Full Service Partnership Outcomes

Findings From Fiscal Year 2023–2024

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Executive Summary

The objective of this annual report is to provide a comprehensive assessment and evaluation of the Full Service Partnership program for Fiscal Year 2023 through 2024 (FY 2023–2024). Full service partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County (SMC)-contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research® (AIR®) is working with SMC Behavioral Health and Recovery Services (BHRS) (hereafter the County) to understand how enrollment in FSPs promotes resilience and improves the health outcomes of individuals served. AIR conducted a mixed-methods study using both primary and secondary data sources to evaluate the FSP program in FY 2023–2024. The data sources for this annual report include: (1) self-reported survey data from clients, (2) health care utilization data from electronic health records (EHRs), and (3) in-depth client and provider interviews. Specifically, this evaluation report summarizes demographics and outcomes for individual clients enrolled in the FSP program in FY 2023–2024 and describes clients' and treatment team members' perspectives and experiences with FSP.

The County currently has four comprehensive FSP providers: (1) Edgewood Center and (2) Fred Finch Youth Center (hereafter Edgewood/Fred Finch),[1] serving children, youth, and transitional age youth (TAY), and (3) Caminar and (4) Telecare, serving adults and older adults. This year's report includes self-reported data from Edgewood/Fred Finch and Caminar since FSP inception in 2006. Telecare modified its EHR system for FSP program data in December 2018 and has encountered challenges in providing the data prior to the EHR system conversion. Due to the change, we report data for Telecare from December 2018 to June 2024 separately.

Exhibits 1 and 2 present outcomes of the FSP program in the County for children (16 years and younger), TAY (16–25 years), adults (25–59 years), and older adults (60 years and older). Self-reported FSP outcomes presented in Exhibits 1 and 2 were obtained only from Edgewood/Fred Finch and Caminar. Because of the reporting systems changes for Telecare, those data are provided in Exhibit 4.

For all outcomes, we compared the year just prior to enrollment in an FSP and the first year enrolled in an FSP. The percentage change is the change in the number of clients with the outcome of interest (e.g., homelessness, incarceration, mental health emergencies) in the year after joining an FSP relative to the year prior to participating in an FSP out of the total number of clients in that age group. For example, out of 118 adult clients, 48 experienced homelessness

[1] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

before enrollment in FSP. This number changed to 35 in the first year following FSP, which is a 27% improvement. We first provide self-reported and EHR outcomes for adults and older adults, followed by child and TAY clients.

Self-Reported Outcomes (Caminar) for Adults and Older Adults. For adults and older adults, most self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP. This finding is shown in the top portion of Exhibit 1. Counts are presented in Exhibit 1 to indicate the number of clients with the outcome of interest, and percentages are presented in parentheses.

- Eight out of a combined 16 outcomes statistically significantly improved for adult and older adult Caminar clients. Fewer adult and older adult clients experienced homelessness, arrests, and mental and physical health emergencies. In addition, employment increased among adult clients.
- Among Caminar clients, no older adults reported being employed before and after they joined FSP. Fewer older adult clients (3 versus 2) reported receiving treatment for substance use disorder. However, given the smaller sample size of the older adults, caution is needed when interpreting a change with small magnitude.

Health Care Utilization (EHR Data) for Adults and Older Adults. For all combined adult and older adult clients, we detected improvements in outcomes from the year before joining an FSP compared with the first year in an FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of clients with any hospitalization,
- decrease in mean hospital days per client,
- decrease in the percentage of clients using any psychiatric emergency services (PES), and
- decrease in mean PES events per client.

These changes were all statistically significant for adults as seen in the bottom portion of Exhibit 1, while only the decreases in percentage of clients with any PES events are statistically significant for older adults.

Exhibit 1. Percentage Change in Outcomes Among Caminar Adults and Older Adults, Year Before FSP Compared With First Year With FSP

FSP outcomes	Adults (25 to 59 years)			Older Adults (60 years and older)		
Self-reported outcomes	***N = 118***			***N = 24***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	48 (41%)	35 (30%)	-27%	5 (21%)	4 (17%)	-20%
Detention or incarceration	35 (30%)	22 (19%)	-37%*	3 (13%)	3 (13%)	0%
Employment	1 (1%)	6 (5%)	500%	0 (0%)	0 (0%)	N/A
Arrests	20 (17%)	4 (3%)	-80%*	3 (13%)	1 (4%)	-67%
Mental health emergencies	87 (74%)	33 (28%)	-62%*	13 (54%)	4 (17%)	-69%*
Physical health emergencies	50 (42%)	17 (14%)	-66%*	6 (25%)	4 (17%)	-33%
Active substance use disorder (SUD)	63 (53%)	60 (51%)	-5%	5 (21%)	5 (21%)	0%
SUD treatment	28 (24%)	33 (28%)	18%	3 (13%)	2 (8%)	-33%
Health care utilization (EHR data)	***N = 404***			***N = 85***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	125 (31%)	59 (15%)	-72%*	22 (26%)	12 (14%)	-45%$^{+}$
Hospital days per client	11.1	3.7	-67%*	9.3	4.0	-57%$^{+}$
PES	211 (52%)	153 (38%)	-56%*	34 (40%)	21 (25%)	-38%*
PES event per client	1.6	1.0	-37%*	0.6	0.1	-46%$^{+}$

Notes. Self-reported outcomes do not include Telecare. SUD = substance use disorder; EHR = electronic health record; PES = psychiatric emergency services; Yr = year. The percentage difference with employment for older adults is reported as N/A because the percentage of older clients with employment was 0% in the prior year and in the year after (from 0% to 0%). Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant. * Indicates a change significantly different from 0 at 0.05 significance level. $^{+}$ indicates a change marginally different from 0 at 0.08 significance level.

Self-Reported Outcomes (Edgewood/Fred Finch) for Child and TAY Clients. The trends for child and TAY clients are similar to those for adult and older adult clients (as shown in the top portion of Exhibit 2), where most of the self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP.

- Twelve out of a combined 16 outcomes improved for child and TAY clients, of which eight improvements were statistically significant. Fewer child and TAY clients experienced homelessness, arrests, mental and physical health emergencies, and school suspensions. There was an improvement in detention or incarceration and rating of school attendance among TAY clients, but not among child clients.
- Three outcomes worsened for child or TAY clients. For child clients, there were statistically significant decreases between the year prior to FSP and the first year after FSP enrollment for both academic grades and attendance. TAY clients reported decreased academic grades during the first year after enrolling in an FSP program, but this change was not statistically significant.

Health Care Utilization (EHR Data) for Child and TAY Clients. For child and TAY clients, we detected statistically significant improvements in outcomes from the year before FSP compared with the first year of FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of clients with any hospitalization,
- decrease in mean hospital days per client,
- decrease in the percentage of clients using any PES, and
- decrease in mean PES events per client.

As shown in the lower portion of Exhibit 2, all decreases except for mean hospital days per client were statistically significant for child clients; the declines in use of PES and mean PES events per client were statistically significant for TAY clients.

Exhibit 2. Percentage Change in Outcomes for Children and TAY, Year Before FSP Compared With First Year With FSP

FSP outcomes	Child (16 years and younger)			TAY (17 to 25 years)		
Self-reported outcomes	***N = 238***			***N = 284***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	9 (4%)	8 (3%)	-11%	33 (12%)	32 (11%)	-3%
Detention or incarceration	27 (11%)	27 (11%)	0%	38 (13%)	31 (11%)	-18%
Arrests	30 (13%)	10 (4%)	-67%*	63 (22%)	20 (7%)	-68%*
Mental health emergencies	94 (39%)	13 (5%)	-86%*	129 (45%)	29 (10%)	-78%*
Physical health emergencies	19 (8%)	1 (0%)	-95%*	58 (20%)	5 (2%)	-91%*
Suspensions	47 (20%)	21 (8%)	-55%*	27 (10%)	6 (2%)	-78%*
Grade (self-rating)	3.32	2.97	-10%*	3.19	3.11	-3%
Attendance (self-rating)	2.24	1.97	-12%*	2.46	2.49	2%
Health care utilization (EHR data)	***N = 214***			***N = 229***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	-91%*	26 (11%)	16 (7%)	-67%
Hospital days per client	1.2	0.1	-91%	4.1	2.0	-51%+
PES	52 (24%)	23 (11%)	-56%*	93 (41%)	58 (25%)	-66%*
PES event per client	0.5	0.2	-54%*	1.1	0.7	-37%*

Notes. EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Red font indicates a statistically significant negative percentage change. Blue font indicates outcomes that significantly improved. Black font indicates outcomes did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP. * indicates a change significantly different from 0 at 0.05 significance level. + indicates a marginally significant different change from 0 at 0.08 significance level.

Exhibit 3 describes the hospitalization outcomes for all clients across all age groups who joined the FSP program since 2006, completed one full year or more in an FSP program, and had EHR health utilization data. Among these clients, we looked at their mean health utilization outcomes in the first year of FSP and the year prior to FSP. As shown, FSP clients had significantly improved hospitalization outcomes across all measures. Exhibits 17–20 further show reductions in hospitalization and PES health care utilization outcomes over the years since the inception of the FSP program.

Exhibit 3. Hospitalization Outcomes for All Combined FSP Clients (*N* = 932)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any hospitalization*	
1 year before	20% (17%–22%)
Year 1 during	10% (8%–12%)
Mean number of hospital days*	
1 year before	6.9 (5.6–8.3)
Year 1 during	2.5 (1.7–3.3)
Percentage of clients with any PES event*	
1 year before	42% (39%–45%)
Year 1 during	27% (24%–30%)
Mean PES events, per client*	
1 year before	1.2 (1.0–1.3)
Year 1 during	0.7 (0.6–0.8)

Notes. PES = psychiatric emergency services. Significance testing was conducted using chi-square tests for percentages and *t* tests for means. * indicates result is statistically significant at the .05 level.

Because of the issue with Telecare's incomplete data noted earlier, we conducted a separate analysis for the self-reported Telecare data. Exhibit 4 shows self-reported outcomes among Telecare clients for the year before FSP compared with the first year with FSP. There were 152 clients in the Telecare survey data who completed at least a year of an FSP between December 1, 2018, through June 30, 2024. Our analysis combined all age groups (TAY, adults, and older adults) served by Telecare for this separate analysis due to the reduced sample size.

Exhibit 4 below shows improvements for Telecare clients in homelessness, arrests, and active substance use disorder, with all decreases in these negative events being statistically significant. No change was observed in the employment outcomes of Telecare clients. Telecare clients had poorer outcomes after joining an FSP in three outcome areas: more Telecare clients reported being detained or incarcerated or having mental and physical health emergencies in the first year of an FSP compared to the year prior to the FSP. However, the change was only statistically significant for the increased experience of mental health emergencies. The increase in self-reported mental and physical health emergencies may be explained by several factors, such as the introduction of more clients with complex medical conditions that require greater utilization of medical services. The increase may also indicate heightened awareness of mental health issues and improved access to mental health services after joining FSP, potentially

leading to increased diagnoses and intervention for previously untreated issues. More regular monitoring and crisis intervention can also detect crises earlier, leading to proactive hospitalizations. Alternatively, individuals may experience heightened mental health challenges during transitions in the first year of joining an FSP, such as reducing substance use, which may result in withdrawal symptoms and new stressors that temporarily elevate mental health emergencies. Fewer clients reported receiving treatment for substance use disorder, although the change was not statistically significant. This change may be interpreted positively if it is a result of better screening and referral to treatment when needed. We also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment.

Exhibit 4. Percentage Change in Outcomes Among Telecare Clients, Year Before FSP Compared With First Year With FSP

FSP self-reported outcomes	Combined Telecare TAY, Adults, and Older Adults (*N* = 152)		
	Yr before	*Yr after*	*Change*
Homelessness	41 (27%)	10 (7%)	-76%*
Detention or incarceration	34 (22%)	42 (28%)	24%
Employment	0 (0%)	0 (0%)	N/A
Arrests	45 (30%)	17 (11%)	-62%*
Mental health emergencies	18 (12%)	54 (36%)	200%*
Physical health emergencies	15 (10%)	24 (16%)	60%
Active SUD	96 (63%)	47 (31%)	-51%*
SUD treatment	10 (7%)	8 (5%)	-20%

Notes. SUD = substance use disorder; Yr = year. Exhibit 4 indicates the change in the percentage of clients with any events, comparing the year just prior to FSP with the first year with FSP. The percentage difference with employment is reported as N/A because the percentage of clients with employment in the year before and in the year after is 0% (from 0% to 0%). Blue font indicates outcomes that significantly improved. Red (and bold) font indicates outcomes that significantly worsened. Red font indicates a statistically significant worse change in outcome. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Outcomes From Key Informant Interviews With FSP Treatment Team Staff and Clients. Many FSP clients and treatment team members we interviewed said they were satisfied with the program but had specific recommendations to improve the program in the future. Exhibit 5 discusses key findings from these interviews.

Exhibit 5. Summary of FSP Treatment Team Staff and Client Interview Findings

Key Client and Treatment Team Experiences With the FSP Program	
Overall experience and satisfaction with the program	• Clients noted supportive and satisfactory experiences with the FSP program, which many attributed to positive interactions with case managers. Their goals for program participation included improving mental and physical health, maintaining sobriety, and continuing education. • Treatment team members reported satisfactory and rewarding experiences as staff members of the FSP program, attributing their satisfaction to the productive and efficient work environment. They identified the greatest needs among FSP clients to be access to counseling and psychiatric services, managing substance use, and housing assistance.
Referral process and initiation of treatment	• Clients reported positive feedback on the referral process and comprehensive assistance provided by multidisciplinary treatment teams during initial meetings. They suggested expanding awareness of the program to make it more accessible to potential clients. • Treatment team members generally described the referral and intake processes to be smooth, emphasizing the importance of the warm handoff from the referring provider. However, they noted that lack of supplemental documentation from referring providers is sometimes a challenge.
Experiences with program services and care	• Clients had positive feedback about their experience with FSP case managers and providers, particularly highlighting case manager availability, responsiveness, guidance, and resources. They expressed gratitude for how strong interpersonal connections with other treatment team members have led to positive impacts on health and well-being. However, some clients described issues with interruptions in care, lack of shared lived experiences with their case managers, difficulty scheduling sessions, and lack of personal agency in treatment decisions. • Treatment team members appreciated strong collaboration and communication within their teams, which they attributed to enhanced client care and role satisfaction. However, they identified challenges including high client caseloads, turnover, emotional demands of the work, and gaps in resources and funding that impact staff well-being and client engagement.
Impact on health and quality of life	• Clients noted improvements in their quality of life after enrolling in the FSP program. • Clients and treatment team members reported that the FSP program had a positive impact on clients' mental and physical health outcomes, interpersonal relationships, social networks, and independence.

Overall, the interviews highlight the positive influence of the FSP program on client well-being that is consistent with improvement in client outcomes seen in the quantitative data results. For example, FSP clients reported feeling more stable and independent after enrolling in the program, particularly among individuals who previously were homeless. These findings align with the increase in clients' declines in homelessness from the year prior to being in FSP and the first year enrolled.

The majority of client and provider interviewees reported being satisfied with the program; however, some noted a few areas of the FSP program that could be improved. Exhibit 6 summarizes recommendations based on these findings.

Exhibit 6. Recommendations Based on FSP Treatment Team and Client Interview Findings

Recommendations	
Recommendation 1: Improve staff retention through additional staff training, mental health resources, and incentives	• Implement a comprehensive and ongoing staff training program. • Provide accessible mental health resources like counseling, stress management workshops, Employee Assistance Programs, and mental health workdays. • Offer incentives to boost longer term retention.
Recommendation 2: Expand workforce and increase staff diversity	• Expand the number of team members, especially case managers, and redistribute some tasks to other staff (e.g., administrative assistants). • Increase the number of multilingual staff to cater to the needs of clients. • Conduct diversity and inclusion training sessions.
Recommendation 3: Increase awareness and accessibility of FSP services	• Implement more robust strategic outreach through schools and other community channels. • Encourage providers to coordinate schedules with clients and their families.
Recommendation 4: Ensure consistent team member assignments and implement notifications of team member transitions	• Establish clear guidelines for case manager assignments and prioritize consistency. • Create and disseminate a provider-level survey before new cases are assigned to assess individual case managers' strengths and workload capacities. • Develop a notification system to ensure clients and team members are promptly notified of any staff turnover, including temporary coverage arrangements.

Background and 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). FSPs 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 for self-reported and EHR data),[2] 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 the health outcomes of the County's clients living with mental illness. A combination of qualitative and quantitative data provide the basis of findings for this year's report. Specifically, two quantitative data sources are used: (1) self-reported survey data collected by providers from FSP clients and (2) electronic health records (EHRs) obtained through the County's Avatar system. In addition, this year's report includes qualitative data collected from FSP clients and treatment team members. These data comprise 35 interviews, with 12 clients and 23 treatment team members from four FSP service providers: Caminar, Telecare, Edgewood Center, and Fred Finch.[3]

Quantitative Analysis

This section provides an overview of the data sources and methodologies used to assess client outcomes in FSP programs from 2006 through June 2024. Self-reported data from Edgewood/Fred Finch, Caminar, and Telecare, as well as longitudinal EHR data from the County Avatar system, are analyzed to track changes in client well-being and hospitalizations over time.

This year's report includes self-reported client data collected by Edgewood/Fred Finch and Caminar providers since FSP inception (2006). We report the self-reported data from Telecare from December 2018 to June 2024 separately due to data challenges: Telecare changed its data reporting system for FSP program data in 2018 and continues to experience technical challenges providing the data prior to the system change.

[2] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.
[3] Fred Finch served fewer clients this year and therefore our team was unable to interview clients from this FSP provider. However, our team did interview Fred Finch team members.

For the self-reported data, providers collected initial survey data through an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the 12-month "lookback" window of the year prior to FSP enrollment. Providers gather survey data on clients during their participation in an FSP in two ways. Life-changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). FSP clients are also assessed every 3 months using the 3-Month (3M) forms. Changes in client outcomes are gathered by comparing data at baseline from PAF forms to follow-up data from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal client-level information on demographics, FSP participation, hospitalizations, and psychiatric emergency services (PES) utilization before and after FSP enrollment. The Avatar system is limited to individuals who obtain emergency care in the County hospitals. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in clients' self-reported and hospitalization outcomes in 2 consecutive years: (1) the baseline year, that is, the 12 months prior to enrollment in an FSP program; and (2) the first full 12 months of the client's FSP participation. Children (ages 16 and younger), transitional age youth (TAY; ages 17 to 25), adults (ages 25 to 59), and older adults (ages 60 and older) were included in the analysis if they had completed at least 1 full year with an FSP program by June 30, 2024 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years since inception of the program (2006) as well as annually, by year of FSP program enrollment.

Appendices provide details about our methodology as well as detailed findings for each outcome. Appendix A presents additional detail on residential outcomes. Appendix B provides outcomes for individual FSP providers. Appendix C provides methodology for the self-reported outcomes and EHR-based hospitalization outcomes (i.e., "quantitative methodology"). Appendix D provides methodology for the qualitative interviews (i.e., "qualitative methodology").

Self-Reported Outcomes

Overview

This section presents outcomes for 816 FSP clients across four FSP providers. The results presented in this section compare the first year enrolled in an FSP with the year prior to FSP enrollment for clients completing at least 1 year in an FSP program.

- The Caminar section presents outcomes for 118 adult (ages 26–59) FSP clients and 24 older adult (ages 60 and older) FSP clients who joined and completed at least 1 year in an FSP since 2006.[4]
- The Edgewood/Fred Finch section below presents outcomes for 238 child (ages 16 and younger) FSP clients and 284 TAY (ages 17–25) FSP clients.
- The Telecare section presents outcomes for 152 FSP clients regardless of age, including youth and TAY clients. We combine findings for all age groups when reporting findings for Telecare clients.

Telecare changed its data reporting system on December 1, 2018, and was only able to provide the data after the conversion date due to data reliability issues. Because of the incompleteness of the Telecare data, we conducted a separate analysis for Telecare's self-reported data.

In this section, we first provide a list of self-reported outcomes collected by all providers. We then present findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception, followed by findings from the analysis using Telecare data since December 2018.

Outcomes Assessed

We describe the self-reported outcomes below. Most of these outcomes are aggregated by age group. Note that employment, homelessness, arrests, and incarceration outcomes are not presented for adults ages 60 or older, due to insufficient observations in this age group for meaningful interpretation.

1. **Clients with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (sources: PAF and KET)
2. **Clients with any reported detention or incarceration incident:** measured by residential setting indicating jail or prison (sources: PAF and KET)

[4] Caminar's self-reported data also includes 77 TAY clients (ages 17–25); however, we excluded them from the analysis due to lack of ongoing data collection for TAY-specific outcomes.

3. **Clients with any reported employment:** measured by employment in past 12 months and date of employment change (sources: PAF and KET)[5]
4. **Clients with any reported arrests:** measured by arrests in past 12 months and date when arrested (sources: PAF and KET)
5. **Clients with any self-reported mental health emergencies:** measured by mental health emergencies in past 12 months and date of mental health emergency (sources: PAF and KET)
6. **Clients with any self-reported physical health emergencies:** measured by acute medical emergencies in past 12 months and date of acute medical emergency (sources: PAF and KET)
7. **Clients with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)
8. **Clients in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)[6]

In addition, we also examined three outcomes specific to child and TAY clients:

1. **Clients with any reported suspensions:** measured by school suspensions in past 12 months (source: PAF) and date suspended (source: KET)
2. **Average school attendance self-rating:** an ordinal ranking (1–5) indicating overall school attendance with 1 indicating lower attendance and 5 indicating higher attendance; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)
3. **Average school grade self-rating:** an ordinal ranking (1–5) indicating overall grades with 1 indicating lower grades and 5 indicating higher grades; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

Mental and Physical Health Emergencies by Living Situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the client's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or foster family, living alone, and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospital setting).

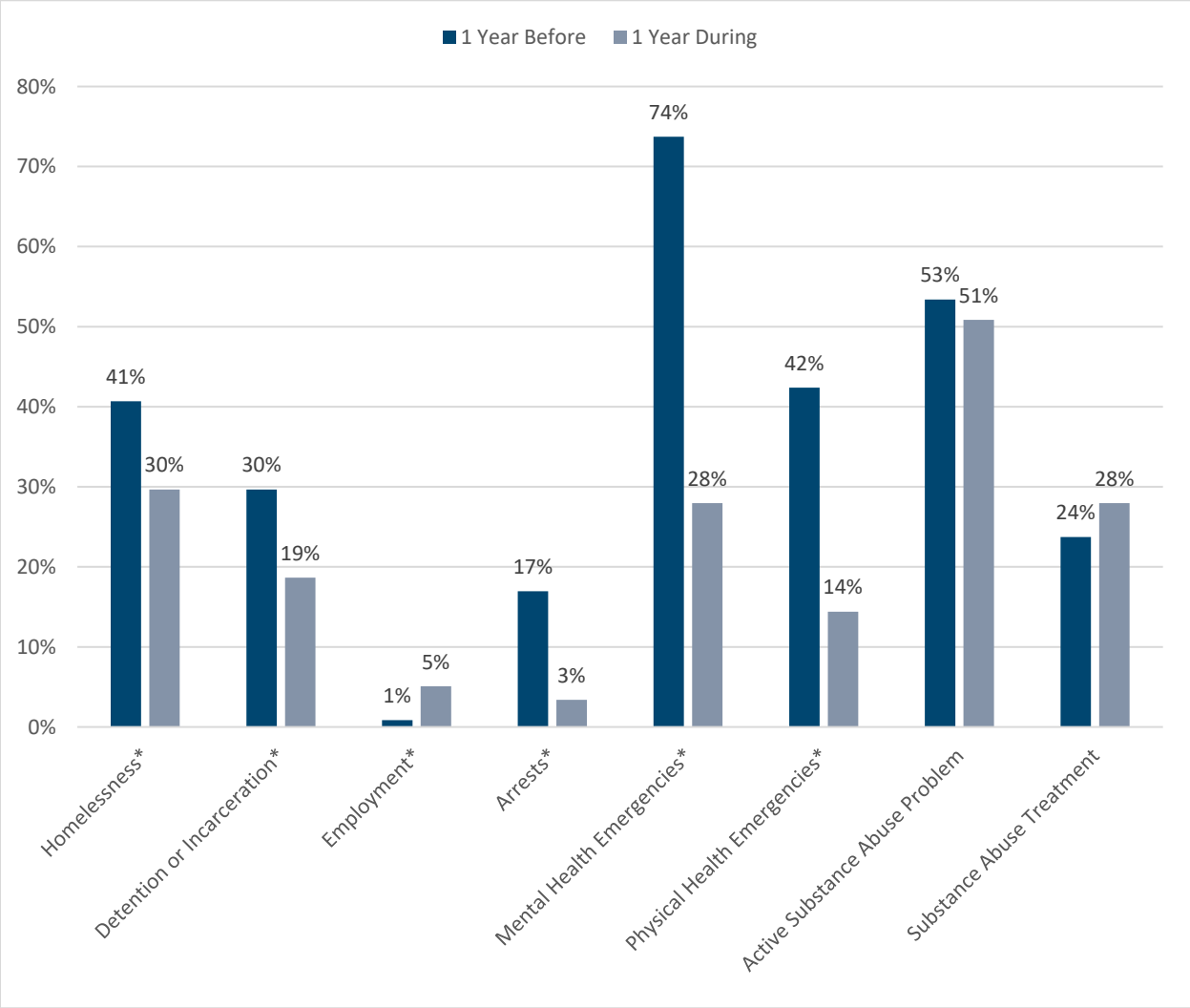
[5] Employment outcome is not applicable to child and TAY clients.
[6] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care. However, if more partners have substance use disorder, there would be more partners reporting receiving treatment.

Caminar

Self-Reported Outcomes by Age Group

Adults. Exhibit 7 compares outcomes for adult clients in the year prior to FSP enrollment with their first year in an FSP. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies statistically significantly decreased after enrollment in FSP. Employment and reported treatment of substance use disorder increased, although only employment was significant. These findings demonstrate improvements for adult clients in the first year of FSP enrollment for all outcomes, and significant improvements for all except active substance use problems and substance use treatment.

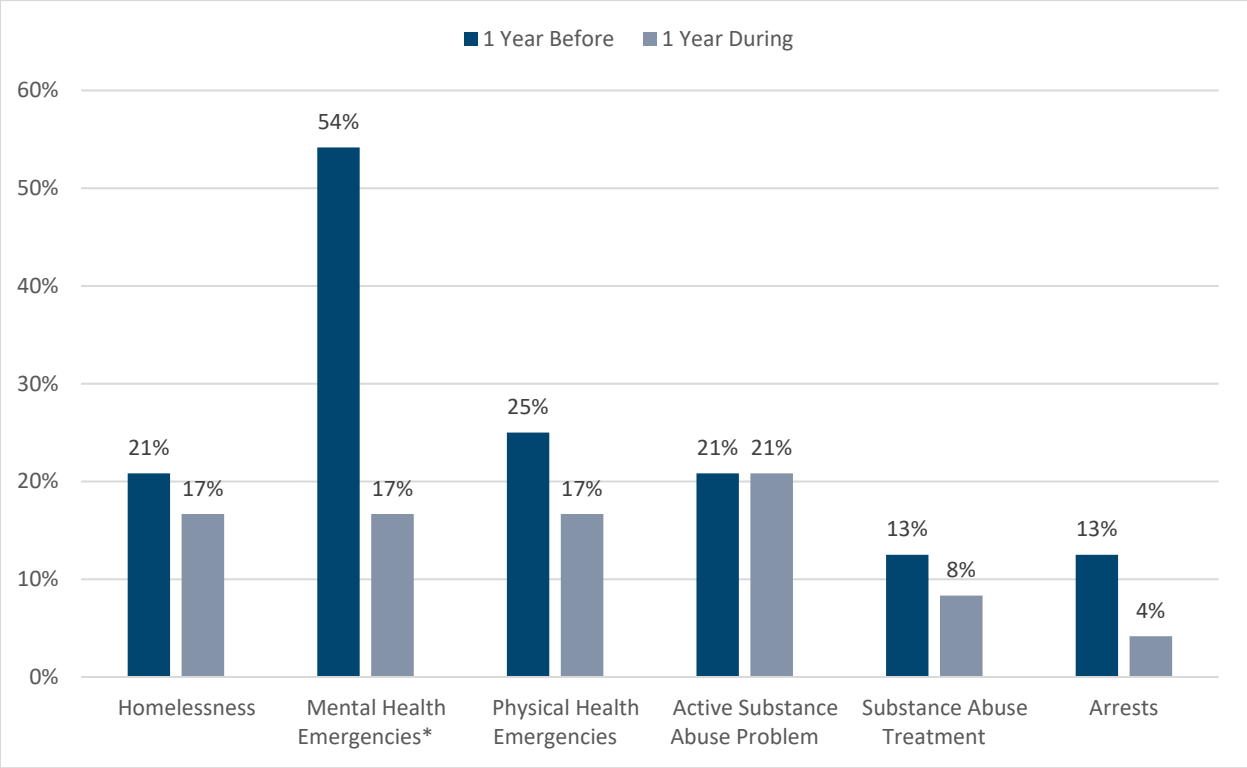
Exhibit 7. Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 118)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Older Adults. Exhibit 8 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult clients (age 60 and above). Similar to adult clients, self-reported mental and physical health emergencies generally decreased. However, the decrease in mental health emergencies is the only statistically significant outcome for older adults. Each of these outcomes demonstrated improvement for older adult clients in the first year of FSP enrollment. The same number of older adults (*N* = 5) reported having an active substance use problem after enrolling in an FSP. Slightly fewer older adults (from three in the year prior to two in the first year of FSP) reported treatment for a substance use disorder during the first year of FSP enrollment compared with 1 year before. Given the small sample size, these results should be interpreted with caution.

Exhibit 8. Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 24)

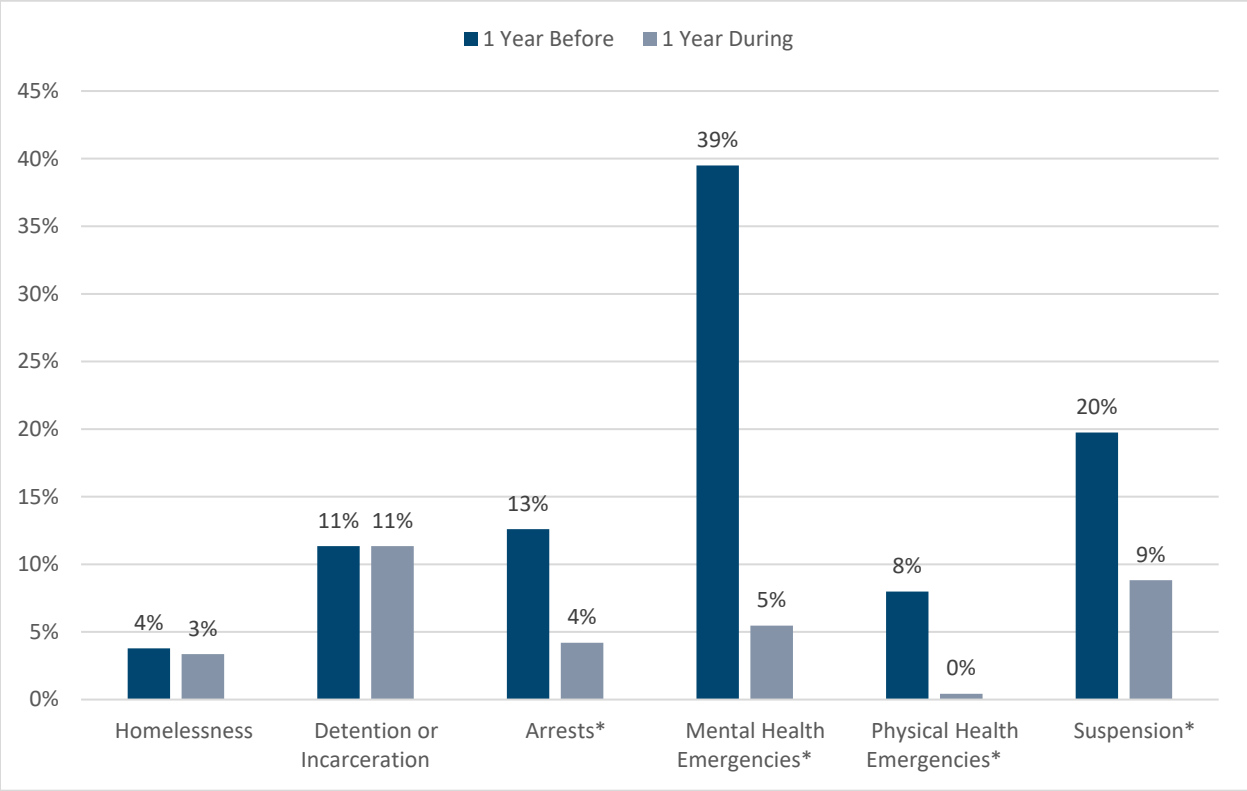


Note. Employment and incarceration outcomes are not presented for older adults due to insufficient observations in this age group for meaningful interpretation. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Edgewood/Fred Finch

Children. Exhibit 9 shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child clients (age 16 and younger). There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in an FSP program. There is a significant decrease in the incidence of mental health emergencies from the year prior to the first year of FSP (39% vs. 5%). Conversely, detention or incarceration remained the same for children (27 incidents in the first year with FSP and 27 in the year prior to FSP enrollment). However, the incidence of arrests decreased after enrollment in FSP (10 in the first year with FSP compared with 30 in the year just prior). The decline in arrests, mental and physical health emergencies, and school suspensions are statistically significant.

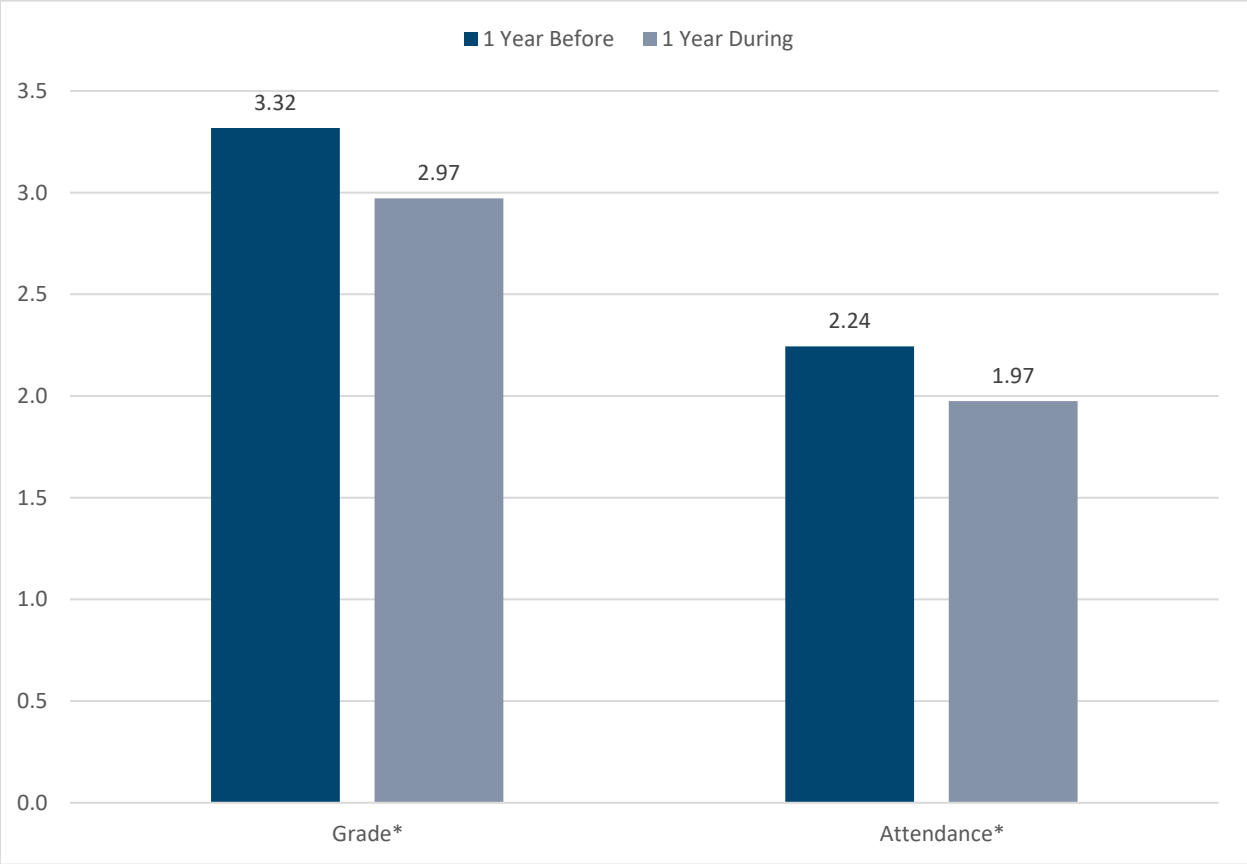
Exhibit 9. Outcomes for Child Clients Completing 1 Year With FSP (*N* = 238)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 10 presents outcomes on self-rated school attendance and grades. School attendance and grades for child clients slightly declined after enrolling in an FSP program. These ratings are on a 1–5 scale, coded such that a higher score is better. Though relatively small, the decreases in school attendance and grades are statistically significant.

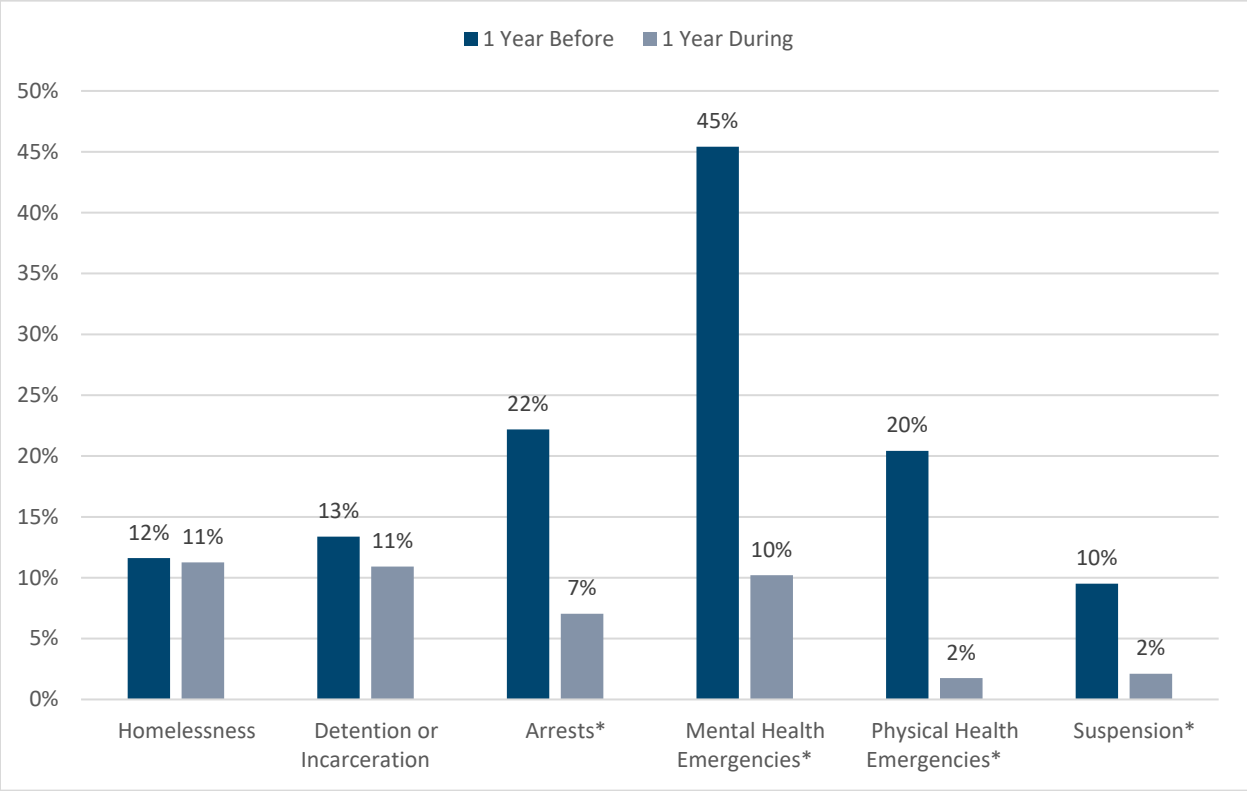
Exhibit 10. School Outcomes for Child Clients Completing 1 Year With FSP (*N* = 238)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale, coded such that a higher score is better.

TAY. Exhibit 11 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY clients.[7] All self-reported outcomes decreased (an improved status), among which improvements in arrests, mental and physical health emergencies, and school suspensions are statistically significant.

Exhibit 11. Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 284)

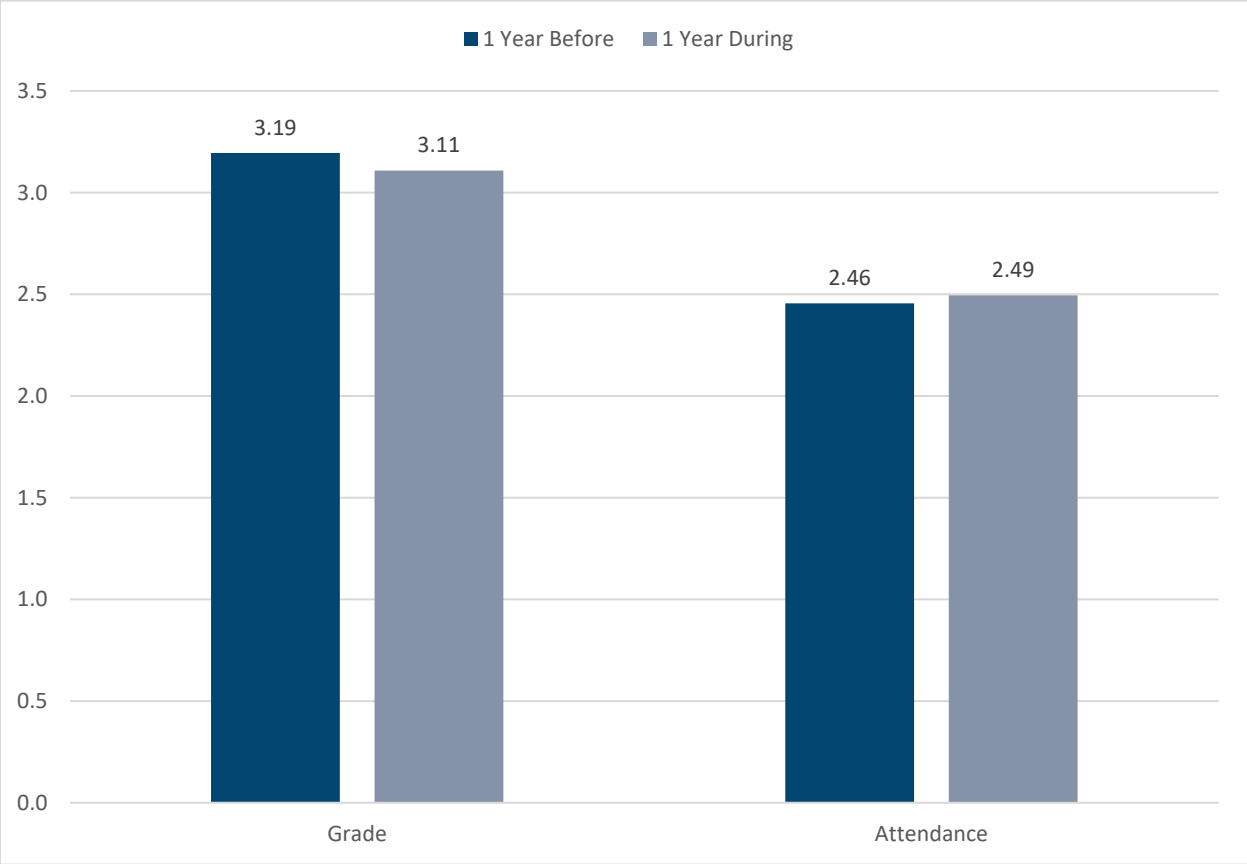


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

[7] The older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY-specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 12 below shows outcomes on school attendance and grades for TAY clients. These ratings are on a 1–5 scale; a higher score is better. There was a small decrease in grades and a slight increase in attendance after enrollment in an FSP. Neither outcome showed a statistically significant difference after FSP enrollment.

Exhibit 12. School Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 284)

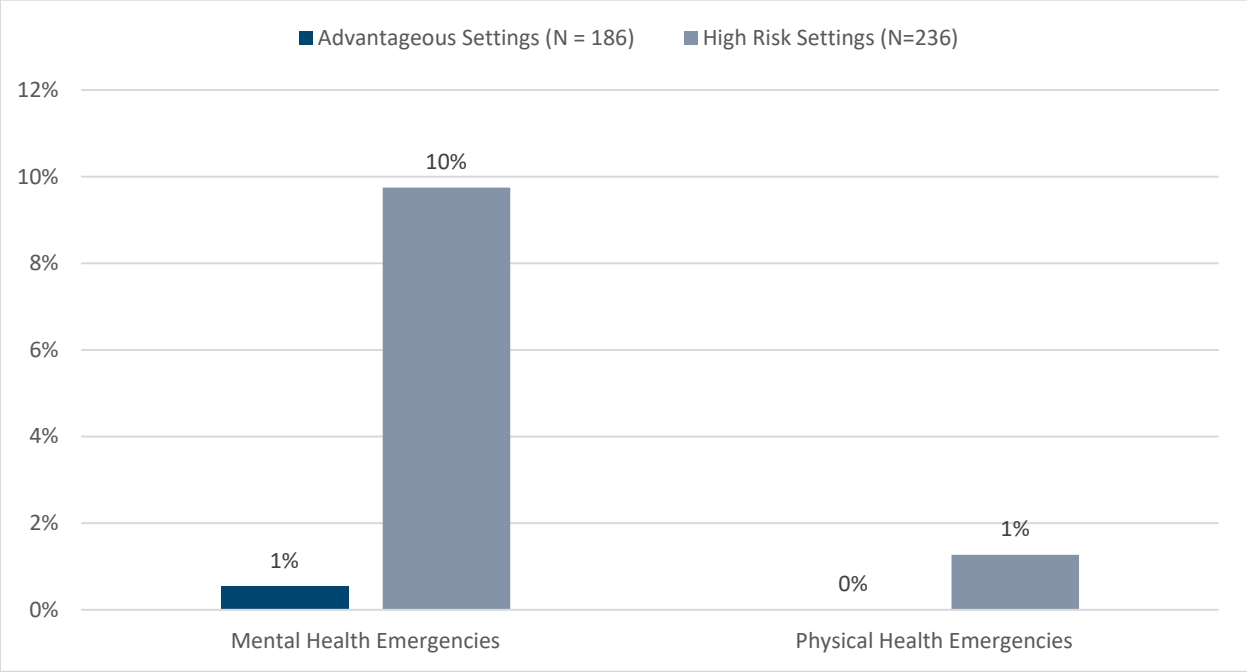


Note. The ratings are on a 1–5 scale; a higher score is better.

Mental and Physical Health Emergencies by Living Situation

Exhibit 13 shows the mental and physical health emergencies in adult and older adult clients living in advantageous versus higher risk living situations in the first year of participating in an FSP. Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High-risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown below, both mental and physical health emergencies were more common among individuals in a high-risk residential setting in their first year of FSP participation.

Exhibit 13. Emergency Outcomes Grouped by Residential Setting

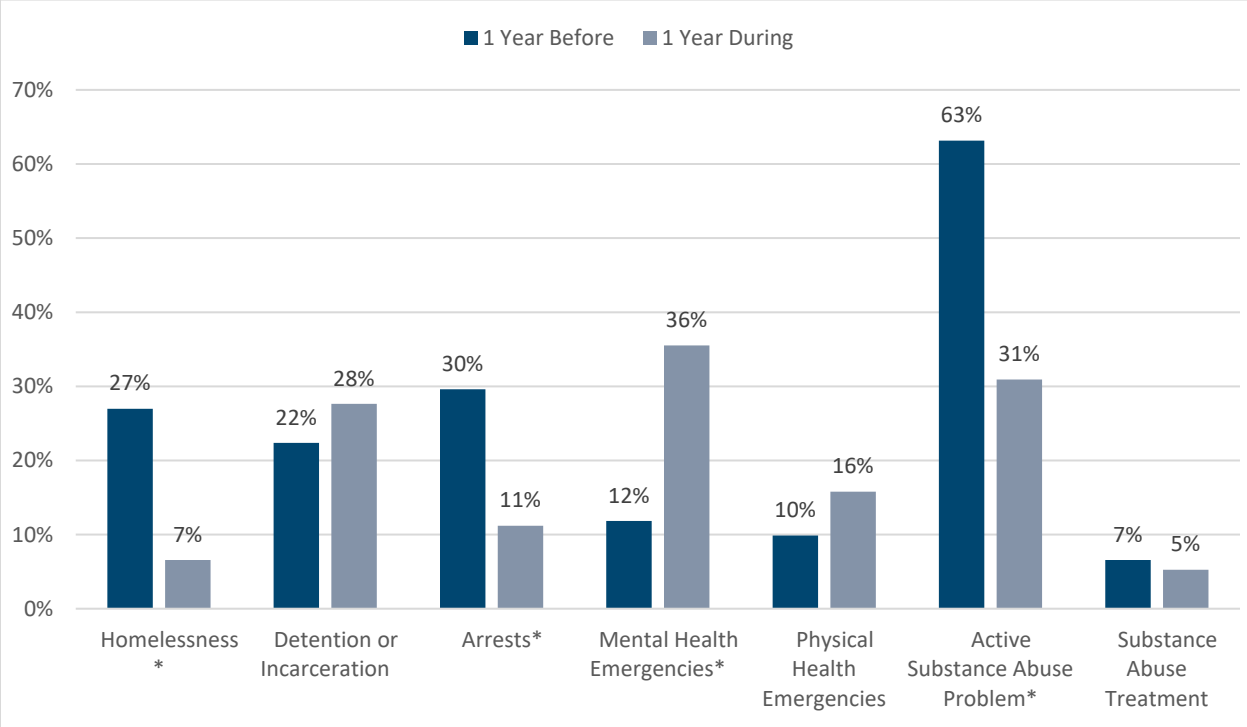


Telecare

Self-Reported Outcomes—All ages

Telecare data include 152 adult and older adult clients who have completed at least 1 year of FSP as of June 30, 2024. Because of the small sample size for Telecare, we combined findings for all age groups. Exhibit 14 shows the comparison of outcomes for all Telecare clients in the year prior to FSP enrollment with the first year in an FSP. Homelessness, arrests, and substance use disorders decreased after enrolling in an FSP, and the decreases are statistically significant. Each of these outcomes demonstrates improvements in the first year of FSP enrollment. Mental and physical health emergencies were more frequently reported in Telecare clients a year after enrolling in an FSP program, although this increase was only significant for mental health emergencies. The increase in mental and physical health emergencies may be a sign of higher engagement with health services, leading to more diagnosis and acute treatment as previously untreated issues become visible. Detention or incarceration was also slightly higher a year after enrolling in an FSP program, but the increase is not statistically significant. Additionally, fewer Telecare clients reported receiving treatment for substance use disorders 1 year during the FSP program compared with 1 year before enrollment. However, we also see a significant decrease in reported active substance use, which may explain the decrease in reported treatment. There were no data for changes in employment.

Exhibit 14. Outcomes for Telecare Clients Completing 1 Year With FSP (*N* = 152)

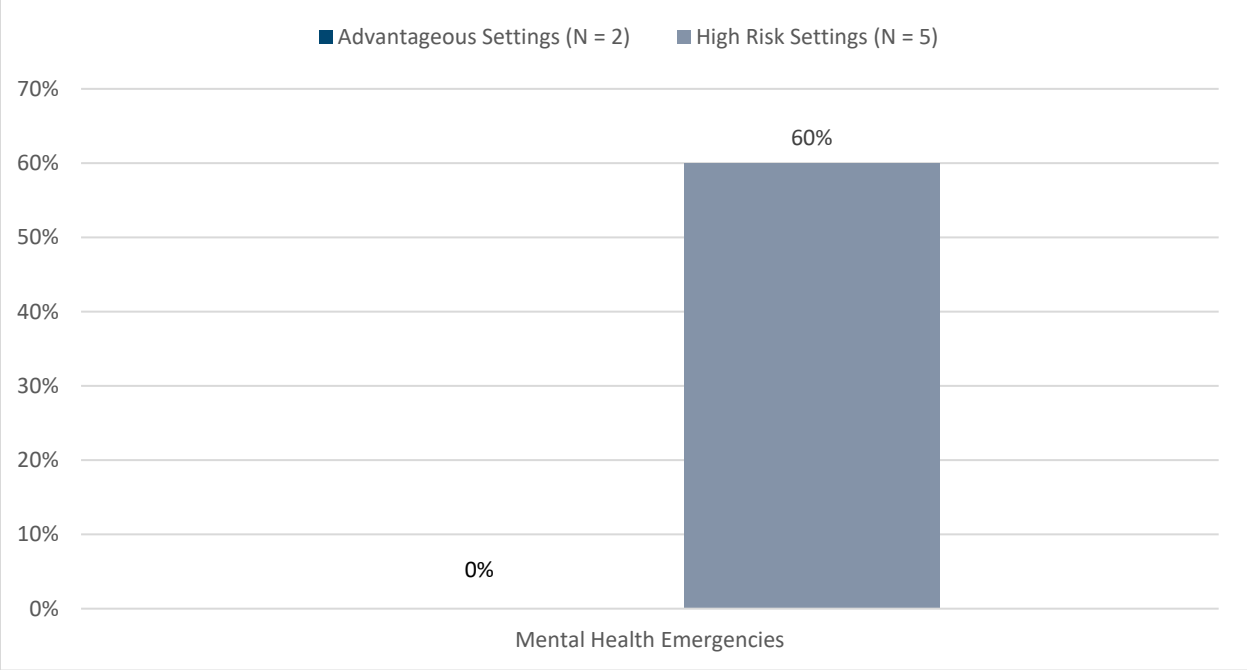


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Mental and Physical Health Emergencies by Living Situation

Exhibit 15 shows the mental and physical health emergencies in adult and older adult clients living in advantageous versus higher risk living situations in the first year of an FSP. Mental health emergencies only occurred in individuals who lived in at least one high-risk residential setting in their first year of FSP participation, with 60% reporting a mental health emergency. Meanwhile, there were no physical health emergencies reported for adult and older adult clients living in a high-risk residential setting or in advantageous situations. However, the sample sizes for both advantageous and high-risk subgroups are small and the results here should be interpreted with caution due to increased potential for bias and may not be representative of the larger population.

Exhibit 15. Emergency Outcomes as a Function of Residential Setting Among Telecare Clients



Health Care Utilization

Overview

This section describes (a) overall health care utilization across all clients from the beginning of an FSP program, (b) health care utilization by age group from the beginning of an FSP program, and (c) health care utilization for clients by year (2006–2023).

Using the County's EHR data, we present four hospitalization outcomes for 932 total FSP clients including 214 child, 229 TAY, 404 adult, and 85 older adult FSP clients:

1. **Clients with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Clients with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months
4. **Average number of PES events:** the number of PES events in the past 12 months

Overall Health Care Utilization Outcomes Across All Clients

We detected statistically significant changes in outcomes from the year before FSP compared with the first year in FSP for all hospitalization outcomes (Exhibit 16). The percentage of clients with any hospitalization decreased by half from 20% before FSP to 10% during FSP. The average number of days spent in the hospital decreased from 6.94 days before FSP to 2.50 days during FSP. The percentage of clients with any PES decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.16 events before FSP to 0.71 events during FSP.

Exhibit 16. Hospitalization Outcomes Among FSP Clients (*N* = 932)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any hospitalization*	
1 year before	20% (17%–22%)
Year 1 during	10% (8%–12%)
Mean number of hospital days*	
1 year before	6.9 (5.6–8.3)
Year 1 during	2.5 (1.7–3.3)

	Percentage/Mean (95% Confidence Interval)
Percentage of clients with any PES event*	
1 year before	42% (39%–45%)
Year 1 during	27% (24%–30%)
Mean PES events, per client*	
1 year before	1.2 (1.0–1.3)
Year 1 during	0.7 (0.6–0.8)

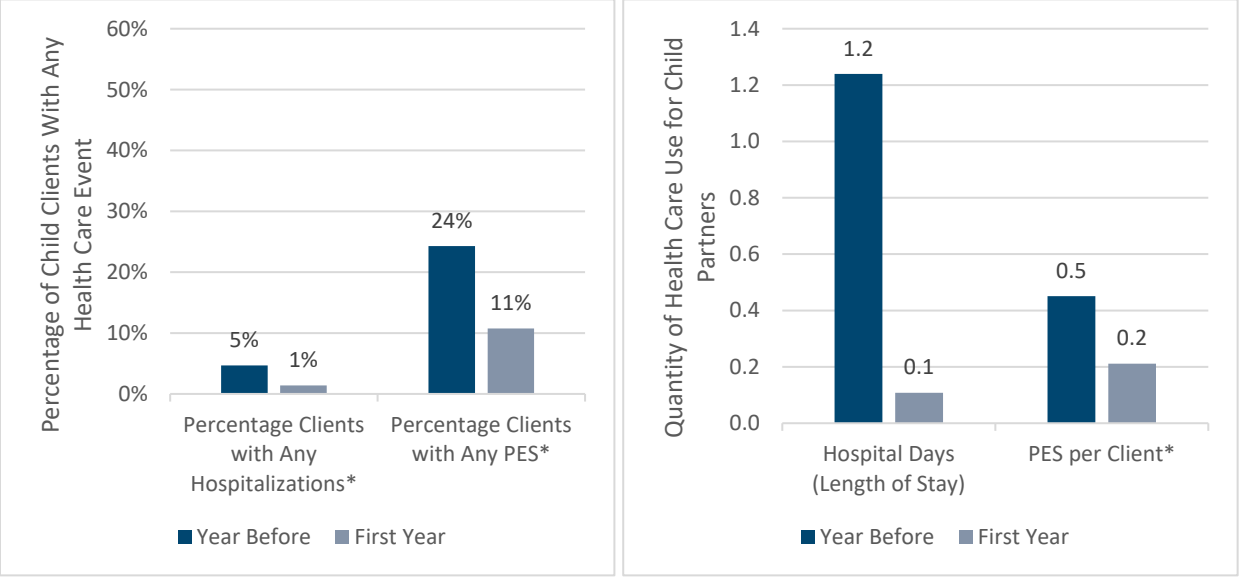
Note. Significance testing was conducted using chi-square tests for percentages and *t* tests for means. * indicates result is statistically significant at the .05 level.

Health Care Utilization for FSP Clients by Age Group

Hospitalization outcomes are presented in Exhibits 17–20 by age group. For all four age groups, the percentage of FSP clients with any hospitalization or PES event showed a statistically significant decrease after joining an FSP. The mean number of hospital days experienced by FSP clients and average number of PES events also had a statistically significant decrease after FSP enrollment for all age groups.

As shown in Exhibit 17, all outcomes but the change in outcome for mean hospital stays are statistically significant for children.

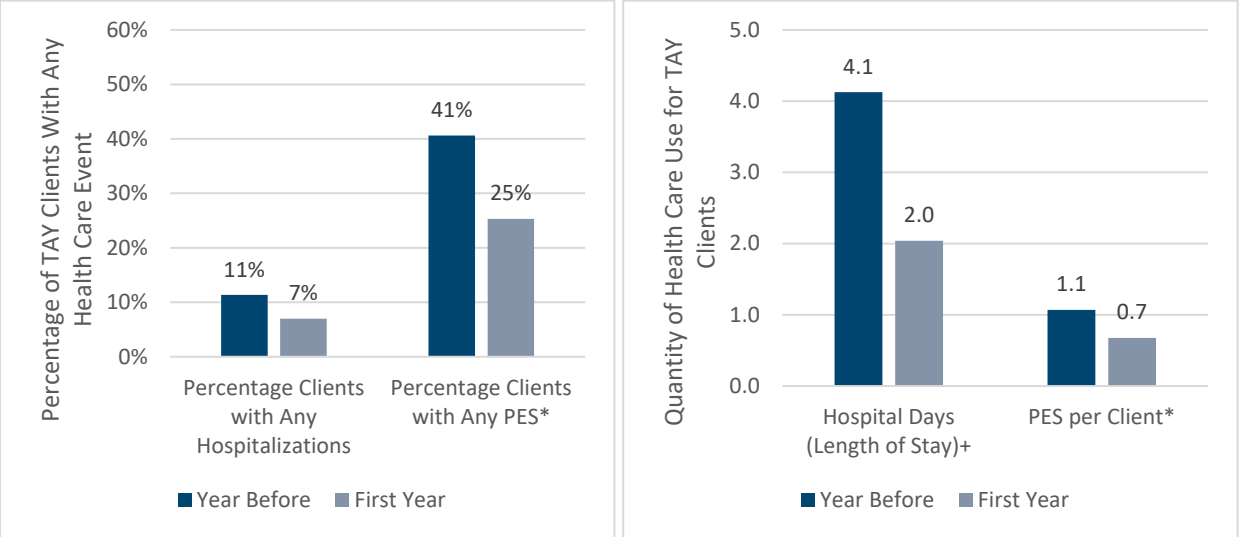
Exhibit 17. Hospitalization and PES Outcomes for Child Clients Completing 1 Year With FSP (*N* = 214)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

For TAY, the change in percentage of clients with PES and the change in mean number of PES events are statistically significant; the change in mean number of hospital days is marginally significant.

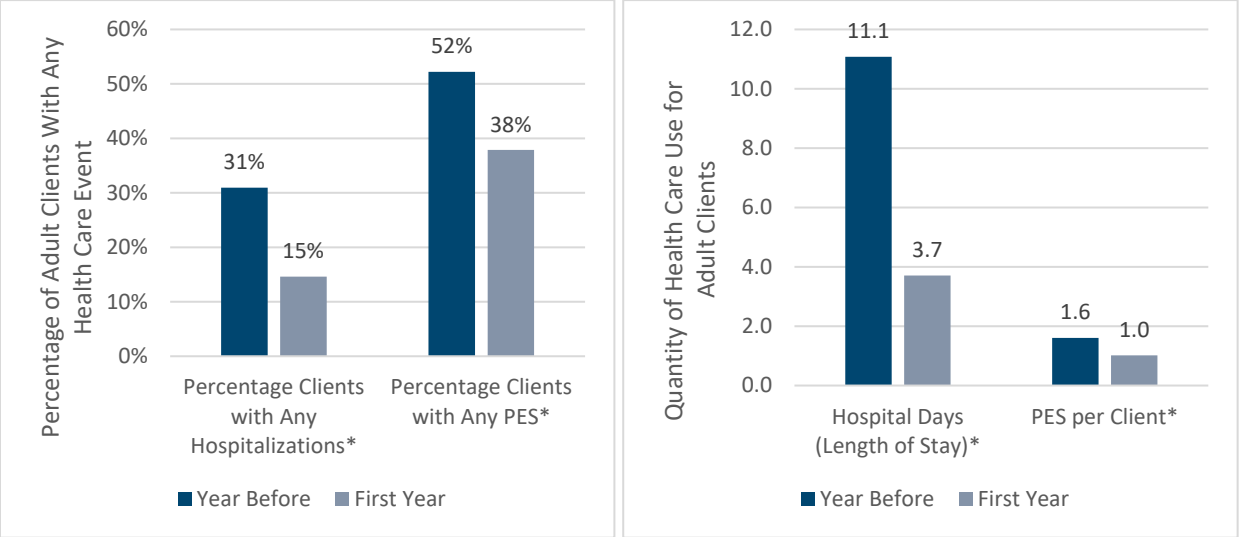
Exhibit 18. Hospitalization and PES Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 229)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. + indicates a change significantly different from 0 at 0.08 significance level.

In Exhibit 19 below, all four outcomes are statistically significant for adults.

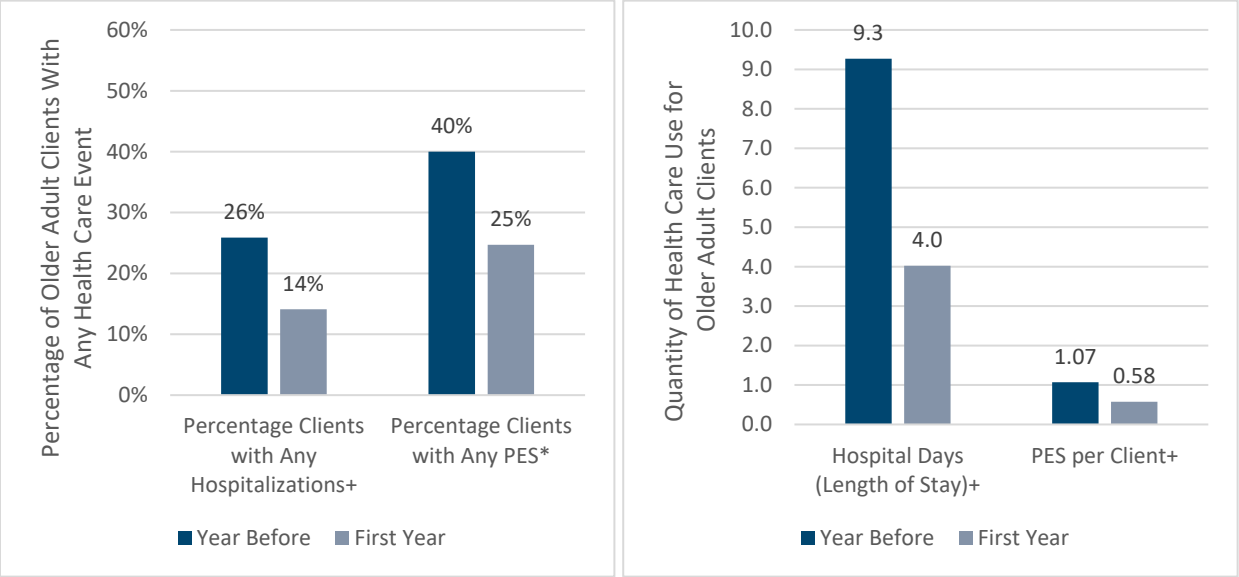
Exhibit 19. Hospitalization and PES Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 404)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

As shown in Exhibit 20, for older adults only the change in percentage of clients receiving PES is statistically significant, and mean number of hospital days and number of PES per client are marginally significant.

Exhibit 20. Hospitalization and PES Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 85)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. + indicates a change significantly different from 0 at 0.08 significance level.

Health Care Utilization for FSP Clients Over Time

Exhibits 21–24 show the four health care utilization outcomes, including the percentage of clients with any hospitalization, mean hospital days per client, percentage of clients using any PES, and mean PES event per client, stratified by year of enrollment. As Exhibit 21 shows, every year the percentage of clients with any hospitalization decreased after joining an FSP program, with the exception of 2022 where percentage remained the same.

Exhibit 21. Percentage of Clients With Any Hospitalization by FSP Enrollment Year

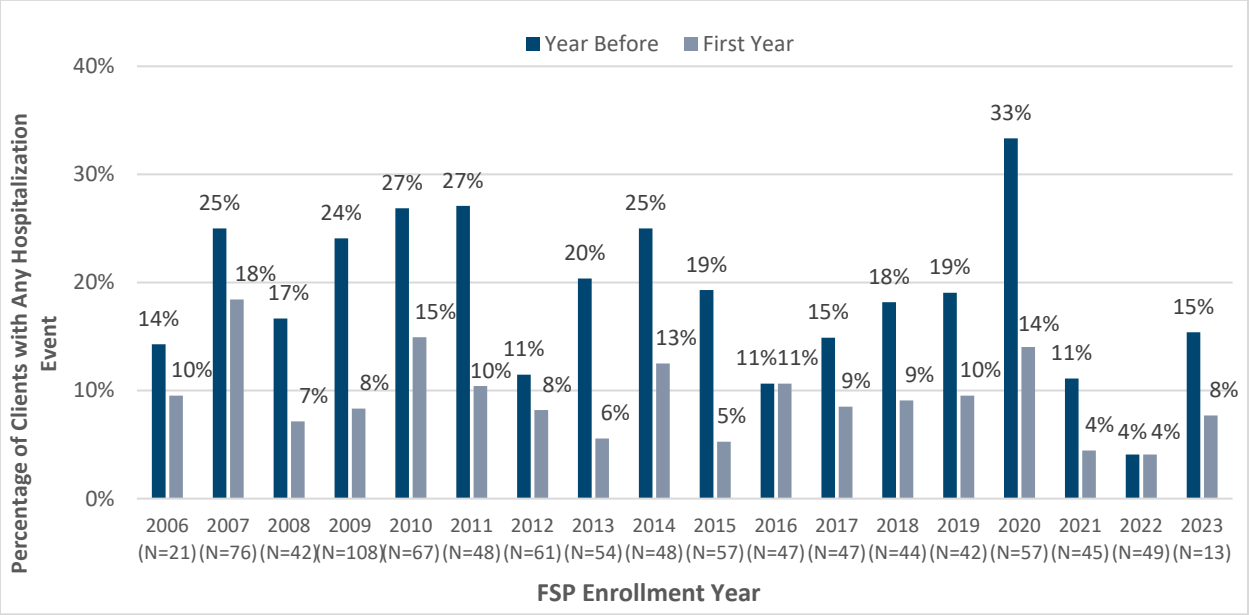


Exhibit 22 displays the mean hospital days per client by enrollment year. Apart from the 2006 and 2007 cohorts, all other years show a decrease in the average hospital days from the year before FSP to the first year of FSP enrollment. Hospital days decreased by an average of over 7 days from the prior year for the 2023 enrollment cohort.

Exhibit 22. Mean Number of Hospital Days by FSP Enrollment Year

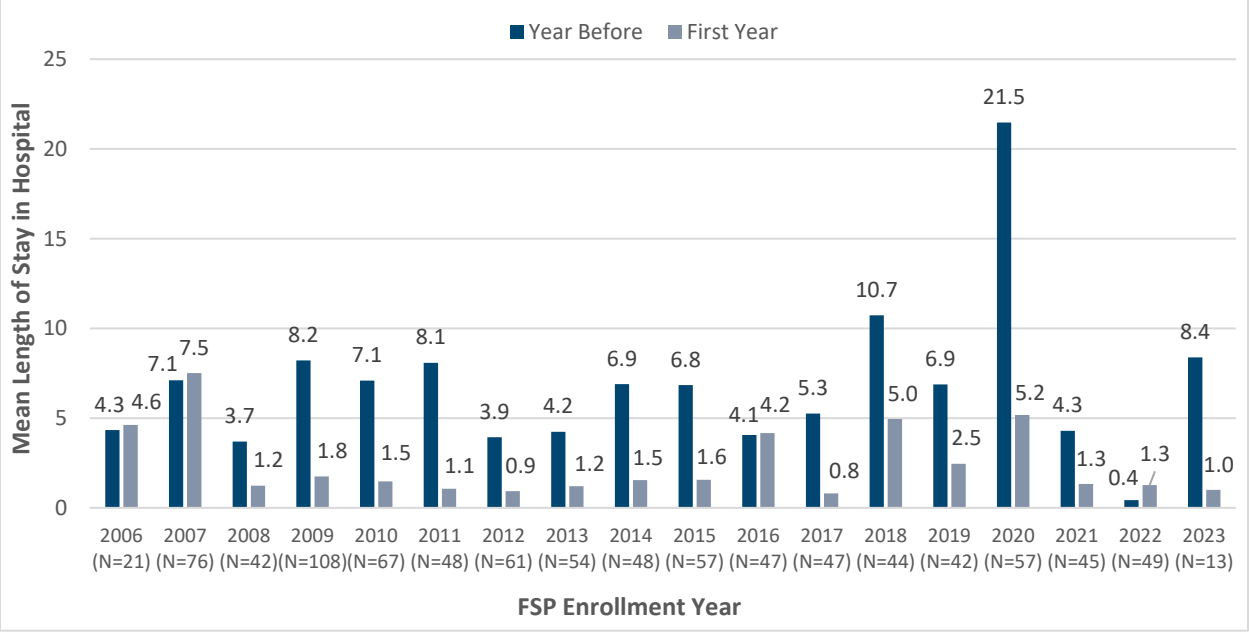


Exhibit 23 below displays the percentage of clients with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event from the year before FSP to the first year of FSP enrollment.

Exhibit 23. Percentage of Clients With Any PES Event by FSP Enrollment Year

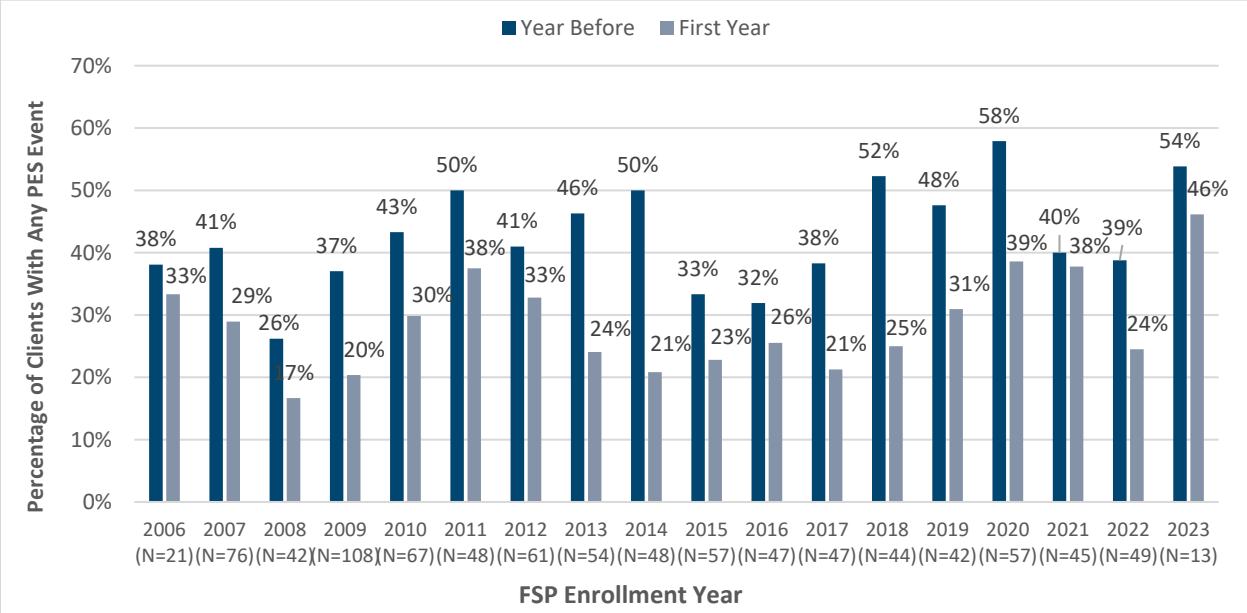
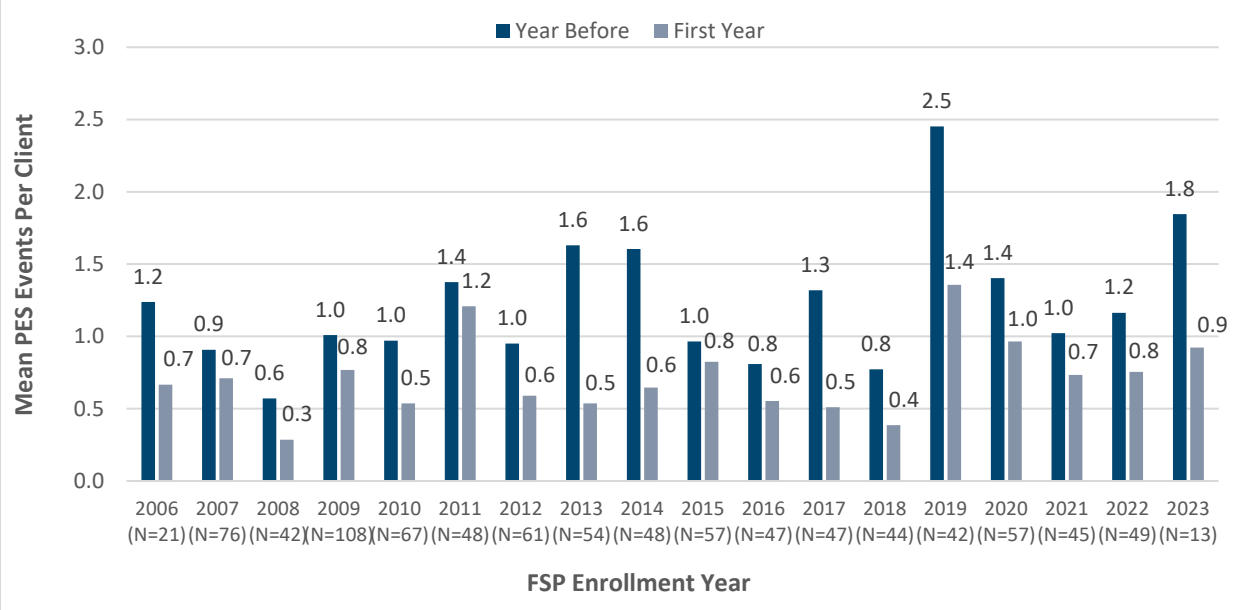


Exhibit 24 displays the mean PES events per client by FSP enrollment year. All cohorts experienced a reduction in PES events from the year before FSP to the first year of FSP enrollment.

Exhibit 24. Mean PES Events by FSP Enrollment Year



The quantitative analysis of the FSP programs reveals significant improvements across multiple client outcomes. The self-reported data show notable reductions in homelessness, arrests, and mental and physical health emergencies, particularly among TAY and adult clients. Employment rates for adults also improved, while youth clients' school-related outcomes, such as attendance and grades, declined slightly. The EHR data results further indicate substantial decreases in hospitalization rates, average hospital days, and psychiatric emergency service (PES) utilization across all age groups. These trends are consistent over time, with marked declines from the year prior to FSP enrollment to the first year of participation. Despite these overall positive outcomes, Telecare clients reported an increase in mental health emergencies, potentially reflecting heightened engagement with health services and improved diagnosis. Overall, the data underscore the effectiveness of FSPs in enhancing client well-being and reducing reliance on emergency care, though areas like academic outcomes for youth clients and early mental health crises may warrant further attention.

Qualitative Analysis

In this year's evaluation report, in addition to the quantitative assessment using self-reported and EHR data, AIR conducted qualitative data collection and analysis to complement the final evaluation for FY 2023–2024. AIR conducted key informant interviews (KIIs) 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. Below we present the analysis results for the completed KIIs.

Qualitative Evaluation Questions

The qualitative data collection and analysis aimed 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. Improving the FSP experience—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. Providing client services and outcomes—what strategies and resources are wraparound treatment team members using to address the behavioral health needs of clients they serve?
3. Improving the FSP experience—what changes do wraparound treatment team members recommend for improving the FSP program?

FSP Treatment Team and Client Interview Findings

This section presents findings from interviews conducted with the 12 FSP clients and 23 FSP treatment team members across the four service providers as described in Exhibit D2 in Appendix D. Findings describe client and treatment team member:

- Overall experience and satisfaction with the FSP program

- Experience with FSP services and care, including strengths and areas for improvement
- Clients' greatest needs and goals for FSP participation
- Opinions about FSP services provided in response to needs
- Perspectives on health and quality-of-life impact
- Recommendations for the FSP program

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

Overall Experience and Satisfaction With the FSP Program

Exhibit 25. Summary of Overall Experience and Satisfaction With FSP Program

Clients	Treatment Team
• Clients had overall satisfactory and supportive experiences with the FSP program. • Clients referenced positive interactions with case managers as a reason for their high satisfaction with the program. • The **average satisfaction rating** across clients was **8.9 out of 10.**	• Treatment team members had overall satisfactory and rewarding experiences as staff members in the FSP program. • Treatment team members shared that the productive and efficient work environment contributed to their high satisfaction with the FSP program. • The **average satisfaction rating** across treatment team members was **8.3 out of 10.**

Clients' Overall Experience

Adult clients, **older adult** clients, and **parents of youth** clients reported that they had supportive and satisfactory experiences with the FSP program and were appreciative of its positive impact on their or their child's mental health. An **adult** client expressed gratitude to program staff for being supportive and responsive, and said,

> *"I can't ask for better team members for me to recover from being homeless and everything else. And they've been very helpful. And I know some are young, but everything they say has really been really helpful and it seems like they know what they're doing and I can reach out to them anytime."* (An **adult** client)

Similarly, an **older adult** client appreciated program staff's support, and said,

> *"They've helped me so much, and I mean, I don't know what else to say. I'm grateful to have them."* (An **older adult** client)

A **parent** of a youth client shared that their child's participation in the FSP program has improved their communication and relationship, and stated,

> *"It's made changes with my family, with my daughters in this case, we have had better communication. The change has been that we have a better relationship, more interaction."* (A **parent** of a youth client)

Client Satisfaction

Clients were asked to rate their satisfaction with the FSP program on a scale from 0 to 10, where 0 indicated the client is not at all satisfied, and 10 indicated that the client felt extremely satisfied. More than half of clients gave the program a score of 9 or higher, while the remaining rated the program between 6 and 8. Across all 12 clients we interviewed, the average client rating for the FSP program was **8.9 out of 10.**

Clients who gave the FSP program a rating between 8 and 10 indicated that they have seen positive outcomes after joining the FSP program, such as reconnecting with their families or pursuing an educational degree. Clients also shared that they appreciated FSP staff members' willingness to meet their needs and provide support when needed. An **older adult** client, who gave the program a score of 9.5, appreciated the support Caminar staff provided them with and said,

> *"I'd just like to give credit to Caminar for helping me so much and being there for me. I don't know what I would do if I was by myself . . . because my mom's older now, so I don't know how much longer I have with her. So, once she's gone, I'm going to be all alone in this world. So, at least I have Caminar as some support network to help me a little bit."* (An **older adult** client)

An **older adult** client, who gave the program a rating of 7.5, said that the FSP program should hire more case managers because *"the present case managers have huge caseloads, and they have a hard time getting around to all their clients."*

An **adult** client, who gave a score of 6, shared similar sentiments about hiring more staff and noted a cumbersome program structure, stating that

> *"If [Telecare] had more staff, there would be more programs available . . . I perceive certain inefficiencies in the running of the program . . . you have to go through one person to get to another person."* (An **adult** client)

Overall Treatment Team Experience

Treatment team members from adult, older adult, and youth FSP programs reported that they were satisfied with their experience in their roles and felt that working with FSP clients is

rewarding. Additionally, they showed appreciation for the effective collaboration and productive environment across the treatment team.

A treatment team member from an **adult** program shared that they appreciate how dynamic the environment of the FSP program is, and reported,

> *". . . What I probably enjoy the most is how dynamic the environment is, and every day brings new challenges and opportunities for growth, for myself, for my clients."* (Treatment team member from an **adult** program)

Two other treatment team members expressed similar sentiments, and said,

> *"I genuinely feel that I have a wonderful supervisor and the overall environment of the team*." (Treatment team member from an **adult** program)
>
> *"It's just a very trusting, open, but also efficient environment because we just have such great people."* (Treatment team member from a **youth** program)

Several treatment team members expressed that providing support to clients has been one of the most rewarding aspects of their experience with the FSP program, stating that, *". . . Knowing that I've been given opportunity and the training to help this population in becoming functional members of society and not just survive, but thrive, is just amazing."*

Team Member Satisfaction

Treatment team members were asked to rate their satisfaction with the FSP program from 0 to 10, where 0 suggested they were not satisfied, and 10 indicated they felt extremely satisfied. More than 70% of treatment team members gave their satisfaction with the program a rating of 8 or higher. Across 23 treatment team members, [8] the average rating for the FSP program was **8.3.**

A treatment team member from an **adult** program, who gave their satisfaction with the program a score of 10, expressed that they were extremely satisfied with their experience, and said,

> *"I am very satisfied with what I do, and I put my heart in it."* (Treatment team member from an **adult** program)

One treatment team member from a **youth** program, who gave a satisfaction score of 9, reported that seeing improvements in clients' quality of life felt rewarding, and said,

[8] One treatment team member did not provide a numerical rating, but they indicated they were satisfied with their experience working for the FSP program.

> *"I got to tell you, I love it. Not because I want to be recognized. It's because I hear success, when the parents [say], I was able to do it and my son was so happy, or my son even later on reflected and said, 'Mama, I noticed you were not yelling as usual.' That is very rewarding to me because I was there." (Treatment team member from a **youth** program)*

A treatment team member from a **youth** program, who provided a satisfaction score of 8, shared that they would like to see more diversity across FSP staff and cultural humility trainings,[9] and said,

> *"I would also say maybe discussing more cultural awareness or cultural trainings that would also relate to our clients. . . . We have a group that's supposed to be about diversity, but it's mostly run by the higher ups, but all the higher ups are Caucasian. So, then it doesn't really transfer to the employees who are diverse."* (Treatment team member from a **youth** program)

Greatest Needs and Program Goals of FSP Clients

Exhibit 26. Summary of Clients' Greatest Needs and Program Goals

- **Clients** shared that their goals for participating in the FSP program include **improving their mental and physical health, maintaining sobriety, and continuing education.**
- **Treatment team members** stated that greatest needs among FSP clients include **access to counseling and psychiatric services**, **managing substance use**, and **assistance with finding stable housing**.

Clients' Goals: Client and Parent Views

- **Improving mental health and overall health:** Nearly all clients shared a goal of improving their or their child's mental health and overall health. One parent of a youth client aimed to improve the mental health of their entire family, and said,

  > *"The goal was to improve the mental health of everyone in the family . . . we were in a declining situation with my daughter in a quite severe situation mentally, and my intention was to get help—to be able to help ourselves, everyone, and get out of this mess that we were in." (**Parent** of a youth client)*

  In addition to improving mental health, clients referenced goals related to physical health. An **older adult** client mentioned that they aimed to exercise more and improve their nutrition intake:

[9] Cultural humility trainings are designed to promote ongoing self-reflection, awareness of personal biases, and respectful interactions across cultural differences, emphasizing lifelong learning and mutual respect. Description from the Georgetown University National Center for Cultural Competence.

"Just stay healthier and stay well, work on my mental health, exercise, eat right, lose weight" (An **older adult** client)

Substance use recovery: Two clients, one adult and one older adult, mentioned that they aimed to minimize substance use and maintain sobriety after being referred to the FSP program from the court justice system:

"I'm in recovery now for marijuana, some drug use. But I'm in recovery . . . I haven't been using any kind of drugs at all." (An **adult** client)

"My goals were to maintain my mental health and stay sober, and not drink and use drugs." (An **older adult** client)

- **Continuing education:** Four clients, two adults, and two older adults, shared a goal of going back to school and pursuing higher education or counseling licenses. Three of the four clients said that continuing education was important to them and are actively working toward this goal:

  "Well, back then when I joined, my goals were to get a college degree, which I did get. . . . It was very important to me that I get that degree." (An **older adult** client)

  ". . . But now I'm back and going to school. I just did my readmission application for school, and also to complete my mental health diversion program that I'm in with the court. . . . I'm finally going back to school, and that's something I wanted." (An **adult** client)

  An **older adult** reflected that they appreciated the emotional and tangible support from the treatment team to renew their counseling license and resume employment:

  "So [a treatment team member] thinks I'm ready to renew my license and start working again, so that's kind of nice. . . . When I'm ready to take classes to renew my license, I'm going to ask them to help me with that. For example, they would know how to do that. You know, call the Board of Behavioral Sciences . . . get a laptop. It's a lot to get my license back. It's a big deal to take [continuing education] units. They will help me with that too." (An **older adult** client)

Clients' Needs: Treatment Team Member Views

The FSP program provides services not only with the goal of improving mental health and substance use recovery, but also to build independent living skills and resiliency to help clients transition into the larger community. When asked about clients' greatest needs, treatment team members commonly referenced assistance with accessing stable housing, access to psychiatric services, and substance use. Team members also noted that clients' needs are individualized: *"there's not a one-size-fits-all answer; it just really depends on the client and what their current situation is."*

- **Mental Health:** Access to Counseling and Psychiatric Services
  Treatment team members emphasized the importance of clients having access to counseling or psychiatric services and referenced the FSP program's focus on mental health and supporting clients in living independently. A team member from an **adult** program and a team member from a **youth** program said,

  > *"I'd also just say having that access to psychiatric and therapeutic services or therapy services is extremely important because you're getting to work with the individual."* (Treatment team member from an **adult** program)

  > *"I think for our population, again, in our FSP, it's a lot of focus on mental health, but also a lot of focus on building independent living skills for our clients."* (Treatment team member from a **youth** program)

  A treatment team member from a **youth** program mentioned that there is a need for FSP services among youth clients, given the lingering impacts of the COVID-19 pandemic on their mental health. They stated,

  > *"There's a lot of isolation from the clients across different diagnoses that they come in with. I think we anecdotally attribute a lot of this to the pandemic and how it's impacted people. . . . I think the underlying need there is that being able to have our services available as long as it takes to actually build a relationship and engage a client."* (Treatment team member from a **youth** program)

- **Substance Use Recovery:** Treatment team members cited managing substance use as one of clients' greatest needs. One treatment team member from a youth program shared that they have seen an increase in substance use among youth clients, and there may be difficulty engaging affected youth in FSP services. They shared,

  > *"And then more frequently, I would say after COVID, I've seen an increase in substance use with the youth that we are working with. And that's been, I think, a resource that sometimes can be difficult to find for our youth and get their buy-in because I think when they hear [Alcohol or Drug Abuse] programs or resources, it sounds really scary and intense, and it can be sometimes."* (Treatment team member from a **youth** program)

  A treatment team member from an **adult** and **older adult** program discussed prioritizing clients' greatest needs when they are referred to the FSP program, and shared that *"if there's substance use involved, then that would take a high priority."*

- **Housing Assistance:** Several treatment team members described the extensive challenges of not only finding affordable housing for their clients, but ensuring they remain housed. Team members shared that being able to stay in a home for an extended period is a challenge they regularly encounter in their work, given the struggles that many clients have with substance

use or independently carrying out activities of daily living. One team member expressed the need for specific housing for clients with co-occurring mental health and substance use disorder as these clients have unique needs that may not be addressed by current housing resources:

> *"I'll say the greatest need that doesn't exist is co-occurring specific housing. It doesn't exist in our county. It's like you either are in mental health-focused housing or you are in substance focused housing. And a lot of the substance-focused housing folks are not equipped to manage clients with severe mental illness."* (Treatment team member for **adult** and **older adult** clients)

Treatment team members also shared that connecting clients to the appropriate housing resources depends on their situation. One team member from a youth program stated,

> *"Well, if our clients are homeless, then it's like connecting them to a shelter. Or, if possible, using the [Mental Health Association] funds or the apartment complex we have, or this also applies to if they're living with family, but getting them into a social rehab where they can learn independent living skills and also have housing that's temporary. So, kind of just finding the right fit of housing depending on their situation*." (Treatment team member from a **youth** program)

FSP Program Services Provided in Response to Clients' Needs

Exhibit 27. Summary of Program Services Provided in Response to Clients' Needs

Services received by most clients:

- *Case management*: rehabilitative activities, motivational interviewing, crisis prevention and management, connection to community resources, and health care advocacy
- *Mental health*: psychiatry, psychoeducation, and therapy that is often community-focused

Additional supports available to clients:

- *Peer support*: group activities, workshops, and socializing with mentors who share similar lived experiences as clients
- *Parental and family support*: family therapists and counselors who provide psychoeducation and techniques for crisis avoidance and recovery to clients' family members
- *Transportation*: for attending medical or legal appointments
- *Housing*: housing specialists/coordinators or case managers provide education, funding, or program-affiliated housing

The following section describes information about client services, based on insights drawn from both client and team member interviews. We also identify the types of team member roles that provide each of these services. The majority of treatment team members interviewed described a highly collaborative environment amongst all team member roles. Although specialist team members provide a specific type of service, such as a housing specialist, they regularly

communicate with the larger team to ensure that the client is maintaining appointments with all members of their treatment team.

- **Case Management:** Clients meet with their case manager, or a rotational team of case managers, more often than with any other treatment team member. These meetings are held in-person (or over the phone when necessary) and usually occur weekly, if not multiple times per week. During these sessions, case managers utilize rehabilitative activities including skill building, behavior modelling, and mindfulness and grounding techniques with the goal of increasing the client's independence. They will often engage in motivational interviewing, reflective and empathic listening, and other therapeutic interventions as needed to prevent and handle crisis situations. In addition, case managers will provide targeted case management to connect clients to resources which may include food, clothing, housing, education, employment, or substance use programs. They also connect clients to medical providers for medication and symptom management.

  > *"I think that it's very important to have fun and depending on, again, whatever they're struggling with in the moment, normally it's just a matter of getting to know the client's likes, dislikes, hobbies, interests, what kind of brings a passion, a spark into their life, and then trying to tie it into what are they currently struggling with."* (A dual diagnosis case manager from an **adult/older adult** program)

  > *"I've asked [the case manager] for help with food assistance and I've also asked her for help with my primary healthcare provider. I asked her about some of my anxieties I was experiencing and she helped me advocate for myself."* (An **adult** client)

- **Mental Health Services:** Clients typically meet with a therapist once or twice per month in person. In addition to individual sessions, therapists also hold monthly family conferences and offer group sessions for multiple clients. During these sessions, therapists will utilize the therapeutic and rehabilitative techniques employed by case managers, as well as provide psychoeducation to inform clients about their symptoms, help clients heal from trauma, and reduce harm for clients with substance use disorders. They incorporate spiritual and religious preferences into their treatment approach and involve clients' families in the treatment program as much as the client desires and is possible. Many therapists enjoy using a community-based approach during their sessions, and listed hiking, painting, or grocery shopping as common activities they use to build their clients' independent living skills.

  > *"Also, I think in this role, especially because we are community-based, I found myself not just sitting in a room with clients just providing therapy. I think that's the bulk, but there have been times where I've taken a client grocery shopping to help them with building social skills and building the skills to run their own errands and things like that."* (A clinician from a **youth** program)

- Psychiatry Services: Generally, clients will attend monthly remote sessions with their psychiatrist. During these sessions, psychiatrists will perform assessments, provide interventions, and prescribe medications for symptom management.

  "[My psychiatrist] practices mindfulness with me . . . And I do think that really helps a lot. I would say that I'm using psychiatry the most." (An **older adult** client)

- **Peer Support Services:** Many clients choose to use peer support services, which are more focused on socializing and building interpersonal skills in a relaxed environment. Peer support staff serve as mentors to clients and build relationships with them through activities such as cooking, playing video games, and taking walks. Clients are more likely to connect with and relate to peer support staff because they share similar lived experiences, which is evident in the sentiments shared by clients who regularly engage in peer support services. In addition to individualized activities, peer support services include weekly group activities and monthly workshops.

  "Being in the program provides me with a sense of community. The other peers that are part of FSP, I talk to them, and I see them, and I go to groups." (An **adult** client)

  "Even though we're providers, we keep it chill and casual and get to know them a little bit more. So, we've had really great conversations, and then it's led to workshops. My team puts on workshops with the clients. We just did a harm reduction workshop, résumé building. We take the relationships that we've gained with them, consider their treatment goals, and then invite the entire community to come to our monthly workshops and activities." (An associate director of peer services from a **youth** program)

- **Parental and Family Support:** Family therapists may meet with any number of family members in addition to the client, and often hold sessions in the client's home. Some therapists find it helpful to meet with the client and one parent initially with the aim of gradually including more family members. They work to reinforce boundaries amongst family members, teach crisis avoidance and recovery-centered techniques, and provide psychoeducation to family members to help them understand the client's situation. Sometimes, child clients are unwilling to discuss their needs with providers, so family therapists will coach parents on how to communicate with their child. Clients and their families may also choose to meet with family counselors.

  *"I hold fast to the idea that families are systems, and if one member is sick, then the system is sick. And so, I try very hard to involve family members as much as I can, and as much as seems clinically appropriate." (A licensed marriage and family therapist from an **adult/older adult** program)*

  "Unfortunately, my daughter's mental health struggles are not something that you can say, oh, it's gone. It's something that she will always have, but with the help of knowing

how to handle it, well, I know how to handle it. Also, as a family, we have been able to work on it and we have kept it under control." (**A parent** of a youth client)

- **Transportation Assistance:** Transportation assistance is available to some clients who may use this service to attend medical appointments or legal appointments in court. Case managers and therapists may collaborate to provide transportation assistance to clients.

Housing Assistance

Clients may utilize housing assistance to find or maintain current housing. Some programs have dedicated housing specialists or housing coordinators that collaborate with case managers. Their involvement is correlated with clients' level of need, and the frequency of their client meetings may range from multiple visits per week to once or twice per month. Services provided may include education, funding, and building independent living skills with the goal of maintaining a clean unit and preventing fires caused by space heaters. Housing staff will involve client family members at the client's discretion and may also provide direct client care if the client is residing in an apartment complex affiliated with the FSP program.

> *"I have a client that he just lost a roommate, so I constantly like calling him just to make sure. . . . I wanted him to be comfortable and understand that we are here to support him and refer him to see his psychiatrist and make sure that he's taking his medication and he has other network support like his parents."* (A housing specialist from an **adult/older adult** program)

Perspectives on FSP Program Referrals and Initiation of Care

Exhibit 28. Summary of Perspectives on FSP Program Referrals and Initiation of Care

Clients	Treatment Team
• Clients had overall positive feedback about referral and initiation of care processes. • Suggested expanding awareness of the program to make it more accessible to potential clients. • Satisfied with comprehensive assistance provided by multidisciplinary treatment team during initial meetings.	• Treatment team members said the referral and intake processes run smoothly. • Identified lack of supplemental documentation from referring providers (e.g., health and ID records) as a challenge. • Warm handoff from the referring provider is essential and could create a service gap if not executed properly.

Exhibit 28 above summarizes the feedback received from clients and treatment team members about FSP referrals and initiation of care. Most of the clients interviewed have been receiving services from the FSP program for 5 years or more, while the remainder of clients joined the program within the past 3 years. One client reported they had been with the same FSP provider for over 10 years, when the provider's FSP program first started.

FSP Referral Process

- **Client Experiences:** Referral sources varied for clients interviewed as part of this year's FSP study. Sources of referral seem to vary between youth and adults. All parents of **youth** clients stated that clinicians, including therapists and psychiatrists, referred their children to the FSP program. Meanwhile, three **adult** clients were referred by SMC's Correctional Health Services staff after their release from prison or jail. Other clients were referred to FSP services by an external provider or therapist, either during a medical appointment, therapy appointment, or hospitalization. One **adult** client was referred during their discharge from a facility as they were transitioning out of a conservatorship. Another **older adult** client was referred during their exit from an assisted living facility. Two **adult** clients reported being referred from other SMC BHRS programs, including the Assisted Outpatient Treatment (AOT) program.

  > *"I heard about [FSP program] from AOT, this outpatient assistance program. When I got out of jail, my case manager from jail signed me up with Caminar. I was on a mental health diversion program, and I was on that for two years. So, I had to be part of taking medication and stuff in order to be out of jail."* (An **older adult** client)

  Many clients shared positive sentiments about their referral and transition to the program, including describing the staff as kind, welcoming, helpful, and knowledgeable. Both adult and youth clients expressed how they viewed referral into the FSP program as an opportunity for them to transition from a hospital or the prison system into a lower level of care facility, and

eventually into the larger community. Overall, clients did not identify any issues or concerns with the current referral process, although one parent of a youth client mentioned that they wish there were greater awareness about the program to make referrals easier:

> *"There needs to be more information about where to find this kind of help for mental health. Making it a bit more accessible, easier to find, I think all of that would help . . . because when I talk about the program, everyone asks, 'where did you find it, who told you about it?' I know other parents who are also going through similar situations to mine, and they ask me how I found it, and there's no easy way to find it. . . . "* (**Parent** of a youth program client)

- **Treatment Team Experiences:** Treatment team members elaborated on the most common reasons for client referrals to FSP. Many clients have received mental health diagnoses such as posttraumatic stress disorder (PTSD), depression, anxiety, schizophrenia, or bipolar disorder. These clients may be exhibiting intense suicidal ideation or self-harm, are unable to attend school, or unable to maintain a job or housing. Youth clients may be referred from their school for truancy or from the court system due to probation or arrest. Often, clients are referred to adult programs as they are aging out of youth services.

  > *"We work with clients that have SMIs [severe mental illness] . . . helping clients that have cycled in and out of inpatient hospitalizations or have been evicted from their homes and are just really getting their footing in society. Especially in the Bay Area, it's not the easiest place to live."* (A treatment team member from an **adult** program)

  Several treatment team members cited the BHRS access line as a main source of referrals to the FSP program. Specifically, county clients, therapists, psychiatrists, social workers, potential clients themselves, or other parties may call the access line to initiate a referral. Clients in jail or under probation may also be referred directly to the FSP program from the county court system. An intake coordinator is responsible for gathering information about the potential client. Multiple treatment team members also mentioned recurring weekly or monthly meetings amongst the county, FSP programs, and community clients to discuss placement of potential clients. Once an FSP program receives a referral, they continue with their intake process to assign a treatment team, gather additional details about the client, and work with the client to develop a treatment plan.

  Like clients, most team members had positive feedback about the FSP program referral process, particularly related to identifying treatment teams, navigating program capacity, and determining client service needs and program placement. Many described the referral form as extensive and providing comprehensive documentation about clients. Although team members' feedback suggests overall that the referral process runs smoothly, some team members described challenges or areas for improvement. A common issue noted across team

members was a lack of supplemental documentation included with the referral form, such as health records and identification records, which can delay the intake process for new clients:

> *"As the client's being referred to us, if all the places were able to provide us proper copies of important documents that are relevant to the client, that would be helpful. For example, copies of their Medi-Cal cards or Medicare cards or IDs, driver's licenses, or other insurance material, things of that sort, so that we don't have to run around looking for them."* (A treatment team member from an **adult** program)

FSP Intake Process

- **Client Experiences:** Clients who joined the FSP program within the past 1–2 years reported they had their first appointments conducted through Zoom—some from inpatient hospitals or from jail—while clients who started the program earlier had in-person appointments. Despite differences in modality and context, clients reported positive experiences with their first interaction with the FSP program, highlighting several factors that contributed to their satisfaction. A common theme is a strong sense of support and positive engagement with team members during the initial appointment. A **parent** of a youth program client appreciated the introduction to and presence of multiple FSP team members at the first virtual appointment, noting how the collective support across members with diverse expertise instilled a sense of confidence in the care provided.

  > *"I was impressed to see everyone. The truth is that when I started, I saw in the first appointment that there were many people involved. For me, it was impactful . . . to see, wow, there are quite a few people who are going to help us. Personally, as a father, I felt quite supported."* (**Parent** of youth program client)

  Other clients reported they initially met with a lead case manager or therapist who then connected them with other team members, such as additional case managers, and psychiatrists.

  These clients similarly echoed their satisfaction with the comprehensive assistance provided in the first appointment, including addressing immediate needs related to housing, counseling, and psychiatric support. Another **parent** of a youth program client recounted from the first appointment:

  > *"It went very well. It was an experience I honestly did not expect, but it cleared up any doubts I had. . . . I was provided with a psychiatrist, a behavioral worker . . . there were about four or five services."* (**Parent** of youth program client)

  However, two **older adult** clients did not feel comfortable with their first assigned case managers and eventually transitioned to different team members, with whom they are satisfied. The initial client experiences with the FSP program emphasize the importance of the

first impression made during the intake process, which can set the tone for long-term engagement and satisfaction with the FSP program. Using a collaborative and multidisciplinary team approach appears to help build trust and create a sense of a supportive environment for clients.

- **Treatment Team Experiences:** A few treatment team members mentioned that warm handoffs are an important part of the intake process and can be especially helpful when working with clients who are difficult to engage. Edgewood team members specified their success by incorporating a clinical coordinator into the warm handoff and intake process, which has reduced intake delays and workload of case managers. In addition, team members across programs identified strong relationships and frequent communication with county and community clients as particular strengths of the process.

  > *"When we have a barrier, or a challenge that is impacting our ability to open a client case, or to process a referral, we have that flexibility to be able to collaborate between both programs to determine how we'll be able to best support the client, and the referral."* (A program director from an **adult** program)

  > *"I think what's worked well is we work very closely with the county in terms of who they were referring us, you know, the county really takes our feedback in terms of the clients and they're very willing to meet us more than halfway in terms of how to best support the clients."* (A behavioral health clinician from an **adult** program)

  Another team member noted difficulty with scheduling the initial client meeting within the required limit of days, either due to current hospitalization or trouble connecting with a working parent. In addition, one team member from a **youth** program identified a service gap in coordinating care that occurs when referring providers (e.g., primacy care providers) discharge clients out of their current services to behavioral health services too quickly. They described multiple instances where clients were excluded from behavioral health services because they had not yet agreed to FSP services, but they had already been discharged from their referring provider's services.

  > *"The bare minimum is to have that warm handoff meeting because a lot of times, the client has a trusting relationship with their provider, but they need a higher level of service so they get referred to us. And then a lot of times, [for] clients, it's difficult to start a whole new relationship with a treatment team. So, if we can coordinate and cross over more, we can build our relationship faster by working close with the current provider."* (A behavioral health director from a **youth** program)

Clients' Experience With FSP Wraparound Services and Care

Exhibit 29. Summary of Clients' Experiences With FSP Services

- Clients gave positive feedback about their experience with FSP case managers, particularly highlighting case manager **availability, responsiveness, guidance, and resources.**
  - Clients were satisfied with how frequently they meet with their case managers and appreciated the ability to communicate in multiple ways (e.g., in-person, phone, Zoom).
  - Clients reported that case managers provide valuable guidance, connect clients with helpful external resources and services, and are attentive to client needs.
- Some clients mentioned issues with **interruptions in care** and **lack of shared lived experiences** with their case managers.
  - Some clients experienced disruptions due to turnover in case managers and expressed a desire for more consistent case manager assignments to avoid frequent changes.
  - An older client felt uncomfortable with younger case managers from different racial backgrounds, citing difficulties in relating due to differences in age and life experience.
- Clients reported strong **interpersonal connections** with other treatment team members and expressed gratitude for how their treatment team interactions have led to **positive impacts on health and well-being.**
  - Clients said they felt supported and highlighted close relationships with psychiatrists, therapists, and other specialists.
  - Clients expressed that treatment teams help them achieve their program goals, such as abstaining from drug use and improving family dynamics.
- Some clients faced **difficulties in scheduling sessions** and **desired greater personal agency** in treatment decisions.
  - Frustrations included repeated cancellations by psychiatrists and challenges in balancing busy schedules with multiple team member appointments.

Experience With Case Managers

- **Case Manager Availability and Responsiveness:** Nearly all clients report meeting with their case managers in-person weekly, and some meet with their case managers multiple times a week. Most clients reported being satisfied with the frequency of communication and appreciated the ability to contact case managers by phone outside of meeting times. An **older adult** client expressed appreciation for the support they receive during weekly meetings with their case manager, and shared,

  > *"I like meeting with my case manager every Tuesday. It's going to have coffee with her and going for a walk along the beach, and then just hanging out with her talking. We talk about recovery and talk about what's going on with me, having a friend that I could talk with and stuff. Having the support from her, I really like that every week."*
  > (**Older adult** client)

An **adult** client shared that several case managers have gone the extra mile to help them with immigration paperwork, and stated,

> *"They've been helping me with the immigration [paperwork] and all that stuff, and they went out of their way to help me, and I appreciate everything that they've done."* (An **adult** client)

- **Providing Guidance and Resources:** Clients shared that case managers provide valuable guidance and resources and expressed that they understood their needs. Case managers also connected clients to external services if they needed additional support.

  A **parent** of a youth client voiced appreciation for their child's case manager, who was attentive to their child's needs and connected them to external resources and services. They said,

  > *"[The case manager] was very good. It's been a very good experience with her. She's a good person who supported me a lot. Very attentive. We started making a list of what things I considered needs. . . . She actually gave me places where I could go, gave me a phone number where I could call, and she was always, always there. She always said, 'give me an update. I want to know if you need anything else.' She was always trying to check in to see if we needed anything."* (**Parent** of a youth client)

  An **older adult** client reported that their case manager connected them with food assistance, employment resources, and any other services they need to become independent.

  > *"They've been very good with getting food donations or referring me to maybe job interviews or what I can do to become more independent and more comfortable with myself and more well-adjusted."* (**Older adult** client)

- **Interruptions in Care:** Three clients mentioned turnover in case managers or therapists interrupted their care or said they would like the same treatment team members supporting them for a longer time.

  Regarding turnover in case managers, **adult** clients expressed that "you get tired of being bounced around" and suggested improvements in continuity of care, "so that you're not switched around and moved around different case managers and doctors."

  A **parent** of a youth client also shared that their child's previous therapist resigned. They shared that the waiting period was longer than expected and their child did not receive services for some time. They said,

  > *"Unfortunately, the therapist who was providing her therapy resigned and she was in limbo. I'm waiting, I have to wait two months to see if she finds someone else. So, when I started looking for help, it also took a long time, but it's because of the therapist's offices,*

so we're in another kind of pandemic situation, because this is urgent."
(**Parent** of a youth client)

- **Case Manager Attributes and Lack of Shared Lived Experiences:** The personality and skills of case managers were factors in clients' satisfaction with FSP services. Many clients reported their ability to create a strong interpersonal connection with their case manager. For example, clients spoke highly of case managers who they felt were attentive, empathetic, supportive, and efficient.

  "[My case manager] he's awesome. He talks to me like a person, not like he's above me."
  (An **older adult** client)

  However, an **older adult** client did not feel comfortable with case managers who were younger and from a different racial background and felt that their difference in age and life experiences made it difficult for case managers to relate to them.

  "I am in my 60s, so you can't go on and give me a 20 or 30 or 40-year-old person to put on me as a caseworker and think that I'm going to be comfortable. . . " (An **older adult** client)

- **Experiences With Other Treatment Team Staff**: Nearly all clients reported positive experiences with their additional treatment team staff, including psychiatrists, therapists, and other specialists. Emerging themes from the interactions described include deep interpersonal connections between clients and their treatment teams and clients' gratitude for positive impacts to their health and well-being resulting from high-quality care. However, a few clients also identified ways to improve their experience with the treatment team, including greater ease of scheduling sessions with treatment team members and more personal agency in making treatment decisions.

- **Personal connection and comfort:** Multiple **adult and older adult** clients reported having a close relationship with their treatment team, and one client even views their team as friends. One **adult** client appreciated extensive conversations with their psychiatrist and feels that they effectively monitor their symptoms and well-being. Most clients feel well supported and cared for by their treatment team and are comfortable with asking for assistance on a variety of topics. However, one client explained that their comfort in asking for assistance depends on the connection they have with their provider.

  "I've never had such a caring team, and I've been in the mental health system ever since I was 18 years old, and I'm going to be 53 in August. I've never had such a caring experience compared to this Caminar yet." (An **older adult**)

- **Positive impact on client care and well-being:** Multiple clients described positive effects from interacting with their treatment team and expressed gratitude for their care. They perceived effective collaboration and a strong sense of commitment amongst treatment team members.

Some explained how their treatment team assists with achieving their goals, such as abstaining from drug use for the sake of their children, maintaining upcoming doctors' appointments, and gaining independence.

> *"I've been trying to maintain my independence and stability of my mental health. And I think that would only have been doable with the help of my treatment team and the aid of the medications that my psychiatrist prescribes me."* (An **adult** client)

In addition, the **parent** of a youth client explained how they learned to care for their daughter's mental health through educational videos, courses, and guidance provided by the treatment team. The **parent** described improved family life and confidence in parenting skills because of the treatment team's support and guidance.

> *"I am very grateful to [the treatment team]. My daughter had episodes. She was hospitalized five times for suicide attempts. We clashed at first because of her condition. I was unaware at that time. I was also unaware of the way to work with her condition and the way to work with depression. . . [FSP] is helping me by giving me tools to start. They give me tools for me to use for my family and for parenting."*
> (A **parent** of a youth program client)

- **Challenges with scheduling and coordinating care:** Two client participants mentioned difficulty in scheduling sessions with treatment team staff, due to limitations posed either by the psychiatrist or the client's family. One **older adult** client exhibited frustration about their psychiatrist repeatedly cancelling their upcoming session, without providing justification.

  > *"I am upset with Caminar, young lady, because I have not seen my psychiatrist. . . . I'm very disappointed because they canceled on me again for no reason. . . . I just need somebody to talk to me and hear me."* (An **older adult**)

  The other participant, a single **parent** of a youth program client, described how their busy schedule creates a barrier to scheduling sessions with their family therapist. However, they mentioned that the flexibility of remote and in-home appointments has helped mitigate scheduling issues.

  > *"It's a bit difficult to schedule appointments and meet in person, you know, not because of her, but because of me. I'm a single parent, you know, and my time is really tight, so the way we do it with her is over the phone."* (A **parent** of a youth program client)

- **Limited agency in treatment decisions:** One **adult** client has been taking medication as prescribed by their treatment team, however, it is the client's preference to lower the dose or discontinue the medication. They explained that although it has helped them to achieve stability, it negatively affects their ability to study and exercise. Despite the client's sentiments, they are still taking the medication as prescribed by their treatment team. The

client wishes their treatment team would be more receptive to their preferences when making treatment decisions:

> *"A big thing in psychiatry is medication, and I've always tried to stay clear of these medications even when I've been forced them in certain situations. . . . I still would prefer to be off medication and try to lead my life that way, but oftentimes people on my team, because I'm still on the injection medication, some of them think that the medication helps and things like that."* (An **adult** client)

Team Members' Experience Providing FSP Wraparound Services and Care

Exhibit 30. Summary of Treatment Team Members' Experiences

Key FSP strengths

- FSP team members highlighted **strong collaboration and communication within their teams**. Frequent and varied communication methods foster a supportive and cohesive environment, enhancing both client care and team member satisfaction.
- Team members emphasized the importance of **meeting clients where they are and providing consistent support**, which contributes to positive client outcomes and satisfaction in their roles.

Challenges to providing services

- Reported challenges include high client caseloads, frequent staff changes, and emotional demands of the work, which can **limit staff capacity and continuity of care**.
- Team members cited that **gaps in resources and funding** impact client engagement and staff well-being.
- Some team members had **challenges engaging clients with high needs and their families** because some clients and families are reluctant to participate in services.

Impact of COVID-19

- Residual effects of the pandemic include challenges in conducting in-person visits and significant staff turnover. However, the pandemic also highlighted gaps in service accessibility, leading to improved flexibility in FSP service delivery and enhanced communication.

Perceived Program Strengths

Almost all FSP team members interviewed have been working at their respective FSP providers for at least 2 years, and several members reported working with the same providers for more than 10 years. The longest tenured treatment team member has been providing care through the FSP program for roughly 20 years. This level of retention underscores the positive experiences and fulfillment that staff derive from their work, contributing to the stability and consistency of care provided to clients. Treatment team members shared various insights into strengths of the FSP program and elements that contribute to their effectiveness.

- **Team Collaboration and Communication:** The most consistent strength mentioned across treatment team interviews was strong collaboration and communication within FSP teams.

Nearly all providers emphasized the importance of frequent and varied communication methods, including texting, phone calls, Zoom meetings, and in-person interactions, to ensure comprehensive and cohesive client care. Team members mentioned that the collaborative environment fosters a robust network of mutual support among team members, contributing to a positive and productive work atmosphere. One treatment team member of an **adult** program noted,

> *"The collaboration is very strong. Our staff are great. We're always getting continuing education, to better our services. . . I work with people that really truly passionate about what they do and the population that we serve."* (A treatment team member of an **adult** program)

This supportive dynamic is mirrored among treatment teams working with both **adult and youth** clients, where team members provide emotional and social support that contributes to better outcomes for team members and their clients:

> *"There's a sense of camaraderie, a sense of taking care of one another if somebody is going through a tough time. . . it makes a difference for both the case managers and the clients."* (A treatment team member of an **adult** program)

A treatment team member of a **youth** program highlighted the importance of this collaborative and supporting team:

> *"When things are going really tough, we tend to lean on one another for support, whether it be on the job or sometimes some of us can be dealing with our own personal situations, and then we got to go to work. We have to do the work for our families that we serve and help us get back to focus. We tend to lean on each other in a very positive way."*

This robust teamwork not only enhances client care but also creates a nurturing and empathetic work environment that helps retain staff, as reflected by another treatment team member's experience:

> *"I think that's definitely what's kept me here this long is just the way in which we work together, so I feel like harmoniously and just the culture we've built here, so I've really enjoyed my experience working with my colleagues."*

- **Strong Rapport and Relationship With Clients:** A major strength of FSP programs highlighted by more than half of treatment team members is the strong rapport and relationships built with clients. Team members emphasized a "whatever it takes" attitude, demonstrating flexibility and commitment to meet clients where they are, regardless of the circumstances.

  > *"The 'whatever it takes' attitude that supports our clients is one of the biggest strengths. . . we'll meet clients wherever they're at, however they're presenting. We're willing to work*

with people. You know, we offer second third chances." (Treatment team member of an **adult** program)

Several treatment team members from **adult** and **youth** programs also expressed profound satisfaction in creating strong connections with clients who help support their recovery journeys. A treatment team member of an **adult** program said,

"I love just seeing and tracking their growth from literally right out of hospitalization to gaining housing and getting employment and managing their symptoms . . . just to see them grow and prosper as individuals."

Similarly, a treatment team member of a **youth** program emphasized the successful approach of the FSP program:

"There's different ways to reach clients and be able to help them on their journey. Just showing up and being there makes a world of a difference. I think that is the biggest intervention that has been successful and showing our members that we believe in them and accept them as they are. Anyone can grow when they feel accepted."

Additionally, treatment members mentioned how flexible and accessible services, such as drop-in centers for youth clients, play a crucial role in building rapport. This approach allows for more meaningful and sustained interactions, contributing to the overall effectiveness of the program in fostering strong, supportive relationships with clients. One treatment team member of a **youth** program explained:

"Those one-on-one conversations mean a lot to me. Having that direct client care, but in a space that is not time-sensitive . . . that's when I think you really get to build rapport with people."

- **Large Interdisciplinary Treatment Teams:** Treatment team members regularly identified the large interdisciplinary teams as a key strength of the FSP program. These teams consist of members from various professional backgrounds, bringing diverse expertise to the table. This variety enhances the ability to address complex client needs and fosters a learning environment among staff. Treatment team members valued the drive and commitment to the work exhibited by their coworkers. They also voiced appreciation for the ability to focus on their specific roles while benefiting from the collective expertise of their colleagues. One treatment team member said the varied expertise allowed staff to learn from each other and problem solve more creatively. A treatment team member of an **adult** program described the positive experience of feeling heard and learning from diverse perspectives:

  "It's really great when we are collaborating and we're all putting in our different opinion and come into a common ground, and just the fact that everybody has a voice."

Another member appreciated the internal supervision among team members, which contributes to professional development and improved service delivery. This structure is particularly effective in maintaining staff engagement and satisfaction, as evidenced by the long tenure of several team members, some of whom have worked at their respective FSP providers for over a decade.

Perceived Challenges to Providing Services

- **Staff Capacity and Staff Turnover:** Almost half of the treatment team members interviewed reported challenges related to staff capacity and turnover, which can overburden existing team members and disrupt continuity of care for clients. Team members cited high caseloads, frequent leadership changes, and the job's emotional demands as main contributors to burnout and compassion fatigue among team members. One treatment team member of a **youth** program noted the nature of the work that can be challenging to team member wellbeing:

  > *"Sometimes the acuity of the clients, it takes its toll. A lot of containment, a lot of emotions from the families and stuff. . . . I'd say our biggest challenges are just the bandwidth sometimes that you have at the end of the day of just talking to so many people and storing so much inside."*

  Apart from reduced team member bandwidth, high caseloads, and staffing issues impact team members' ability to provide consistent and effective care to FSP clients:

  > *"The biggest challenge is just having more clients on your caseload than you can handle. . . Some stuff just doesn't get done or fast enough because it is so much. . . . I think it can be frustrating for [clients]. And sometimes it causes them to split because they do have so many case managers. It's definitely challenging to them when we don't have time to get certain things done and when they have to wait on things, or when they start something with one case manager and then have to finish it with another case manager."*
  > (A treatment team member of an **adult** program)

  A treatment team member of a **youth** program echoed this sentiment and recounted the toll on clients when staff leave unexpectedly: "*A staff member leaves and sometimes we don't know about it. One time, there was a client who we haven't heard from for a while and . . . the clinician left, and we didn't know that the clinician left. It wasn't our fault, but it seems that we kind of triggered an emotion with the client because she was so close to this clinician*."

  Treatment team members from adult programs identified recommendations that would help mitigate the challenges related to staff retention and burn out. These include the need for more competitive compensation, additional training and resources, mental health support,

and improved collaboration with community and schools. One treatment team member from an **adult** program suggested programs build in rest and recovery time into schedules:

> *"This job is really hard, very stressful and fast-paced, and there's no self-care. It would be pretty great if the county or the agency contracted a Self-Care Day or Week."*

- **Resource Limitations and Service Gaps:** Multiple treatment team members from **adult and youth** programs mentioned gaps in resources and funding as an important challenge faced by FSP programs. Treatment team members noted the need for funding to get essential items for clients, provide adequate staff compensation, and pay for staff transportation or other needs when going into the field. Team members also stressed how resource limitations and funding challenges create barriers to service provision, impacting both client engagement and staff well-being. For example, a treatment team member of a **youth** program said fewer program resources impacts operational aspects of the FSP programs, such as food budgets for youth drop-in centers, which can influence client participation:

  > *"Because the prices of goods have gone up in the world, we spend more money, and if they want our numbers to go up, but if we don't have enough food on site, people don't come in."* (Treatment team member of a **youth** program)

  Another treatment team member of a **youth** program described how funding is directly linked to staff retention and turnover, which is another major challenge:

  > *"Sometimes it takes a little longer to hire someone or not, but that really helps so you just don't get people with too high a case load. And I think that a lot of times, that all comes down to economics . . . that means for people to be able to be paid enough at their job so they can live in the Bay Area when doing their job. So, when it comes to the county, I would really hope if they're weighing the idea of saving, it's like, if you save a little money now, does it end up costing more in the long run? We could have one less therapist and move people's cases up a little bit, save that one salary. But if the other three therapists all burn out and you end up with constant turnover, then you have to invest way more money in all the whole hiring process and training and all that stuff."* (Treatment team member of a **youth** program)

- **Engaging Reluctant Clients and Families:** While most team members reported good engagement with clients, four treatment team members from **youth** programs and one treatment team member of **adult** programs described persistent challenges engaging clients, particularly those with high needs, and their families in therapeutic services. A treatment team member from an **adult** program underscored the difficulty in supporting clients effectively when they are not fully engaged in treatment*: "Until a client is willing to engage in that treatment, sometimes we experience a challenge in being able to support them to the best of our ability."* This sentiment reflects the delicate balance between addressing client

needs and managing potential risks associated with lack of engagement. Similarly, a team member from a **youth** program emphasized the struggle with engaging clients with high needs in long-term therapeutic interventions: "*A lot of the clients who have the most need, it's hard to get them to see the value in engaging in some of these longer term things like doing therapy and stuff when they're surviving day to day.*"

One treatment team member of **youth** programs also noted difficulties in engaging with parents and family members who may have initial distrust or are hesitant to participate in treatment: "*usually by the time a family gets to our program, they've probably been struggling for years and they might be discouraged or just not have a lot of motivation to engage or work on changes*." Another treatment team member described unique challenges in cases involving nonbiological caregivers, such as foster parents or relatives, who may feel less inclined to participate fully in treatment because they do not want or feel they are responsible for participating in treatment.

Continual Impact of the COVID-19 Pandemic

- Client and treatment team interviews from this year suggest a minimal influence of the COVID-19 pandemic on FSP programs and most team members noted program services have since returned to prepandemic levels. None of the clients interviewed reported feeling that the COVID-19 pandemic currently affects their FSP services. Four clients joined the FSP program within the last 2 years after COVID-19 emergency measures were lifted and thus experienced fewer direct impacts from the restrictions. Despite diminished impacts, treatment team members noted residual influence of the pandemic on service delivery and program staffing. One **older adult** client expressed gratitude for the postpandemic return of weekly in-person sessions with his psychiatrist. However, other clients accustomed to virtual communication during the pandemic still prefer phone or Zoom interactions and are reluctant to meet for face-to-face sessions. This reluctance can present challenges in providing case management and treatment that requires frequent contact or is more effective in-person, such as assessing clients' mental and physical states and conducting therapy.

  > *"What I am seeing is sometimes clients have gotten used to limited contact but FSP levels of care are intensive case management, with three points of contact per client, per week. . . So sometimes we're still working with clients to explain to them, 'I can't conduct just a phone session with you. We're face-based. I need to see you."* (Program director of an **adult** program)

  In some cases, COVID-19 continues to affect other logistical aspects of care delivery. One treatment team member of a **youth** program explained that conducting in-home visits can be complicated when COVID-19 spreads within families, leading to extended periods before in-person visits can resume. Organizationally, the pandemic created considerable staff turnover,

particularly among case managers and other leadership roles. One treatment team member of an **adult** program described how this turnover reshaped the management structure of their FSP program by reducing the number of case managers:

> *"During the pandemic, all managers one after another had departed . . . they also minimized the job role so there's not as many managers now*." (A treatment team member of an **adult** program)

On the other hand, interviews highlighted how treatment teams learned to quickly adapt service delivery during the pandemic and developed more robust infrastructure to provide more flexible service delivery. For example, one treatment team member of a **youth** program explained the pandemic exposed gaps in service accessibility, particularly for young parents and caregivers who struggled to attend in-person sessions prior to pandemic shutdowns. With this information, the program is now able to provide services to clients more effectively.

> *"We learned through the pandemic, by having to shift everything, that there were folks that cannot physically come to the center. Also, just accessibility is a thing. And for folks who are caregivers, it was impossible to come. So, we were able to give services to them."* (A treatment team member of a **youth** program)

While most FSP services have returned to pre-pandemic norms, the residual lingering effects and challenges of the COVID-19 pandemic emphasize the need for ongoing adaptability and enhanced communication to ensure effective client engagement and support.

Perceived Impact of FSP Program on Quality of Life

Exhibit 31. Impact on Clients' Quality of Life

Clients reported that the FSP program had a positive impact on multiple areas of their lives, including:

- mental and physical health outcomes
- strengthening interpersonal relationships and social networks
- developing independence

Both clients and treatment team members report that the FSP has a substantial positive impact on clients' well-being and quality of life. Clients reported feeling seen and heard and respected in the FSP program compared with other programs they were previously involved in. These sentiments speak to the quality and caliber of the treatment team and demonstrate the strength of having treatment team members who truly care about their clients. Reported client outcomes, such as improved mental health, quality of life, maintaining sobriety, and reduced hospitalizations, demonstrate the beneficial outcomes of this partnership. When reflecting upon

the overall impact of the FSP program, treatment team members felt overwhelmingly proud of the positive impact it has had on their clients' health and lives.

- **Improvements in mental and physical health outcomes:** In terms of health outcomes, clients praised the FSP program for its impact on their mental and physical well-being. Specifically, clients referenced improvements in sleeping habits, a reduction in hospitalizations, and positive interactions with case managers and other treatment team members when discussing improvements in overall health:

  > *"So overall, it's helped me to be back to normal like I did before, with my weight and my sleeping and all that stuff. And my health has been a lot better, I haven't really had any outbursts at all."* (An **adult** client)
  >
  > *"I have stayed out of the hospital, which has been good."* (An **adult** client)
  >
  > *"I think my mental health is doing a little bit better gradually, as long as I go to meetings regularly and meet with my case manager, talk to my psychiatrist, take my medication."* (An **older adult** client)
  >
  > *"Of course, it's not like it's 100% improved, but there's quite a noticeable difference. So that change in quality of life has been very, very, very, very good for us."* (**Parent** of a youth client)

- **Improvements in familial and interpersonal relationships:** Clients shared that there have been positive effects on the quality of interactions with others, particularly family members. A **parent** of a youth client shared that they have a better relationship with their daughter after another provider referred her to the FSP program. They specifically credited an improvement in communication as a contributing factor in their improved relationship:

  > *"It's made changes with my family, with my daughters in this case, we have had better to keep that going. I think I'm in a good place."* (An **adult** client) *communication. The change has been that we have a better relationship, more interaction. I feel a totally different quality of life than I had before. Of course, it's not like it's 100% improved, but there's quite a noticeable difference. So that change in quality of life has been very, very, very, very good for us."* (**Parent** of a youth client)

  An **adult** client expressed similar sentiments about reconnecting with family members and an improvement in familial relationships since joining the FSP program and stated that *"I've been connected with my family since I started [FSP program]. I think our relationship now has gotten better."* Another **adult** client also mentioned reconnecting with friends and the impact of this change on their wellbeing:

  > *". . . I had some difficult circumstances with friends and things like that, but now I talk to some of them and they talk to me, and so that's good."* (An **adult** client)

- **Integration into community and social networks:** Treatment team members commented that the FSP program provides invaluable social support and keeps clients connected to larger community. One team member from a **youth** program shared that clients have made new friends and are more independent after their transition out of the FSP program.

  > *"Usually when clients graduate [from] our program, they're able to be more resourceful or self-independent, they're able to keep an employment or make new friends or connect with a drop-in center to make new friends or attend outings. So, they're more self-sufficient."* (Treatment team member from a **youth** program)

  Clients, particularly **older adult** clients, described an increase in socializing with friends and other people and indicated that these connections improved their well-being:

  > *"It's enriched my life a bit. It's improved my symptoms by socializing a little bit more. By socializing more and stuff, it's increased my mood a little bit."* (An **older adult** client)

  > *"I'm connected to a lot of the people. . . . I went to a reunion, 50th reunion, so we touched base again and we connected. So that was good. That was a scary thing for me and [name of service provider] really helped me with that."* (An **older adult** client)

  Additionally, some clients shared how connections with others made through FSP program services have helped them build their social skills and a sense of community:

  > *"It's good to develop my social skills or use my social skills and meet other peers. . . . I've made some friends in the program as well. It's helpful to meet people who are also peers in the community."* (An **adult** client)

Recommendations

This section presents recommendations for improving implementation of the FSP program based on the quantitative and qualitative findings. This year's recommendations emphasize staff retention through enhanced training, mental health resources, and incentives, similar to last year's recommendations. However, this year there is an added focus on providing opportunities for treatment team members to continue education and specialized training for diverse client needs. Additionally, this year's recommendations introduce the need to ensure consistent team member assignments and to implement a system to communicate team member transitions, as well as increasing awareness and accessibility of FSP services.

Overarching Recommendations

Overall, the combined findings across the self-reported data, EHR data, and client and treatment team member interviews suggest that the FSP program has improved outcomes across all populations served. Furthermore, the key informant interviews illustrate a high level of satisfaction with the program. These findings suggest the program should continue to expand and serve the needs of county residents. While there is consistent evidence of improved client-level outcomes each year, the interviews help illuminate some challenges and possible solutions. Additionally, the data collection process over the past year provided critical insights into existing gaps and methodological strengths, informing targeted recommendations to enhance the rigor and relevance of both qualitative and quantitative analyses moving forward.

Future Program Implementation Recommendations

Improve staff retention through additional staff training, incentives, and mental health resources. 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 staff. To address challenges noted above, we recommend a multifaceted approach that focuses on providing enhanced staff training, mental health resources, and team-building initiatives to treatment team members:

- *Implementation of a comprehensive and ongoing staff training program.* Some treatment team members suggested that enhanced staff training programs and opportunities to attend conferences may aid in improving staff retention. One treatment team member noted that attending conferences on wraparound programs would allow team members to learn from other programs and incorporate successful approaches into their own programs. Another treatment team member thought staff would benefit from cultural and age-group specific training to relate more effectively with clients. AIR recommends SMC BHRS to work with

service providers to offer more ongoing staff training and conference opportunities, such as case manager training, with an emphasis on direct engagement and strengthening professional skills. This training should also emphasize cultural awareness and training around supporting diverse clients across different age groups, such as young adults. By broadening the education and skill set of the treatment team members, they will be better equipped to manage their caseloads and provide more personalized support to clients.

- *Provide mental health resources for staff.* In addition to training opportunities, FSP providers should take steps to prioritize the mental health and well-being of FSP staff. Several team members reported feeling burned out due to the challenging situations with clients and extended caseloads. We suggest SMC BHRS work with the service providers to offer their staff mental health or "self-care" workdays and accessible mental health resources, such as counseling and stress management workshops through services, such as an Employee Assistance Program.
- *Incentives to boost longer-term retention.* We suggest the implementation of longer term retention strategies that go beyond immediate staff concerns. These strategies 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 career anniversaries or milestones.

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

Expand workforce and increase diversity to enhance satisfaction and service delivery. While clients are generally satisfied and appreciative of 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. 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 addition to the staff retention measures we recommended above, if resources permit, we recommend the County work with FSP service providers to recruit additional team members, especially case managers, to not only serve FSP clients but also alleviate the burden for current members. Another strategy to consider is redistribution of tasks. If possible, nonessential tasks can be redistributed so that essential team members, like case managers, can focus on core responsibilities. Service providers can implement this strategy by hiring administrative assistants or employing technological tools.

In expanding the workforce, we recommend a focus on increasing workforce diversity. FSP clients come from various cultures and backgrounds 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 improve 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.

Increase awareness and accessibility of FSP services. Clients and treatment team members highlighted a gap in awareness and referrals to FSP programs, leaving many potential beneficiaries unaware of available resources. A **parent** of a youth client expressed gratitude for the services their child receives but emphasized that other families could benefit if they knew about FSP programs. This feedback suggests the need for increased outreach and visibility, such as distributing information through schools and community channels. Schools serve as a central point for community interaction, making them an ideal venue for distributing information about youth and family mental health resources. Additionally, a **youth** program team member noted underutilization due to low referrals despite available capacity. Strengthening connections with school counseling and health services could improve referrals and prevent resource underuse. Another **parent** also mentioned that frequent, multiple appointments overwhelmed their family, leading to session refusals. To enhance accessibility, the County should encourage FSP providers to coordinate schedules with families, ensuring services remain both supportive and manageable.

Ensure consistent team member assignments and implement notifications of team member transitions. A key issue raised in interviews was inconsistent case manager assignments and poor communication during staff transitions. Clients expressed frustration, with one adult client reporting a 3-month gap in care after their therapist resigned. These disruptions can hinder trust-building and trigger feelings of abandonment, making future engagement harder. To address this, AIR recommends the County collaborate with FSP providers to establish clear guidelines for consistent case manager assignments and implement a notification system to promptly inform clients of any changes. These guidelines 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. In addition, FSP programs should develop a notification system so that both clients and team members are promptly informed of any transitions within the treatment team, including temporary coverage arrangements, and ensure sustained quality of care. Assigning the same case manager when possible and ensuring timely communication of staff changes can foster trust, continuity, and better client-team member relationships.

Quantitative Data Collection

Integrate Telecare data into the existing self-reported data from Edgewood/Fred Finch and Caminar providers for analysis in future program evaluations. Currently, Telecare cannot provide FSP clients' data prior to December 2018. Therefore, the sample size for Telecare does not reflect the actual enrollment and impact of the FSP program for those enrolled with Telecare. Integrating Telecare data will allow the County to report consolidated results for all providers since FSP inception in 2006 and enhance data completeness and quality. AIR is in ongoing conversations with Telecare to develop a process to upload their historical and current data to the state data reporting system. AIR is continuing to work with the County and Telecare to convert Telecare's self-reported data into the accepted format by the state reporting system that can be merged with data from the other FSP providers.

Qualitative Data Collection

This year, the AIR team conducted qualitative data collection to better understand the current implementation and impact of the FSP program, following the qualitative evaluation last year. We planned to complete 35 interviews with FSP clients and treatment team members, with the goal of recruiting roughly equal numbers of participants from the two adult and older adult service providers (i.e., Caminar, Telecare). Between the youth and TAY service providers (Edgewood, Fred Finch), we expected to recruit more participants from Edgewood given the small number of current Fred Finch clients. Despite conducting 12 of 15 planned client interviews, we reached the goal of completing 35 total interviews by over-recruiting team member interviews and extending the data collection period. To improve client recruitment for future FSP qualitative data collection, we propose the following recommendations:

Increase participation incentives to improve client participation. Despite efforts to balance client participant recruitment across various service providers, we faced challenges, particularly with recruitment from Fred Finch who was unable to identify any available clients. To strengthen interest in participating in future evaluations, we recommend increasing the financial incentive for client interviews. Currently, clients and parents of clients (in the case of youth and TAY clients) receive a $30 stipend for their participation, which may be considered as insufficient compensation for their time when accounting for the high cost of living and inflation in San Mateo County.[10] Further, most individuals and families served by SMC BHRS have lower incomes and are eligible for Medi-Cal, suggesting FSP clients may be facing economic difficulties. Our experience, combined with feedback from the County and insights from similar qualitative data collection efforts, suggests that enhancing incentives to a minimum of $50 may make participation more

[10] Bureau of Labor Statistics. "San Francisco Area Economic Summary." *Bureau of Labor Statistics*. Last modified April 28, 2023. https://www.bls.gov/eag/eag.ca_sanfrancisco_md.htm.

appealing to clients, thereby boosting recruitment and participation rates for future data collection.

Leverage FSP service providers in the recruitment outreach process. To increase client participation in interviews, particularly among Fred Finch FSP clients, we recommend involving FSP treatment team members, such as child welfare workers, in the recruitment process. These professionals have established trust and rapport with clients because they regularly engage with them in a supportive capacity. By providing FSP providers with information about the project's aim and significance, confidentiality measures, and the potential benefits of participation, they can introduce the project face-to-face and in a manner that addresses client concerns and encourages participation. Additionally, FSP providers may have a better understanding of the unique challenges of their clients and can provide insight into recruitment strategies that suit their contexts. They may also be able to directly assist clients in scheduling interviews and navigating technological challenges.

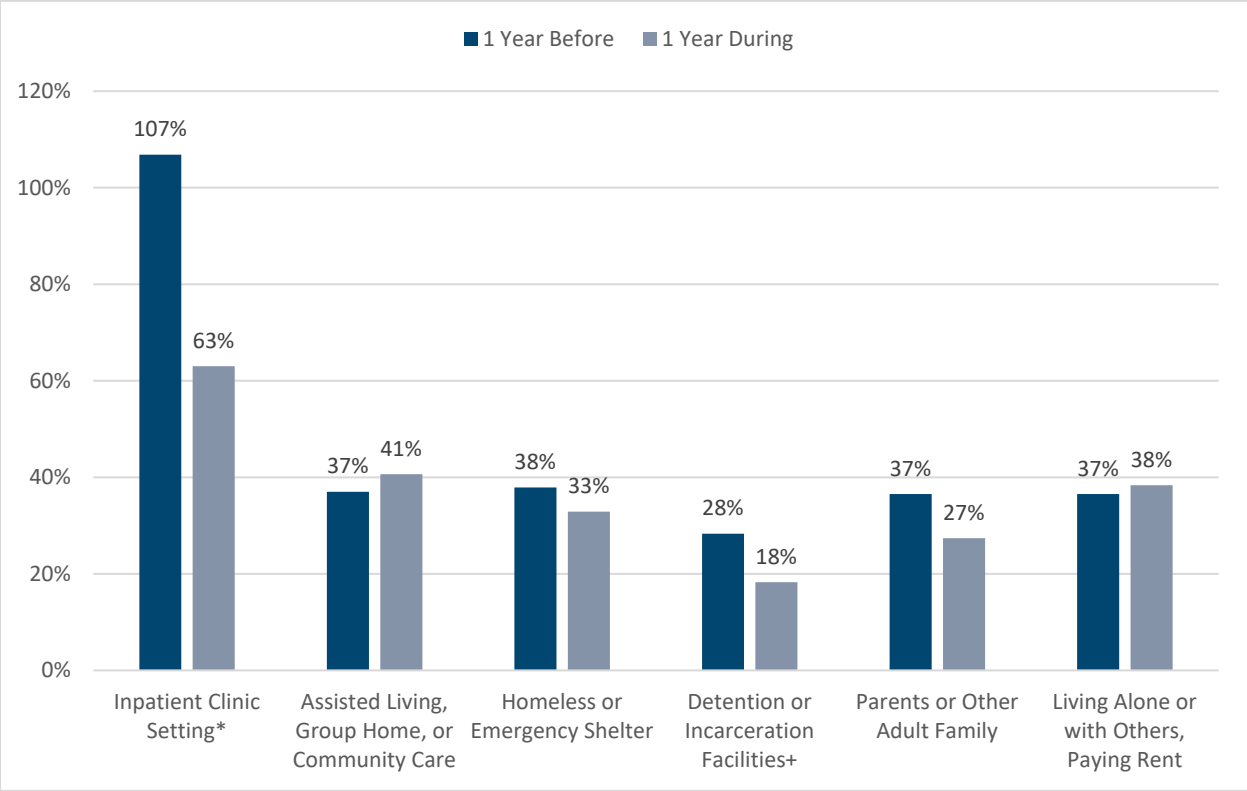
Appendix A. Additional Detail on Residential Outcomes

For residential setting outcomes by full service partnership (FSP) provider, we present all the categories of living situations and compare the percentages of any clients spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. There are currently four comprehensive FSP providers in San Mateo County (the County): Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch), serving children, youth, and transitional age youth, and Caminar and Telecare, serving adults and older adults. A list of all residential settings and categories is presented in Appendix C with the methodological approach.

We used self-reported data from Caminar for Exhibit A1, data from Edgewood/Fred Finch for Exhibit A2, and data from Telecare for Exhibit A3. As shown in Exhibits A1–A3, the percentage of clients reporting any time in an inpatient clinic or living with parents decreased. Further, the percentage of clients who were homeless or living in a shelter decreased for Caminar and Telecare and remained the same for Edgewood/Fred Finch clients. In contrast, the percentage of clients who reported any time living alone or with others and paying rent increased. In general, there appears to be a shift in living situations from institutional settings (clinics, shelters, detention centers) toward living alone or with others in group homes, signaling improvement in independence after FSP enrollment. The emphasis on housing assistance in the FSP programs may help clients establish more stable living situations, which in turn can reduce stress, support recovery efforts, and deter behaviors that might otherwise lead to arrests or homelessness.

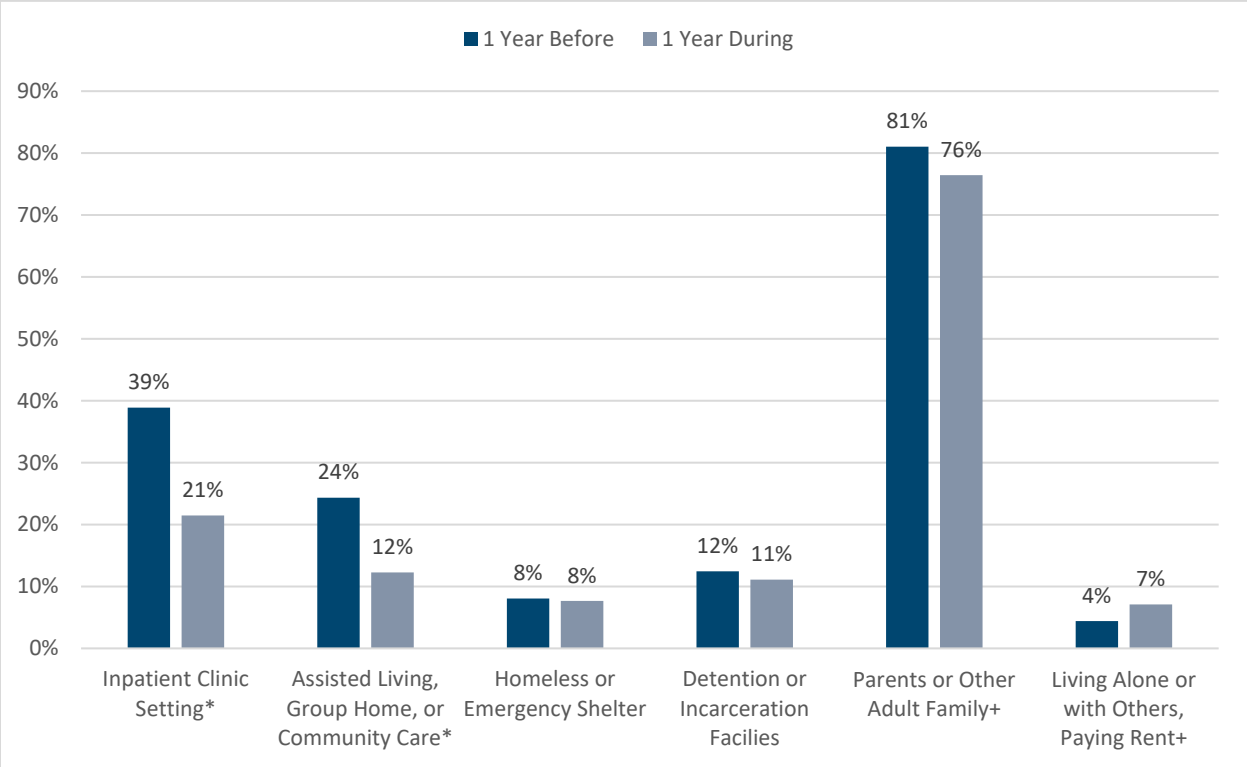
Inconsistency across providers is observed for clients reporting any time in assisted living, group home, or community care environment: the percentage for Caminar and Telecare clients increased between the 2 consecutive years, while the percentage for Edgewood/Fred Finch clients decreased. For Caminar and Edgewood/Fred Finch, there were reductions in the percentage of clients reporting any time in detention or incarceration facilities, whereas the percentage increased among Telecare clients. Asterisks in the exhibits denote outcomes that are statistically significant.

Exhibit A1. Percentage of Caminar Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 219)



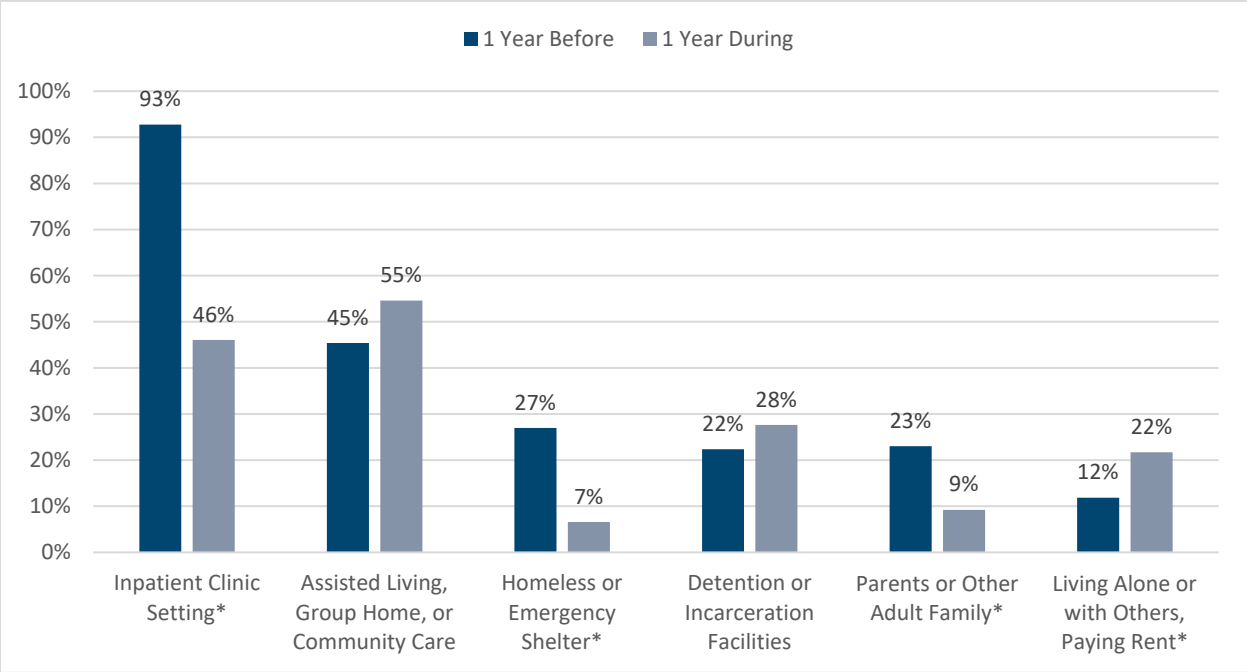
Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. An outcome with + indicates that the change in that outcome is marginally significantly different from 0 at 0.08 significance level.

Exhibit A2. Percentage of Edgewood/Fred Finch Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 522)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. An outcome with + indicates that the change in that outcome is marginally significantly different from 0 at 0.08 significance level.

Exhibit A3. Percentage of Telecare Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 152)



Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Appendix B. Additional Detail on Outcomes by FSP Providers

This section provides outcomes by each FSP service provider. Exhibits B1–B3 present the percentage of clients with any events the year just prior to full service partnership (FSP) enrollment and the first year in an FSP, as well as the percentage of improvement for each FSP provider. Percentage improvement is the change in percentage of clients who experienced the named event in the first year of FSP participation compared to the percentage of clients experiencing the event in the year prior to participating in an FSP.

As shown in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. Among these, outcomes on detention or incarceration, employment, arrests, mental, and physical health emergencies are statistically significant.

Exhibit B1. Percentage of Caminar Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 219)

Survey outcomes, Caminar	1 year before	Year 1 during	Change (%)
Homelessness	38%	33%	-13%
Detention or incarceration	28%	18%	-36%*
Employment	1%	3%	600%
Arrests	22%	7%	-69%*
Mental health emergencies	70%	28%	-60%*
Physical health emergencies	37%	12%	-67%*
Active substance use disorder	49%	48%	-4%
Substance use disorder treatment	19%	22%	15%

Notes. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Exhibit B2 shows improvement for Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch) clients in all outcomes except for self-rated academic grade and school attendance. All but the outcomes on homelessness and detention or incarceration are statistically significant.

Exhibit B2. Percentage of Edgewood/Fred Finch Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 522)

Survey outcomes, Edgewood/Fred Finch	1 year before	Year 1 during	Change (%)
Homelessness	8%	8%	-5%
Detention or incarceration	13%	11%	-11%
Arrests	18%	6%	-68%*
Mental health emergencies	43%	8%	-81%*
Physical health emergencies	15%	1%	-92%*
Suspension	14%	5%	-64%*
Academic grade	3.28	3.02	-8%*
School attendance rating	2.31	2.15	-7%*

Notes. Blue font indicates outcomes that improved. Red font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

As shown below in Exhibit B3, there are improvements when comparing the year prior to FSP to the first year during FSP for Telecare on four out of eight available self-reported outcomes. Of these, outcomes on homelessness, arrests, and active substance use disorder are statistically significant. There are worse outcomes for detention and incarceration, and mental and physical health emergencies, though only the outcome for mental health emergencies is statistically significant. Additionally, fewer clients reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may help explain the decrease in reported treatment. The percentage difference with employment is reported as N/A because the percentage of clients with employment did not change (from 0% to 0%). Therefore, the denominator is 0.

Exhibit B3. Percentage of Telecare Clients With Outcome Events by Year and Percentage Change in Prevalence of Outcome Events (Year before FSP vs. the First Year of FSP Participation) (*N* = 152)

Survey outcomes, Telecare	1 year before	Year 1 during	Change (%)
Homelessness	27%	7%	-76%*
Detention or incarceration	22%	28%	24%
Employment	0%	0%	N/A
Arrests	30%	11%	-62%*
Mental health emergencies	12%	36%	200%*
Physical health emergencies	10%	16%	60%
Active substance use disorder	63%	31%	-51%*
Substance use disorder treatment	7%	5%	-20%

Note. Blue font indicates outcomes that improved. Red font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. * indicates a change significantly different from 0 at 0.05 significance level.

Appendix C. Quantitative Methods

Methodology for Full Service Partnership Survey Data Analysis

The full service partnership (FSP) survey data are collected by providers through discussions with clients and should thus be viewed as self-reported outcomes. Among the service providers included in these analyses (Edgewood Center and Fred Finch Youth Center [hereafter, Edgewood/Fred Finch], Caminar, and Telecare), 893 clients completed a Partner Assessment Form (PAF) at intake and completed a full year with FSP since program inception.

In general, three data sets were used for this report: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. All providers provide their data sets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Because of data reliability issues, Telecare only provided the data after its data system change, with data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch clients, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child and transitional age youth (TAY) clients. Caminar and Telecare serve primarily adult and older adult clients, and a small number of older TAY clients. Caminar's older TAY clients (*N* = 77) are excluded from the TAY-specific self-reported outcomes because Caminar does not reliably complete the ongoing program surveys for this age group (i.e., KET, 3M). Exhibit C1 describes the age group of clients completing at least 1 full year of FSP from 2006 to 2024 by provider. For Telecare, these data include December 2018 through June 2024.

Exhibit C1. Age Distribution of Clients With a Minimum of One Full Year of FSP Participation, by Provider

Age group	Edgewood/ Fred Finch	Caminar	Telecare	Total[a]
Child (ages 16 and younger)	238	—	—	238
TAY (ages 17–25)	284	77	15	376
Adult (ages 26–59)	—	118	103	221
Older Adult (ages 60+)	—	24	34	58
Total	522	219	152	893

[a] Telecare clients in the analysis include only those who joined the FSP after December 1, 2018, due to data availability. Telecare clients were not reported in the survey outcomes by age group. A separate analysis was conducted for Telecare clients; it combines all age groups because of the small sample size.

A comprehensive assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the state's documentation.

Client type (child, TAY, adult, and older adult) is determined by the Partnership Assessment Form (PAF) data.

- For Caminar and Edgewood/Fred Finch, records with the following specific Age Group codes were selected:
  - Caminar: Selected records with Age Group codes of "7" (TAY client, ages 17 to 25), "4" (adult client, ages 25 to 59), and "10" (older adult client, ages 60 and older).
  - Edgewood/Fred Finch: Selected records with Age Group codes of "1" (child client, ages 16 and younger) and "4" (TAY client, ages 17 to 25).
  - In both cases, Age Group codes were confirmed using the data file's continuous *Age* variable.
- For Telecare data, clients were given an age-appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF," "Adult_PAF," and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2024.

All data management and analysis were conducted in Stata. Code is available upon request.

Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in Exhibit C2.
2. The baseline data were populated using the variable PastTwelveDays (Caminar and Edgewood/Fred Finch) or res_past12m_days_int (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. The client's first residential status after they joined FSP is determined by the Current (Caminar and Edgewood/Fred Finch) or res_curr_dsr (Telecare) collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there

was one residence with a later date (as indicated by the variable DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]), this residence was the first residential setting. If the residences were marked with the same date, both were considered part of the client's first year in an FSP.

4. Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]) occurring within 1 year of the FSP partnership start date. If no residential data were captured after the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2. Residential Setting Categories and Corresponding Classification Values Used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with nonrelative	5
Homeless or emergency shelter	
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Levels 0–11)	11

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
Group home (Levels 12–14)	12
Community treatment	13
Residential treatment	14
Inpatient facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't know	
Don't know	18
Other	17

[a] Setting names determined by the following guide: http://www.dmh.ca.gov/POQI/docs/FSP_Data_Dictionary_October_2011.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a nonzero, nonblank value for one of the following variables (note that variable names differ slightly by data set):
    a. Any competitive employment in the past 12 months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

b. Any other employment in the past 12 months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in an FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the client was assumed to have zero arrests in the year prior to FSP.
2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET file contained no information on arrests, the client was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* [Caminar and Edgewood/Fred Finch] or *emr_mental_p12* [Telecare]) and physical health emergencies (*PhysRelated* [Caminar and Edgewood/Fred Finch] or *emr_physical_p12* [Telecare]), respectively. If either of these fields were blank, the client was assumed to have had zero emergencies of that type in the year prior to FSP.
2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, if the date is within the first year with an FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1" = physical; "2" = mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year of an FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* [Caminar and Edgewood/Fred Finch] or *sub_co_mh_sa_probl_past* [Telecare]) and participation in substance use disorder treatment and recovery services (*AbuseServices* [Caminar and Edgewood/Fred Finch] or *sub_sa_services_now* [Telecare]). If these fields were blank, the client was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.
2. Ongoing substance use disorder data were populated using the 3-month data variables of the same name. Any record of an active substance use disorder or participation in a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for County EHR Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain emergency care in the San Mateo County (the County) hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 932 clients who were both (a) included in the County's EHR system and (b) completed 1 full year or more in an FSP program by the June 2024 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2024.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and psychiatric emergency services (PES) admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the corresponding program codes. In addition, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3. Program Codes Among Clients Ever in an FSP

Program code	Program value
Psychiatric hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric emergency services	
410702	Z410702 SMMC PES-termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Note. Data represent all utilization from FSP clients for these codes, as pulled from Avatar on September 17, 2024.

Client type (child, TAY, adult, and older adult) was determined by the client's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode history* table.

As we have discussed in the previous year's report, the distribution of clients by age group is different between the County's EHR data and the FSP survey data. This disparity is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the client was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the County's EHR data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

Appendix D. Qualitative Methods

Methodology for Full Service Partnership Interviews

Participants

This analysis included 35 interviews with 12 clients and 23 treatment team members. AIR worked with San Mateo County (SMC) Behavioral Health and Recovery Services (BHRS) staff and the four FSP service providers (Exhibit D1) to recruit clients and treatment team members. Exhibit D2 presents the number and types of clients and wraparound treatment team members whom we have interviewed and included in this analysis across the FSP service providers. Note that we were not able to recruit client participants from Fred Finch.

Exhibit D1. 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 and 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 D2. Summary of Interviewees

FSP Service Provider(s)	Clients	Wraparound Treatment Team
Edgewood Center	**2 parents** whose children have accessed services through FSP in the last year or are currently accessing services through FSP	**13 team members including:** • Program manager (3) • Case managers (2) • Behavior coach (2) • BH Clinician/Substance Use Specialist (2) • Parent client (1) • Emerging adult client or peer ambassador (1) • Crisis response worker (1) • Housing specialist (1)
Fred Finch Youth Center*		**1 team member** including: • Program manager (1)
Caminar	**6 clients** who accessed FSP in the last year or are currently accessing services through FSP	**5 team members** including: • Case manager (1) • BH Clinician/Substance Use Specialist (1) • Crisis response worker (1) • Program manager (1) • Housing specialist (1)
Telecare	**4 clients** who accessed FSP in the last year or are currently accessing services through FSP	**4 team members** including: • BH Clinician/Substance Use Specialist (3) • Case manager (1)
Total Interviewees (35)	**12 clients**	**23 team members**

*Fred Finch Youth Center was not able to identify any client participants at the time data collection ended.

Interview Format and Length

Each interview lasted about 30 minutes in length and was conducted virtually using Zoom software. When participants had technical difficulties with the Zoom software, the AIR team conducted interviews by directly calling clients or treatment team members. A trained, bilingual interviewer with Spanish as their primary language conducted the interviews with Spanish-speaking participants. Interviewers obtained consent and permission from all participants before starting the recording. There was one participant who requested not 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 between participants.

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