Commission for Behavioral Health

Executive Summary

> *"They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]."*
> *– FSP Programs Director*

The need for wide-scale, long-term solutions to California's mental health crisis has never been clearer. The number of homeless Californians and those engaged in the criminal justice system due to serious mental illness continues to grow. Despite expanding budgets, the state struggles to meet the needs of the estimated 2 million adults and children living with serious mental illness or serious emotional disturbance. Full Service Partnerships (FSPs) represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they require to gain stability and maintain independence. On the continuum of care, FSPs are the last effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization.

FSPs provide services across the lifespan including to children, transition aged youth[1], adults, and older adults. A unique component to FSPs is that services are available 24/7 and can include therapy, assistance planning transportation to medical appointments, housing assistance, and more.

Report to the Legislature

Senate Bill 465 directs the Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on improving outcomes for FSP clients. In these reports the Commission is charged with reporting on:

- Individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room use, and crisis service use.

[1] Youth ages 16-25

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- Analyses of separation from an FSP and the housing, criminal justice, and hospitalization outcomes for the 12 months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements.
- Recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

This is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill 465. Since its initial report, the Commission has carried out extensive work to better understand what needs to be done to improve FSPs and move the needle on hospitalization, homelessness, and incarceration for Californians with serious mental illness. This includes conducting targeted outreach, community forums, a statewide survey, and research efforts. In total these efforts reached participants from 45 counties (77 percent of counties).

This current report has two priorities. The most essential of these is to present the required information to the Legislature as directed by Senate Bill 465. The second priority is to examine FSPs as systems of care and illuminate how system-level issues, such as programmatic inconsistencies and State-mandated data collection and reporting policies and practices, impact quality of care and client outcomes. This is followed by a set of findings and recommendations, some of which are already underway, such as performance management and technical assistance to improve the quality of client care.

Figure 1: Learning Efforts, 2023-2024

Targeted Outreach	Community Forums	Statewide Survey	Research
• **87** participants • **40** organizations • **22** counties • **28%** identified as people of color • **24%** shared they had personal or family experience of behavioral health challenges	• **145** participants • **76** organizations • **29** counties • **43%** identified as people of color • **44%** shared they had personal or family experience of behavioral health challenges	• **228** participants • **35** counties • **57%** identified as people of color • **46%** shared they had personal or family experience of behavioral health challenges • Average of **10 years** of experience in FSPs	• **3** deep dives on county contract practices • **2** case studies on data collection and reporting • **2** pilot projects on performance management • **4** site visits (3 adult and 1 child/TAY)

Overview of FSP Partnerships

> *"Some of the best [parts] of FSP are related to our ability to join with the client wherever they may be. We make great connections with humans in need."* – County Behavioral Health Agency

To date, FSPs have served more than 222,145 clients, averaging tens of thousands of clients each year. About two-thirds of Full Service Partnerships are with clients over the age of 16 and one-third are with clients 15 and under, which is important as FSP service delivery largely differs by age group. Below is a brief description of each of the five categories of FSPs. Of these five, four are age specific and one is focused on justice-involved adults.

Child FSPs provide intensive, in-home mental health services for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.

Transition Aged Youth (TAY) FSPs provide comprehensive, high-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.

Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a serious mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.

Older adult FSPs are for adults 60 and older with histories of homelessness and/or incarceration. These FSP programs often use the Assertive Community Treatment (ACT) model.

Forensic FSPs serve justice-involved adults with serious mental health needs and co- occurring substance abuse disorders.

Statewide, more than half of FSP clients are people of color, although the racial and ethnic makeup of FSP clients varies by region and age group. The data show that about 60 percent of adult client and about 30 percent of child/TAY clients are or were housing insecure. The Commission expects that these numbers underestimate the actual count as data on homelessness is often incomplete.

With regards to psychiatric diagnoses, the most common primary and secondary diagnoses that adult clients have received over time are: 1) schizophrenia/psychotic disorders; 2) depressive disorders; and 3) substance use/addictive disorders. This aligns with the aims of FSPs and suggests services are reaching the intended population. The data for children/TAYs presents a different pattern. The most reported diagnoses are: 1) depressive disorders; and 2) trauma/stressor-related disorders. These diagnoses speak to the deep emotional and psychological needs of the young people being served by child/TAY FSPs.

Service Utilization and Outcomes

> *"[FSPs] create conditions to live with more dignity, be housed, … to transgress barriers, to have a soft landing and abundance of resources … [They give people their] own voice and connection back to families."* – Participant from Community Forum 1

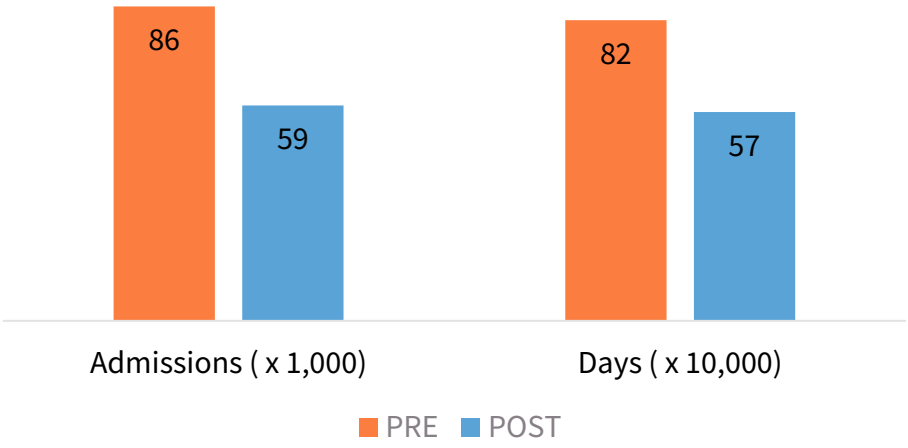
Joining an FSP can be an incredibly important step towards stability and health for many people living with serious mental illnesses and/or substance use disorders. But joining an FSP is just the first step. Clients must stay long enough to reap the full benefit of the services provided. Child and TAY clients tend to have shorter enrollment periods than adults. At the two-year mark, 50 percent of adult clients were no longer active members of their FSP partnership, compared to 77 percent for child/ TAY clients. A positive interpretation is that younger clients are reaching their goals faster than older clients, and

there is evidence to suggest this is true. Overall, 48 percent of child/TAY clients and 28 percent of adult clients exit an FSP partnership due to meeting their goals. This was the most common reason for both groups.

With regards to hospitalization pre and post joining an FSP, if one looks at data between 2012 and 2022, it shows a decrease in both number of inpatient psychiatric admissions and in total days clients spent in the hospital for those stays. FSP clients experienced 85,590 psychiatric hospital admissions in the year prior to joining an FSP compared to 58,638 in the year after joining an FSP, a reduction of 41 percent.

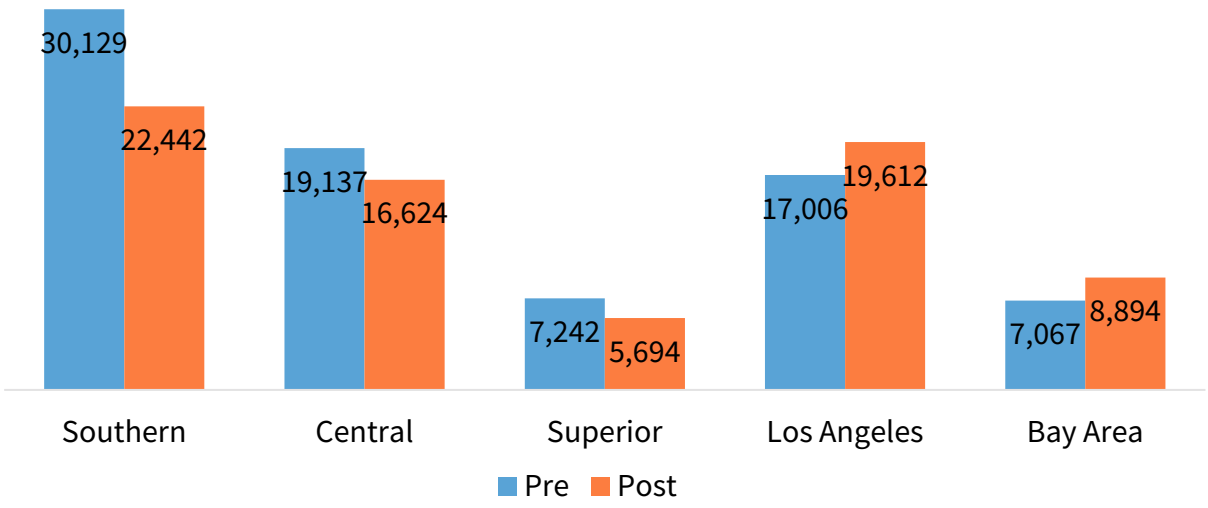
Similar trends exist for days spent in the hospital for those admissions, with hospital days in the year prior to joining an FSP coming in at 818,653 versus 568,348 afterwards, a reduction of 31 percent.

Figure 2: Comparing Psychiatric Hospitalization Pre and Post Joining an FSP



When examining crisis service utilization, we see a more complex pattern. The Figure below presents pre- and post-crisis service use for individuals enrolled in an FSP between 2019 and 2022. The blue bar represents the total crisis services FSP clients used one year prior to joining an FSP, and the orange bar represents the total services used in the year after joining an FSP. If service use was the same before and after, the orange and blue bars would be at the same height. Rather, in the Southern, Superior, and Central regions clients had higher service use prior to joining an FSP. This is a different pattern than in Los Angeles and the Bay Area, where clients' service use went up after getting connected to an FSP.

Figure 3. Crisis Service Usage Pre and Post FSP Enrollment Varies by Region



Findings and Recommendations

Statewide Data Infrastructure

> *"[The] biggest barrier to data entry is the disconnect between what is valuable to the State and what is valuable to person in care ..."* – FSP service provider

A substantial portion of this report is dedicated to the challenges that current data collection and reporting processes pose for FSP providers and counties. Providers are swimming in the administrative burden that results from redundant data entry with no practical purpose or benefit to clients. Providers are left to either keep secondary paper copies of forms and hand calculate client outcomes or pay for supplementary software to track their client's progress.

Proposition 1 makes clear that accountability and transparency are foundational to behavioral health transformation. It is the Commission's goal to highlight the implications of the current data system and elevate solutions for the Department of Health Care Services to consider as they shape the future of data collection and reporting for FSPs.

The Commission's findings suggest the existing Data Collection and Reporting (DCR) system is not sufficient for capturing the accurate, high-quality data necessary for accountability and transparency

in FSPs. The Commission recommends the existing DCR system be replaced with a more flexible, adaptive, provider-centered system or be overhauled to have the following features at its core: functionality, customization, brevity, and interoperability.

While the Commission is aware that this suggestion is not one that can be implemented easily, or quickly, it also recognizes it is essential to reducing administrative burden on service providers and counties alike and improving the quality of data necessary for accurate accountability and transparency under Proposition 1.

Performance Management

Performance management focuses efforts on getting clients to their goals in a timely and efficient manner. It prioritizes client outcomes and creates an avenue of accountability for providers. Performance management is key to ensuring inputs produce results, but does more than improve outcomes. When executed with care and fidelity performance management can reduce provider stress by offering clarity and direction in a seemingly endless cycle of work. Performance management should be viewed as a tool with equal benefit to clients, supervisors and staff.

This report's findings suggest most counties are not currently engaged in substantive performance management practices. Lack of funding and resources is partially responsible but equally so is the hesitation of many providers to engage in performance management. The Commission recommends California launch a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity. Furthermore, the Commission suggests an evaluation of the plausible impact and resources needed to create scalable performance management statewide.

Outcomes Contracts

> *"What is the goal of the person in care? It doesn't have to be the goal of the State. What do they want out of [FSP] and are we meeting their goals? If you don't start with that, I don't know how you are going to get anyone to engage. One of the person's goals was to have teeth so they could smile. That was their whole goal from the FSP. Then they could go for a job and show up and be present. If you don't focus on that, celebrate it, and work on it, you'll never get to the downstream goals [like housing stability]."*

The current contracting practices between counties and providers do not place enough focus on reaching outcomes, including client-specified outcomes. The Commission recommends counties include performance metrics, that include client-specified goals, into future contracts with service providers. The Commission also suggests outcome based contracting be thoroughly vetted and an evaluation should be conducted to identify:

- Impacts on providers, both immediate and long term
- Disproportionate impacts on certain demographic groups and regions
- Impacts on both state-specified and client-specified outcomes
- Impacts on retention, step down, and service utilization
- Sustainability and scalability of such models statewide

Funding

Contracted providers shared their confusion around how to maximize FSP dollars, including what services were billable and to whom. The Commission was surprised to learn that about one in 10 providers were funding FSP services strictly through CSS funds and not billing to Medi-Cal. Even providers who were successfully braiding funding were overwhelmed with changes to billing through CalAIM and the potential funding changes through Proposition 1.

The Commission suggests technical assistance and training for counties and service providers on:

- Braiding funding and sustainability
- Clarity around Medi-Cal billable services
- Impacts of CalAIM: Developing new county-to-provider payment models that support FSP service delivery and account for technical changes that occurred as part of CalAIM payment reform
- Impacts of Proposition 1

FSP Service Delivery Models

The Commission's extensive conversations and information gathering suggests most service providers would benefit from increased structure in both process and approach to service provision. Guidance on what service delivery models are best suited to particular populations, and best practices within these models, could go far in providing the kinds of supports service providers have requested. Under the new BHSA, each county will be required to implement the following models through their FSPs: Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, and High

Fidelity Wraparound. As currently written, counties with under 200,000 residents may be granted an exemption from this requirement by the California Department of Health Care Services.

The Commission recommends California develop and disseminate clear service model guidelines for FSP programs statewide, including:

- A clear definition of what an FSP is, and what the shared goals of FSPs are.
- Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one.
- Recommended evidence-based practices for treatment models specified in BHSA.
- Guidance on selecting an appropriate treatment model.

Staffing and Resources

The ongoing workforce crisis significantly affects all aspects of FSP programs. FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover.

The Commission suggests the State invest significant resources in identifying scalable solutions that can:

- Widen the Pipeline
    - Create a stronger behavioral health workforce pipeline by building relationships with local universities and developing internship programs specifically tailored to prepare future clinicians to succeed in FSP settings.
- Increase Incentives/Benefits
    - Provide financial resources for counties to raise wages in areas most struggling to fill positions or offer workforce incentives like subsidized housing, loan repayments or paid internships.
- Reduce Provider Stress
    - Support counties in developing trainings on specific high-stress and high-priority topics, including billing, documentation and data entry, housing, and serving individuals with SUDs.
- Utilize Peers
    - Invest in expanding peer certification and placement programs, including licensing, training, and post placement supports. Peers are more than a workforce shortage

solution; they are key to increasing client retention and ultimately improving client outcomes.

Next Steps

This report lays out, as clearly and practically as possible, the Commission's recommendations for bringing transformational change to FSPs. Below are the Commission's current and forthcoming efforts to make these recommendations a reality.

In February of 2024, the Commission allocated $20 million in Mental Health Wellness Act funds towards a technical assistance and capacity building strategy to:

- Advance sustainable funding solutions through the restructuring of current funding models to increase efficiency and impact.
- Strengthen the workforce by identifying innovative, scalable workforce development solutions to increase capacity and reduce turnover.
- Improve accountability by developing metrics of success, identifying key client outcomes, and improving data collection and reporting practices.
- Fortify current infrastructure by strengthening service delivery models connected to the broader continuum of care.

The Commission is currently developing a request for proposals, not to exceed $10 million, for technical assistance and capacity building focused on:

- Value-based contracting and performance management
- Improved service delivery

Supplementing the substantial investment of $20 million mentioned above, the Commission has several additional projects underway aimed at improving FSPs. The first is a best practices toolkit for service providers, currently in development in collaboration with Third Sector Capital Partners. This toolkit will bring together recommendations and best practices identified by FSP service providers and county behavioral health staff into a single resource that will be widely available for public use.

The toolkit will focus on the following five topics and is expected to be available in summer of 2025:

- Peer and paraprofessional supports in the workforce
- Services and treatment for individuals with substance use disorders
- Collaboration with community and cultural partners

- Step down-levels of support
- Outreach and engagement

Simultaneously, the Commission launched two pilot projects with Healthy Brains Global Initiative to provide performance management capacity building and technical assistance to FSP service providers in Sacramento and Nevada counties. In these pilots, counties and service providers work together to identify performance goals and develop performance monitoring tools to track progress towards these goals. Results from these pilots will also be available in the summer of 2025.