



Report to the Legislature on Full Service Partnerships

Approved by the Mental Health Services Oversight and
Accountability Commission

January 25, 2023

For submission to the Fiscal and Policy Committees of the Legislature



Table of Contents

Executive Summary	2
Background and Purpose	3
Relevant Legislation	4
History	5
Full Service Partnership Programs	8
Types of FSPs	10
Evidence of Success	11
Local Evaluations	11
Statewide Evaluations	11
Guiding Questions	12
Immediate Opportunities and Next Steps	22
Developing a Strategic Reporting and Capacity Building Plan	22
Appendices	24
Data Sources for FSP Analysis	24
Initial Data Analysis	26

Executive Summary

Biennial reporting on Full Service Partnership (FSP) programs is required under Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021). This first report provides an overview of California’s deployment of FSP programs established under the Mental Health Services Act and outlines the steps the Mental Health Services Oversight and Accountability Commission has underway to strengthen the use of these programs in response to high numbers of mental health consumers who are struggling with housing, justice involvement, and hospitalization.

Early evidence on the effectiveness of FSPs suggests that these programs, when implemented with fidelity, can reduce hospitalizations, criminal justice contacts, and improve housing stability for consumers with severe and persistent mental illness. However, California is experiencing an increase in the number of individuals with unmet mental health needs who are unhoused, revolving in and out of hospital emergency departments and the criminal justice system, and often deemed incompetent to stand trial and committed to state hospitals.

In its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing number of Californians with serious and persistent mental health needs that are going unmet.¹

Recognizing the potential of FSPs to be a critical component of the State’s response to those unmet needs, the Commission gathered information on the history and purpose of FSPs, reviewed the evidence base of their effectiveness, conducted an initial analysis of available statewide FSP data, and mapped the alignment of the reporting requirements outlined in SB 465 with existing quality improvement efforts across the state, particularly through innovation efforts supported by county behavioral health leaders.

This initial exploration and analysis revealed three primary concerns:

1. The State faces data quality challenges that impede its capacity to fully understand the effectiveness of FSPs in preventing homelessness, justice involvement, and

¹ https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

hospitalization.

2. Despite regulatory requirements, counties do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3. California has not established sufficient technical assistance and support to ensure the effectiveness of FSP programs and support improved outcomes.

Given these challenges and the importance of FSPs in the continuum of treatment services within California for some of the most vulnerable individuals with mental health needs, the Commission submits this initial report to the Legislature, including a set of recommendations for next steps.

Background and Purpose

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a “whatever it takes” approach to meeting needs – or Full Service. By supporting recovery with individuals who otherwise would be caught in a cycle of hospitalizations and incarcerations, FSPs help people develop and advance toward personal mental health goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the Mental Health Services Act and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

Several converging factors have prompted policy makers to raise concerns that California's investments in FSPs may not be adequate to meet the growing need. These include:

- State and communities struggling with an increasing number of residents living unhoused, many with unmet mental health needs.
- Waiting lists to enter State hospitals for mental health care under felony Incompetent to Stand Trial designations.
- Ongoing reliance on local law enforcement and community hospital care as mental health consumers cycle in and out of mental health crises.

Relevant Legislation

In October 2021, Governor Newsom signed legislation directing California’s Mental Health Services Oversight and Accountability Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on fortifying state and community response to the needs of Californians who can benefit from these programs (SB 465, Eggman, Chapter 544, Statutes of 2021). Welfare and Institutions Code Section 5845.8 states that the Commission’s reports shall include:

- Information regarding individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room utilization, and crisis service utilization.
- Analyses of separation from a 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 and recommendations to strengthen California’s use of FSPs to reduce incarceration, hospitalization, and homelessness.

In September 2022, the Legislature passed, and Governor Newsom signed, the Community Assistance, Recovery and Empowerment (CARE) Act (SB 1338, Umberg, Chapter 319, Statutes of 2022), establishing a framework to improve access to mental health services for persons who

are untreated, undertreated, or unstably housed and experiencing schizophrenia spectrum and other psychotic disorders. The framework begins with establishing a mechanism for mental health consumers and counties to negotiate individualized service plans – called CARE plans - with the courts serving as an oversight entity and authorized to compel county participation in those plans. While mental health peers and their allies have raised concerns that the CARE Act could be implemented in a coercive manner, the intent is for the Act to lead to improved access to and engagement in care. Recognizing that FSPs are intended to serve individuals who are at risk of homelessness, criminal justice involvement, and with a history of hospitalizations, the CARE Act is expected to increase demand for FSP services. For example, the development of Individual Service and Support Plans – comparable to the newly required CARE Plans – are a required component of Full Service Partnerships.

In response to SB 465 and the likelihood that the CARE Act will increase the need for effective FSP services, the Commission’s goals are to improve understanding of how FSPs operate, how they can best serve mental health consumers, and highlight strategies to reduce unnecessary participation in the CARE Act process because there is more access to quality FSPs. These efforts are intended to improve the effective use of limited public sector mental health funding, reduce costs, and improve outcomes for mental health consumers and their families.

History

In November 2004, California voters passed Proposition 63 and enacted the Mental Health Services Act (MHSA). The MHSA established new requirements for county mental health systems, including improved focus on persons with serious and persistent mental health needs, new requirements for prevention and early intervention, and a mandate for investments in innovation to drive transformational change in public mental health systems. The prevention and early intervention language of the MHSA includes an expansive focus on interrupting homelessness, criminal justice and child welfare involvement, school failure, unemployment, suicide, and prolonged suffering.

The MHSA also established a new revenue stream to support community mental health.

The Act levies a 1 percent annual tax on personal income over \$1 million. More than \$3 billion is generated each year to fund public mental health systems and services in California.

California's investment in Full Service Partnerships (FSPs) evolved from advocacy efforts in the 1990s to reduce the number of people who were sent to locked state mental hospitals when they could be served in the community at lower cost with better outcomes. In 1999, the state passed legislation to establish four pilot projects across California to fund comprehensive and integrated care for persons with high risk for homelessness, justice involvement, and hospitalization. Early results found that program participants decreased the number of days in a hospital by 66 percent, jail days were reduced by 82 percent, and days living unhoused by 80 percent.² One of the funded demonstration projects, a community program called The Village, was administered by the Mental Health Association of Los Angeles and incorporated a range of recovery principles into its work. In addition to success in reducing hospitalization, criminal justice involvement, and days unhoused, The Village was able to support employment for the clients they served.³

In response to these results, California expanded funding for the pilot program to include more sites around the state. Follow-up evaluations confirmed early findings: housing is a critical component of recovery; people with serious mental illness can achieve housing stability with adequate support, and consumers with the most challenges (e.g. struggling with a substance use disorder, recently incarcerated, living on the streets at enrollment, etc.) were not harder to support or keep in housing compared to mental health consumers with fewer challenges.⁴

Building off these early successes, the subsequent passage of the MHSA – and the funding it generated – created optimism that California would be able to address the needs

² https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf

³

<http://static1.1.sqspcdn.com/static/f/1084149/15474792/1323450497457/49AnOverviewoftheVillage.pdf?token=yLvMwOUGOEYES7lmmLBuALqeTCU%3D#:~:text=The%20Village%20Integrated%20Service%20Agency%20in%20Long%20Beach%2C,system%20change.%20At%20the%20Village%2C%20we%20have%20had>

⁴ https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf

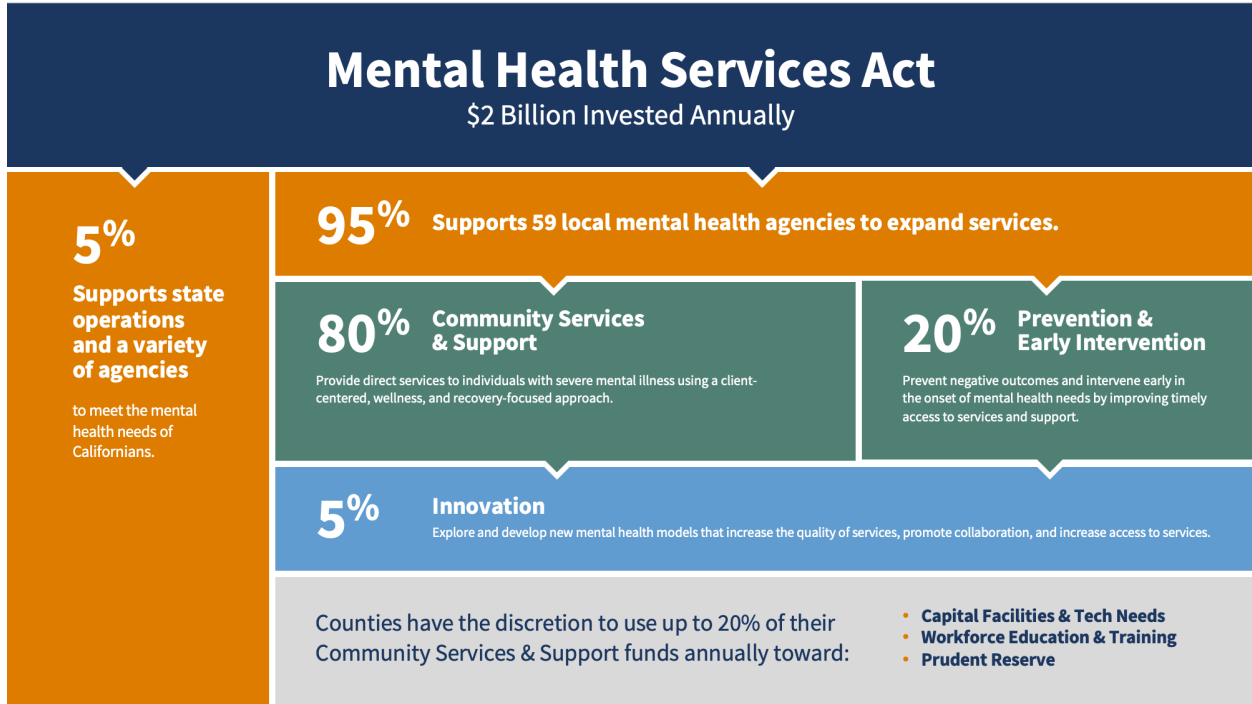
of mental health consumers with the most complex needs without relying on long-term hospitalization, criminal justice involvement, or seeing large numbers of Californians living on the streets because of unmet mental health needs.

Under the MHSA, the revenues generated each year are shared between the State and California's 59 local behavioral health agencies.⁵ The State receives 5 percent of MHSA revenues to fund state operations, provide grants to county behavioral health departments, and to support other needs. The bulk of MHSA revenues – 95 percent – are allocated to local behavioral health agencies through a distribution formula that is largely based on the population of each local agency and the mental health needs in their communities.

Under the MHSA, local behavioral health agencies – which are typically counties – are required to distribute those funds into a minimum of three MHSA components. The largest share of the funding – 76 percent – must be dedicated to Community Services and Supports (CSS) or core mental health services for persons with more severe or serious mental health conditions. Counties are required to dedicate 19 percent of the funds they receive for prevention and early intervention activities. The balance, 5 percent of the funds, are required to support innovative efforts to improve services and outcomes. County behavioral health leaders have the option to set aside up to 20 percent of the CSS funding each year to fund a Prudent Reserve, support workforce education and training, or address capital facility and technology needs.

⁵ While there are 58 counties in California, there are 59 local mental health authorities. Sutter and Yuba Counties are one entity, and the City of Berkeley and Tri-Cities are carved out from their respective counties.

Figure 1: MHSA Distribution Summary

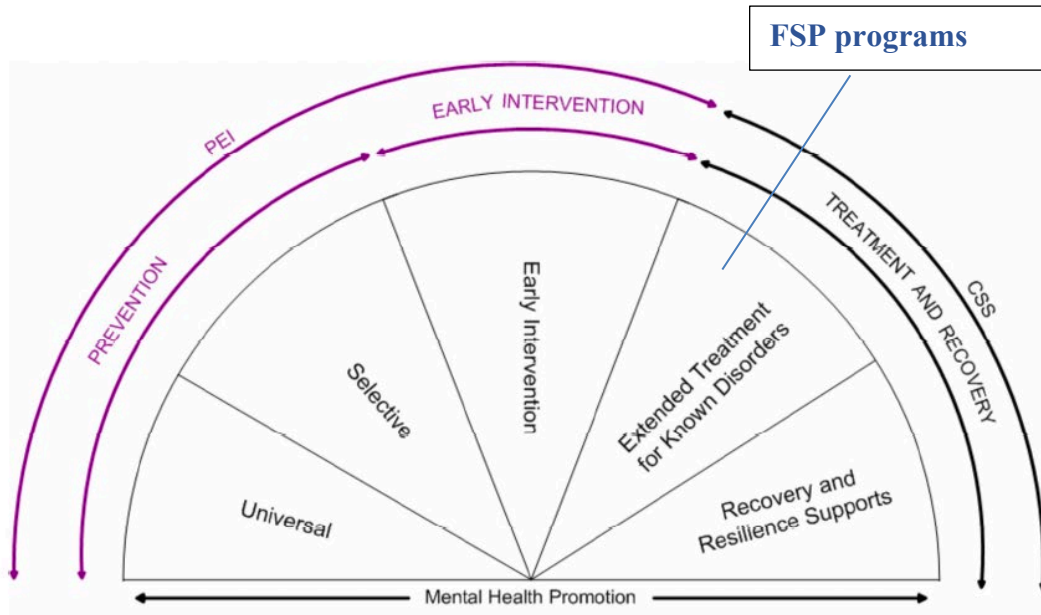


Recognizing the significance of FSPs in supporting mental health consumers with serious and persistent needs, and the focus of the MHSA on recovery, housing, and reducing criminal justice involvement, Section 3620, subdivision (c) of the MHSA regulations requires counties to dedicate a “majority” of MHSA CSS funding for FSPs. Counties also are allowed – subject to consultation with local mental health partners and community members – to use prevention and early intervention funds, with some limitations, to support children and youth who may need FSP services.

Full Service Partnership Programs

A unique quality of Full Service Partnerships (FSPs) is that the approach to treatment planning and service delivery emerges from a negotiation between the client and the provider. The question that launches the treatment planning process is often, “What do you need as a partner in your recovery journey?”

Figure 2: Mental Health Continuum



FSP programs under the MHSA are team-based and recovery-focused, typically based on intensive case management or assertive community treatment (ACT).⁶ The approach to FSPs is not manualized or standardized. Each FSP participant is intended to receive services and supports that are tailored to their needs and integrated through the “whatever it takes” approach. Recognizing that FSP clients often have a long history of unmet mental health needs and considerable involvement with hospitals and the criminal justice system, access to care is available around the clock. A Personal Services Coordinator/Case Manager is required to respond to the client or family 24 hours a day, 7 days a week to provide after-hours support when necessary.⁷

⁶ ACT is an evidence-based practice that uses a multidisciplinary team approach with assertive outreach in the community.

⁷ California Code Reg. Tit.9 § 3620

Clients can be referred into an FSP from psychiatric hospitals, emergency departments, and other mental health programs, as well as outreach workers, homeless shelters, jails, and community-based organizations.

Each California county behavioral health department establishes eligibility criteria for participation in an FSP program and many FSPs are run by contracted providers which results in additional variation in program design and eligibility within a given county. Despite that variation, clients typically must meet the following criteria: be homeless or at risk of homelessness; involved or at risk of involvement with the criminal justice system; frequently hospitalized for mental health challenges or frequent users of emergency department services.⁸

Types of FSPs

FSPs are designed and tailored to address the needs of various age groups and subpopulations:

- Child FSPs: intensive in-home mental health service program 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: comprehensive and higher-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: Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.
- Older adult FSPs: for adults 60 and older with histories of homelessness and/or incarceration, these FSP programs often use the Assertive Community Treatment (ACT) model.

⁸ <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201100384>

- Forensic FSPs: These programs have a focus on justice-involved adults with serious mental health needs and co-occurring substance abuse disorders.

Evidence of Success

Earlier iterations of FSPs had demonstrated measures of success, such as fewer hospitalizations, increased housing stability, and less involvement with the criminal justice system. Since the passage of the MHSA in 2004, there have been several evaluations to determine statewide impact, along with numerous local efforts to quantify the success of FSPs. These evaluations show that FSPs can be highly effective at achieving the goals of lower criminal justice involvement, reductions in homelessness, fewer hospitalizations and emergency department visits, and cost savings.

Local Evaluations

- Cost savings: A 2018 report by RAND found that Los Angeles' FSP investment has resulted in \$82 million in cost savings over five years.⁹
- Improved housing and less criminal justice involvement: San Francisco's FSP evaluation found a reduction in arrests and time in other restrictive settings along with improvements in the quality and stability of housing.¹⁰
- Improved access to services and less homelessness: San Diego County found that participation in an FSP was associated with improved access to care and better housing outcomes.¹¹

Statewide Evaluations

- Fewer emergency department visits: One study found that FSPs were highly effective in reducing emergency department visits – compared to usual care, the odds of FSP

⁹ https://www.rand.org/pubs/research_briefs/RB10041.html

¹⁰ <https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/SFMHSA5YearReport-2010.pdf>

¹¹ <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/210805>

clients visiting the emergency department were 54 percent less after 12 months of treatment and 68 percent less after 18 months.¹²

- Decline in emergency mental health services: In a study looking at children ages 11-18, researchers found that before FSP enrollment, participating children had high and increasing rates of mental health emergency services, and after enrollment, had rapid reductions in emergency services use compared to children who did not receive FSP services.¹³
- Less criminal justice involvement: An internal analysis conducted by the Commission draws upon data from FSP providers and criminal justice data from the California Department of Justice. That work found a strong association between FSP participation and reductions in arrests. Participants had a 47 percent reduction in arrests in the 12 months following participation in an FSP compared to 12 months before participation.

These and other evaluations indicate that FSP programs can and do reduce criminal justice involvement, emergency department and psychiatric inpatients stays, and improve housing stability.

Guiding Questions

The history and initial evaluations of FSP programs suggests they represent opportunities to drive down the numbers of Californians who are unhoused, justice involved and facing hospitalization because of unmet mental health needs, yet California has seen increases in each of those challenges.

Cities and towns across the state are struggling to meet the needs of people living in encampments throughout the state. Research suggests the number of people who are homeless in

¹² <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201100384>

¹³ <https://www.ingentaconnect.com/content/wk/mcar/2017/00000055/00000003/art00015>

2022 increased by 22,500 from 2019 to reach 173,800.¹⁴ While housing affordability is a primary driver of homelessness, individuals with mental health needs are particularly vulnerable and at risk. Current data on the numbers of the unhoused Californians with mental health needs are limited; however, research done prior to the pandemic found that rates can be as high as 75 percent for the chronically homeless, and between 30 and 50 percent for the population of unhoused.¹⁵

Similarly, the state faces an increase in the number of Californians who are determined by the courts to be incompetent to stand trial and committed to programs administered by the California Department of State Hospitals. The state is investing more than \$1 billion in a multi-year plan to address the increased need for services through 2025-26. Research from the Department of State Hospitals indicates that individuals coming into the state hospital system are cycling through the local criminal justice system – with nearly half having 15 or more arrests prior to being sent to a state institution, with many of those failing to receive community mental health services in the six months prior to the latest charge that resulted in a state hospital commitment. The California Department of State Hospitals also reports that some 71 percent of clients return following discharge from a state hospital with new felony charges and an Incompetent to Stand Trial designation by the courts.¹⁶

State officials suggest the increase in demand for state hospital beds is directly tied to the number of Californians with Schizophrenia Spectrum disorders who are not receiving community-based care and, as a result, are becoming involved with the criminal justice system.

¹⁴ <https://calmatters.org/housing/2022/10/california-homeless-crisis-latinos/>

¹⁵ <https://siepr.stanford.edu/publications/policy-brief/homelessness-california-causes-and-policy-considerations#:~:text=The%20prevalence%20is%20particularly%20high,Culhane%201998%3B%20Poulin%20et%20al>

¹⁶ https://www.dsh.ca.gov/About_Us/docs/IST_SolutionsBudgetOverview_08-01-22.pdf

Community hospitals also report high numbers of mental health clients cycling through hospital emergency departments, and confusion over the role of contracted FSP providers when clients land in emergency departments needing crises mental health services.

Finally, in its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing numbers of Californians with serious and persistent mental health needs that are going unmet.¹⁷

The Commission's initial review of data relating to FSP identifies three primary concerns:

- 1) The State faces data quality challenges that impede its capacity to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization.
- 2) Despite regulatory requirements, county behavioral health departments do not appear to be allocating mandatory minimum funding levels to support FSP programs.
- 3) California has not established sufficient technical assistance and support to ensure that FSP programs are meeting to goals of reducing homelessness, hospitalizations and justice involvement.

Despite the initial success of FSPs, significant numbers of Californians with mental health challenges lack stable housing, are involved in the criminal justice system, and are cycling through state and community hospitals. These concerns suggests that California's investment in FSPs is not meeting the current need and raises the following questions:

- 1) How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?
- 2) What lessons can be learned from exemplary programs to improve the efficacy of the overall FSP initiative?

¹⁷ https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

- 3) Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs and intended outcomes?
- 4) What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?

These questions, along with the descriptive questions outlined in Welfare and Institutions Code 5845.8 are addressed below.

How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?

To address this question, the Commission explored existing state data systems that contain information on persons served by Full Service Partnerships. Unfortunately, the data in the state’s primary FSP reporting system is inadequate to provide clear and reliable information on the effectiveness of individual FSPs and the broader FSP initiative.

The Department of Health Care Services maintains a Data Collection Reporting (DCR) tool that was designed to receive information on FSP programs across the state. The DCR was intended to gather information on FSP enrollments, key events in the life of participants, and quarterly updates on progress toward goals and services received. Preliminary review of data from the DCR indicates significant gaps in required reporting. For instance, the DCR is intended to gather demographic data on persons served. Demographic data are important to enable the tracking of disparities in access to care across racial, ethnic, age and gender subsets of California’s population. A review of data from the 2020-21 fiscal year revealed more than a third of persons listed as receiving FSP services had no racial, ethnic or gender data linked to their FSP enrollment through the DCR.

The DCR also includes a reporting requirement for “Key Events,” defined as any significant change related to housing, education, employment, emergency services, arrests, health issues,

transfer to a new FSP provider, or disenrollment from the program. These events are reported through a Key Event Tracker, which is intended to provide a snapshot of changes in key quality of life areas that are tracked on a continuous basis throughout the course of participation in the FSP. There is no limit to the number of key events that can be submitted into the data system and monitored over the course of FSP enrollment.

Recognizing that Key Event data can reflect incidents of arrests, housing instability, hospitalizations, and changes in FSP enrollment, these data are of high value in demonstrating outcomes associated with FSP involvement. To meet the goals of FSP involvement, key events should trend toward stability in care, housing, and avoidance of criminal justice involvement and hospital use. Currently key event data are unavailable for a significant subset of FSP clients. Given the considerable risks that FSP clients face for criminal justice involvement, housing instability and hospitalization, the Commission would anticipate robust data on key events for enrollees. It is unclear if key event data are not being submitted by providers, if the data are not finding their way into the Key Event Tracker, or if there a high percentage of FSP enrollees who fail to experience “key events,” which would seem unlikely.

Through the DCR the state has the potential to track relevant information about key events of a consumer as they move through an FSP; however, the DCR does not track other critical information such as services provided and progress toward goals. This information is more likely to be captured in provider/county electronic health records, and there is currently no data reporting mechanism by which that information is reported to the state.

In the absence of more complete data sets on FSP participants, the Commission has explored opportunities to link FSP enrollment data with other data sets on justice involvement, hospitalization, employment, and housing status. As reference above, the Commission pursued an exploratory link between data held in the DCR with data gathered by the California Department of Justice (DOJ). Those data were reflected justice involvement prior to 2018. We

are currently working to receive updated data from the DOJ that can be linked to current FSP enrollment data.

Similarly, the Commission is working to identify potential datasets that can be linked to DCR client data to explore hospital use, employment, homelessness and housing status.

To improve the ability to monitor the outcomes and impacts of FSPs on key priorities, the Commission is exploring the strengths and limitations of the existing data systems and strategies to improve access to existing data, pathways to improved state-level reporting and the need to streamline reporting requirements. It is unclear if existing data reporting requirements are cost-effective and how they could be modified for improve cost-effectiveness. To pursue these questions and develop potential recommendations, the Commission will work with the Department of Health Care Services, mental health clients supported by FSPs, county behavioral health leaders, FSP providers, and other subject matter experts.

What lessons can be learned from exemplary programs to improve the efficacy of California's overall FSP initiative?

In 2019 the Commission partnered with ten local behavioral health departments and a non-profit consultant to explore strategies to strengthen emphasis on outcomes through the design and delivery of FSP services. This project, the Multi-County FSP Innovation built upon a project launched by the Los Angeles County Department of Mental Health with support from Third Sector, a non-profit technical assistance provider. Following Los Angeles County's initial work, the Commission provided financial support to extend participation to nine additional counties. The project was designed to strengthen how counties contract for FSP services with an emphasis on creating incentives for FSP providers to focus on outcomes. In addition to Los Angeles, Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, Ventura, Stanislaus, Napa, and Lake counties participated in the Multi-County FSP Innovation Project, in partnership with Third Sector. The project was designed with the following goals:

- Develop a shared understanding and more consistent interpretation of FSP’s core components across counties, creating a common FSP framework.
- Increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.
- Improve how counties define, and pursue priority outcomes across FSP programs.
- Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.
- Develop new and/or strengthen existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

To allow for flexibility, FSP programming can vary greatly from county to county, with different operational definitions and data processes; however, this diversity of approaches presents challenges in understanding and telling a statewide impact story. The Multi-County FSP Innovation Project is intended to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties are leveraging the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.¹⁸

Participating counties worked together to identify standardized measures for tracking what services individuals receive and how successful those services are. Guided by more than 200 interviews with FSP consumers, family members, and peers, 50 provider focus groups, and recommendations around evidence-based practices, the counties selected and defined five measures to compare across counties for adult FSP participants:

- Frequency and location of services

¹⁸ https://tscp.wpenginepowered.com/wp-content/uploads/2022/03/Multi-County-FSP_Year-2-Summary-Report-2-10-FINAL-1.pdf

- Increased stable housing, including stable, temporary, and unstable housing arrangements
- Reduced justice involvement; including incarcerations and arrests
- Reduced utilization of psychiatric services; including reduced psychiatric and crisis stabilization unit (CSU) admissions
- Increased social connectedness

While some of these outcome measures were historically collected, none were tracked with consistent definitions or metrics across counties. These new, standardized measures should allow participating counties to share and discuss their data collaboratively, identify best practices, and engage in continuous improvement activities collectively. In addition, these counties now collect and track social connectedness data – a recommendation elevated by service recipients – as a key outcome for individuals with serious mental illness.

As part of the Multi-County Full Service Partnership Innovation Project, counties came up with a set of recommendations to the Department of Health Care Services (DHCS) to improve the DCR system. These recommendations were drafted into a memorandum and submitted to DHCS, acknowledging the department’s Comprehensive Behavioral Health Data Systems Project to modernize and streamline data reporting across California’s multiple behavioral health data systems, including the DCR. The Commission endorses these recommendations which include concrete feedback on improving communication support, technical system enhancements, and pre-procurement process suggestions.

The Multi-County Full Service Partnership Innovation Project is currently in its evaluation phase and involved a limited subset of county behavioral health departments. Consistent with the comments above, the Commission will continue its work with the Multi-County Innovation project, explore opportunities following the evaluation to engage additional counties and partner with the Department of Health Care Services to improve the utility of existing data reporting requirements and data systems.

Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs?

In 2021, the MHSA generated an estimated \$2.8 billion in funding to support community mental health services. Of those funds, \$2.3 billion were distributed to county behavioral health departments, which resulted in the following allocations:

- Community Services and Supports (CSS): \$1.6 billion
- Prevention and Early Intervention (PEI): \$423 million
- Innovation: \$99 million

State regulations require “a majority” of CSS funds to support FSP programs. However, in 2010, likely in response to fiscal uncertainties the state was facing at the time, the former Department of Mental Health issued an Information Notice clarifying that for the 2011-12 fiscal year only, the state would calculate the minimum FSP investment to reflect all FSP expenditures, including any federal funding used to support FSP programs. The Information Notice changed the rules for county FSP spending from requiring counties to meet their “majority” expenditure requirement with MHSA revenues, with federal and other funds being in addition to the MHSA investment, to a new formula that would lower MHSA and thus overall expenditure requirements for FSPs. County behavioral health officials state that despite Information Notice 10-21 communicating that this change in fiscal rules applied only for the 2011-12 fiscal year, in the absence of subsequent information, the counties have continued to operate under the temporary direction.

The Mental Health Services Act was passed with clear and compelling goals to reduce justice involvement, homelessness and support community-based care, which is often interpreted as meaning also reducing reliance on hospitalization. The subsequent regulatory requirement to dedicate the “majority” of Community Services and Support funding for FSPs signals the opportunity that FSPs represent to avoid these negative outcomes. Yet uncertainly on the state’s

fiscal rules has hampered opportunities to ensure an adequate investment in FSPs across California's 59 local behavioral health agencies.

As part of its work under the terms of SB 465, the Commission will work with the Department of Health Care Services and county behavioral health leaders to clarify the fiscal requirements relating to FSPs and strengthen utilization of existing resources to support improved FSP outcomes.

What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?

As depicted in Figure 2 above, FSPs exist within a continuum of services and are at the higher end of treatment services. While existing state databases do not allow a clear understanding of who is presently served by FSP providers, discussions with state and county behavioral health leaders indicate that FSPs are best suited to support persons with schizophrenia and related disorders that involve psychosis. As such, the Commission is working to explore opportunities to best engage individuals at the initial stage of psychosis and to prevent the escalation of needs that would result in new demands on FSP programs. In other words, the State of California needs to build out a robust FSP service delivery system that is responsive to the needs of people with serious and persistent mental health care needs, and the state also must work to reduce the escalation of mental health needs and the demand for FSP services.

Research on early psychosis intervention indicates that there are clinically beneficial and cost-effective approaches to care delivery that can prevent the escalation of needs.¹⁹ The Governor and Legislature have supported several initiatives to increase upstream interventions that can lower demand for high-cost FSP services, particularly the expansion of access to early psychosis interventions.

¹⁹ <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/s12888-015-0650-3>

As the Commission’s work on Full Service Partnerships progresses, we want to explore the impact that expanded access to early psychosis services can have as an FSP prevention strategy.

Immediate Opportunities and Next Steps

Developing a Strategic Reporting and Capacity Building Plan

Given the requirements of the Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021) and the learning from the four key questions established in this initial report, there is significant groundwork to cover before the next report is due in November 2024.

The Commission’s strategic reporting and capacity building plan for FSPs will incorporate clear and concise goals and objectives for data collection, monitoring, and reporting. It will incorporate a plan and process for community engagement and outline a process for capacity building, program improvement, and community feedback.

The plan also will reflect principles of diversity, equity, and inclusion, to ensure that the state’s investment in Full Service Partnerships supports efforts to reduce disparities, particularly as they relate to criminal justice involvement, homelessness, and hospitalization.

As mentioned above, the process for developing a strategic data reporting and capacity building plan will incorporate the following:

1. Formation of an Advisory Group. The Commission will convene a group of subject matter experts to inform the work moving forward, including FSP providers, state and local agencies representatives, consumers, family members, and others. The Advisory Group will be tasked with informing all aspects of the Commission’s work on FSPs.
2. Identify Opportunities for Capacity Building. As the Commission has learned through the Multi-County FSP Innovation Project, there is diversity in FSP programs in terms of eligibility criteria, services provided, step-down criteria, other program

elements and measures of success. The project also has revealed opportunities to engage county behavioral health leaders, FSP providers and others to support capacity building and technical assistance to improve the design and delivery of FSP services and supports. The Commission is exploring opportunities to build off of the Multi-County FSP Innovation Project, involve more counties and improve access to technical assistance and support for all counties.

3. Conduct a landscape analysis to understand FSPs within the continuum of prevention, early intervention, and treatment. With the passage of the CARE Act, greater attention to individuals who are deemed Incompetent to Stand Trial, and efforts across California to enhance early psychosis programs, there is a tremendous opportunity to critically examine where FSPs fit into California's larger continuum of care. For example, investing in upstream prevention and early intervention approaches should, over time, reduce the number of individuals who need FSP services. In other words, if the system of care can identify, treat, and stabilize an individual at the point of their first psychotic break, evidence suggests that their trajectory changes and they are less likely to become homeless, develop substance use disorders, and become involved in the criminal justice system. The Commission will work with and support related efforts underway at the Department of Health Care Services.
4. Data quality improvement efforts. As discussed, there are numerous data issues with the DCR related to accuracy, completeness, and quality. For example, without complete data on race/ethnicity, it is difficult to disaggregate results to explore potential disparities in outcomes by race/ethnicity. The DCR also lacks service/treatment information making it impossible to map specific services to positive outcomes. The Commission will explore opportunities to collaborate with DHCS and county partners (e.g. the Multi-County Innovation project on FSPs) on existing efforts to improve these data systems so that they accurately tell the FSP story and help document success and challenges across the state.

5. Data linkage and population-based analyses. The Commission will explore opportunities with the Department of Health Care Services to link individual-level data from the DCR with other state-based datasets, such as data from the California Department of Health Care Access and Information and the DOJ, to better understand population-level outcomes associated with FSP services.
6. Provide recommendations for investment strategy for FSPs. Given the confusion over expenditure rules and uncertainty over whether individuals who meet the criteria for FSP services are getting enrolled and served, the Commission is exploring opportunities to analyze current FSP expenditures, develop an estimate of unmet need in the state, and potential recommendations for reforming expenditure rules, establishing expectations for expanding FSP treatment capacity, and related strategies.

Appendices

Data Sources for FSP Analysis

The State of California has four primary data sources available to understand the operations of Full Service Partnerships (FSPs) and the outcomes they achieve for mental health clients and the communities where they live. The Department of Health Care Services maintains two of those data systems: the Data Collection and Reporting (DCR) system, which was designed specifically to receive information on clients involved with FSP, and; the Client Information System (CSI), which has data on all mental health clients served by county mental health departments.

Additional data systems include those maintained by the California Department of Health Care Access and Information (HCAI), which includes data on hospitalizations and discharges, and data held by the California Department of Justice relating to criminal justice involvement.

To support this initial effort and future work, the Commission will primarily rely on these data systems and access additional data, or data collection methods, as needed.

Under existing state regulations, each county behavioral health department is required to submit to the state detailed data on clients served through Full Service Partnerships. Those requirements are outlined in Title 9 of the California Code of Regulations. At the time an individual enters into a FSP, the county is required to collect the following information and submit it to the Department of Health Care Services (DHCS) within 90 days:

- Residential status, including hospitalization or incarceration
- Educational status
- Employment status
- Legal issues/designation
- Sources of financial support
- Health status
- Substance abuse issues
- Assessment of daily living functions, when appropriate
- Emergency interventions

Additionally, at any time during the course of participation in an FSP, counties also are required to report any emergency interventions, or changes in living situation, educational or employment status and criminal justice involvement. The reports are known as Key Event reports. Counties also are required to provide quarterly assessments for each FSP participant that provide data on the following:

- Educational status
- Sources of financial support
- Legal issues/designation
- Health status
- Substance abuse issues

As with the initial assessment data, Key Event data and quarterly assessment data are required to be submitted to the DHCS within 90 days of collection.

In addition to the DCR system, which holds data only on FSP clients, DHCS maintains the CSI data system, through which counties are required to report information to the state on all persons receiving mental health services from a county. Those receiving services through Medi-Cal and those who are not enrolled in Medi-Cal are required to report into the state's CSI data system. Counties are required to report on client demographics and descriptions of the services provided within 90 days of providing services (CCR Title 9, 3530.10, Information Notice 19-051).

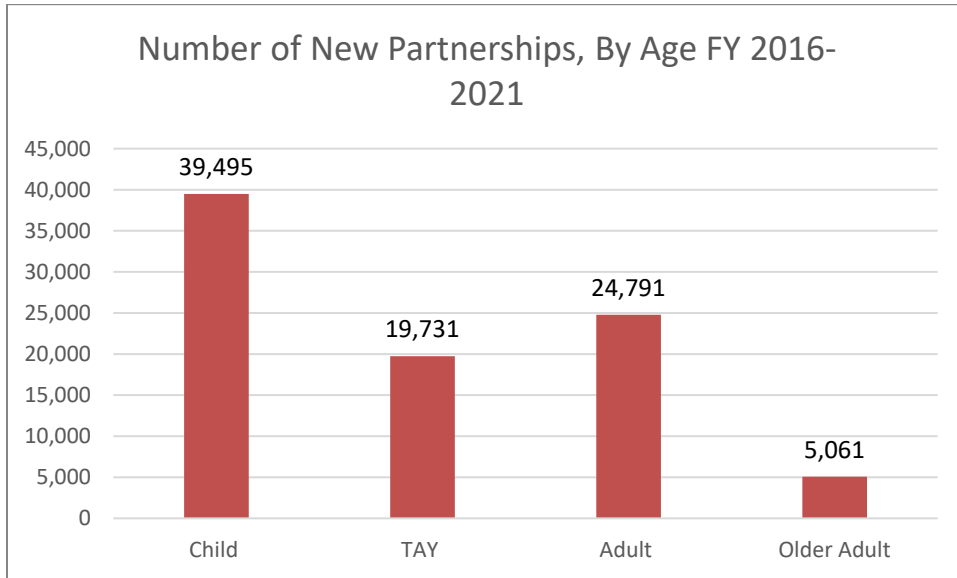
The Commission receives data regularly from the DHCS to support existing efforts to monitor FSP programs. These data sources include: FSP DCR database and the MHSA CSI. Additional data use agreements with the HCAI provide the Commission with patient discharge data (PDD) for hospitalizations.

Initial Data Analysis

Partnerships by Age

Figure 2 shows the number of new partnerships (e.g. clients) who enrolled in an FSP over the last five years (between FY 2016-2021), by age group. Child FSPs are an important service, with 44% of all new partners falling into the 0-15 age group. The percentage of clients by age group has remained stable over the last five years, with children constituting approximately 45% of new enrollments; transition age youth were 22%; adults were 28%; and older adults were 6%.

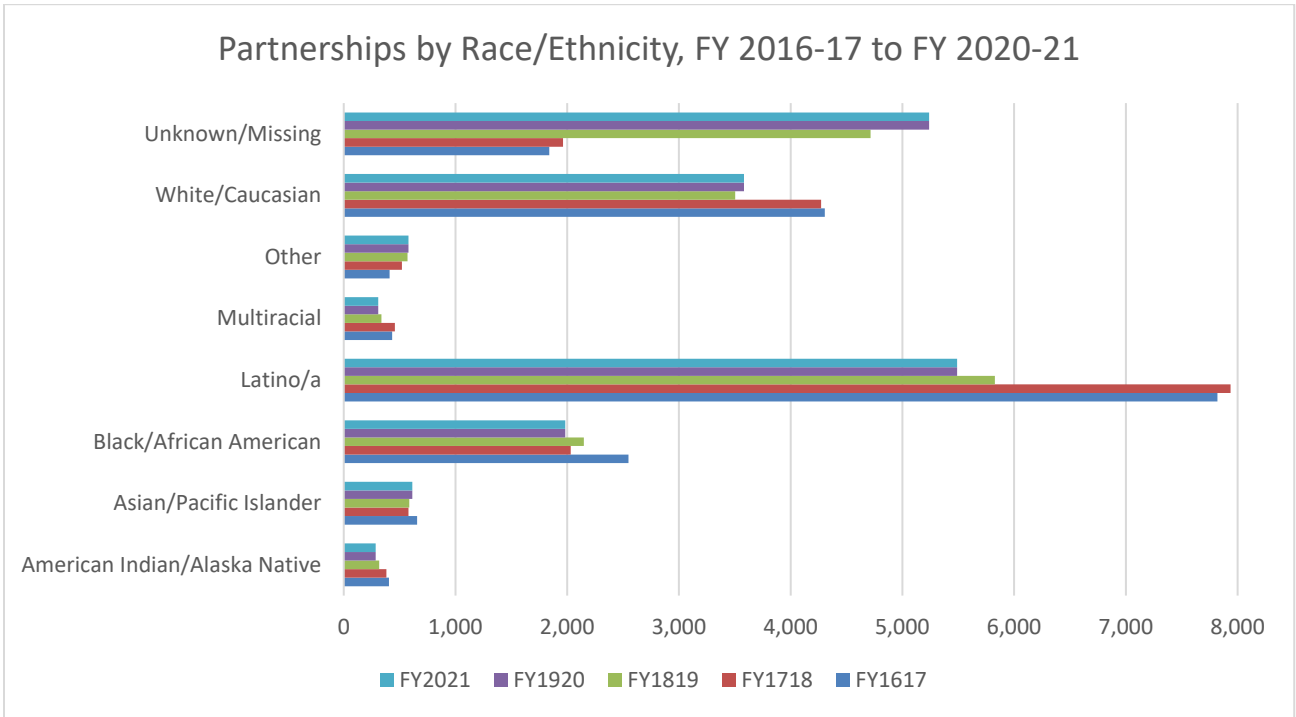
Figure 3: Number of New Partnerships, By Age, FY 2016-2021



Partnerships by Race/Ethnicity

Comparing trends by year for partners served by race/ethnicity is challenging because the number of partners with no race/ethnicity reported in the DCR has increased.

Figure 4: Number and Percentage of Partners by Race/Ethnicity, FY 2016-17 to 2020-21



Partnerships by Gender

Comparing trends by year for partners served by gender is also challenging because the number of partners with no gender identified increased between FY 2016-17 and FY 2020-21. In FY 2016-17, 53% of those served identified as male; 43% as female; 5% as Other; and less than 1% were Unknown. In contrast, in FY 2020-21, gender was designated Unknown for 27% of partners. The challenges of the COVID pandemic may have impacted data quality.

Discharges from FSPs

One of the triggers for a Key Event Tracker (KET) is a discharge of a client from the FSP. There are multiple reasons why a partnership might be discontinued, including:

- Target population criteria not met
- Partner decided to discontinue FSP participation
- Partner moved to another county/service area
- After repeated attempts to contact partner, they cannot be located
- Community services/program interrupted (e.g. partner moves to a higher level of care,

will be serving a jail sentence, placed in juvenile hall, serving prison)

- Partner has successfully met their goals such that discontinuation of FSP services is appropriate

Of the 215,404 partners in the DCR system, 164,902 had a KET with a discharge reason (76.6%). Over the last five years, there were 58,482 discharges. Table 1 summarizes the reasons for discharge.

Table 1: Reasons for Discharge from FSP, 2016-2020

Reason for Discharge	Percentage
Met Goals	41%
Partner discontinued FSP partnerships	19%
Partner could not be located	18%
Partner moved to a different service area or county	10%
Service interruption (e.g. jail, prison, juvenile hall, residential treatment)	7%
Target population criteria not met	5%
TOTAL	100%

An initial analysis of inpatient hospitalizations was conducted. Inpatient admissions were identified between one year before each FSP began, during the FSP, and for one year after the FSP ended. Table 1 shows that inpatient admissions one year after FSPs between FY 14/15 and FY18/19 were less than half the number of admissions in the year before each FSP began (46 per 100 FSPs before and 20 after). For each year examined, inpatient admissions reduced significantly during the FSPs and even more after the FSP as compared to the year before.

Table 2: Psychiatric Inpatient Admissions Before, During, and After FSP, FY 2015-FY 2018

		Psych Inpatient Admissions			Annualized Admissions per 100 FSP Years			Change After/Before		
FY	Nbr. FSPs*	Before	During	After	Before	During	After	Ratio	t-value	Prob t
FY14/15	12,674	7,098	5,580	2,972	56	38	23	0.42	-25.0	<.0001
FY15/16	13,149	6,996	4,727	3,122	53	36	24	0.45	-21.8	<.0001
FY16/17	15,640	6,742	3,957	2,748	43	32	18	0.41	-23.1	<.0001
FY17/18	13,541	5,029	2,463	2,318	37	28	17	0.46	-19.9	<.0001
FY18/19	5,048	1,720	542	841	34	27	17	0.49	-9.2	<.0001
Total	60,052	27,585	17,269	12,001	46	34	20	0.44	-45.6	<.0001