guidelines, including but not limited to, Section 206 (Occupancy and Income Requirements), and Section 211 (Tenant Selection).

Persons qualifying under this definition are persons who are at high-risk of long-term or intermittent homelessness, including:

(1) Pursuant to Welfare and Institutions Code Section 5849.2, persons exiting institutionalized settings, such as jail or prison, hospitals, institutes of mental disease, nursing facilities, or long-term residential substance use disorder treatment, who were Homeless prior to admission to the institutional setting;

(2) Transition-Age Youth experiencing homelessness or with significant barriers to housing stability, including, but not limited to, one or more evictions or episodes of homelessness, and a history of foster care or involvement with the juvenile justice system; and others as set forth below;

(3) Persons, including Transition-Age Youth, who, prior to entering into one of the facilities or types of institutional care listed herein, had a history of being Homeless as defined under this subsection (f)(3): a state hospital, hospital behavioral health unit, hospital emergency room, institute for mental disease, psychiatric health facility, mental health rehabilitation center, skilled nursing facility, developmental center, residential treatment program, residential care facility, community crisis center, board and care facility, prison, parole, jail or juvenile detention facility, or foster care. Having a history of being Homeless means, at a minimum, one or more episodes of homelessness in the 12 months prior to entering one of the facilities or types of institutional care listed herein.

The CES (as defined in Section 101(n)), or other local system used to prioritize persons At-Risk of Chronic Homelessness for available Assisted Units may impose longer time periods to satisfy the requirement that persons under this paragraph must have a history of being Homeless.

(4) The limitations in subsection (w)(a)(iii) pertaining to the definition of “Homeless” shall not apply to persons At-Risk of Chronic Homelessness, meaning that as long as the requirements in subsections (f)(1) - (3) above are met:

i. Persons who have resided in one or more of the settings described above in subsection (f)(1) or (f)(3) for any length of time may qualify as Homeless upon exit from the facility, regardless of the amount of time spent in such facility; and

ii. Homeless Persons who, in the 12 months prior to entry into any of the facilities or types of institutional care listed above, have resided at least once in any kind of publicly or privately operated temporary housing, including congregate shelters, transitional, interim, or bridge housing, or hotels or motels, may qualify as At-Risk of Chronic Homelessness.