San Mateo County Behavioral Health and Recovery Services FY 2022–23 Full-Service Partnership Program: Qualitative Analysis Memo

Manxi Yang, MPP, Cristian Valenzuela, MA, MSc., Danielle Agraviador, MPH, Meera Ragunathan, Christine Walsh, PhD, Tania Dutta, MPP, PMP

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Introduction

The Mental Health Services Act (MHSA), enacted in 2005, provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through full-service partnerships (FSPs). FSP programs provide individualized integrated mental health services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. There are currently four comprehensive FSP providers in the County: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch), serving children, youth, and transitional age youth (TAY), and Caminar and Telecare, serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in an FSP is promoting resiliency and improving health outcomes of the County's clients living with mental illness. In this year's evaluation, in addition to the quantitative assessment using self-reported and Electronic Health Records data, AIR has carried out qualitative data collection and analysis to complement the evaluation. AIR conducted key informant interviews (KII) with FSP clients and members of the wraparound treatment team to understand their experiences with the FSP program, perceptions of impact, and factors affecting the implementation of the FSPs in San Mateo County. This memo provides interim analysis results for the completed KIIs. Information from the interviews will be used to complement quantitative data collection and analysis and incorporated into the final evaluation report for FY 2022-23.

Qualitative Evaluation Questions

The qualitative data collection and analysis aims to answer the following Evaluation questions:

Clients

1. Client experiences – how do clients perceive their experience with FSPs?
2. Interaction with wraparound treatment team - how is the wraparound treatment team helping clients achieve their goals?
3. Impact of pandemic – in what ways did the COVID-19 pandemic affect FSP services and client experiences?
4. Future of FSP – what changes do clients recommend for improving their FSP experience?

Treatment Team Members

1. Wraparound treatment team (integrated and comprehensive) experiences – how does the wraparound treatment team perceive their experience with FSP?
2. Client services and outcomes – in what ways are wraparound treatment team members using the FSP program to address the behavioral health needs of clients they serve? How is success measured?
3. Impact of pandemic – how did the COVID-19 pandemic affect ways in which services were provided for the FSP program?
4. Future of FSP – what changes do wraparound treatment team members recommend for improving the FSP program?

Methods

Participants

This analysis included 23 completed interviews, with 9 clients and 14 treatment team members. AIR worked with San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) staff and the four FSP service providers (Exhibit 1) to recruit clients and treatment team members. Exhibit 2 presents the number and types of clients and wraparound treatment team members that we have interviewed and included in this analysis across the FSP service providers. Note that we were not able to recruit any participants, either treatment team members or clients, from Fred Finch despite several outreaches.

Exhibit 1: FSP Service Providers

Service Provider	Description	Population served
Edgewood Center	Edgewood's FSP provides services to help clients stabilize and maintain current placements, while offering comprehensive mental health services.	Children, youth, and transitional age youth (TAY)
Fred Finch Youth Center	Fred Finch Youth & Family Services FSP serves foster youth and provides an array of services to promote wellness, resilience, and stability in the youth's home. Services include safety planning, behavioral interventions, as well as family and individual support.	

Caminar	Caminar FSP provides services to individuals who are among those in most need in San Mateo County and integrates streamlined, holistic health care utilizing the best-practice model of assertive community treatment. The team includes the added benefit of medical clinic services and a 24-hour on-call emergency response service.	Adults and older adults
Telecare	Telecare FSP provides "Integrated Service Delivery" to San Mateo County residents who have symptoms commonly associated with a profound psychiatric disability (or disabilities) and who may also have co-occurring disorders (such as substance use or medical conditions), and serious life stressors such as problems obtaining or maintaining housing or involvement with the legal system.	

Exhibit 2: Summary of Interviewees

FSP Service Provider(s)	Clients	Wraparound Treatment Team
Edgewood Center **Fred Finch Youth Center***	3 parents of youth program clients who have accessed services through FSP in the last year or are currently accessing services through FSP	• Program manager (1) • Emerging adult partner/Peer partner (1) • Family partner (1) • Behavior coach (1)
Caminar **Telecare**	3 older adult clients and 3 adult clients who accessed FSP in the last year or are currently accessing services through FSP	• Program manager (2) • Case managers (4) • Behavioral Health Clinician(s)/Substance Use Specialist(s) (1) • Crisis response workers (1) • Housing specialists (2)
Total Interviewees	**9**	**14**

*Fred Finch Youth Center was not able to identify any participants.

Interview Format and Length

Each interview lasted about 30 minutes in length and was conducted virtually using Zoom software. When participants had technical difficulty with the Zoom software, we conducted interviews by directly calling clients or treatment team members. The interviewer obtained consent and permission from all participants before starting the recording. There was one

participant who did not want to be recorded, for which a note-taker joined the interview and took notes.

Analysis

All interviews except one were recorded and transcribed. For the interview that was not recorded, we used the notes from the interview for the analysis. A deductive method was used to code the transcripts. We then conducted a thematic analysis of the concepts, exploring similarities and differences within and across participants.

FSP Treatment Team and Client Interview Findings

This section presents findings from interviews conducted with 9 FSP clients (6 adult and older adult clients and 3 parents of youth program clients) and fourteen FSP treatment team members across three service providers, including Edgewood, Telecare, and Caminar. AIR spoke with 3 parents of youth program clients who received services from Edgewood, 3 adult and older adult clients from Telecare, and 3 adult and older adult clients from Caminar. Of the fourteen treatment team members we interviewed, 4 worked at Edgewood, 4 worked at Telecare, and 6 worked at Caminar. Findings describe clients' and treatment team members':

- Overall experience and satisfaction with the FSP program.
- Perspectives on Referrals and Initiation of Treatment
- Experience with FSP Services and Care
- Opinions about FSP program services provided in response to needs
- Perspectives of the impact of the pandemic

We generally refer to the FSP clients, including parents of youth program clients, we interviewed as "clients", FSP treatment team members as "treatment team members", and FSP service providers, i.e., Edgewood, Telecare, and Caminar, as "service providers."

1. Overall Experience and Satisfaction with the FSP Program

a. Clients Experience

i. Overall experience.

Adult clients, **older adult** clients, and **parents** of youth program clients reported that they had overall supportive and satisfactory experiences with the FSP program and expressed appreciation for its positive impact on their or their child's mental health. In terms of improved quality of life, one **adult** client attributed the improvement of their mental health to the program and stated,

> *"It's hard for me to put in words how much I appreciate this program and the people involved in it that have come into my life because it's made it a better life for me and I'm a happier person now than I was, and a lot of it has to do with this program."* (An **adult** client)

Clients also shared that the program's services were beneficial, and they were able to access a multitude of resources, such as stable housing. These services provided clients with the support they needed and contributed to the improvement in their quality of life. For example, one **adult** client expressed gratitude that *"I'm not living in the homeless shelters or on the side of the hot freeway anymore,"* and another **adult** client explained that *"it's got so many services that helped me out with so much stuff and were really supportive to me toward everything I need."*

Two clients, one **parent** of a youth program client and one **adult** client, indicated that the support they received from staff members was encouraging. The **parent** of the youth program client appreciated that staff members were easily accessible, and said, *"when my daughter has had crisis, they have always been available to talk."* The **adult** client shared similar sentiments and explained that when they felt depressed or low in mood, their case manager was available to talk and go on a walk with them. After going on these walks, this client felt supported and experienced a lift in their mood. They elaborated,

> *"Sometimes I get depressed and my mood's really down, and then when I see the case manager, she'll lift me up and make me feel better just going for a walk. What we do is she meets me at my house and we go for a walk down to the ocean… And it lifts my mood sometimes… She try (sic.) and cheer me up a little bit and helps me a little bit, so it's nice."* (An **adult** client)

ii. Satisfaction Scale.

Clients were asked to rate their satisfaction with the FSP program on a scale from 0 to 10, where 0 suggested that the client felt not at all satisfied and 10 indicated that the client felt extremely satisfied. Over half of clients gave the program a score of 9 or higher, while the remaining rated the program between 5 and 8. All 9 clients provided a score for the FSP program.

One **adult** client, who gave the program a score of 10, cited personal growth as the primary reason for their high level of satisfaction. This client shared that their mental health significantly improved after enrollment in the FSP program and said,

> *"I'm doing better than I've ever done, really, in my life. My mental health's doing much better than it's ever done and it's a prime example of people watching over me and support and getting the support I need and the love from my family…I never done this well mentally in my entire life, so I'm grateful for that."* (An **adult** client)

Another **adult** client, who gave the program a score of 6, referenced an initial lack of communication as the reason for their lower level of satisfaction. However, they noted that there has been a recent improvement in communication and frequency of check-ins with staff members.

> *"Now that they're kicking in a little bit more frequently and checking in with me, I guess I'd say a six...It was a three though, the first year and a half to two years…They were very absent in my first two years as far as when they would show up and how they provided services."* (And **adult** client)

b. Treatment Team Experience

i. Overall experience

Overall, treatment team members from both **adult and youth** programs reported being satisfied with the work they are doing under the FSP programs. They referenced working with dedicated and passionate team members, helping clients solve their challenges, and enjoying the work as reasons for their overall satisfaction. A treatment team member from an **adult** program said,

> *"What I enjoy about it is that it provides me with constant challenges to work on and to try and overcome, so it's not boring. We are, I think, pretty good at selecting from people who are passionate about working with very difficult, often some of the most difficult clients in the county, and they require a great deal of moral support as it relates to really supporting them in doing, number one, a good job from a clinical perspective; number two, making sure that safety is provided for and so forth. Again, I really love doing mental health and challenging situations, so I enjoy it."* (A treatment team member from an **adult** program)

When asked about their experiences collaborating with others on the treatment team, treatment team members from both **adult and youth** programs also reported overall satisfaction. One treatment team member from an **adult** program said, *"Teamwork is a big part of what we do. We try our best to support each other and we never want to draw a line in the sand when it comes to the success of our members or our clients."* While many treatment team members reported having good cohesion within their existing teams, they also described challenges related to burnout and staff retention as well as communication with newer staff, management, or external agents. Treatment team members from both **adult and youth** programs stressed the importance of increased communication and collaboration among treatment team members, especially given possible turnover among staff. A treatment team member from an **adult** program said,

> *"I think we just need continuing communication and following up, constantly following up and not letting the ball drop. Because what happens sometimes is either there's a change of guard and then you have to start all the way from scratch. So I think maintaining a history of a client is also important. Usually what happens is I'll get a new case manager and then she'll come up to me with this big whole list of, "Oh my God, my client needs this, this, this, this." And I'm like, "Yeah, this has been an ongoing issue with your client and we've not been able to fix it." So I think what they need to do is make sure that each client has a background in a, like, face sheet (...) So I think communication and keeping track of what's happening with each client when there's a turnover transition, like a change of guard, would be good. So we're not starting from scratch again."* (A treatment team member from an **adult** program)

A treatment team member from a **youth** program said,

> *"I think if the actual TAY FSP members, if we met in some way regularly and talked about the clients, because maybe they have a client who would really benefit from the drop-in centers, but they haven't really talked to that person yet. Maybe we can be that kind of liaison for them. And I know that the clients who do go to the drop-in centers, we do talk about them with their treatment team. So that is helpful. So just maintaining that would be good."* (A treatment team member from a **youth** program)

2. Perspectives on Referrals and Initiation of Treatment

a. Experiences with FSP Program Referrals

i. Client Experiences.

Sources of referral seem to vary between **youth and adults**. All **parents** stated that their children were referred by their clinicians, including therapists, psychiatrists, and pediatricians from school, clinic, or hospital settings. For **adults**, a few clients noted that they were connected to the FSP program when they were in jail, one client mentioned that they were referred from a rehab facility and another client was referred from the hospital. Clients did not identify any issues or concerns in this process.

> *"Initially I was in, before I went to jail, I was living in encampments on the side of the freeway. I think when I was in jail, they set me up with Telecare services before I was discharged. So when I got into the recovery house, Free at Last, case managers started visiting me to see the doctor on the laptop. And so I got prescription medication, and approved with disability pretty quickly. But I believe it was a service that was connected with me before I was discharged from jail. So I had psychiatric services."* (An **Adult** client)

Clients described their goals when joining the FSP program. **Parents** of youth clients aimed to improve their children's mental health and obtain emotional help. One **parent** mentioned that

their child has serious depression and has made several suicide attempts, so they hope the program can help mitigate the depression and suicidal ideation. As for **adults**, some mentioned that they would like the FSP program to help them stay off drugs, get housing and employment, become independent, improve their mental health, and alleviate depression symptoms.

> *"So, my child had a mental health crisis and wanted to take his own life four times. He was accepted in three different hospitals, in San Mateo, San Francisco, and Sacramento. So, he had a therapist in [a clinic], and that therapist decided that he needed to be part of a more consistent program, where he could receive attention more frequently, including a weekly therapy session. So, they referred me to the [Service Provider] program. I was referred there from that clinic, also from my child's school, also from the hospital…" (A **parent**)*

> *"Well, I wanted to get clean and sober, and I wanted a roof over my head, and I wanted to get a real job...and I was on the street homeless and it was just a real bad role. So I tried to hook up with, first [Service Provider], and then [Service Provider], to help me out." (An older **adult** client)*

ii. **Treatment Team Experiences.**

Treatment team members from **adult and youth** programs noted that clients are typically referred to their organizations from the San Mateo County's Behavioral Health and Recovery Services (BHRS), which decides which service provider is more appropriate for a client in need of services. After the initial referral, programs typically have an intake process in place in which treatment team case managers and other treatment team members collect additional client information, share program materials with clients and identify treatment goals.

Most treatment team members interviewed said they were satisfied with existing referral processes they have in place. What makes referral processes successful, according to treatment team members, is having streamlined process, defined steps, and clear communication channels which allow the team to start serving a client as soon as they are referred. As mentioned by one treatment team member from a **youth** program, "*we definitely have our protocols to start serving [and] start moving like busy bees as soon as we get the referral (…). What I can tell you is that as soon as we get a referral from my supervisor, we have already a team that we start communicating. So, the communication piece definitely in coordination is something that works well*."

However, while they seem to operate well overall, some treatment team members from **adult** programs mentioned that they sometimes receive inaccurate client data or insufficient background information during referral processes. This makes the intake and onboarding process, as well as the experience of providing treatment and services, less efficient. The following treatment team members from **adult** programs, for example, shared how getting incomplete or incorrect information during a referral process can complicate or slow down the process of

onboarding clients, developing a pertinent treatment plan, or can raise issues when allocating a client in proper housing:

> *"The case manager gets a referral packet about a client's medications and diagnosis. The referrals [our case managers] get are not the best because they often do not have background information. [They then do their] own intake where they ask questions about their history, but this often takes months. There is information that professionals know, and psychiatrists know, which they [the healthcare professionals] do not share. If the referral process was more in depth, it would make the process of onboarding clients easier."* (A treatment team member from an **adult** program)

> *"If I'm not given accurate information [during the referral process]; if they [the client] sugarcoat it or kind of hide something and then we find out that something happened, that this client was actually evicted or is about to be evicted, then you're just enabling… (...)it's a snowball effect and it affects other people living around them and then affects the neighbors, then affects the property management then and then the bigger picture is if it affects the partnership and then we lose the apartment and then I can't house clients. Then it affects the clients directly that way too. So, I need accurate reporting on that*." (A treatment team member from an **adult** program)

Receiving accurate and detailed information is very helpful for the intake/onboarding process for a client.

> *"We try to get as much information along with the referral packet as possible. That includes previous hospitalizations and discharge summaries for mental health organizations for those hospitalizations or incarceration if there's interaction with correctional health. Med lists, stuff like that. (...) Receiving sufficient documentation. Now, of course, sometimes that's not available but receiving it when it is, is super helpful."* (A treatment team member from an **adult** program)

b. Experience with Intakes and Initial Interaction

i. Client Experiences.

Some clients we interviewed have been with the FSP program for more than 10 years, others started receiving services from the program in the past 1-3 years. In general, clients reported neutral experience with their first interaction with the FSP program. Two clients mentioned that the first appointment was about information gathering and introducing the program and the services, another client noted that they did not know what to talk about with their therapist in the initial appointments, which has improved over time. Two clients expressed some frustration about their initial interaction, which occurred during the COVID-19 pandemic. One of them noted that their first appointment was during the pandemic, and the program staff showed up without notice at their recovery house for their first virtual appointment. The other client also mentioned

that their first appointments (in the past year or so) were over the phone, and it took them a lot of effort to get in-person appointments.

> *"They just arrived at the recovery house and was like, "We have a doctor's appointment on the laptop that we have to do." And since it was COVID-19, we had to take precautions for me to be set up in a separate house that didn't bring the case manager in and exposed anybody else that was in the residential treatment house. And so it was really awkward and they didn't preannounce that they were making an appointment or anything with me. They just showed up and had the laptop for me to meet with the doctor."* (An **adult** client)

Another client also mentioned that their first appointments (in the past year or so) were over the phone, and it took them a lot of effort to get in-person appointments.

ii. Treatment Team Experiences

According to treatment team members from **adult** programs, all programs have clearly defined intake processes which take place in the following days or weeks after a client has been referred and assigned to a program. Intake processes include sharing informative program materials with clients about existing FSP services and safety plans; collecting client information (e.g. contact information, other background information, family and medical history, substance use and housing history) which adds (or corrects) initial information received during referral processes; completing client forms; assessing client needs and problems; identifying existing legal issues (e.g., conservatorship) release of information forms (ROIs) and emergency contacts; defining client goals; and elucidating appropriate services or a treatment plan or problem list in order to achieve said goals.

For **adult** programs, While case managers take the lead as the initial point of contact during a client's intake, they often collaborate with other treatment team members (including therapists or clinicians) throughout the intake process, each meeting with the client at different moments to collect all necessary information. Additionally, housing staff may also carry out their own intake processes, which include their own assessment and research into a client's prior residential information.

As a result of the intake process, and based on each client's goals, some **adult** programs develop a treatment plan, which is designed by the clinical team in collaboration with the case manager. Each treatment plan is unique and follows the needs of the client as well as the assessment by the clinical team. According to a treatment team member from an **adult** program:

> *"…[the treatment plan] is client based. They work with the client directly to see what types of goals or interventions they would like. [The treatment team] worked with a client recently who felt isolated and lonely, they explored what that would look like and how to support her, by connecting her with resources like the YMCA (…) The client and the CM*

develop this, and the client has to sign this when it's completed." (A treatment team member from an **adult** program)

Other **adult** programs have decided to stop designing defined treatment plans and, rather, create problem lists for clients that they address throughout treatment and services. As one treatment team member from an **adult** program said:

> "*We don't necessarily do a treatment plan anymore. We have problem lists. We kind of identify, whatever was on the referral on the problem list, and then as we meet with the client and we talk with them and get to know them more, we can add more items to their list. For example, some of the things that we have frequently on people's problem lists are needs assistance with accessing community resources or communicating with providers. We can support them with those things. It's not a formal treatment plan, but we talk to them about their goals and then we provide interventions to support them to take steps to get towards their goals. (…).*" (A treatment team member from an **adult** program)

Interview participants who were treatment team members from **youth** programs did not serve in roles where they took part in the intake process, however they shared that they do collect demographic information from clients. One treatment team member from a **youth** program said, *"We ask demographics, for when we report out, of course, so we'll ask in terms of race, gender identity, also system involvement…but we'll ask if they had IEPs in schools, or if they're in the foster youth system, et cetera. Then we also ask what they are interested in. Are they interested in ... Is it socialization with their community? Are they interested in getting food or hygiene or bus tickets? Like physical resources. Or if they're interested in learning how to get a job or applying for school. Things like that."*

These participants did not mention involvement in the development of client's treatment plans. One treatment team member said that in their role they work under client's treatment plans, but they also create their own behavior plan. They said, *"So although I'm working under the diagnosis from the clinician, I'll create a behavior plan specific to the behaviors that are occurring due to the diagnosis. So those will range from aggressive behaviors to isolation, suicidal ideation, school refusal, elopement, just to name a few. And so what I do is create a plan to solely focus on minimizing and reducing those behaviors."* Another treatment team member said they create a plan of care with their clients. They said, *"We have what we call plan of care. So we have once a month family meetings that we call family conferences. We all gather together. When I say we as the treatment team, the facilitator who is very neutral, doesn't know much about the family and the family, and it is their voice. They choose the different domains."*

3. Experience with FSP Services and Care

a. Clients Experience

i. Experience with Case Manager

In general, clients are satisfied with and appreciative of the support from their case managers, although people may have varied experience depending on who they work with. Several themes emerged from clients' feedback, including accessibility and responsiveness, support and guidance, variability in case manager assignment, trust and communication issues, and skills and personalities.

- **Accessibility and responsiveness:** Some clients reported that their case managers were highly accessible and responsive. They appreciated being able to reach out to them even outside of scheduled meetings. However, others had a different experience, where they felt that the case managers were not as responsive as they would have liked, often attributing this to case managers being assigned too many clients.

  > *"And she's pretty good when she's around, but she's not always around 'cause she's got a lot of clients, and sometimes I can't get ahold of her and sometimes things don't work out, but I'm still hanging in there with her, and seeing what we can get accomplished and that's all I can do... just hang in there with her."* (An older **adult** client)

  One older **adult** client shared that engaging in more discussions with staff about external resources, such as stable housing, would be beneficial. They expressed frustration that staff members occasionally missed scheduled meetings where they were supposed to discuss obtaining access to long-term housing, and stated that *"…If I'm waiting on these people and they don't come by, it really frustrates me, but I got to wait on them because I can't do it myself. I can't do it myself."* One **parent** of a youth program client had a similar perspective about communication, and mentioned that *"there is not as much communication as I would like."* This **parent** added that, after coming back from a vacation, they did not hear from staff members about scheduling more therapy appointments for their child. They stated that regular therapy sessions helped their child by allowing her to *"express herself better, talk more, and overall share what she was feeling in a better way,"* and felt that engaging in more communication with staff members, in order to schedule consistent therapy appointments, would be beneficial.

- **Support and Guidance:** A recurring theme was the valuable support and guidance that case managers provided. Some clients felt that case managers were effective in understanding their issues and guiding them toward solutions. Especially when the clients

were dealing with emotional concerns or insecurity, case managers were acknowledged for offering reassurance and stability.

> **"***Well, just a lot of insight like with questions that I have about certain things and stuff about recovery and staying stable and stuff like that. When I get insecure about like when my mom passes away, what I'm going to do with myself? That is when [case manager] helps me, reminds me that everything's going to be all right and stuff like that. I'm really grateful for what [case manager] does."* (An **adult** client)

- **Variability in Case Manager Assignments:** Some clients expressed dissatisfaction with being assigned to different case managers. They noted that they were not always sure who their assigned case manager was, which sometimes led to issues in communication. Additionally, they experienced variation in the quality of service and responsiveness from different case managers.

  > *"That really varies because each week I have a different case manager assigned to me. And [CM1] will be my next week's case manager, and they never respond to my text messages and never show up for any appointments when I'm assigned to him. But then there's [CM2] and [CM3] who call and check in on me when they're assigned to me for the week that they have."* (An **adult** client)

- **Trust and Communication Issues:** Trust emerged as an important factor in the client-case manager relationship. Some clients felt uneasy having certain case managers involved in personal aspects of their lives, due to concerns about judgment or lack of trust. This sometimes created a barrier in communication and collaboration.

- **Case Manager Skills and Attributes:** The personality and skills of case managers played a role in client satisfaction. For example, clients spoke highly of case managers who they felt were empathetic, supportive, and efficient. However, clients were less satisfied with case managers they perceived as unresponsive or lacking in communication skills.

ii. **Experience with Other Treatment Team Staff**

In general, clients had positive experiences with other treatment team members, including psychiatrists, therapists, and other staff. Many clients appreciate the support and assistance they receive from the clinicians in the FSP program and acknowledge the positive impact on their mental and physical health from clinicians and other staff. Some clients noted that there are areas for improvement, including ensuring consistency in therapy sessions, and improving attention and preparation for appointments. Additionally, the personal connection and comfort level between the clients and the clinicians emerged as an important factor in the clients' satisfaction and perceived effectiveness of the services. We summarized some emerging themes below:

- **Positive Impact**: Several clients shared that the other (than case managers) members of the wraparound team played an essential role in supporting their children or themselves. For example, one client spoke positively about how the wraparound team helped their son with emotional regulation, communication skills, and organization of thoughts. Another client expressed satisfaction with the support from a therapist and how it led to significant improvements in their life. One client felt comfortable with their psychiatrist, appreciating her therapeutic approach and consistent encouragement towards achieving personal goals, such as sobriety, eating healthy, and maintaining wellness.

  > *"So they had helped him stabilize and grow up emotionally so that he wouldn't get exasperated over everything...And I think they also helped him quite a bit with his confidence to socialize with his peers […]Trying to get him organized and thinking through things...So they helped him get his thoughts in chronological order, where before he was really just spread out everywhere. […] they really helped with his communication skills quite a bit."* (A **parent**)

- **Personal Connection and Comfort**: A few clients felt comfortable and connected with their psychiatrists, therapists and other staff, indicating that this connection was crucial for them. They appreciated when their treatment team members were attentive and understanding, making them feel valued and understood.

- **Lack of Attention or Not Meeting Clients' Needs**: However, some clients shared concerns regarding inconsistencies in services and a lack of preparation or attention from certain clinicians. One client mentioned frustration with a psychiatrist who seemed unprepared and distracted during appointments, which led to confusion about medication. Another client expressed dissatisfaction with their therapy, feeling it wasn't meeting their needs.

  > *"And that's because when I'm on the phone with [Psychiatrist] or on the laptop with him, a majority of the times he's commuting into work and doesn't have my file with him or we're over the phone and he's had people come into his office and have conversations with him while I'm trying to have an appointment with him over the phone. So I just gotten frustrated that he doesn't seem to remember who I am or remember what medications we're even discussing because he's not prepared, or his attention's distracted. So they're going to have me meet with a new doctor."* (An **adult** client)

- **Lack of Regular and Consistent Sessions**: One **parent** raised a significant concern for the availability and consistency of therapy sessions. They specifically emphasized the need for more frequent and consistent sessions for their child, who was struggling with mental

health issues, including recurring suicidal ideation. The lack of regular sessions was seen as detrimental to the daughter's wellbeing.

> *"And since April, they've now only been able to schedule one appointment with my daughter. Only one! What I see is that the time it's taking…. I've always fought for her, to get her treatment. […] And now, next week, [Treatment Team Member] also cancelled because she will be out, and my daughter will again go on for two weeks without a session. So, what I want to say is that I do think my daughter has improved with this program, but I still feel she needs more intensity, more frequency of a treatment. […] I was just saying that I do see changes in my daughter, especially when the therapy is more consistent and regular. But now, I see her more unbalanced."* (A **parent**)

- **Concern about Unusual Therapy Methods:** One **parent** reported a concerning experience with a behavioral health therapist who employed unorthodox methods, such as having the child eat chili peppers during therapy. This led to a breakdown in communication and trust between the family and the program.

> "*The second session was also at home. And for that session they made my child eat chili peppers. And when I saw that, it didn't seem right to me. I don't know much about this, but I kept my mouth shut. So I didn't agree with eating the chilis as part of the therapy. But if that's how it works, I'll let it be*." (A **parent**)

- **Expansion and Clarity about FSP Services:** One **parent** of a youth program client recommended that the program should be expanded and offered to more people, and specifically suggested having group sessions for teenagers, so *"they can feel stronger or more confident"* as a result. One **adult** client expressed that they were still uninformed about different aspects of the FSP program, including what the program is supposed to provide and what they should expect from staff members. They elaborated,

> *"Just the fact that I'm still uninformed or don't have a real definition of what a full-service provider provides. I feel like I'm in the dark about what relationship we're supposed to actually have in that title. So it would be helpful to be more informed of what I could expect from them and not just fumble through it. And to have a clear idea of what I can anticipate in their provisions would be helpful." (An **adult** client)*

b. Treatment Team Experience

i. Assess clients' progress.

The way service providers assess clients' progress varies between them, and also may be different depending on each client's needs. Treatment team members from an **adult** program said once a final treatment plan with goals has been defined for a client (which can take up to 30 or 90 days, depending on the case), they re-asses client progress every three months and, in conversation with the client, identify barriers, completed goals, and update the treatment plan accordingly. To record these assessments, some staff from this service provider use Credible, an electronic software which records each client's treatment plan. Treatment team members also log progress notes in every assessment, which explains how each service provided is helping achieve each goal. While treatment team members had positive opinions about this assessment process, one treatment team member thought that the software choice was unnecessarily complicated and not user-friendly.

For this service provider, housing specialists have a regular inspection process in which they assess client's home safety and maintenance. They do not have standardized indicators, as housing challenges and needs vary client to client, but do ensure to check in on housing situations on a semi-annual basis:

> *"What we do is a semi-annual housing inspection. And we go to each apartment and of course we see how they keep their place. We do safety checks. Like, if the furniture is too close to the furnaces or if the boxes are blocking up the furnaces, if the entrances are blocked… So we do an assessment of safety, we do an assessment of maintenance needs, and making sure that the clients are not housing unauthorized guests. When we notice that the client does not meet expectations, we address those expectations."* (A treatment team member from an **adult** program)

Treatment team members from another **adult** program do not have a predefined structure to assess progress. The treatment team track advances in each case's progress notes and decides on a client-to-client basis how often to meet and discuss possible updates to a client's problem list. As explained by one treatment team member:

> *"So, I don't think that there's necessarily one specific way that we track progress overall. I think a lot of it is in conversations that we're having with our clients and observations that we're making. And I think most case managers probably document that in their progress notes. (...) I think that our program is still trying to figure out a better system to update [problem lists]. There's some things that the case managers are limited to where we can update. We can only add Z codes if we don't have any type of certification or license. And so, there's some things that we might need our supervisors or our nurse to assess for before we can add them to problem list. So, we don't have a system right now, but definitely, annually, when we're doing their consent packets and we're reviewing their chart, we look at those problem lists."* (A treatment team member from an **adult** program)

Lastly, treatment team members of a **youth** program shared a variety of ways they assess progress among clients. One treatment team member from a **youth** program said that behavioral coaches and mental health clinicians, who have weekly sessions with young clients, use a client dashboard which tracks client symptoms, behavior, and mood. This dashboard can then be used to generate data summaries which track client progress, can be shared with the parents and families, and inform any changes in the provision of services:

> *"[The Dashboard] is kind of an Excel sheet that we keep and it's a number system. Kind of like a graph scale that we're able to input numbers to say: "This week, behaviors happened three times a week for X amount of minutes." And then it provides us a graph to see: was this week a good week? Was it tougher? And that way it helps us to track the progress. And then also checking in on those weekly treatment team meetings with the team to see what's coming up in session with them when they're with the client, while also checking in with the parents for collateral to see what's going on in the home and see how effective are the tools that we're implementing to manage the behaviors and symptoms." (A treatment team member from a **youth** program)*

Other treatment team members from this **youth** program described using a web-based platform to track client's goals and take notes on their progress. One treatment team member said, "*Sometimes I might see a treatment goal like, "Client aims to practice meditation twice a week," or something. So I might check in and be like, "Hey, are you into mindfulness at all?" And then we'll talk about it and then we'll see how far they've gotten with that goal.*"

ii. Involving Family Members.

When asked how treatment team members involve family members or caregivers while treating clients, programs that serve **adults and older adults** shared that they gather information about their client's family members or caregivers' at intake and do not involve them without client's permission. For example, four treatment team members mentioned that a release of information (ROI) form needs to be completed for treatment team members to communicate with their client's family members or caregivers. A treatment team member from an **adult** program described the process of involving a client's family member, and how it can be beneficial to a client's treatment. They said,

> *"For instance, we get a new client and the client says, I have a really close relationship with my mom, so we have to get permission. Hey, do you give me permission to speak to your mom about your program goals and improvement and things overall, everything, the client says, yes, they sign, they give us the contact information, and then we just connect with them, if the client is disengaged a little bit or for whatever reason, we need to call their mom. If the mom was on the ROI release of information, we contact the mom. And sometimes it helps us a lot because sometimes the clients are not very honest or cannot always be honest with us. So*

getting someone else's point of view of, let's say the client lives with the mom and the mom can give us her point of view and help her, hey, your mom said that you need help with, I don't know, locating a job still and kind of helping us connect to help the client." (A treatment team member from an **adult** program)

One treatment team member from a **youth** program said they meet with the parents or caregivers of clients weekly as a way to involve them in a client's treatment. They said,

> *"What we do is we like to collect kind of behavioral reports from the parents. What were symptoms like, overall mood, any behaviors that were exhibited that were a challenge, and also positive things. When behaviors came up, were they able to utilize the tools? And then within those meetings we start to build kind of their toolbox. So we introduce them to coping skills, how to be that person that is able to co-regulate their child by using the tools. So a lot of times what I do is I'll role play with the family or the parents, depending on who is involved."* (A treatment team member from a **youth** program)

This treatment team member also shared that parents and caregivers have access to a crisis line that can assist them if conflict arises with the client after hours when treatment team members are not available.

Two treatment team members from **youth** programs said in their roles they do not communicate with client's family members. One treatment team member said, *"We can't really talk to their caregivers or parents or anything like that because of our confidentiality agreement. So we can't even disclose if they've been to the center or not."*

iii. Overall Success and Challenges.

When reflecting upon the overall successes and challenges of their FSP program, treatment team members felt overwhelmingly proud of the positive impact it has on their clients' lives. Treatment team members also shared what they perceived to be key successes and strengths of their programs, as well as relevant challenges or limitations.

- **Large interdisciplinary treatment teams:** a first major strength highlighted by treatment team members from **adult and youth** programs was the fact that the FSPs counted on a large treatment team, which include members from different backgrounds. Treatment team members valued the drive and commitment among their coworkers. While one treatment team member from an **adult** program said that the varied expertise allowed staff to learn from each other and problem solve more creatively, another valued the internal supervisions among team members which:

  > *"[Our main] strength I think is definitely having the huge wraparound team. And not only with the team being kind of large and supportive in that way, but we also meet for individual supervision. And then we have our pod meetings, which is*

similar to group supervision where we can really rely on management to help if we're struggling at any point with a case that we're feeling stuck and we're kind of hitting a wall, just getting that further consultation." (A treatment team member from a **youth** program)

- **Integration into community and social networks:** A major success of the program mentioned by treatment team members is helping clients integrate into and participate with the communities around them. While mental health services or housing support, both for individuals as well as entire families, are key pieces of the work carried out by the service providers, treatment team members saw them as steppingstones which allows clients to then connect with others and live independent lives. As said by one treatment team member, connecting clients with surrounding community activities provides a sense of autonomy that can significantly improve clients' quality of life:

  "I think for a lot of our clients [this program has] given them the opportunity to not be in an institution, and I think that that is really important. I think that we do have some clients who are fairly low functioning, but with the proper support, they are able to live at the community level and have some sense of freedom and independence. I think that it has definitely had a positive impact on the quality of life" (A treatment team member from an **adult** program)

- **Strong rapport and relationship with clients:** Treatment team members from **adult and youth** programs highlighted the rapport and relationship building between case managers and clients and mentioned the importance of providing a space and a connection for clients to be seen and heard by building an empathetic relationship as a key strength:

  "*A lot of clients come to me and say they're so appreciative of [program], that [program] is there for them to support them and listen to them and help them and guide them. And they're very, very, very, very appreciative of the support that they get from the case management team. Providing them empathy and just listening to them... It's very important for them to be heard and not just told what to do."* (A treatment team member from an **adult** program)

- **Limited funding and resources:** Multiple treatment team members from **adult and youth** programs mentioned limited funding as an important challenge faced by the FSP programs. One treatment team member from an **adult** program, for example, said that they felt constrained with the available funding to support clients' everyday needs, and wished that additional program funds were available to finance gift cards, transportation costs, or other logistical needs that clients often struggle to cover themselves. Another treatment team member from an **adult** program said that limited program resources

directly impacts program staff, as it reduces the amount of available trainings, keeps salaries low, and may make treatment team members feel undervalued:

> *"I think the main challenge is not having the resources to do things. First, there's not a good support system for our staff to have the training, and the education, and the confidence to go out and do the interventions and skills that we need to do. I think we have very poor training in our program and I'm very vocal about that. And I've tried to mitigate that by creating trainings, but there's just a lack of time. (…) And then of course pay. Pay is low for what we do. I've advocated for raises and stuff and been told no multiple times, which if I do ever leave this position, it'll probably be because I make as much as the next person that just started a week ago and doesn't have any skill. So I feel really undervalued in my position."* (A treatment team member from an **adult** program)

- **Staff capacity and staff turnover:** Another limitation is the capacity of treatment team members from both **adult and youth** programs and staff rotation, which overburdens existing staff and creates challenges when building rapport with clients. One treatment team member from an **adult** program said this was particularly challenging for case managers and behavioral health staff, who find themselves having to support too many clients at once: *"people are overworked. Ideally this program should work, but people are given too many cases. People are given too many crises to deal with at a time."* While more than half of treatment team members interviewed did not think that staff turnover was frequent, those who mentioned it said it could strongly hinder the relationship-building process between program staff and clients, many of which are navigating challenging emotional experiences:

  > *"I know it's a nonprofit and we have a lot of people and a lot of [turnover]. So people come and go and I see families many times get affected by that because they come to us with trauma. Sometimes losses, so even losing a person that is part of their [treatment] team is a big loss for them. They have connection, they develop rapport (…). So I wish we didn't have to do that, but it's part of life and people move on. That will be something that I see as a limitation."* (A treatment team member from a **youth** program)

Treatment team members from **adult** programs made recommendations that would help mitigate the challenges related to staff retention and burn out. This includes providing higher pay, more trainings for new and existing staff, and increased community building and mental health support. One treatment team member from an **adult** program said:

> *"The training, the support for staff, and retention of staff is the problem because we get really talented people. We get people that go out there and do it really well and then they leave and our clients suffer. And I think if we supported staff more, if they didn't feel like they didn't know what they were doing ... we've had a lot of clients in the past couple months pass away from accidents or physical health conditions. And I just talked to somebody this morning who was like, "I just need to keep working." And I'm like, "No, you've had two clients die this year, and one was this week." And I'm like, "You should take some time off." But again, there's no support for her to know what to do. And I'm fearful that she's going to burn out because she's dealing with intense things without support. So I think the biggest thing is the training and support for staff."* (A treatment team member from an **adult** program)

Treatment team members also made recommendations that would improve overall program operations. For example, a treatment team member from an **adult** program mentioned that they are getting more clients with a history of violence as a result of a state-level court changes, which may be a safety concern for their staff. They said:

> *"Some changes were made on the state level as it relates to us getting clients from the courts (...) we also get clients with quite a substantial history of violence. And I'm a manager, I got to look out for my staff's safety too. And we have to navigate some pretty dicey situations where we have, I need to provide for both the safety of my staff in addition to the safety of the client (…) "in addition to the lame 4% [cost of living increase]. I'm sorry, I can't mince my words on that. It's so profoundly disappointing. My staff deserve to get paid better than that. Especially given all of the inflation. And we can't compete with other counties. We can't compete with other counties' CBOs. We can't compete with [Another service provider]. And the thing is, it's psychologically difficult work."* (A treatment team member from an **adult** program)

One treatment team member from an **adult** program and one treatment team member from a **youth** program requested bigger budgets that would go towards client and staff resources. Three treatment team members from **youth** programs requested more time and space to collaborate and communicate with upper management and other treatment team members. One treatment team member from a **youth** program said, *"I really wish we had some kind of meeting or something where we all come together and all discuss the clients and things like that. Because for now, when we do have meetings with clients, it's really just me and the other full-time staff members talking with the treatment team members, and then I relay it to the other peer partners, but not as good."* Another treatment team from a **youth** program said, *"I would also say with upper management, just being able to collaborate more frequently with the treatment teams since we're kind of*

doing the groundwork, and they'll check in periodically more so when crisis arrives. But I think it's important for them to know too, just kind of what's going on more frequently with the families that we're working with."

- **Lack of language diversity:** Three treatment team members (two from **adult** programs and one from a **youth** program) mentioned the need for more bilingual staff members. While all service providers had staff that spoke Spanish on their treatment teams, some specific roles did not have a bilingual member. Additionally, one treatment team member from an **adult** program said that they would like to have more staff that also spoke other languages, not only Spanish, to help all other non-English speaking clients.

  > *"I wish we could have more bilingual clinicians that they can really serve a specific need. If there's a language barrier, of course there's bilingual team members within the team like myself, but let's say a therapist will be a better fit if [he/she] speaks the same language of the parent."* (A treatment team member from a **youth** program)

- **Keeping housing:** Four treatment team members from **adult** programs described the extensive challenges of not only finding housing for their clients but also ensuring they remain housed. Respondents said that being able to stay in a home for an extended period is a major challenge they regularly encounter in their work, given the struggles that many clients have with substance use or carrying out activities of daily living. One respondent highlighted that the biggest barrier to successfully keeping long-term housing is substance use, as it can negatively affect relationship with property managers, neighbors or other community members in a significant way. In turn, housing specialists emphasize the need to communicate effectively with clinical and mental health members of the treatment team in order to provide continuous coordinated support:

  > **"***It's more difficult when the client has substance use issues. And that's the challenge when it comes to housing. Just because once they're under the influence it's very difficult. Unless they're high functioning alcoholic or high functioning, it's very difficult for them to maintain their housing (...) when they come out and start behaving, interacting inappropriately with other people around them, that causes a lot of friction. That's when property management gets involved. And then we have to either find other housing for them because it's very difficult"* (A treatment team member from an **adult** program)

  Two treatment team members from **adult** programs also had recommendations regarding housing. One treatment team member said, "*A day center for the homeless to me is the biggest need with San Mateo County."* Another treatment team member recommended

disconnecting housing from their program entirely, suggesting that clients' access to housing funding operate independently than access to other program services. They said,

> *"We really need housing to not be connected to the program. That's gumming up the works. Because we have clients that could otherwise step down to another program, but their housing funding through the subsidy program is connected to the program itself. And what happens is, yeah sure, I could discharge a client and they will lose their housing in decomp in short order. That's not a wise clinical choice, but it's an artificial barrier that's put in by the system, the way the system is operating. What would be much better is to have access to vouchers for our clients in the AOT program where they can get their housing and it doesn't matter what program they're in. That way we can step them down and they're not at risk of losing housing, and then therefore decomping, and they can continue their journey and step up into a different program as necessary or something like that."* (A treatment team member from an **adult** program)

4. FSP Program Services Provided in Response to Clients' Needs

The following section lists the various services that were mentioned both by client and treatment team member interviews. In accordance with the FSPs "all it takes" model, the services provided to clients are varied and tailored to individual needs. In general, all clients have received some degree of case management services, and either therapy or psychiatric services (or both). Some clients also receive logistical support and assistance with activities of daily living (ADLs), such as transportation, housing, parental and family support.

- **Case Management**: Clients have case managers assigned to them, with whom they generally meet once a week or once every two weeks. The case managers may rotate, and clients can meet them in person or via call. Case managers tend to be the main point of contact for clients, from the moment they initiate services. According to treatment team members, case managers coach clients throughout activities of daily living (such as managing budgets or personal hygiene), guide them through different services provided by the FSP, and provide socioemotional support by accompanying clients and checking in on them regularly.

> *"Linking coordination, processing their emotions, it varies from client to client. A client who wants to be connected to housing would be linked to vouchers or shelters depending on the clients need. ADLs, [if they] have a hard time managing, and if their hygiene has decreased, she will check in with them to assess barriers and then develop a plan to connect them to portable showers. If a client reports depression, she will call them to meet in person, if they report suicidal ideation,*

they will make a safety plan regarding triggers and how she can support them. (A treatment team member from an **adult** program)

"We do a little bit of everything. So sometimes we have clients who are homeless so we will connect them with core agencies if they're interested in being placed at a shelter. Or if they need access to food we can connect them to food resources, things like that. A lot of referring and connecting to resources. We also have some people who are not living at a supervised placement, and so they might need more help, more assistance with medication. And so we might deliver their medications weekly to them and kind of talk to them more about that, and how they're doing with taking them on their own and if they need additional support with that. We go to appointments with members if they want us to. We provide transportation if needed. And then, we also provide support with psychiatric appointment" (A treatment team member from an **adult** program)

- **Mental Health Services**: Clients also receive therapy services. Sessions typically take place once or twice a week. Family members are sometimes involved in these sessions, especially when servicing younger populations. Treatment team members highlight that therapy sessions, which may address a variety of issues such as anger management and coping tools, are key to helping clients in other aspects, such as maintaining housing or employment.

- **Psychiatry Services**: Clients have access to a psychiatrist for medication management, generally once every three weeks or a month. The meetings with psychiatrists can be in person, though often are conducted remotely (e.g., via Zoom or phone call).

- **Transportation Assistance**: Some clients receive assistance with transportation, but mostly on special occasions or for appointments. For instance, one **parent** mentioned their child being taken to bowling on his birthday and another mentioned receiving help with transportation for housing-related appointments and renewing a driving license. One **adult** client mentioned that the FSP program helped them receive services from a program that offer free bus or shuttle ride for the disabled. Case managers are most often the team member who provides transportation services or accompanies clients getting around when needed.

  "Oh, [Case Manager] has always offered me transportation to my psychiatry appointment if I ever wanted to go down there and see her in person. She's taken me to DMV to renew my license." (An **adult** client)

> *"Same thing I mentioned before when clients: a lot of transportation. A lot of clients need transportation services and they oftentimes have a preference of me transporting the clients, which I don't mind in that time that we are in the car. I take advantage to get to know the client more. Things like that. And the client… maybe because my client is Spanish speaking and she knows that I speak Spanish and I can translate for her. Maybe that's why she has a preference of me taking her."* (A treatment team member from an **adult** program)

- **Housing Assistance**: Clients receive support in searching for and securing housing. Some clients stay at housing facilities associated to the service providers. However, some clients reported difficulties in receiving adequate assistance, and one client reported that she had received a housing voucher but was not able to get help from the program staff in house hunting. Among the service providers, some have staff focused exclusively on helping clients find and secure housing, such as housing specialists or housing coordinators who work collaboratively with case managers. Housing staff also work to ensure clients stay housed by helping them understand leases, keep houses clean and ensure they follow tenant rules.

> *"And that's really been pushed hard by the director of the homeless shelter that I was staying at. She called a few times to ask why they weren't providing services and they hustled to provide a case manager within 24 hours to get me grocery shopping or help me move into my apartment and whatnot. Because they weren't really helping me apartment hunt when I got a housing voucher, like they should have. So I learned through the director of the housing or the homeless shelter that they were supposed to be providing more than they were."* (An **adult** client)

- **Parental and Family Support**: In addition to supporting the clients, the program also helps the family members. For example, one **parent** mentioned that there is a staff member who helps them as a parent, and that there is a teenage peer who meets with their child.

> *"In addition to the therapist we see a total of four people. The therapist, the psychiatrist, a man who helps me as a parent, and a younger teenager who also meets with [Child client]. She now goes mostly in-person. Only the psychiatrist is via zoom."* (A **parent**)

One **parent** stated that a therapist from the FSP program coordinated an emergency response when their child took many pills, though this action was taken without the consent of the family member and led to dissatisfaction with the program.

"So, the next week my daughter started to take pills again, all the Benadryl. I found her, gave her milk and told her I would take her to the doctor. So I reached out to [A Therapist] and I told her: look, I'm taking my daughter to the hospital because she took many pills, and I'm letting you know. And [The Therapist] said, OK, you can take her to the hospital or I can send our team. I and I said, don't worry, I'm letting you know that I will take her. Well, then the problem happened: as soon as I put on my shoes, I had five emergency vehicles here at my home. So, she called them. I had only called her to let her know what was going on. But I was very upset because they didn't respect what I had told them. What the ambulance was going to do, taking my daughter to the hospital, is what I was going to do." (A **parent**)

In addition to identifying the different services provided, treatment team members were also asked what they thought was the greatest need they encountered among their clients. Interestingly, treatment team members mentioned a wide range of priorities they considered as the highest need among clients. Multiple treatment team members from **adult and youth** programs mentioned social networks and support as the greatest need, as clients often felt lonely and had to navigate the challenges of creating bonds while experiencing mental health and housing challenges. As mentioned by the following treatment team members:

"I think that the biggest need is connection and social support. And maybe that's bias because of the pandemic. Most of the people I work with complain about feeling really lonely, really isolated, really not understood, really craving thought discussions with other people. Especially into the other problem is that they're really seen as just very much their mental health condition, not as people; and they're only surrounded by people that are also experiencing similar mental health conditions. (…) They feel really lonely, they feel really disconnected from the world, and I think that's the biggest need is to feel like they are connected to people because that will help with building self-esteem and interacting with the world. It's the biggest thing I see." (A treatment team member from an **adult** program)

"The greatest need that I've noticed in the years that I've worked with [service provider] is that I would say 75% of the clients that are referred to us and that we take have no family contacts. And so they kind of draw to us because clients look to us as family. The main way that we address the need is we, well, under our contract we have to meet with the member and have at least two contacts with the member per week. But for clients who need more attention than that, then we will definitely make that decision that we need to see them more than two times a week." (A treatment team member from an **adult** program)

Multiple treatment team members from **adult and youth** programs said that the greatest need among clients was managing activities of daily living, including tasks like managing personal finances, applying to jobs, accessing social benefits, upkeeping personal hygiene, and cleaning their apartments.

> *"Probably budgeting their finances. A lot of our members receive social security benefits, so they're on a pretty fixed income. And then connecting their other resources, so if they need to get CalFresh or if they are interested in building job skills, getting connected to VRS, which is vocational rehabilitation services. And then sometimes, it's just kind of coaching them on their ADLs. We have some clients who have a low level of insight, and so talking to them about what a hygiene routine looks like, how often you should be showering, what it looks like to take a shower, what kind of items do you need"* (A treatment team member from an **adult** program)

Accessing mental and behavioral health support was also mentioned as a greatest need, especially for individuals who faced suicidal ideation, aggressive behaviors. Treatment team members from **adult and youth** programs highlighted the importance of this need, as mental health challenges impact a variety of other aspects of life, such as finding and maintaining housing or employment, performing in school, or sticking to prescription medication.

> *"Overall, if I have to categorize, I would say there's a lot of aggressive behaviors that I'm seeing, needing support with a lot of suicidal ideation, school refusal (...) So those are some of the needs that I feel like I work on with the clients the most, is those kind of behaviors that are impacting just their day-to-day functioning."* (A treatment team member from a **youth** program)

5. Impact of the Pandemic

a. Clients Experience

When clients were asked about the impact of the COVID-19 pandemic on FSP program services, four of them indicated that the services they received were negatively affected. Clients' perspectives about the impact of the pandemic included inaccessibility of program services or external resources, virtual services being less effective than in-person services, and difficulty adhering to the six-foot social distancing requirement. For example, one older **adult** client expressed that the pandemic was a barrier to accessing treatment services and external resources, including stable housing. They stated,

> *"The COVID-19 really made everything haywire. It made everything a lot worse, and harder to get services…Harder to go to a house long term."* (An **older adult** client)

One **parent** shared that when their child's services transitioned to virtual platforms, they were not as effective as in-person services. They explained that *"it wasn't like they weren't trying, but I really do think…just being in front of them is a better situation."* An **adult** client indicated that they met with their case manager, who helped set up a computer for virtual counseling appointments, but they could not adhere to the six-foot social distancing requirement during these in-person interactions. They further articulated that having the case manager sit next to them during their virtual appointments was uncomfortable, and said,

> *"There was no way to not be six feet from each other. So I felt like we were constantly being exposed to whatever case manager was handling my case at the time... And even if we were gloved and masked, we still would have to sit next to each other while [the doctor] would be trying to have a small counseling session with me. And that made it awkward because it didn't feel confidential."* (An **adult** client)

Although their services were impacted by the pandemic, clients shared that treatment team members continued to support them. One older **adult** client expressed appreciation that treatment team members called frequently to check on them, brought food for them, and continued to offer transportation services.

> *"Well, during COVID they brought me food. They called and checked in and if I needed transportation they were there for that...Yeah, they just been through everything."* (An **older adult** client)

The second client, a **parent** of a youth program client, also indicated that they received food assistance from the program, and said,

> *"During the pandemic they helped us with some cards we used for food."* (A **Parent**)

On the other hand, one **adult** client reported that the services they received during the pandemic was actually increased and mentioned that they were able to get vaccines earlier through the help of the FSP program. They also noted that infected people from their housing program were adequately isolated and were provided with meal and supplies.

> "*It actually increased. I was able to get the vaccine during the first wave of vaccination, because where I live in my apartment, it's an enclosed apartment building. So we were able to get the vaccine at the first wave of them giving out the vaccine. [...] And we only had three COVID incidents in our 33 dwellings, 33 apartments. And we only had three cases and then they isolated us. I didn't get COVID, but the people that did were provided with meals in their rooms so they can isolate. They provided them with everything that they needed to. They quarantined one of the restrooms for them. They kept them isolated from the rest of us so we wouldn't have a outbreak.*" (An **adult** client)

b. *Treatment Team Experience*

Like clients, treatment team members from **adult and youth** programs also noted that the services they offered were negatively impacted. Treatment team members perspectives about the impact of the pandemic included having to limit services and resources, pivoting to meeting clients outside or virtually, and inability to connect or get in touch with clients easily. A treatment team member from an **adult** program said,

> *"COVID was a struggle because even though we worked through COVID, it changed our operating system because we used to have clients that come into our office and for clients that were homeless, it kind of felt like they always had a place to go. We went into COVID and we didn't have that option because clients weren't able to come into our office and we still aren't having clients come into our office. That's a big piece that our clients are missing. (...) it affected us in a big way because, during COVID, even though we were still working and were making contact with our members, we were only making contact through phone calls. And if a client had an appointment, before the pandemic we would take our clients to appointments. But once the pandemic hit we had to start outsourcing transportation for our clients to get to appointments because we weren't allowed to transport with clients."* (A treatment team member from an **adult** program)

A treatment team member from a **youth** program agreed that in-person services were impacted by the pandemic, but shared ways that their clients have adapted to the changes. They said,

> *"Well, definitely I believe that being one-on-one, eye to eye contact, being in person, hands on, yes, that definitely [was] impacted. But at the same time, until this day now, even though we can meet in person, at least with me, most of my families, they choose to be still [on] Zoom. And the reason being is because... they're saving on gas or time or they're tired from work. That means they're going to have more quality time with the families. So we adapt."* (A treatment team member from a **youth** program)

Recommendations

This section presents recommendations for both future qualitative data collection and the FSP program implementation based on the qualitative findings.

Qualitative Data Collection

Improving recruitment strategies

This year we conducted the first qualitative data collection to better understand the implementation of the FSP program. We planned to complete 30-35 interviews, with the expectation that we would recruit roughly equal numbers of participants from all four service providers (Caminar, Telecare, Edgewood and Fred Finch). However, Fred Finch was unable to identify any interested clients or treatment team members resulting in 23 completed interviews. After discussion with the SMC BHRS team, we decided to conclude the qualitative data collection with the 23 interviews. Based on our experience in this year's recruitment, inputs from the SMC, and our experience from other similar qualitative data collection activities, we propose the following recommendations for improving recruitment for future data collection.

- Start recruitment earlier: Starting the planning for recruitment earlier can provide ample time to identify, approach, and secure commitments from potential interviewees. It allows for addressing any unforeseen challenges and gives participants adequate time to adjust their schedules. In addition, more frequent reminders and check-ins as needed could help improve recruitment of clients and treatment team members.
- Tailored Outreach: We recommend customizing outreach efforts for each service provider. Before the recruitment activities, it might be helpful to have a virtual meeting with each service providers' stakeholders, where we could introduce the project's aim and significance. We can use these meetings to understand their unique challenges and work with them to co-create recruitment strategies that suit their contexts.
- Future RFP requirements: If feasible, SMC may consider adding a requirement for service providers participating in data collection activities in future RFP release.

Future Program Implementation

Strengthen communication between clients and treatment team

Although clients reported satisfaction with their case managers and treatment team, they noted some areas of improvement. Some clients mentioned an initial lack of communication with their therapist that affected their satisfaction with the program and one commented that their initial interactions with team members felt unstructured. Given the initial intake is typically the first exposure clients have with the FSP program, it is necessary to ensure the process is thorough and

informative and sets a positive tone to build rapport moving forward. To address this gap, we recommend BHRS should work with service providers to develop standardized introductory text for team members to follow during the initial intake. The introduction could provide clear and comprehensive information about the treatment team members, their roles, and the services they offer. This information will help set clear expectations from the beginning and ensure that all clients, regardless of treatment team member, understand who will be involved in their care journey and what to expect in follow-up care.

Beyond the initial intake with client, it is important to ensure team members provide more consistent and responsive communication throughout the course of program interactions. To this end, we suggest providing guidelines to case managers for responding in a timely manner to client inquiries and messages. If a case manager is handling a large caseload, FSP service providers could consider implementing systems that ensure clients' messages are acknowledged and addressed within a reasonable timeframe. Another strategy would be to establish a feedback mechanism where clients can provide input on their experiences with specific treatment team members. Brief surveys can help identify areas for improvement and ensure that adjustments are made based on client feedback.

Improve staff retention through additional staff training, mental health and safety resources, and community building

The treatment team is the backbone of the FSP program and continual investment in team members is crucial to creating and maintaining effective relationship-building with clients. Interviews with treatment team members highlighted concerns around staff burnout and a desire for increased collaboration among them. To address noted challenges, we recommend a multifaceted approach that focuses on providing treatment team members with enhanced staff training, mental health resources, and team-building initiatives:

- **Implementation of a comprehensive and ongoing staff training program.** Some treatment team members suggested that enhanced staff training programs may aid in improving staff retention. One treatment team member noted that greater substance use disorder training would be helpful since it is an emerging area with broad impact across various team members. AIR recommends BHRS should work with service providers to offer more ongoing staff training opportunities, especially for specialties like SUD, with an emphasis on hands-on engagement and structured training for new staff. This training should also emphasize effective client engagement, communication, and rapport-building skills. By broadening the skill set of the treatment team members, they will be better equipped to handle their caseloads and provide more personalized support to clients.
- **Provide mental health resources.** In addition to training opportunities, steps should be taken to prioritize the mental health and well-being of the staff. Several team members

reported feeling burnt out due to the challenging and potentially dangerous situations with clients. We suggest BHRS work with the service providers to offer their staff mental health workdays and accessible mental health resources, such as counseling services and stress management workshops through something like an Employee Assistance Program. Additionally, one treatment team member mentioned they would like resources to feel better equipped when facing potentially dangerous client situations. We recommend establishing protocols and resources to address potential secondary trauma or burnout that may arise from working with clients dealing with challenging emotional experiences.

- **Incorporate team-building activities.** Another important step that can be taken is to create a supportive working environment. This can mitigate feelings of burnout and encourage team members to collaborate, share insights, and learn from one another. Additionally, there is documented evidence that team bonding activities can boost motivation, increase employee engagement, and improve confidence, all of which contribute to greater morale and productivity in their role.[1] To foster a sense of community among the treatment team members and address burnout and isolation concerns, we recommend the implementation of team-building activities. Other ideas include creating in-person or virtual staff support groups and forums for sharing experiences and strategies.
- **Incentives to boost longer-term retention.** We suggest the implementation of longer-term retention strategies that go beyond immediate staff concerns. This would include offering career development opportunities, pathways for advancement, and incentives for long-term service, such as special recognitions or rewards for staff member dedication on significant anniversaries or career milestones.

By combining these measures, FSP service providers can build more resilient and effective FSP treatment teams. This, in turn, will strengthen client-staff relationships, improve program outcomes, and reduce staff turnover rates, ultimately benefiting both the staff and the clients they serve.

Expand workforce and increase diversity

While clients are generally satisfied and appreciative for the services they received from treatment team members, especially their case managers, some clients expressed frustration that sometimes their case managers are not available for their needs, and other clients requested more frequent psychiatric services. Understandably, given the workload of treatment team members and the varying and greater needs of program clients, it is difficult to accommodate all the requests from clients. Addressing such an issue may require workforce adjustments. In

[1] Nielsen, K., Nielsen, M. B., Ogbonnaya, C., Känsälä, M., Saari, E., & Isaksson, K. (2017). Workplace resources to improve both employee well-being and performance: A systematic review and meta-analysis. *Work & Stress, 31*(2), 101-120.

addition to the staff retention measures we recommended above, if resources permit, we recommend BHRS work with service providers to recruit additional team members, especially case managers, to not only better serve FSP clients but also alleviate the burden for current members. Another strategy to consider is redistribution of tasks. If possible, non-essential tasks can be redistributed so that essential team members like case managers can focus on core responsibilities. This can be done by hiring administrative assistants or employing technological tools.

In the process of expanding the workforce, we recommend a focus on increasing workforce diversity. FSP clients come from various culture and background and may use a primary language that is different from English. A few treatment team members mentioned the need for more bilingual staff members. Having a workforce that mirrors the diversity of the clientele may enhance service delivery and ensure that clients feel understood and represented. Increased linguistic competency can also ensure clear communication and build trust with clients. In addition, it may be beneficial to conduct diversity and inclusion training sessions for all staff members to foster a workplace culture of understanding and respect, ensuring that clients from all backgrounds feel welcome and understood.

Expand access to and availability of FSP sessions

Some clients including a **parent** of a child with suicidal ideation expressed concerns about securing consistent therapy sessions. A potential first step to fill this gap is by conducting a comprehensive assessment of the treatment team's capacity to offer more sessions. Specifically, FSP providers should consider offering “emergency” or “urgent” sessions to accommodate clients' needs, especially when urgent or critical. Another viable option is for FSP providers to hold "office hours" or a regularly scheduled block of time each week for urgent/emergent issues. As needed, a mix of in-person and virtual sessions can be offered to increase flexibility and accessibility to align with clients' preferences and circumstances. Research suggests that virtual therapy options are as effective as face-to-face sessions while reducing traditional burdens related to travel and transportation.[2] Some clients may be even more comfortable with virtual sessions, especially younger clients who tend to be familiar interacting with people using technology.[3] Although some clients reported that they prefer in-person services, virtual sessions can serve as an effective alternative to address clients' urgent psychiatric care needs when case managers need more flexible scheduling options.

[2] Carlbring, P., Andersson, G., Cuijpers, P., Riper, H. and Hedman-Lagerlöf, E., 2018. Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis. *Cognitive behaviour therapy, 47*(1), pp.1-18.

[3] Sweeney, G. M., Donovan, C. L., March, S., & Forbes, Y. (2019). Logging into therapy: Adolescent perceptions of online therapies for mental health problems. *Internet interventions, 15*, 93-99.

Ensuring consistent case manager assignments

Relatedly, one theme underlying limited session availability and communication that emerged from the interviews is inconsistent case manager assignments. Some clients voiced that inconsistent case manager assignments, resulted in communication problems and differing service quality levels. Given these concerns, AIR recommends that BHRS should work with the FSP service providers to set clear guidelines for assigning case managers and only moving them off in exceptional circumstances. This might involve a provider-level survey before new cases are assigned to assess individual strengths and workload capacities. Caseload distribution should only be done if providers are overwhelmed with too many cases or crises to manage simultaneously. Assigning clients to the same case manager whenever possible can help foster a sense of continuity and trust, ultimately leading to better client-staff relationships and improved outcomes.

Streamline care coordination efforts and data management between staff members

Treatment team members shared different ways of managing and sharing clients' progress, needs, and other information. Some service providers use tools such as dashboards to record and track information about the clients. Other service providers elect to use informal ways through conversations, note-taking, and group meetings to gauge client progress. While multiple ways work, some treatment team members noted issues when taking over the caseloads of previous or departing staff members due to a lack of standardized assessment, often relying instead on progress notes to determine the frequency of meetings, treatment plans and updates for individual clients. Gathering all the necessary information from across varying sources requires additional time and can contribute to delays in the onboarding process. The feedback from treatment team members highlights the need for improved communication practices within and across programs. To provide transitional support, we recommend BHRS work with providers to establish a standardized client data system, including a standard client progress assessment form, to facilitate information gathering, management and sharing across team members. Efficient sharing and documentation are pivotal not only for streamlined operations but also to maintain data integrity and security, especially when it involves sensitive client information. Service providers can consider implementing a HIPAA-compliant document management system or a built-in mechanism through the electronic health record system currently in use. Such systems not only allow for centralized storage of data and facilitates easy access by authorized team members from any location and on any device, but also enable role-based access to the sensitive clients' information.

Consider providing housing coordination and assistance for discharged clients

A treatment team member provided perspectives on housing that may need to be considered. They noted that they have clients who are ready to be discharged from the FSP program, but their

housing funding is connected to the FSP program. Therefore, discharging a client means that they would lose their housing. To address this dilemma, we recommend BHRS work with service providers to provide housing coordination and assistance, in housing vouchers for example, for discharged clients. Such measures could help discharged clients to transition back to independent living in the community and could alleviate treatment team's hesitation about discharging a client, which in turn may help save FSP program resources and distribute those to other clients in need.

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