INN16 FSP Co-Occurring Disorders Project
Operated by Stanislaus County Behavioral Health & Recovery Services
Final Report

Issue Addressed

Mental health treatment providers in Stanislaus County have seen a great proportion of people with severe mental illness and co-occurring substance use disorders (SUDs) in recent years. These co-occurring SUDs were and are substantially interfering with the effectiveness of their clients' mental health treatment. In Fiscal Year 2013/2014, 61% of adult Full Service Partnership (FSP) clients received a substance abuse/dependency diagnosis. While all FSPs serving adults work with this issue and should have the capability to diagnose and treat SUDs (e.g. IDDT), there are some individuals for whom the extreme extent of their SUD behavior created challenges and reduced the effectiveness of the FSP. As a result, this population was significantly un/underserved. Stanislaus County stakeholder processes have repeatedly identified the issue; "Treatment options for people struggling with both substance abuse and mental illness" as one of the priority mental health adaptive dilemmas that should be addressed in an innovative manner. This persistent behavioral health challenge has rarely been successfully addressed by traditional methods/interventions.

A central aspect of the issues lies in the fact that mental health treatment and SUD treatment are similar and overlap each other, but there are some areas that are significantly different in approach, training, and philosophy. These areas include, but are not limited to, engagement versus enabling, abstinence versus meeting the client where they are at in their life, hopefulness for recovery versus the desire to drink or use drugs without consequence, empowerment of the individual versus acceptance of the individual's powerlessness over drugs and alcohol use.

Description of Project

Stanislaus County proposed to test the efficacy of an FSP that would provide co-occurring disorder –focused services in which the co-occurring issues the clients present will be the first "lens" through which the clients' recovery needs and strengths are viewed. This FSP is known as the ***Co-occurring Disorder FSP*** or ***COD FSP***.

The primary focus of the project was on increasing the quality of services, including better outcomes by creating shared understanding and vision amongst staff and with clients through a client-centered, stage-based approach, enriched with primary care and housing services. The emphasis was on using the Stage Based Treatment framework for both mental health and SUD concurrently and deliberately, addressing the sometimes contradictory strategies indicated for each stage separately.

We expected to learn whether this approach can make a difference in the lives of people with mental illness and substance use disorders in a way that traditional approaches have not. This unique approach was different from other FSPs and held the potential to advance knowledge and contribute something new to the field of mental health. This innovation project made a change to an existing mental health practice that had not yet been demonstrated to be effective with the clients who suffer with disabling co-occurring issues.

This Innovative approach created a unique FSP that was intended to integrate primary care access, a “housing first” approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and practice. Stage-based treatment, access to housing and primary care, low case load ratio, 24-7 availability, supportive services funds and a team–based approach were central to achieving expected outcomes.

The learning questions explored through this project included:

1. Will clients be successfully engaged by receiving a combination of services through this new FSP?
2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?
4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs’ perspective?
5. Will access to integrated primary care positively affect outcomes?
6. Will employing an integrated ”Housing First” approach positively affect outcomes?
7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

The overarching learning outcome focused on helping to inform the behavioral health field about what combination of strategies and services are most effective at the different concurrent mental health and SUD recovery stages for individuals with these co-occurring issues.

Plan for and Analysis of the Effectiveness of the Project

Defining and measuring success for this Innovation Project was based on the learning questions described above. Since this Innovation project made a change to an existing mental health practice that had not yet been demonstrated to be effective for the population experiencing both a serious mental illness as well as a co-occurring SUD, an emphasis was placed on learning about the effectiveness of processes as well as the impact on the quality of services. Therefore, both formative and summative aspects of evaluation were considered. For example, although Stages of Recovery frameworks have been used before for both Mental Health and SUD programs, it was hypothesized that ***how*** they are being used by collaborating staff would make a difference in positively impacting client progress.

Multiple methods of data collection, both qualitative and quantitative, were utilized to address the learning questions and help answer the overall question of what combination of strategies and services were most effective at the different concurrent mental health and SUD recovery stages. Data collection methods included are described below.

- Collection of demographic and encounter data to understand the population served, the type of services, and the length of time the population stays in the Project
    - Source: Electronic Health Record (EHR)

- Tracking of clients' referrals and linkages to other services and/or community support
    - Tracking forms were used to collect data regarding the types of referrals and rate of successful connections to other resources and support systems. The COD FSP staff assisted in developing the forms to ensure appropriate and accurate data would be collected.
    - Staff collected and documented linkage information weekly
    - Source/Tool: Tracking forms (See Attachment #1)

- Documentation and staff focus group regarding the application and emphasis on Stages of Recovery frameworks - the Mental Health Recovery Treatment Stages (MHRTS) and the Substance Abuse Treatment Scale (SATS)
    - Staff documented the work surrounding the Stages of Recovery frameworks and how concurrent use of the frameworks affected their work and client outcomes.
    - A qualitative analysis of this documentation revealed the strengths and challenges of using the sometimes contradictory language and methods of the two frameworks.
    - A focus group was conducted at the end of the Innovation project to discuss the findings and explore the information collected further from a staff perspective. From this process, insight was gained about how staff utilized the two frameworks to create shared understanding of clients' recovery needs to most effectively impact client progress.
    - Source/Tool: Focus Group Agenda/Questions (See Attachments #2 and #3)

- Tracking of client stages of change with MHRTS and SATS
    - Staff utilized MHRTS and SATS to gauge stages of change and documented the results
    - Analysis revealed how much change was measured through the tools and if the changes aligned with staff judgement
    - Staff documented both successful and unsuccessful interventions from multiple stages to determine if there were strong relationships between stages, interventions, engagement, and recovery outcomes.
    - Source/Tools: MHRTS, SATS, Tracking Sheet (See Attachments #4 and #5)

- Consistent documentation of strategy and service efficacy
    - Staff completed "journal" entries regularly to record their analysis of what was working and what was not working as well.
    - Successes, challenges, and opportunities were documented and discussed as a team to provide support, and process and evaluate possible changes.
    - Source/Tools: Journal Forms (See Attachment #6)

- Administration of client surveys
    - Surveys were administered bi-annually to provide information regarding access, satisfaction, engagement, and effectiveness of the Innovation Project and the services. It was decided to use Consumer Perception Survey data exclusively in order not to overburden clients with multiple surveys.
    - Source/Tools: Mental Health Statistics Improvement Program (MHSIP) survey for Adults and Older Adults (See Attachments #7 and #8)

- Tracking and analysis of client residence status/homelessness, incarceration, arrests, medical and psychiatric hospitalization, and state and long-term hospitalizations
    - Client data was collected through a DCR-LA (Data Collection and Reporting-"Look Alike") system. Since the COD FSP was an Innovation Project rather than a Community Services and Supports (CSS) funded program, data could not be entered into the State DCR system. However, the information was captured in a system that mirrors the DCR, using the same forms as the State DCR. (See Attachments #9, #10, and #11 for DCR-LA forms)
    - This data was used to capture and compare outcomes to other Stanislaus County FSP programs funded with CSS dollars.
    - It was expected that clients receiving services through this FSP would mirror, if not exceed, the success rate of other FSPs within BHRS.
    - When applicable, it was attempted to compare outcome data for clients who previously received FSP services, and then were referred to and received services through the Co-occurring FSP. It was expected that those who were previously not highly successful experience improved outcomes by receiving an appropriate and convenient combination of FSP services for co-occurring disorders. However, only aggregate data could be compared.
    - In addition, a comparison of DCR outcomes for clients in other FSPs was made to client outcomes in this Innovative FSP that first focuses on co-occurring disorders.
    - Source/Tool: DCR-LA, EPLD (Enhanced Partner Level Data) reports

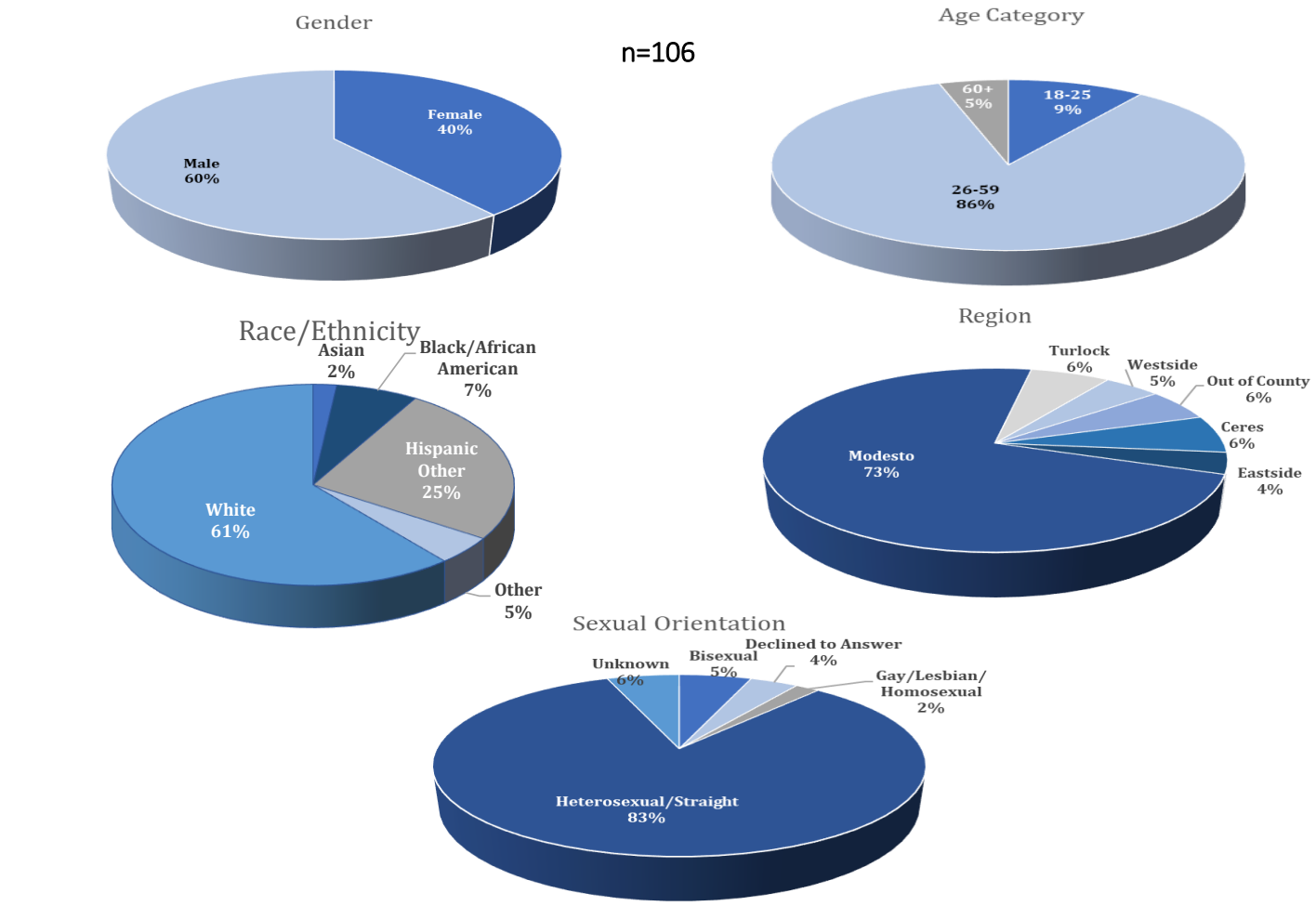
It was planned to utilize a peer group to review the data throughout the project, but this was not accomplished. However, the final report will be shared with the peer group, BHRS staff, and stakeholders.

Unless otherwise specified, the data and analysis presented below reflects the time period from the Project start date to the Project end date (as an Innovation Project), which is 4/11/2016 – 5/31/2019. This time period is 1,146 days, or slightly over 3 years of the active project, keeping in mind that it takes time for a project to be fully implemented with staff having a full caseload.

Unique Client Data

Encounter data, including assignments (opening to a subunit/program), services, and demographics were collected through the Electronic Health Record (EHR). The total number of unique clients served during the operational time of the Project is 106. Below is a summary of this data.

#1 Client Demographics



Of the 106 clients, 40% were White males, 21% White females, 13% Hispanic males, 12% Hispanic females, and 7% males of another race/ethnicity, and 7% females of another race/ethnicity (Black, Asian, or Other). In addition, 7 of the 10 clients who were 18-25 years old were women.

The Innovation Project initially consisted of five components that were assigned “Subunits” in the EHR. The COD FSP originally was comprised of mental health engagement, assessment, and treatment components, along with SUD assessment and treatment components. As the project launched and progressed, the staff found that it did not procedurally make sense to continue utilizing the two subunits reserved for SUD only for the COD FSP. The project found that the use of existing assessment and treatment programs was more effective. Staff continued to be closely involved in the SUD assessment and treatment of clients open to the COD FSP, which is one of the significant differences between the COD FSP and other FSPs.

Below is a summary of the number of clients served by assignments (meaning that they were enrolled in a particular subunit) and services.

Subunit Key

Subunit	Name
3120	COD FSP Mental Health Engagement
3121	COD FSP Mental Health Assessment
3122	COD FSP Mental Assertive Community Treatment
3125	COD FSP Substance Use Disorder Assessment
3126	COD FSP Substance Use Disorder Outpatient Drug Free

#2 Unique Clients by Assignments

Unique Clients Assignments Served by Period	3120 MH Engagement		3121 MH Assessment		3122 MH ACT		3125 SUD Assessment		3126 SUD ODF		Total		
	Unique Client Count*	# Assign-ments	Unique Client Count*	# Assign-ments	Unique Client Count*	# Assign-ments	Unique Client Count*	# Assign-ments	Unique Client Count*	# Assign-ments	Unique Client Count within SU	Unique Client Count*	# Assignments
4/11/16 - 6/30/16	11	12	2	2	8	8					21	11	22
FY 16/17	55	59	6	6	40	43	11	12	4	4	116	65	124
FY 17/18	27	29	3	3	44	47	16	18	3	3	93	58	100
FY 18/19	31	37	6	7	49	51	5	6			91	67	101
Sum Unique Count	100	122	17	18	73	85	23	36	4	4	217	112	265

*Assignments remaining open from FY to FY will be counted each year, but only once in the sum.
*Assignments may be open for the period, but have no services entered in the period reported, therefore unique client counts may differ between assignments and
*Excludes client with case # 0(zero)
Data source: Data Warehouse

As expected, the largest number of unique clients were in the engagement subunit, and then to the ACT subunit. The total unique clients in the Project was quite consistent over the three fiscal years, averaging 59 clients who received services each year during the three full fiscal years.

#3 Unique Clients & Service Counts

Services to Unique Clients by Period & SU	3120 MH Engagement		3121 MH Assessment		3122 MH ACT		3125 SUD Assessment		3126 SUD ODF		Total	
	Unique Client Count	# Services	Unique Client Count	# Services	Unique Client Count	# Services	Unique Client Count	# Services	Unique Client Count	# Services	Unique Client Count by Period	# Services
4/11/16 - 6/30/16	9	34	1	1	8	143					9	178
FY 16/17	51	202	4	4	40	2115	11	12	4	7	64	2340
FY 17/18	20	54	3	3	40	2401	16	17	3	5	53	2480
FY 18/19	19	76	6	8	49	2813	5	6	0	0	59	2903
Sum Unique Count	87	366	14	16	73	7472	23	35	4	12	106	7901

Excludes client with zero case #
Data source: Datawarehouse - Services table

As an FSP that serves extremely hard-to-engage individuals, 87 individuals were enrolled in the engagement component; 83% of those individuals were assessed, 15% being SUD assessments. In addition, 60% were eventually enrolled in the ACT level of the COD FSP. Engagement with this population is very time consuming and staff have shared that time spent engaging is directly related to the quality of the relationships built with clients and ultimately the outcomes for clients. Staff consistently shared comments such as "*Success with hard to engage client…[involves] being patient, light touch and consistent, frequent contact*" and "*learning to build relationships sometimes slowly, building trust.*" These comments depict the critical nature of engagement time.

An average of 43 clients (129/3) per fiscal year were served in ACT, but averaged 24 *unique* clients (73/3) per year across the three fiscal years. This data, along with the COD FSP length of stay data and qualitative data, indicates that clients do move in and out of the COD FSP, and also indicates that there is a high rate of client carry over from fiscal year to fiscal year when they are engaged. To illustrate this, the average length of stay in ACT was 383 days, meaning that many clients spanned at least two of the fiscal years. These are the clients that also had the best outcomes as discussed later in the report.

Service Data

The vast majority (93%) of the services provided across the COD FSP were direct services, while the remaining 7% indirect services were outreach/engagement (4%), conservatorship administration (1%), clinical meetings (1%), and screening/other assessment (1%).

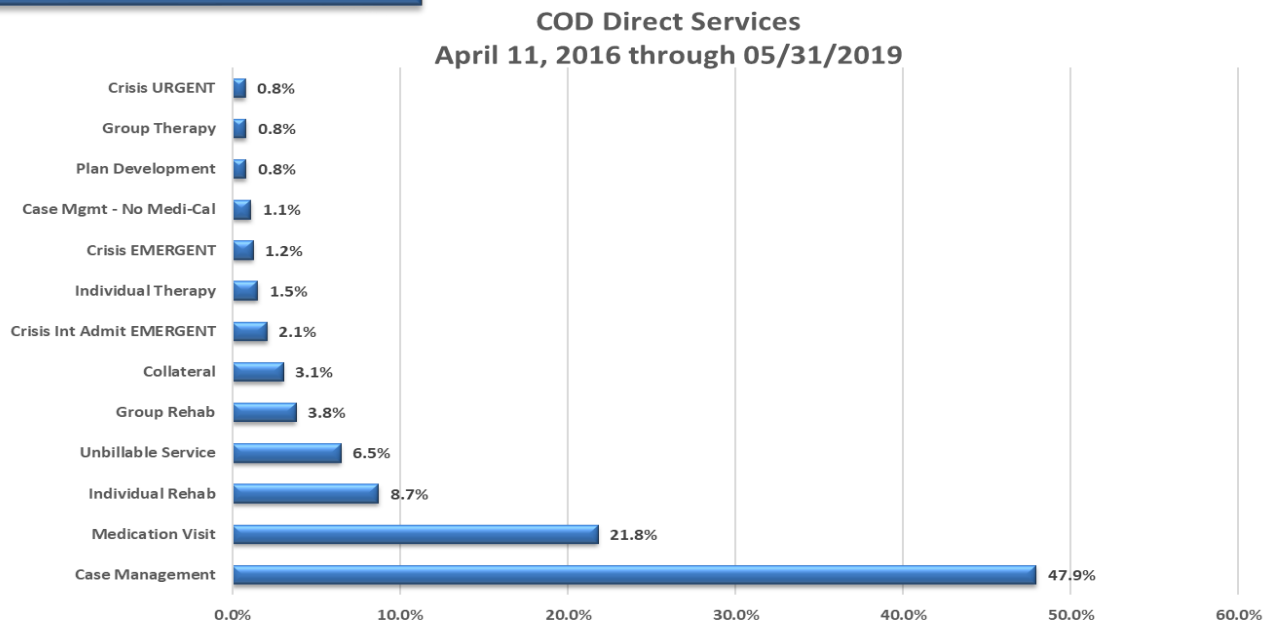
#4 Direct Services

As illustrated in the charts to the right and below, close to 50% of all direct services were case management (47.9%), followed by medication visits (21.8%), then individual rehabilitation (8.7%). This is consistent with the premise that case management for the COD FSP population is critical for stabilizing, meeting foundational needs, and building trust. Medication visits and individual rehabilitation services are also critical, but are not as frequent nor time intensive.

Direct Services

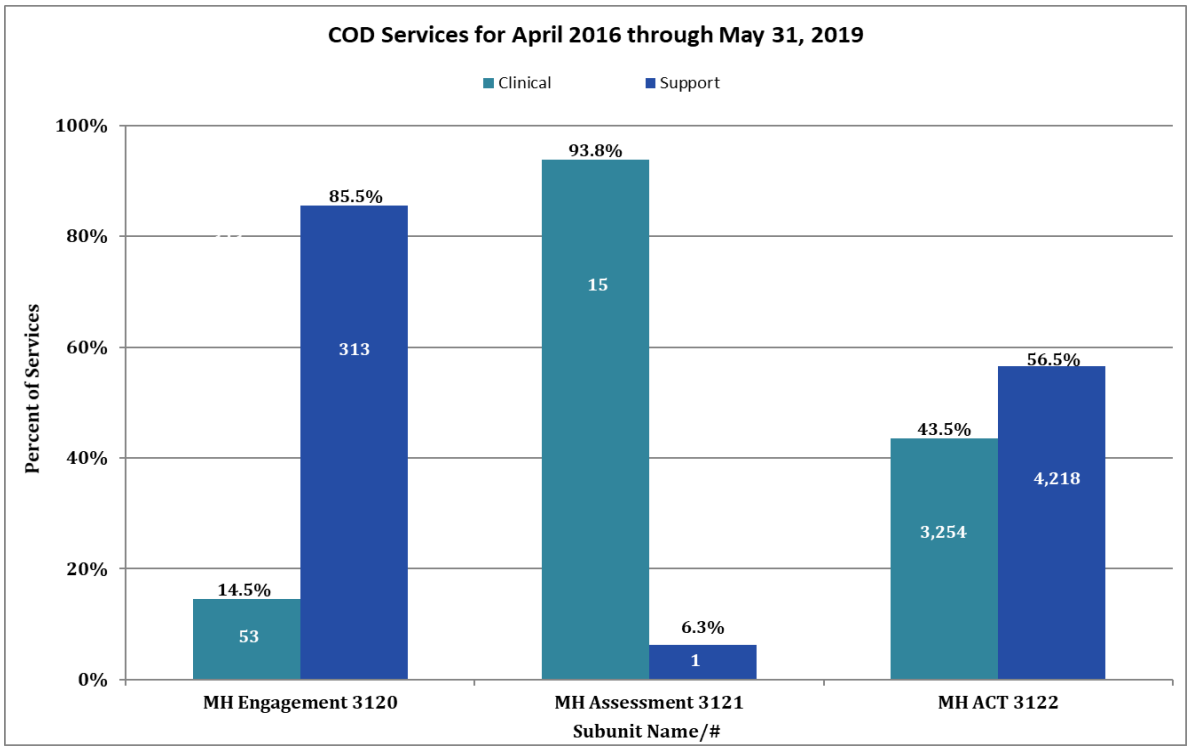
Service Code	Service Description	# Services	%Type
50	Case Management	3,458	47.9%
20	Medication Visit	1,573	21.8%
35	Individual Rehab	627	8.7%
909	Unbillable Service	466	6.5%
36	Group Rehab	274	3.8%
33	Collateral	220	3.1%
58	Crisis Int Admit EMERGENT	149	2.1%
30	Individual Therapy	109	1.5%
57	Crisis EMERGENT	89	1.2%
908	Case Mgmt - No Medi-Cal	78	1.1%
13	Plan Development	57	0.8%
32	Group Therapy	57	0.8%
77	Crisis URGENT	56	0.8%
Total Direct Services		**7,213**	**100.0%**

#5 Direct Services



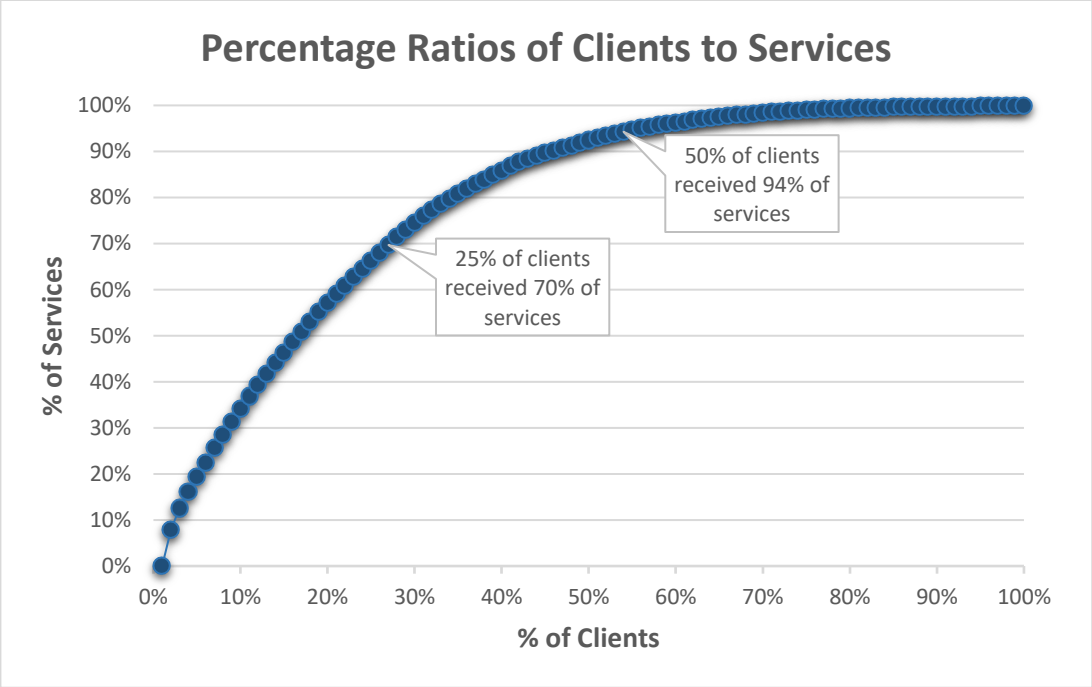
The following chart further indicates the distribution of types of services provided to the COD FSP clients by Project component. For the purposes of this report, clinical services are categorized as services provided by clinicians or psychiatrist/nurse staff, and include individual or group therapy, assessments, crisis intervention, and med services. Support services are categorized as the services that support those clinical services such as case management and outreach and engagement.

#6 Clinical & Support Services



It is again clear that support services, mainly case management, are an extremely important feature of the COD FSP, for both outreach/engagement and at the ACT level. It is also worthy to note that the ratio of clients to services is quite low, meaning that a relatively small number of clients received a large proportion of the services. The chart below portrays the percent of clients in relation to the percent of all services provided. The data shows that a fairly small percentage of the clients receive a large percentage of the total services, indicating strong engagement with concentrated services for those clients.

#7 % Ratios of Clients to Services

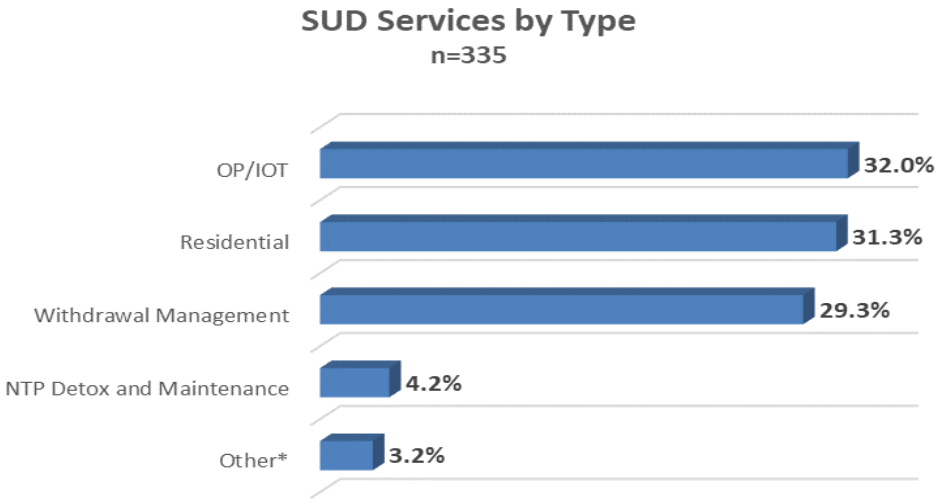


Percentages are based on 106 clients and 7,901 services (including non-treatment services)

SUD Services

A critical aspect of this Project was to ensure that both mental health and substance use issues were being addressed concurrently. Of the 106 unique clients, 40% were connected to SUD services, including SUD assessments, Outpatient Treatment (OP), Intensive Outpatient Treatment (IOT), Perinatal Intensive Outpatient Treatment, Residential Treatment, Withdrawal Management, Narcotic Treatment Program (NTP) Detox and Maintenance, Adult Drug Court, and Forensic SUD Engagement. Below is a chart depicting the distribution of SUD services. OP and IOT SUD services were the most prevalent, followed by Residential and Withdrawal Management.

#8 SUD Services by Type



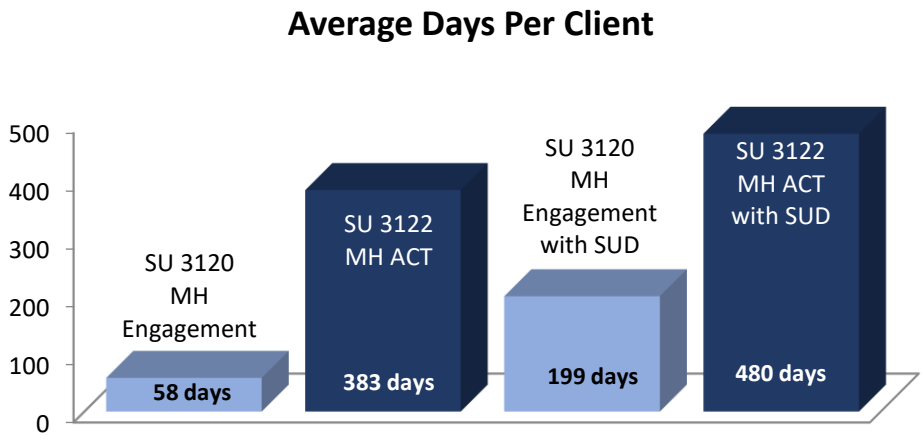
*Drug Court, Forensic SUD Outreach, Perinatal IOT

As mentioned previously, as clients entered into SUD treatment programs, the COD FSP staff were continuously engaged, working in conjunction with SUD program staff and remaining as a support system for clients. Staff have shared that this collaboration is imperative for the clients' success. One staff commented, "…*a client reported to me she felt supported by the whole team and felt like the whole team was there to support her. [The] client was able to maintain stabilization while transitioning from SRC [Stanislaus Recovery Center] residential [treatment] to…sober living due to this support.*" Another stated, "*By being co-located on SRC's campus and having a client in the COT IOT [Co-occurring Treatment Intensive Outpatient Treatment] program and connected with our team, the client has been working and reaching treatment plan goals. Ultimately it has increased peer support and continuous linkage to the FSP*." These comments support how important it was in this Project to not only make a referral, but maintain relationships and continuous contact with the client and with the program to which he/she was referred.

Length of Stay

Throughout the project, staff noted how time intensive it was to effectively engage, build trust, and maintain relationships with clients. One staff wrote that it was important to *"allow client[s] time to 'Buy in' for treatment offers,"* while another stated the importance of "*being present in client's life, and having time to support client needs*." Consequently, the length of stay in the engagement and ACT levels were expected to be representative of this observation. It was also expected that clients in the COD FSP would be connected to SUD services preferably while still open to the COD FSP, but even after discharge. The following data illustrates the average length of stay for clients in the engagement and ACT levels of the COD FSP, as well as the average length of stay for those clients who received SUD services outside of the COD FSP during the project time period.

#9 Average Days Per Client

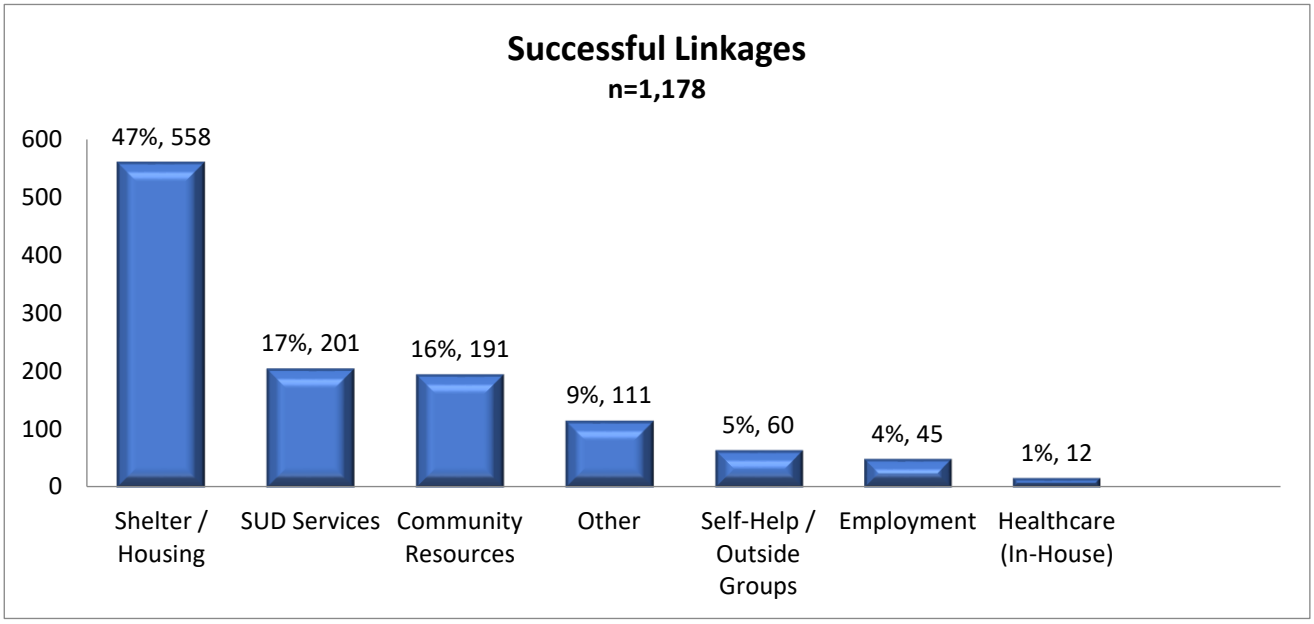


The average length of engagement was close to 2 months, recalling that about 60% of the clients then moved into the ACT level. When the length of additional time spent in SUD programs are added to that, the average length was over 6 months. Similarly, the average length of time in the ACT level was slightly over 12 months and 16 months with SUD services. In addition, the length of time that clients stayed in the ACT level increased each year of the project. For example, the average length for the first full year was 150 days, increasing to 209 during the third year.

Referrals and Linkages

Not all services were provided by the COD FSP or other BHRS treatment programs. A key component of the success of some clients is connection with community resources and community/peer support. Referrals and the success of linkages were tracked to analyze which resources were most prevalent and successful. The results are illustrated below.

#10 Referrals & Linkages



A total of 2,111 referrals were made for 56 clients, and 1,178 (56%) were known to be successful. Of the 56 clients who were referred, 90% had at least one successful linkage. It is apparent that the most successful referrals were made in the area of shelter and housing. These were followed by SUD services and community resources. Also of note, 29 clients participated in a recovery community of support, which means that each experienced a successful linkage to a community resource that specifically supports recovery (e.g., AA, NA, NAMI, etc.). Attachment #12 provides the list of the programs and resources for referrals.

Client Perspective and Progress

At the foundational core of this Innovation Project is dedication to meeting clients where they are – physically where they are living/staying, as well as where they are with their behavioral health challenges. Building relationships and doing "whatever it takes" were key elements for successful outcomes. Throughout the entire Project, checking in with clients often was an expectation for staff. There were also formal check-in points with surveys and intervention tools.

Consumer Perception Survey

The consumer perception survey administration yielded 24 responses, 13 in 2017 and 11 in 2018. The results can be seen in Attachments #13 and #14. Although it was a small sample size and not enough to show statistical significance, it is worth noting that there were several subscale areas of improvement. The subscales "Access", "Outcomes", and "General Satisfaction" all indicated more favorable results in 2018 compared to 2017. Increased satisfaction and access improvement could be attributed in part to COD FSP being more fully staffed during the 2018 survey period, as it has been stated that a full staff makes a tremendous difference in the quality of services. Staff were likely
able to respond more quickly and having a psychiatrist on the site also made it more convenient to be seen. In addition, it is worth noting that the clients' perceptions of their outcomes improved to 70% in very critical areas of improved functioning such as "Able to deal with crisis" and "Symptoms not bothering as much."

#11 Consumer Perception Survey Results

Subscale	Questions	Percent Favorable May 2017 n=13	Percent Favorable May 2018 n=11
		73 answered questions	*65 answered questions*
Access		**79%**	**92%**
	Services Location		
	Staff willing to help		
	Staff returned call 24 hours		
	Service times good		
	Received services needed		
	Saw psychiatrist as needed		
		90 answered questions	*86 answered questions*
Outcomes		**60%**	**70%**
	Able to control life		
	Able to deal with crisis		
	Get along better with family		
	Better in social situations		
	Better in school/work		
	Housing situation has improved		
	Symptoms not bothering as much		
		38 answered questions	*33 answered questions*
General Satisfaction		**81%**	**100%**
	Like services received		
	Still would choose this agency for service		
	Recommend this agency to family or friends		

MHRTS and SATS – Tools for Process and Outcomes

The Mental Health Recovery Treatment Stages (MHRTS) and the Substance Abuse Treatment Scale (SATS) tools were utilized by staff to check in with clients regarding the clients' stages of recovery. These tools helped to show client recovery progress as measured by positive changes in stages of recovery as illustrated below:

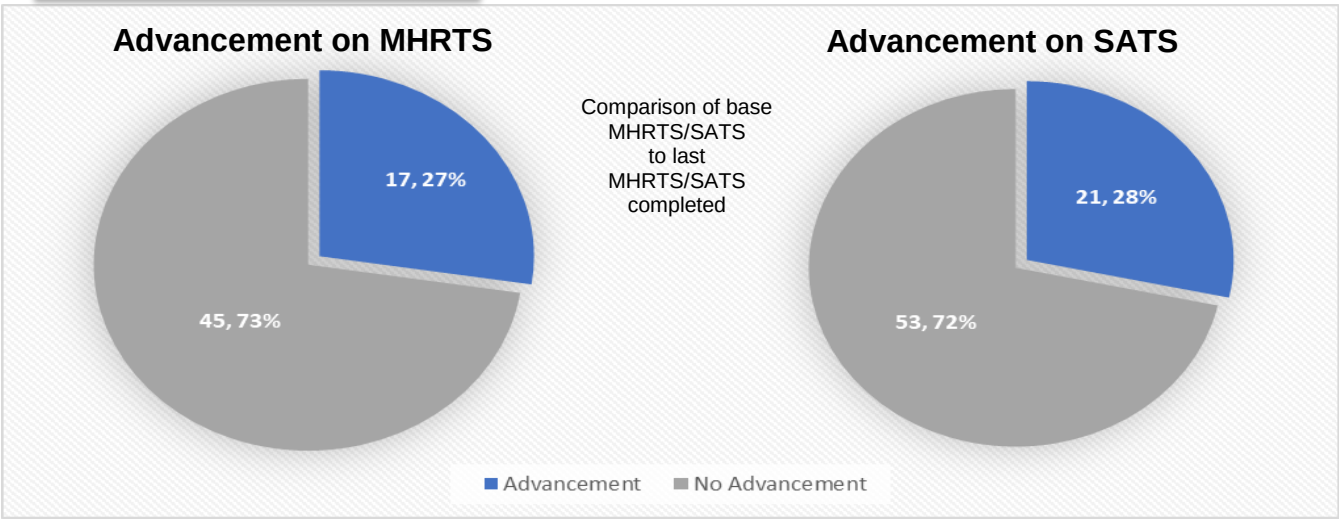
MHRTS	Recovery Progress	SATS
0 – No mental health problems reported		1 – Pre-engagement
1 – Pre-engagement		2 – Engagement
2 – Engagement/Outreach		3 – Early Persuasion
3 – Contemplation/Exploration		4 – Late Persuasion
4 – Recovery Awareness		5 – Early Active Treatment
5 – Stabilization/Beginning Recovery		6 – Late Active Treatment
6 – Active Recovery		7 – Relapse Prevention
		8 – In Remission or Recovery

Staff consistently worked with clients to evaluate recovery progress within the framework of the MHRTS and SATS stages concurrently. The hypothesis was that if staff were aware of the language and intervention methods of both the mental health and substance use disorder frameworks in relation to the client's recovery progress concurrently, the challenges could be addressed. The MHRTS and SATS were intended to be both a tool to reveal outcomes, but also a tool to lead staff to appropriate interventions. Mixed results were realized for both intentions.

MHRTS/SATS as Outcomes Tools

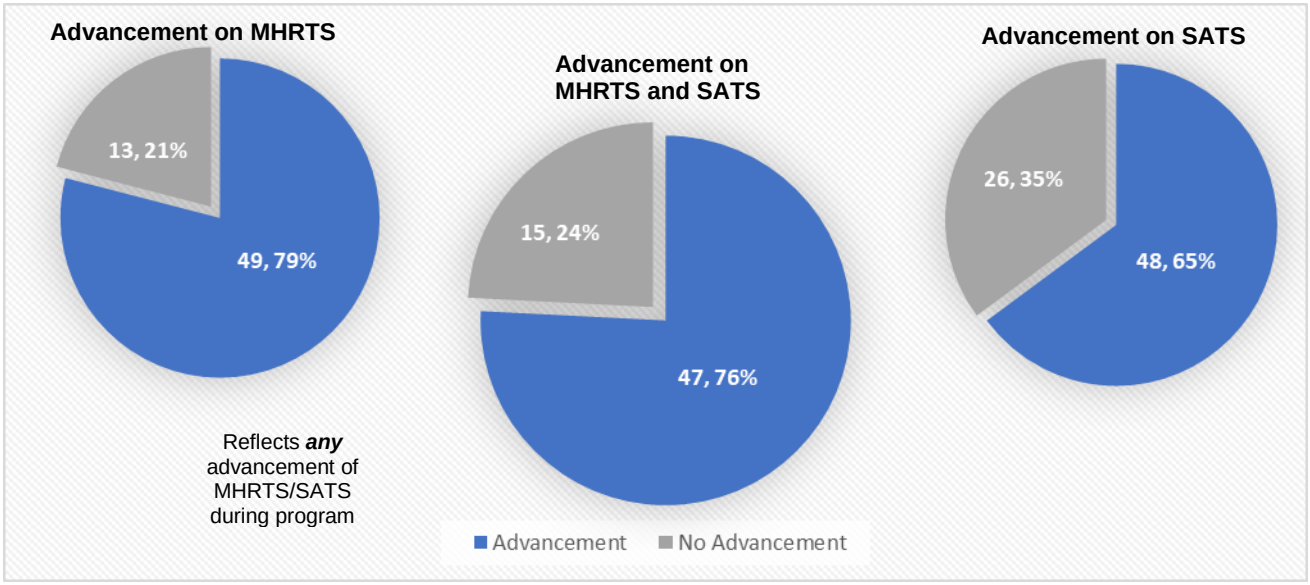
Although some outcomes insights were gained, the MHRTS and SATS did not work as well as intended as outcomes tools. The results are illustrated below.

#12 MHRTS & SATS Advancement



As shown above, there was 27% and 28% client advancement on the MHRTS and SATS, respectively. Those who advanced in MHRTS were in the COD FSP an average of 14 months, while those who advanced in SATS were in the COD FSP an average of 11 months. However, according to staff during both the journaling process and the focus group, this data does not capture all the vicissitudes involved with client recovery progress. Two main themes have emerged: 1) Clients at this level move up and down the scale multiple times throughout recovery; and 2) The tools are not sensitive enough to the small, but very meaningful, changes in recovery for clients in this Project. A different look at the data shows change more accurately, but still does not cover the nuances that staff shared. The different charts below reflect any advancement on the MHRTS/SATS during their time in the COD FSP. This means that there could be two steps advancement and one step back or any combination of movement forward and back within the recovery process. However, by viewing the data in this way, recognition can be given to movement in recovery at any time. The charts illustrate that 76% of the clients advanced on both the MHRTS and SATS.

#13 MHRTS & SATS Advancement



Some staff did find the MHRTS and SATS useful to track progress, stating, "*Using the MHRTS and SATS has been successful tool for the program. I've been able to see where my clients progress or digress in their recovery*." However, others were more critical of the tools' use for this purpose. Multiple individuals commented that often clients were in extremely early stages of recovery throughout the Project, and it was difficult to see progress through the tools – there was movement ***within*** stages, but not as much ***between*** stages. During the planning of the Project, the "micro-steps" between pre-engagement and engagement in both mental health and SUD were underestimated. In order to be more helpful, the tools would need to be more sensitive to the "micro" changes clients made, including the baby steps along the way to recovery. Most staff concurred that observations of client improvements were more encouraging than the scale ratings that didn't capture those small successes. It was suggested that a tool more sensitive to this population's "successes" or a tool that focused on positive relationship building would be more useful, accurate, and motivating. According to one staff, "*Recognizing any progress is something to celebrate!*"

MHRTS & SATS as Process Tools

Although the MHRTS and SATS were limited as outcomes tools to depict progress, staff did utilize the tools for process, relationship building, and intervention purposes in different ways. Several staff journal comments indicated that MHRTS and SATS were helpful in utilizing a stage-based approach, writing, "*Using [a] stage based approach has been successful (i.e., MHRTS and SATS) in identifying where our clients are at.*" Others observed that the tools had value in conceptualizing and guiding interventions and opening discussions amongst team members. The tools acted as conduits for discussions, especially when there was friction between disciplines (mental health and substance use). They assisted in maintaining a concurrent stage-based approach and facilitated critical discussions from a co-occurring view. One staff observed that the team used the tools to "force" a focus on SUD in a more structured manner.

As MHRTS and SATS were intended to guide interventions, staff also tracked the interventions used in conjunction with the MHRTS and SATS ratings. The table below lists the co-occurring strategies suggested for the various stages of recovery (additional definitions and details can be found in Attachments #4 and #5). It also depicts the percentage of clients for which each strategy was used. There were 59 clients for which there were strategies recorded for MHRTS and SATS. The strategies/interventions were recorded and analyzed separately for the MHRTS and SATS since a strategy may have been instrumental in progress along the MHRTS spectrum but not SATS or vice versa. For example, motivational interviewing may have been successful in establishing regular treatment for mental health but not for SUD.

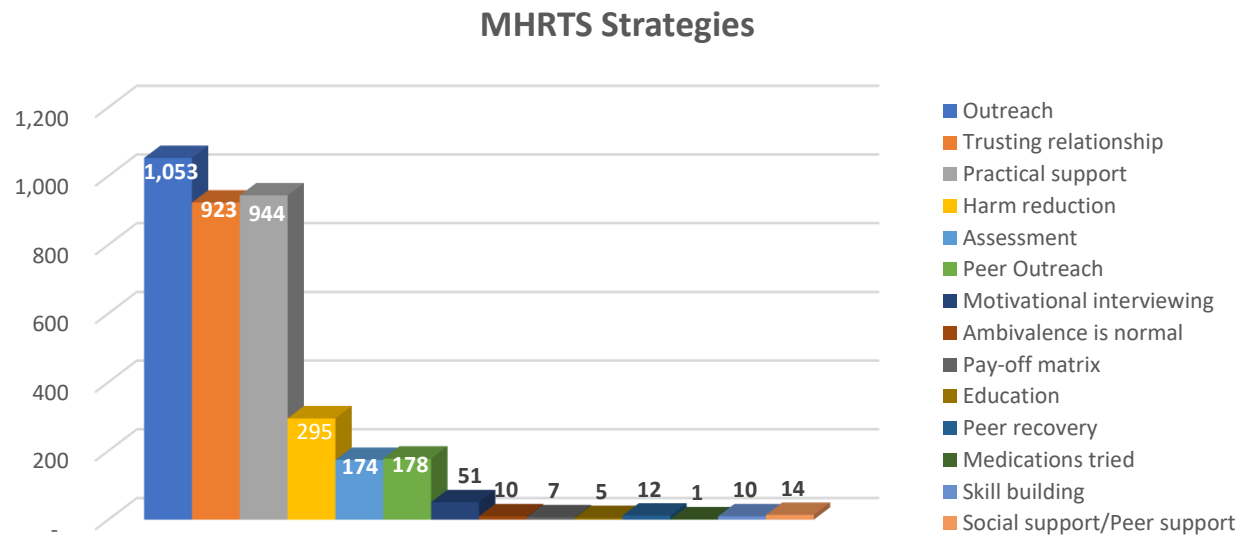
#14 % Clients by Strategies

n=59 % Clients for which strategy was used for appropriate MHRTS Stage	Co-occurring Strategies	n=59 % Clients for which strategy was used for appropriate SATS Stage
97%	A Outreach	97%
98%	B Trusting relationship	100%
98%	C Practical support	93%
59%	D Harm reduction	71%
47%	E Assessment	51%
49%	F Peer outreach	49%
22%	G Motivational interviewing	19%
12%	H Ambivalence is normal	22%
7%	I Pay-off Matrix	5%
2%	J Education	-
14%	K Peer recovery	-
2%	L Medications tried	-
10%	M Skill building	-
14%	N Social support / Peer support	-
-	O Cognitive behavioral interventions	-
-	P Medications / side effects actively managed	-
-	Q Integrated timelines (AOD, MH, and trauma)	-
-	R Other therapeutic interventions	-
-	S Other therapeutic interventions	-
-	T Planning	-
-	U Recovery lifestyle	-
-	V Social Support	-

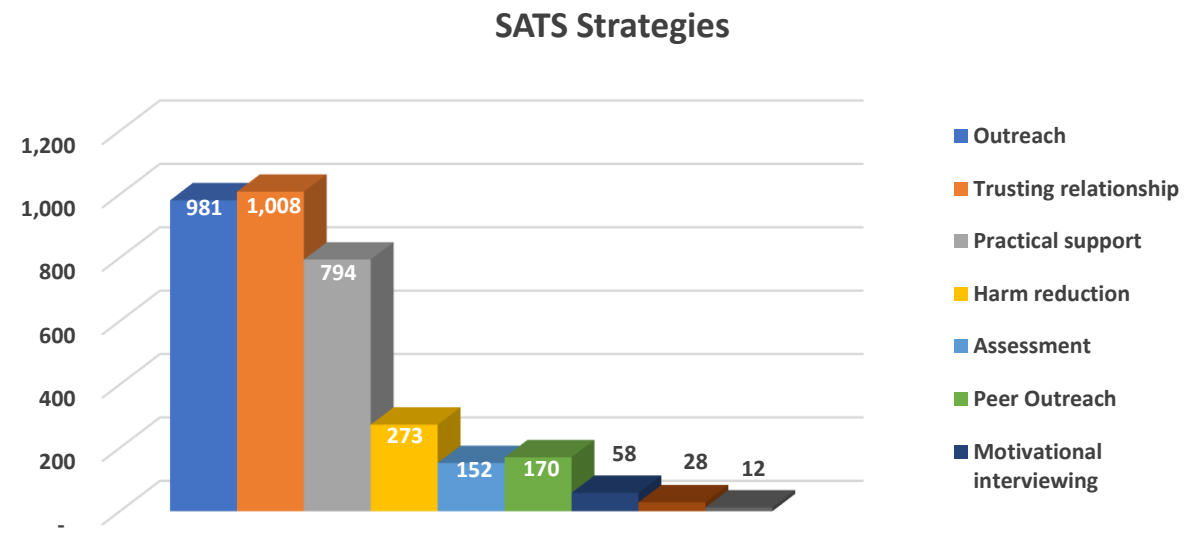
The strategies O through V are those listed for higher levels of recovery, and it is evident that those strategies were not typically utilized for the clients in this Project. An exception to this was in the area of medications (P). The staff who were completing the MHRTS and SATS were not the staff using medications as an intervention, so that was not captured on the MHRTS and SATS. This strategy was indeed used by medical staff. For both the MHRTS and SATS, the strategy focusing on trusting relationships is the most widely used (almost all clients), followed by practical support and outreach. Every time a strategy was used, staff also recorded if it was successful. The co-occurring strategies yielded an overall success rate of 92% for MHRTS stages (54 of the 59 clients received successful intervention with at least one strategy), and an overall success rate of 93% for SATS stages (55 of the 59 clients received successful intervention with at least one strategy).

Depicted below is a summary of the number of times strategies were used during the COD FSP Innovation project time period.

#15 # of MHRTS Strategies Utilized



#16 # of SATS Strategies Utilized



Again, it is apparent that the strategies recommended during the first two levels of recovery "pre-engagement" and "engagement/outreach" are those strategies utilized the most. With slight order differences between MHRTS and SATS, the three strategies ***Outreach, Trusting relationship,*** and ***Practical support*** make up approximately 80% of all of the strategies utilized.

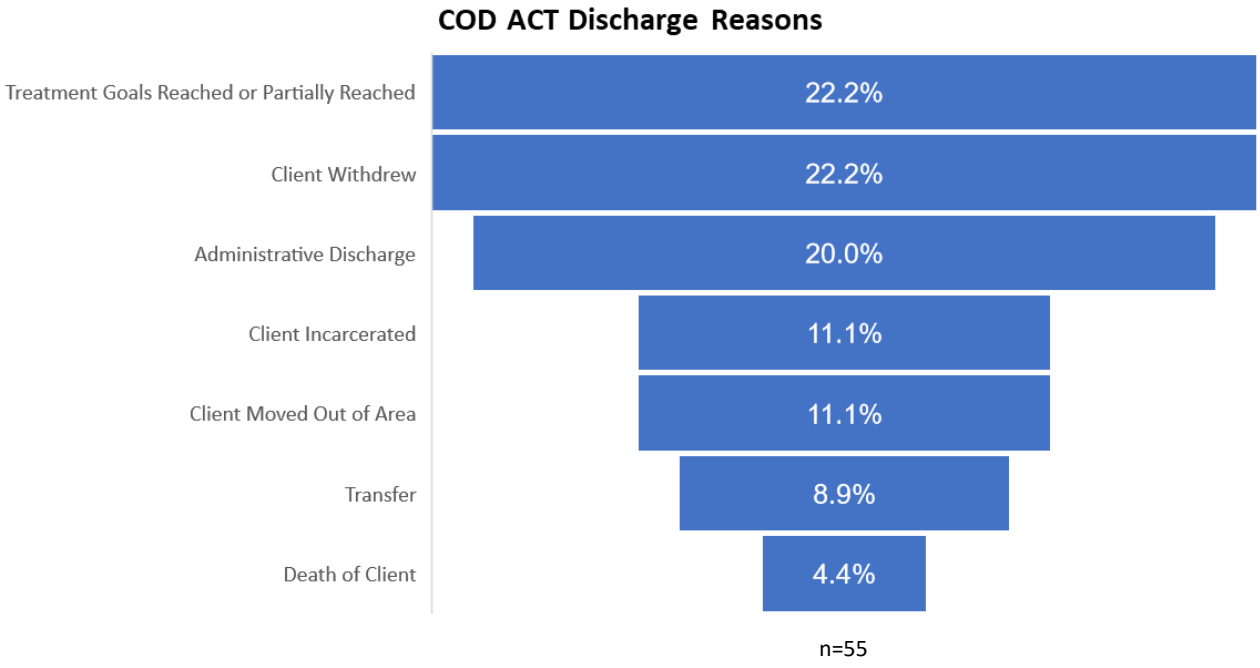
These strategies and interventions were at the core of team discussions. However, it was extremely clear that building relationships and rapport with clients are at the heart of this work. This theme was reiterated in both staff journals as well as the staff focus group. As one staff member aptly noted, "*Rapport is everything. No rapport equals no opportunity for intervention*." These tools also helped facilitate communication and collaboration so that the team could consistently be "on board" with appropriate interventions.

Outcome Data

Discharge Data

There was a total of 111 discharges from the COD FSP Engagement subunit and 55 discharges from the COD FSP ACT subunit during the Innovation project time period. As discussed previously, clients move in and out of the COD FSP for multiple reasons. For the Engagement subunit, 60% of the discharges were to transfer the client to another treatment or non-treatment program, administrative discharges (when clients were not present) accounted for another 8%, incarceration 2%, and death 2%. The client withdrew voluntarily 3% of the time and met goals another 2%. The ACT level discharges yielded the following results:

#17 Discharge Reasons



Data Collection and Reporting-Look Alike (DCR-LA)

As earlier stated, the primary reason this Innovation project was proposed was in recognition that the target population consists of extremely difficult to engage individuals with complex mental health and substance use disorders. Many of these individuals were already receiving services from other adult FSP programs but were not necessarily fully engaged in the services. About 23% (17) of the 73 clients who received services in the COD FSP ACT level during the project time period had previously been open to the ACT level of a different FSP. The goal was to compare FSP DCR data for these individuals to determine if the new combination of services, stage-based approach, and practices/processes would yield improved outcomes for these clients. Several issues, including missing partnership information and outdated data prevented an accurate evaluation. However, the data from the other FSP programs were compared to the aggregate COD FSP data.

The following are results for the 17 individuals enrolled in ***other*** FSP programs prior to the COD FSP. The average length of stay was almost 28 months in the previous FSP programs.

#18 Prior FSP Data

Outcomes for Other FSPs prior to COD FSP	
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging in the FSP (the baseline)	**Outcomes for clients in their first year in FSP** **n=17**
Jail Days	↑ **55%** (from 11 clients with 895 days to 10 clients with 1,383 days)
Homeless Days	↑ **102%** (from 10 clients with 2093 days to 14 clients with 4235 days)
Mental Health Hospitalizations	↑ **209%** (from 9 clients with 175 days to 12 clients with 540 days)

Data Source: DCR-LA EPLD Residence Report

As illustrated, there were increases in jail days, homeless days, and mental health hospitalizations for this group of clients. Although there was a decrease of one in the number of clients with jail days, the remainder of the outcomes were not positive. Below are the results of the COD FSP clients.

#19 COD FSP Outcomes

Outcomes for FSP clients for period of 4/11/2016 through May 31, 2019

COD FSP			
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging in the FSP (the baseline)	**Outcomes for clients in their first year in FSP** **n=37**	**Outcomes for clients in their second year in FSP** **n=18**	**Outcomes for clients in their third year in FSP** **n=4**
Jail Days	↓ **45%** (from 13 clients with 631 days to 5 clients with 349 days)	↓ **86%** (from 7 clients with 264 days to 3 clients with 37 days)	↓ **100%** (from 1 client with 90 days to 0 clients with 0 days)
Homeless Days	↓ **51%** (from 21 clients with 3,279 to 14 clients with 1,602 days)	↓ **99%** (from 7 clients with 1,150 days to 2 clients with 9 days)	↓ **100%** (from 2 clients with 241 days to 0 clients with 0 days)
Mental Health Hospitalizations	↑ **56%** (from 29 clients with 558 days to 19 clients with 869 days)	↓ **98%** (from 14 clients with 221 days to 3 clients with 5 days)	↓ **97%** (from 4 clients with 72 days to 1 clients with 2 days)
Arrests	↓ **63%** (from 20 clients with 41 arrests to 8 clients with 15 arrests)	↓ **65%** (from 10 clients with 17 arrests to 3 clients with 6 arrests)	↓ **100%** (from 2 clients with 2 arrests to 0 clients with 0 arrests)

Data Source: DCR-LA EPLD Residence Report

Of the 58 clients who agreed to be a "partner" and share their information/data, 37 clients were in the COD FSP ACT level for 1 year or more, 18 clients for 2 years or more, and 4 clients for 3 years or more. This chart includes the outcomes for clients in their first, second, and third year. All areas of outcomes showed improvement during each of the three years in the COD FSP. Although there was an increase in the number of mental health hospitalizations for clients in their first year in the FSP, there was a decrease in the ***number of clients*** with hospitalizations. The data also shows that the outcomes improve as clients are in their second and third years.

The following tables display outcomes during the same time period for the other Adult FSP programs at BHRS to compare to the COD FSP outcomes.

#20 Other FSP Data

FSP-01 Telecare SHOP			
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging in the FSP (the baseline)	**Outcomes for clients in their first year in FSP** **n=269**	**Outcomes for clients in their second year in FSP** **n=178**	**Outcomes for clients in their third year in FSP** **n=119**
Jail Days	↓ **24%** (from 61 clients with 2,666 days to 40 clients with 2,028 days)	↓ **27%** (from 38 clients with 1,230 days to 23 clients with 902 days)	↑ **21%** (from 24 clients with 791 days to 20 clients with 957 days)
Homeless Days	↓ **77%** (from 66 clients with 11,419 to 40 clients with 2,605 days)	↓ **80%** (from 44 clients with 7,397 days to 14 clients with 1,470 days)	↓ **86%** (from 27 clients with 4,407 days to 15 clients with 629 days)
Mental Health Hospitalizations	↓ **17%** (from 199 clients with 5,266 days to 139 clients with 4,380 days)	↓ **34%** (from 126 clients with 3,010 days to 62 clients with 1,985 days)	↓ **46%** (from 79 clients with 1,732 days to 38 clients with 938 days)
Arrests	↓ **32%** (from 70 clients with 133 arrests to 42 clients with 91 arrests)	↓ **61%** (from 44 clients with 93 arrests to 21 clients with 36 arrests)	↓ **53%** (from 32 clients with 59 arrests to 16 clients with 28 arrests)

Data Source: DCR EPLD Residence Report

FSP-05 Integrated Forensics Team			
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging in the FSP (the baseline)	**Outcomes for clients in their first year in FSP** **n=106**	**Outcomes for clients in their second year in FSP** **n=51**	**Outcomes for clients in their third year in FSP** **n=23**
Jail Days	↓ **69%** (from 84 clients with 7,448 days to 45 clients with 2,312 days)	↓ **55%** (from 40 clients with 3,973 days to 19 clients with 1,776 days)	↓ **62%** (from 16 clients with 1,535 days to 7 clients with 590 days)
Homeless Days	↓ **49%** (from 32 clients with 5,207 to 25 clients with 2,639 days)	↓ **45%** (from 11 clients with 1,457 days to 12 clients with 796 days)	↑ **114%** (from 3 clients with 297 days to 6 clients with 636 days)
Mental Health Hospitalizations	↑ **15%** (from 44 clients with 866 days to 43 clients with 995 days)	↑ **48%** (from 20 clients with 314 days to 18 clients with 464 days)	↑ **249%** (from 10 clients with 192 days to 7 clients with 670 days)
Arrests	↓ **48%** (from 84 clients with 204 arrests to 40 clients with 106 arrests)	↓ **55%** (from 38 clients with 94 arrests to 16 clients with 42 arrests)	↓ **67%** (from 16 clients with 48 arrests to 7 clients with 16 arrests)

Data Source: DCR EPLD Residence Report

FSP-06 High Risk Health			
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging	**Outcomes for clients in their first year in FSP** **n=154**	**Outcomes for clients in their second year in FSP** **n=91**	**Outcomes for clients in their third year in FSP** **n=64**
Jail Days	↓ **19%** (from 17 clients with 751 days to 9 clients with 610 days)	↓ **77%** (from 9 clients with 398 days to 3 clients with 91 days)	↓ **99.5%** (from 6 clients with 206 days to 1 client with 1 days)
Homeless Days	↓ **75%** (from 31 clients with 6,208 to 18 clients with 1,574 days)	↓ **90%** (from 16 clients with 3,529 days to 4 clients with 353 days)	↓ **99.9%** (from 11 clients with 2,205 days to 3 clients with 3 days)
Mental Health Hospitalizations	↑ **38%** (from 88 clients with 1,953 days to 56 clients with 2,694 days)	↓ **24%** (from 50 clients with 1,096 days to 19 clients with 837 days)	↓ **19%** (from 36 clients with 774 days to 15 clients with 629 days)
Arrests	↓ **47%** (from 17 clients with 30 arrests to 6 clients with 16 arrests)	↓ **60%** (from 8 clients with 20 arrests to 3 clients with 8 arrests)	↓ **100%** (from 5 clients with 11 arrests to 0 clients with 0 arrests)

Data Source: DCR EPLD Residence Report

FSP-07 Integrated Service Agency			
For each year of outcomes, the # of days/events/arrests is compared to the # of days/events/arrests for those clients 1 year prior to engaging	**Outcomes for clients in their first year in FSP** **n=168**	**Outcomes for clients in their second year in FSP** **n=157**	**Outcomes for clients in their third year in FSP** **n=147**
Jail Days	↓ **75%** (from 15 clients with 1,735 days to 11 clients with 430 days)	↓ **78%** (from 13 clients with 1,307 days to 6 clients with 294 days)	↓ **79%** (from 12 clients with 1,142 days to 4 clients with 237 days)
Homeless Days	↓ **79%** (from 20 clients with 2,174 to 14 clients with 467 days)	↓ **78%** (from 17 clients with 1,711 days to 5 clients with 371 days)	↓ **92%** (from 15 clients with 1,255 days to 7 clients with 100 days)
Mental Health Hospitalizations	↑ **38%** (from 73 clients with 2,989 days to 69 clients with 4,127 days)	↑ **1%** (from 66 clients with 2,635 days to 46 clients with 2,665 days)	↓ **48%** (from 62 clients with 2,479 days to 38 clients with 1,294 days)
Arrests	↓ **48%** (from 16 clients with 44 arrests to 11 clients with 23 arrests)	↓ **53%** (from 14 clients with 36 arrests to 8 clients with 17 arrests)	↓ **72%** (from 12 clients with 32 arrests to 2 clients with 9 arrests)

Data Source: DCR EPLD Residence Report

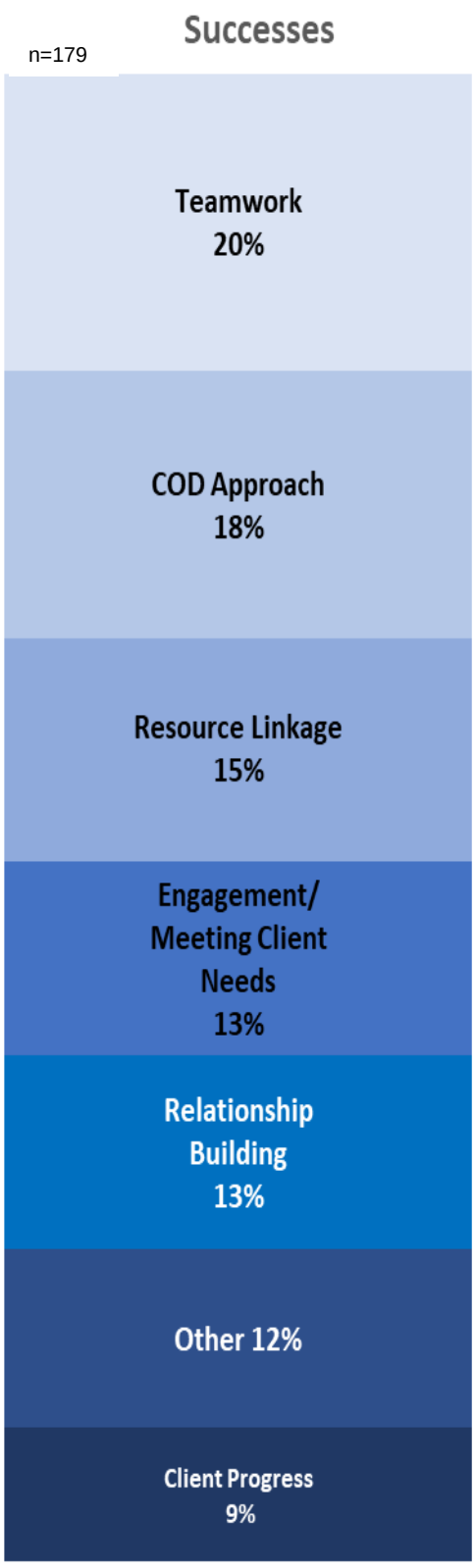
All of the FSP programs had positive outcomes in multiple domains during this time period. However, there are some differences in target populations (e.g., Integrated Forensics Team clients are those on probation and/or have frequent contact with law enforcement), as well as the numbers served. Each FSP program is specialized in specific areas to best serve particular client populations. As discussed previously, the Innovation Project was proposed to address a gap in the system for serving very difficult to engage individuals with co-occurring disorders. Those clients engaged in other FSPs prior to the COD FSP did not have the positive outcomes seen for the most part here. However, the COD FSP is showing promise serving this population with early positive outcomes.

Assessing Project Successes and Challenges Through Qualitative Data

An important component of the evaluation of this Innovation project was the consistent collection of feedback from staff from the initial stages of the Project throughout the three years. Staff were asked to provide this feedback through team “learning meetings”, journaling, and a focus group. They were consistently asked to reflect upon the learning questions of the project through each of these methods. Although discussions about specific clients and interventions were critical and occurred in other team meetings, the learning meetings focused on maintaining awareness of the different approach this Project was trying when working with the co-occurring disorder population. The critical concepts of meeting clients where they are and utilizing the stage-based approach for mental health and SUD concurrently were kept in the forefront of all of the work through these meetings. This was also a time when staff were encouraged to be open about what was working well in the Project and amongst the team, as well as what was not working as well. In order to have these intensive conversations, staff were expected to enter journal entries (see Attachment #6) weekly before the learning meetings to provide reflections about the learning questions.

During the incipient stages of the project, both the journaling and learning meetings were critical and quite useful in building awareness in utilizing a stage-based approach and keeping the learning questions of the Innovation project in the forefront. As the project progressed, the journaling practice diminished substantially, and many of the entries continued to be very similar in nature, with slight variations depending on the circumstances of the Project (e.g., staff turnover, higher caseloads, etc.). However, this practice illuminated key themes that were again confirmed in the staff focus group when the project ended. Staff were asked to reflect on their learning and any shifts in thinking while working in the Project. The request was to comment on successes, challenges, areas for improvement, as well as observations about practices/processes that were most effective for the team and clients. The following charts depict the major themes in each of the areas staff were asked to reflect upon. The theme “other” includes the comments/observations that were not easily categorized or were lone comments. Each section includes the total number of comments and the percentage of comments/observations that were part of each theme that surfaced. Examples of the journal entries for each theme are also included. When applicable, relevant discussions from the focus group (see Attachment #3) are added for additional insight into the staff’s thoughts and observations about the Project and work.

#21 Qualitative Success Data



- "As a team we have learned to communicate better, which benefits everyone. Being responsive to team and personal needs has helped a lot. We regularly link with SRC and other agencies (especially methadone clinics and housing support services), and keeping those relationships open and healthy have been a benefit to us when linking clients to needed services."
- "I liked getting suggestions from team on how to engage client like enroll client in literacy program, connecting with facilitating groups at Empowerment Center."
- "Working as a team to an agreed upon outcome for clients. Asking for input from team mates as ways to improve outcomes."

- "Observing client as a whole person, not just a "substance user" or mentally ill – it's an 'and' not an 'or'."
- "Validating client strengths, reframing negative views of self, combined with consistency of staff supports and hope in client recovery."
- "I liked how we are working towards always remaining client centered and meeting the client where they are at."
- "Viewing client from family systems as important as MHRTS/SATS & stages of change."

- "Connecting clients to needed services in the community and supporting them to follow through."
- "Meeting clients where they are at and getting them to Doctors to get needed medications. Connecting clients to SRC from psych hospital."
- "Our clinicians taking the initiative and scheduling our clients for therapy, as there was a disconnect in the past."

- "The team worked with consistent thoughts, beliefs, perceptions of co-occurring disorders to meet client needs and engaged clients on agreed upon goals through positive relationship with client."
- "Outreach and engagement of COD is a priority. We get people into treatment."
- "Staff was able to get client to lab appointment. Client was unable to do it on her own. Helping to establish trust with client. When client was nervous about getting blood work done and normalized client's feelings."

- "Being present in client's life, and having time to support client needs."
- "Validating clients is effective in gaining trust."
- "Build rapport to develop relationship that fosters trust with client."
- "Although some clients appeared stressed/ frustrated at times, it seemed they trust the team to help them through."

- "I'm realizing co-occurring disorders require a lot of support from the family."
- "Housing first for client at Garden Gate."
- "Having the ability to do a collateral with family members and client."

- "I felt successful when I was with a client. Having a conversation with him and being able to get him to laugh and smile. After all of the consistency of working with the client and being able to help him into his apartment."
- "Observing client take his medication daily and see him get better."

In the area of “Successes”, the most predominant themes were in the areas of teamwork, the different approaches the Project was utilizing, and linking clients to resources. Engagement and relationship building, which seem to go hand-in-hand, were also prevalent. Staff reflected often about the importance of working closely as a team, listening to each other (really “hearing”), and supporting each other in their work. They realized that this work is not for lone individuals, but for a “community” of providers.

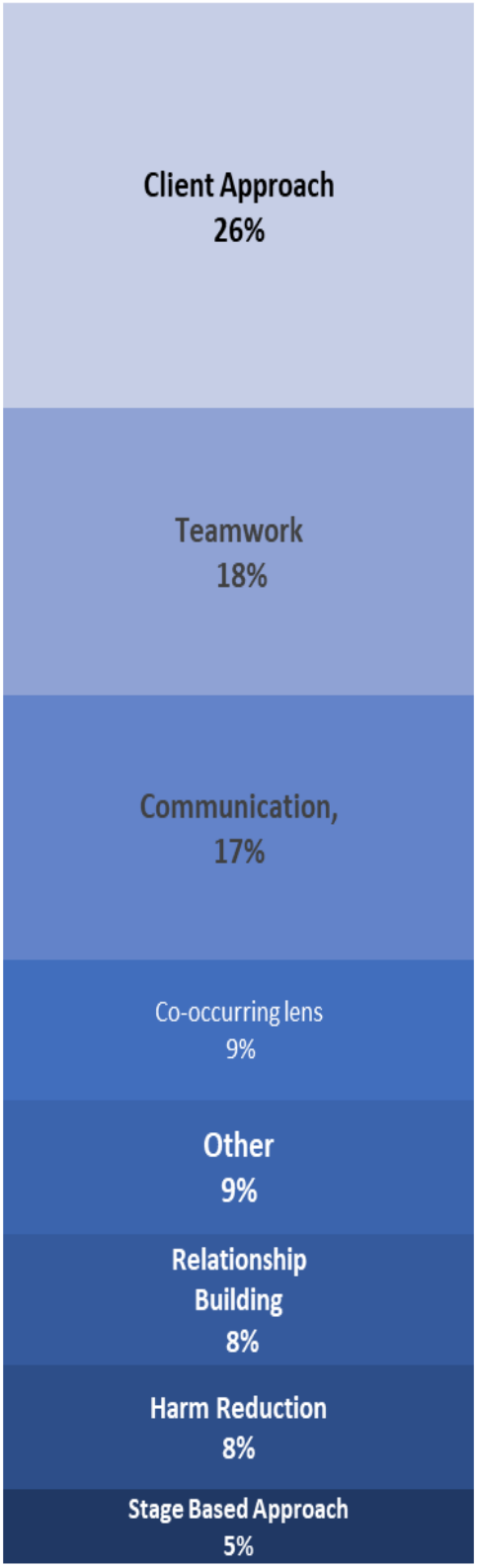
The staff focus group also supported this philosophy, reiterating the importance of team dynamics and being able to trust and rely on one another. To reinforce this, team relationships need to be attended to and nurtured. The daily team meetings and weekly learning meetings allowed for increased communication opportunities among disciplines, sharing of multiple perspectives, and cohesiveness. Case consults and planning also allowed for staff to adjust to clients’ needs. The learning meetings also reinforced the team’s shared vision and tenets of the Project, and encouraged the team to remain focused on the innovative approaches expected to improve clients’ lives. The meetings served as a reminder of the purpose of the work. Staff also shared that the learning meetings helped structure the Project, aiding staff to stay aligned with the goals of the Projects, stating “Interventions would be different if the goal was clear instead of focusing on just putting out fires [crises].”

Staff also reflected often on the COD FSP approaches that were central to the Innovation project. The use of the stage-based approach through a co-occurring lens, meeting clients where they are, and a more “whole person” foundation yielded successes in working with clients and a real commitment to keeping these approaches the focus of the work. Staff found that these approaches provided this hard-to-engage population a sense of dignity and respect, which went a long way in building trust and relationships, ultimately leading to progress for the client. Within these approaches is the core belief in dignity and viewing the client as a person rather than a diagnosis. Critical to dignity and respect is to reserve pre-judgment and hear an individual’s story, as well as believing in his or her capabilities.

#22 Qualitative Practices & Processes Data

Practices & Processes

n=181



- "Exploring clients aspirations rather than assuming client desires. Encourage!."
- "Client centered and strength-based combined with patience and hope for client personal discovery and commitment to recovery/wellness"
- "I have changed my own views & try to view through a new lens, not past experiences with the same clients."
- "Meeting clients where they are at. Keeping an open mind and listening to clients needs."
- "Understand: practice the process of identifying client moments of clarity rather than following psychosis (Draining). Remember to remain with client in the present instead of focusing on symptomology."

- "Team meetings/client consultation from multi-disciplinary team is effective."
- "Team meetings and effective communication has been working."
- "Communication and teamwork are essential- we need one another as these difficult clients will increases burnout."
- "Team building - e.g. telling each team member what you see is a strength and how that effects clients & team alike."
- "Team meetings focusing on each team members perspective of each client and how they are engaging ongoing support and relationships."

- "Team continues to strengthen communication. Team is building stronger relationships with community partners."
- "I feel the learning meeting is a great place to have effective communication due to feeling like a safe environment…"
- "Frequent contact with clients & community providers promote effective communication & overall continuum of care."
- "Open communication during team meetings. I was able to share what was bothering me."

- "Co-Occurring lens. Person centered. Build relationships, high level of outreach and engagement. Stage based approach, go the extra mile."
- "Keeping the co-occurring lens focus; effective, respectful and assertive communication."

- "High fidelity = following the model as closely as possible assertively."
- "Being consistent across staff practices/process as it applies to each client individually."
- "Working with these clients is more about the process than the outcome."
- "Learning more about practices and processes so I can better service clients."

- "Working on relationship to get client to open up and take the opportunity to use clients' willingness to engage in treatment."
- "Good neighbor policies with community agencies/resources."

- "Meeting client where they are at. Using/clean harm reduction and looking towards a new way of living. Assisting clients with identified needs."
- "Harm reduction, keeping an open mind, supporting client even if they make poor choices."

- "[Using the] learning meeting and actually using the MHRTS & SATS to track where our client is at."

In the area of “Practices & Processes”, the most prominent themes were the changes experienced in communication and teamwork. Most of the staff reflected consistently about the benefits of intentional efforts to bolster effective communication and teamwork. In particular, the regularly scheduled team meetings allowed staff to share progress as well as struggles. However, every meeting was not without conflict. The intentionality of supporting each other, being accountable to one another, and feeling safe to have an open dialogue have provided an environment for this team that has made a difference. A meeting specifically dedicated to “learning” for the purpose of this project has been a stimulus for deeper conversations and non-judgmental exploration. The meetings have also kept the “co-occurring lens” and stage-based approaches in the forefront, reminding the entire team of the focus. Staff shared that this intentionality helped them help their clients. As one staff stated, “*Communication and teamwork are essential – we need one another as these difficult clients will increase burnout*” and “*Discussing at length clients individually helps team meet their needs. Being able to help them with needs helps our clients be more successful.*” Building trust through communication and team building amongst staff proved to be just as important to the success of the Project as building trust with clients.

Another practice that worked well for the COD FSP was utilizing a harm reduction philosophy. Staff observed that the more consistent clients were with mental health medications, the less their drug use affected their functioning. It was recognized that clients ***can*** be treated successfully while still using.

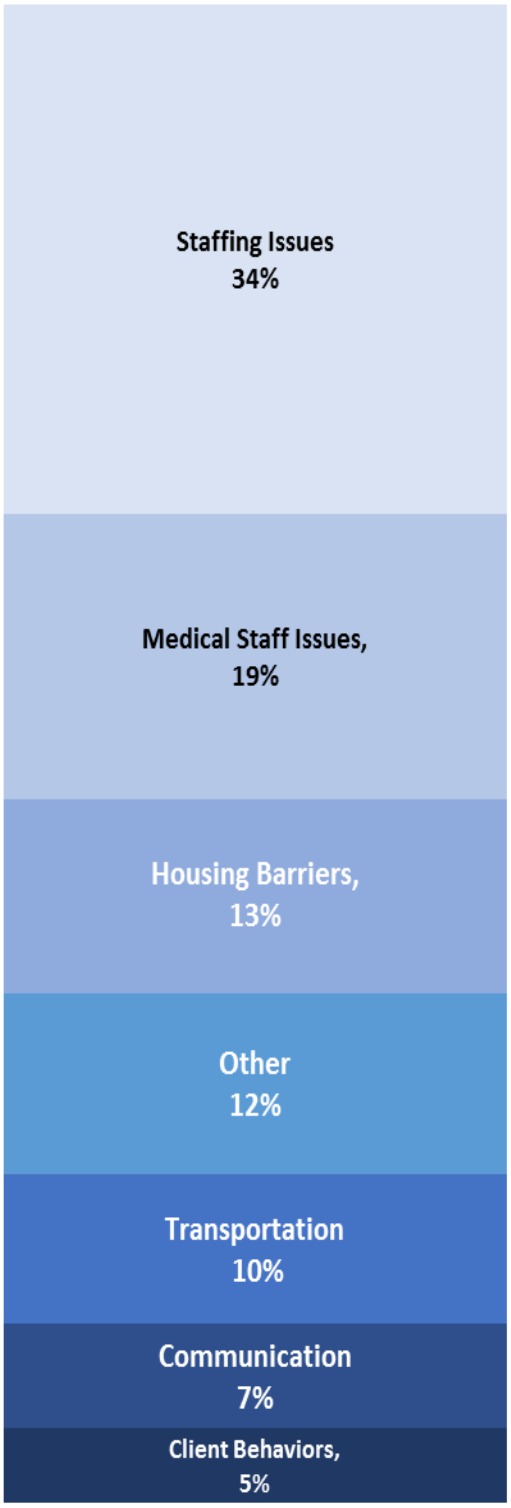
Of note is that this area of comments diminished after the first year of the project. During the first six months especially, staff wrote about how the team was developing good communication and a safe environment for sharing. The comments continued to be consistent, and it seemed that working and meeting together in the way that was established from the beginning became the norm rather than a “different” practice. It became a natural part of the Project.

The staff focus group confirmed this information. Staff related that this was a key element to a program that serves this population. Being accountable to one another and trusting each other is critical, and very palpably benefits the clients. As a staff member aptly expressed, “*I am noticing when the team’s communication is strong client services improve*.”

#23 Qualitative Challenges Data

Challenges

n=281



- "More staff needed to accommodate the number of referrals for FSP/eval of co-occurring."
- "Case load rising-1:10 ratio has not enough time to engage at level needed."
- "Staffing issues/no clerical."
- "1:10 case load ratio versus workload. Lack of staff negatively impacts resources to assists clients & whatever it takes approach."
- "Too many referrals coming in for engagement."
- "Not being fully staffed."
- "Not enough staff to transport clients due to having clients that require two staff."
- "There are things that HAVE to be done - not enough time to do indirect time - no hard requirements re: engagement."

- "Not being able to integrate primary care. No psychiatric nurse, difficult to obtain needed services."
- "This week was difficult not having a psychiatrist in-house and a regular RN to assist with clients who may have primary medical issues more so than mental health."
- "Not having access to a medical doctor to help facilitate referrals to appropriate services to meet client needs. Difficulties getting client established with a PCP and the several month wait before they go to see the doctor."

- "Not enough housing at all levels of care."
- "Housing and placement barriers, respite."
- "Not having enough housing for clients. We work with hardest to engage clients. They burn out of placement and it's hard to place them."
- "Being a housing first program and with minimal housing for our clients."

- "Other programs not allowing our clients the opportunity to have a second chance."
- "Adding program to building changes populations/environment of the building."
- "Inhibited to use wrap around funds in a way that allows a client to obtain a reward that they want to engage."

- "Transportation remains an issue because our clients are not always able to use public transportation to get to their appointments. Most do not have private transportation. They rely on our transportation, however staff have to engage with other clients, transport clients to various appointments or groups, and facilitate the groups."

- "Staff become stressed, communication reduces."
- "When other programs release clients & fail to properly notice the team."

- "A client called for 2 weeks straight, cussing me out and saying inappropriate things."
- "Clients' poor follow through due to learned behavior."

In the area of “Challenges”, the most prevalent theme was not having enough staff. Fully staffed, the Project consisted of a program coordinator, a psychiatrist, a nurse, a clinician, three behavioral health specialists (BHS), an administrative clerk, and volunteers. There were several times during the three years that these comments diminished substantially as these were the times that the Project was fully staffed. Throughout the duration of the Project, the level of staffing, as well as staff turnover, impacted the team in terms of morale and their sense of success. As previously discussed, teamwork, trust, relationships, and communication are critical to this Project’s success. Staff shared that when the COD FSP was not fully staffed, it was not possible to spend the time building upon or even maintaining these areas as the time was dedicated to directly serving the clients.

Amongst the various staffing changes during the three years, the program coordinator was a very stable component of the team. This stability helped maintain the consistency of the Project focus and learning. This leadership remained steadfast to the learning objectives of the project, and to the support of the team to serve clients with quality and integrity. Team members observed this through their journals as well as during the focus group. One staff stated, *“…[the coordinator] should be very proud of the accomplishments of the program.*”

Although the clinician role was always staffed, at times it was the coordinator who covered the position. There was a turnover of four clinicians during the time period, some for very short periods of time, and this affected team cohesiveness and continuity. There was also a period of time when the Project didn’t have a clerical staff member. This also affected the flow of the Project, continuity of scheduling, and consistency of contact for clients. The BHS role was quite consistently staffed with some turnover. The Innovation Project was viewed as an opportunity and positions were often filled by transfers within the department. Both men and women, as well as bilingual individuals staffed these roles, and the clients benefited from being matched well with a BHS. Again, the coordinator filled in when the team was without one of the BHS staff due to the critical nature of the role.

The psychiatrist and nurse staffing was perhaps the most challenging, and probably had the greatest impact on the Project. For over 50% of the project period, there was not a consistent on-site psychiatrist, and at all phases of the Project there was a time period without one. There was always coverage through other programs, but according to staff, not having a psychiatrist on the premises diminished the effect of the Project. In addition, it was critical to have a doctor who was aligned with the ACT model and with the stage-based, co-occurring disorder treatment philosophy that uses the harm reduction approach. The absence of a doctor with a harm reduction approach during some time periods of the Innovation Project did affect the team and Project. There was also a turnover of six nurses, which also affected the team and the clients. As stated multiple times, consistent interaction and time with other team members and clients are critical in building trust, relationships, and yield better outcomes.

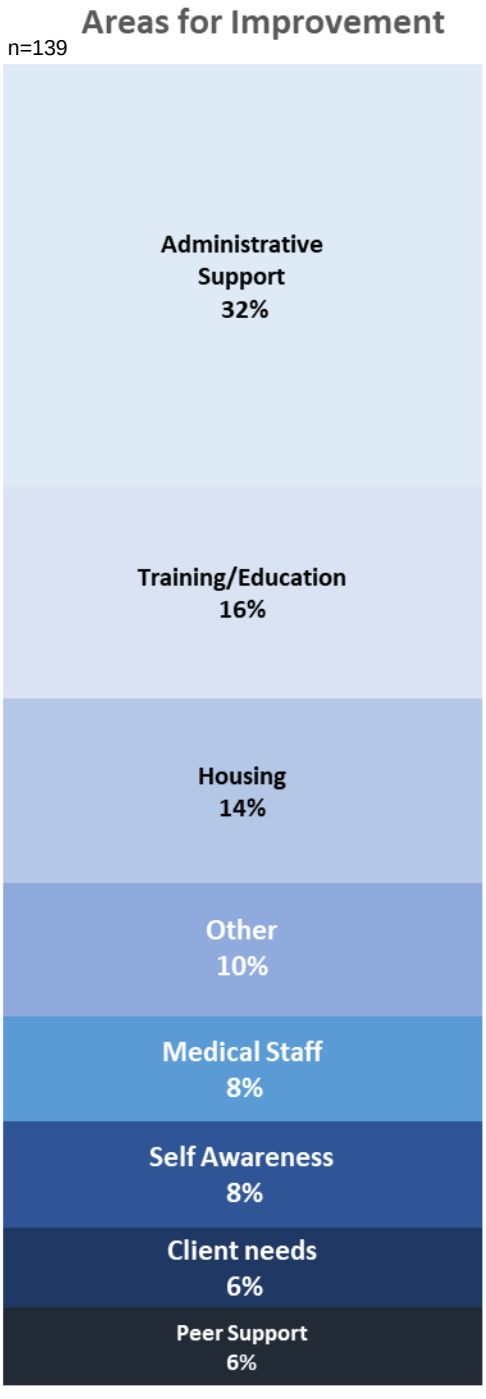
Although this section is dedicated to staffing challenges, it is important to discuss volunteers here. There were seven volunteers during the project, two of which became part-time staff. Both men and women volunteers were a huge asset to the Project and assisted in multiple ways (e.g., transporting, peer support). During the focus group, the staff commented on how valuable the volunteers were for the success of the Project.

Even during the times that the Project was fully staffed, there were still concerns about how the work with this population is so time intensive, and a lower caseload would make a substantive difference in client progress. According to the Project leadership, staff to client ratio of 1:7 was

ideal, 1:8 or 1:9 could be managed, but 1:10 and above was not sustainable for staff or optimal for clients to sustain progress or increase positive outcomes.

As a "housing first" Project, another major challenge was the lack of housing options. Staff observed that they worked with the hardest to engage and hardest to place clients, so finding housing in an environment of housing shortages to begin with, was a frustrating issue.

#24 Qualitative Areas for Improvement Data



- "[Upper administration] can listen to staff perspective on needs of clients and staff."
- "Coordinators need to focus on clinical needs of highest risk population and needs of staff who burn out w/this population the focus should not be on outside meetings."
- "Support/benefits/pay raise for direct line staff to avoid service interruptions (ie: strike, raise staff turn over)."
- "System doesn't acknowledge or incentivize engagement."
- "Getting notes in on time."
- "Building space for teams/client interaction to feel safe /welcomed."
- "[Recognizing] progress not perfection."
- "Follow up and getting paper work completed."
- "[Support for] better time management."

- "Whole system education regarding co-occurring treatment lens."
- "Clients are discharged from programs- SRC, Respite, other programs due to behavioral issues with lack of understanding those symptoms and behavioral issues are the reason in which client is in program."
- "New staff [need] understanding/learning of ACT Model."
- "[Need for] increased training."

- "[Need] more resources for board & cares."
- "Housing first vs. harm reduction…Housing first site dedicated to this population."
- "I continued to advocate for the clients to receive…even though they've had conflicts at programs, regarding relapses."

- "Consistency in engagement across the system. Integrating families with client care. Location being far from… areas clients frequent-inconvenient for clients."
- "The lens our community view this population through can improve, Viewing with an open mind and not by past experiences."

- "Ability to maintain [psychiatrist] for continuity of care."
- "[Need] flexibility of doctor (late appointments, switching [appointments]."
- "[When] nurse is on site [it]…makes getting clients to appointments more efficient and collaboration more effective."

- "Keeping an open mind, listen to other peoples' views, don't defend position but roll with the challenges of situations."
- "I learned to become more self aware if my belief system and not cause it to be a roadmap for our clients."

- "[Important to] always ask clients if there are needs that program hasn't identified or how program can meet client needs that vary from program."

- "I feel clients would be more successful if they had support from people who have mental illness and substance abuse problems."

Staff also reflected upon areas to improve upon. Given that this Innovation Project focused on learning, staff were keenly aware that there were always areas for improvement in the Project itself as well as personal growth and development. Many areas for improvement were already discussed under challenges, and reiterated here.

“Administrative Support” encompasses support from the department and leadership, as well as the capacity for administrative duties like paperwork. Staff commented on the desire for the department to better understand the work of the Project and how difficult, and sometimes frustrating and tiring it can be. Staff shared that being “on call”, both formally and mentally can lead to “burn out” if staff are not broadly and directly supported. There is also recognition that although documentation is very important, it can be quite stressful juggling that amidst crises and intensive time spent with clients.

“Training/Education” includes Project staff training as well as training and educating the whole department, system, and community. Understanding the issues confronting the people with co-occurring disorders is imperative to non-stigmatizing care and treatment both through service provision and in the broader community.

Two areas that were also covered through the challenges section are lack of appropriate housing and having consistent and flexible psychiatrists and nurses. Again, as “housing first” is a primary tenet of the Project, it is critical to have resources for housing. It is especially difficult to place these clients since many have “blown out” of housing or have had negative experiences. As the medical staff are also a critical component of the Project, consistency and flexibility are key.

Meeting client needs will always be a part of improving a program. Staff have identified that increased peer support, especially through peer groups is an area that could be improved. In addition, garnering client feedback through 1:1 conversations, as well as more formal methods is a way to improve.

During the focus group, similar issues surfaced. Staff also discussed the difficulty of tracking data consistently and how paperwork could be overwhelming while providing quality services to a hard-to-engage population. The team agreed that with increased numbers of referrals, there was much less time to do the critical reflection work. It became more difficult to have intentional and focused discussions about vision, goals, and gaining multiple perspectives about interventions using the stage-based approach from a co-occurring lens. Increased client needs led to decreased relationship building and communication amongst staff members. The 1:8 staff to client ratio seemed to be the right ratio for the best quality service for this population due to the support and attention for the staff to do their best work.

What was Learned

Were clients successfully engaged by receiving a combination of services through this new FSP?

The data detailed above demonstrates the level of engagement and success clients have experienced during this Innovation Project. Charts #3, #4, and #5 illustrated how many clients were engaged, at what level, and with what services. The services were a combination of mental health, SUD, psychiatric and medication services along with housing, community resources and other referrals. Chart #7 showed how a small proportion of clients received a large proportion of services, indicating more intensive engagement, and Chart #8 provided information about clients' engagement in SUD services. The length of stay in the COD FSP depicted in Chart #9 was also an indicator of engagement, but not as lone data; successful linkages and outcomes in conjunction with this data were the better indicators. The MHRTS and SATS tools also provided some evidence of successful engagement as clients moved along the recovery stages.

Probably the strongest theme that emerged regarding the successful engagement of clients is that this population takes ***time*** to engage. Staff have consistently shared prior to treatment services, and even prior to more formal conversations, they spent a considerable amount of time and energy finding and engaging with individuals. Building trust and relationships were the key to successful engagement. During the focus group and through journaling, words such as **Persistent, Consistent, Rapport, and Time** spoke volumes in what was needed to engage with individuals. One staff exclaimed, "*Never give up on building rapport and relationships. You need to take the TIME to build and you can't believe what can happen!*" Another stated that building rapport is about "everything and anything"; it is not just treatment. In this Project, staff met clients where they were and being a "provider" alone didn't work.

Did using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?

The Innovation Project team utilized the MHRTS and SATS to anchor the focus on stage-based treatments for both mental health and SUD concurrently. Overall, staff indicated that this approach and the tools helped bridge the relationship with clients, meeting them where they are and determining how staff could help at whatever stage they associated with. Being able to work on both mental health and SUD issues concurrently also resulted in stability for the clients. They did not need to go to another provider completely, and were able to sustain the relationship already built with the COD FSP staff.

Another benefit with stage-based treatments in the COD FSP is that the doctors were comfortable with a client still using drugs, and were willing to treat them "where they were" – they did not need to be completely free of drug use. Staff were very positive about the benefits this provided clients, including decreased stigma and being able to decrease their drug use as they started feeling better with medication. The doctor was able to do this because of the close teamwork – the team was watching out for the clients and helped monitor their status. Staff went out every day to support clients to fully participate in the treatment prescribed, including

taking medications, attending meetings, etc., and this allowed the doctor the confidence in prescribing psychiatric medications.

The stage-based approach also assisted in the differentiation of symptoms, and allowed for extra support in specific areas. Being in tune with the stages led to different expectations for different individuals based on their stage for a more individualized treatment. Although the MHRTS and SATS helped with a stage-based focus, staff found that it was more about viewing individuals through a co-occurring lens and less about the tool itself. Even so, the data from the MHRTS and SATS in conjunction with the DCR-LA outcomes shows promise for this approach.

What engagement strategies and interventions emerged from this concurrent stage-based approach that were most effective for this population?

Data in this report supports that the pre-engagement and ultimate engagement with clients through the building of trust and relationships were the most effective strategies that emerged. With relationships and time, engagement became an invitation rather than coercion. Although this is not a new concept, according to staff, the extent to which it made a difference for client progress was phenomenal. Through the flexibility of the Innovation Project, staff recognized the impact of doing "whatever it takes," using the team approach with clinical judgement, accountability, and supervision. One staff stated that the idea that you can't work harder than the client is not true – it is expected and necessary at this level, and that staff wear many hats to meet client needs for success. Another powerful statement was, "*FSPs live in the grey – nothing is black or white. We can miss opportunities if they did [function as black or white].*" Staff also shared that it was most effective in working with this population to "push boundaries" while grounded in clinical practice and implemented ethically.

Charts #13, #14, and #15 illustrated which strategies/interventions were utilized the most and which strategies/interventions were utilized for the greatest and lowest percentages of clients. It was quickly recognized that many clients in the COD FSP were in the very early stages of recovery, and therefore the first several strategies were the most effective. Staff felt so strongly about the importance of effective outreach and engagement that a document was created to explore and specify what were (and were ***not***) powerful outreach and engagement techniques, and the skills necessary to put them into action (See Attachment #15).

While utilizing the concurrent stage-based approach, what practices/processes were most effective from staffs' perspective?

Several strong themes emerged from this Innovation Project related to practices and process that were most effective for the FSP co-occurring population. The first was the importance of teamwork and excellent communication while utilizing the concurrent stage-based approach. The second was the critical need to build relationships and rapport with clients (and potential clients), and this takes time and persistence. These themes were discussed in multiple sections of this report, but perhaps cannot be emphasized enough. Other practices and processes included fidelity to the ACT model in conjunction with the focus of the project, as well as regular meetings that kept the vision and mission of the Project at the forefront. These meetings allowed the Project staff to share experiences of what worked, using some trial and error based on meaningful discussions. As clients were seen in the early stages of the Project, the vision became more crystalized, and learning and understanding increased. The staff felt

like they were creating their “own lane”, using new “whatever it takes” concepts and exploring what did work.

Support from leadership and taking care of self and each other to prevent “burn out” were other practices that staff found critical. As more referrals and clients came into the COD FSP, there was less time for formal meetings and the learning and support became less formal but still present. Complex clients made it more challenging to focus on the formal learning plan, but it became even more critical to share caseloads, overlap roles, and remain supportive and accountable to the team. Text threads and GroupMe were also methods of communicating with the entire team at once to keep everyone “on the same page.” Overall, the practices and processes that maintained or built teamwork, communication, and relationships within the Project were the most effective for staff. Intentional and attentive time with clients which led to trust and relationships ultimately led to increased progress for both mental health and substance use issues.

Did access to integrated primary care positively affect outcomes?

This was a part of the project that did not develop as planned. There were challenges integrating primary care that could not be overcome for the purpose of this Project due to the unavailability of primary care providers. It should be noted that staff did connect clients with primary care whenever possible. They also recommend integrating primary care if at all possible for this model.

Did employing an integrated “Housing First” approach positively affect outcomes?

This was another area that was extremely challenging. The staff did take the “Housing First” approach whenever possible, but it was evident that the lack of housing in our county limited the staff’s ability to implement this approach fully. Staff continuously commented in their journal entries and during the focus group about the frustration encountered while trying to place clients in suitable housing. Often the staff encountered challenges when clients had already “blown out” of housing. Staff did whatever they could to work with the community and other agencies to bolster the COD FSP reputation and relationships so that clients might receive a second chance with housing.

However, when housing was available, this was a critical component to the success of clients. Stabilization of housing and meeting basic needs were foundational to moving forward in recovery stages. As illustrated in the DCR-LA data (Chart #19), homeless days decreased 51% in clients’ first year of the Project (37 clients), and the number of clients homeless decreased from 21 to 14. During clients’ second year (18 clients), homeless days decreased 99% dropping to 9 homeless days for 2 clients. During clients’ third year (4 clients), no homeless days were experienced.

Did co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

There were certainly advantages and benefits to being co-located on an SUD/co-occurring treatment site, Stanislaus Recovery Center (SRC). Staff cited the following: "*We regularly link with SRC…and keeping those relationships open and healthy have been a benefit to us when linking clients to needed services*." Staff also shared that follow through was easier and better, allowing for easy access both ways (SRC and COD FSP). In addition, when clients received treatment, being on the same campus allowed staff to continue to support clients, visiting regularly to maintain the relationship and trust that was essential to engagement and continued success. Moreover, the "Campus" knew the clients, creating familiarity and communication. This also prevented the need to call law enforcement at times. Peer support also was more convenient. Peers provided support at the COD FSP in a safe, comfortable, and non-stigmatizing place.

However, as the Project progressed, there were also unexpected challenges. As noted by several staff, SRC staff turnover made it difficult to maintain relationships with providers. Also, when BHRS implemented the Drug MediCal Organized Delivery System (DMC ODS) during the last four months of the project, staff noticed SUD changes that made treatment flexibility less accommodating for the COD FSP clients. They experienced changes in treatment processes which they felt made it more difficult to accommodate clients. For example, according to the COD FSP staff, the increased structure of SUD services has negatively impacted the assessment wait and clients may no longer be interested or cannot be found. In addition, when caseloads increased, time for engaging other SUD providers was limited so relationships were not maintained as well. This change can be attributed to the regulatory requirements to track timeliness of service and the SUD Services System of Care enacting a new care coordination team. This situation has already improved as DMC ODS continues to develop and processes have become smoother.

The site environment also changed with the implementation of DMC ODS. The Care Coordination Team (CCT) was co-located in the same building, and created some challenges with space issues. As the lobby was shared, the environment changed with the mixed clients, and the COD FSP clients found that they couldn't "hang out" comfortably any more as the feeling of safety decreased. Also, before sharing building space, COD FSP staff worked in more informal ways, such as through naturally occurring conversations to help reduce barriers.

Another challenging issue was integrating clients who were still using drugs and alcohol into SRC's residential program, which is abstinence based like all other residential SUD programs. SRC programs offered a Harm Reduction outpatient group for those not ready to fully abstain from substances. Although this was an option, COD FSP staff found that clients were more successful working with staff more skilled in interventions for severe mental illness along with substance use disorders. These groups did take place through COD FSP, but there were not enough staff or clients to offer them consistently.

Recommend this Project to Others?

This project is recommended for others to replicate. Many of the lessons learned were discussed throughout the report, but one area that should have more attention when considering implementation is the integration of SUD services within the FSP program. As stated earlier, there were two subunits (components of the Project) set up for SUD assessments and treatment to be able to fully address both mental health and SUD treatment needs within the one FSP program. The leadership of the Project found that the regulatory requirements around assessing individuals for SUD treatment were too stringent for this population as the treatment plan was only valid for 90 days. In addition, there were not enough clients at one time or staff to create a more robust SUD treatment component within the COD FSP. Therefore, the program utilized adjunct services through the co-located SRC. The COD FSP did utilize a harm reduction model and created groups to support the model.

When the project was set up as a co-occurring FSP, it was meant to be an integrated ACT model. However, from the beginning, it was separated by subunit due to the billing and treatment services structure. It is a bifurcated system and separately funded, making a pure FSP program very difficult to accomplish. This Project found that even the billing system alone made the FSP ACT level “clunky” rather than fluid. The separation on paper also does not encourage staff to view and treat clients as a whole as the systems requirements are quite different (e.g., treatment plan interval differences). The conclusion that the Project leadership made is that mental health and SUD must be fully integrated in requirements and practice for the co-occurring population to be most effectively treated.

Another very important part of implementation to consider is the hiring of staff. Due to the importance of teamwork and communication, as well as the population served with intensity, the hiring decisions are critical. The work is not for everyone, and it takes an individual with a passion for the work, and being comfortable taking some risks with good judgment and support to be successful. When a staff member is not a fit, it not only takes a toll on the individual and could impact clients, but it significantly affects the team dynamics as well. The team had a strong commitment to the clients and shared the mantra, “Never give up hope as so many do – you can always make a difference.” It is critical that all staff share that philosophy.

Continue this Project Under a Different Funding Source?

During the Representative Stakeholder Committee (RSCC) meeting that was held on February 1, 2019, stakeholders were provided with an overview of COD FSP operations and data through a PowerPoint and interview style presentation (see Attachment #16). As part of this RSCC meeting feedback was gathered to not only evaluate the meeting but to determine if participants understood the content provided; obtaining feedback is a consistent part of the RSCC process. Participants at this meeting were provided with a Learning and Feedback Form, and comments that were collected through this form indicated that stakeholders wanted to continue funding the COD FSP.

Following the February 1, 2019 meeting there was a concentrated effort by BHRS staff and leadership to ensure that funding could continue to support COD FSP. At this time the 2019-2020 Annual Update was being developed and continuing the COD FSP could certainly be part of that planning.

On March 19, 2019 an RSCC meeting was held to review the 2019-2020 Annual Update. As part of this update review it was announced that the Co-Occurring Disorders Innovation Project that was originally funded through Innovation dollars would continue to be funded as a Full-Service Partnership Program under Community Services and Support. Learning and Feedback Forms were distributed once more and the feedback from the form was extremely favorable.

The MHSA Annual Update for 2019-2020 reflects the COD FSP program funded under CSS in the funding summary of the plan.

Materials Developed to Communicate Lessons Learned and Project Results

This report will be posted at www.stanislausmhsa.com. At the end of the Innovation Project, a presentation of data and results was presented to stakeholders. Stakeholders were given the opportunity to ask questions or clarify any information. No other reports, manuals, or materials were developed.

ATTACHMENT 1

FSP Co-Occurring Disorders Project
Weekly Summary Sheet

Name:	**Week of:**
DOB:	**Staff Provider Name:**
Case #:	

1. Other referrals made (Successful Engagement in Communities of Support):

Type	Referral Code(s)	Date(s) followed up with Client	Follow-Up Outcome Code(s)	Follow-Up Outcome Codes
☐ Self-Help/Outside Groups				1. Could not contact 2. Did not follow through 3. Appointment made 4. Engaged at least once 5. No program openings 6. No program available 7. Still engaged 8. No longer engaged 9. Successfully completed
☐ Community Resources				
☐ Healthcare (In-House)				
☐ Employment				
☐ Shelter / Housing				
☐ SUD Services				
☐ Other: _____				

2. MHRTS:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

MHRTS Intervention Used: _____ **Successful:** ☐ Y ☐ N

MHRTS Intervention Used: _____ **Successful:** ☐ Y ☐ N

MHRTS Intervention Used: _____ **Successful:** ☐ Y ☐ N

Comments:

3. SATS:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

SATS Intervention Used: _____ **Successful:** ☐ Y ☐ N

SATS Intervention Used: _____ **Successful:** ☐ Y ☐ N

SATS Intervention Used: _____ **Successful:** ☐ Y ☐ N

Comments:

Still Open: ☐

FSP Co-Occurring Disorders Innovation Project

Facilitated Group Learning Debrief
November 6, 2019

Agenda
I. Introductions
II. Background/Overview of Innovation Project – Why are we here?
III. Learning Questions
IV. Facilitated Group Learning Discussion

Innovation Project Learning Questions
1. Will clients be successfully engaged by receiving a combination of services through this new FSP?
2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?
4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?
5. Will access to integrated primary care positively affect outcomes?
6. Will employing an integrated "Housing First" approach positively affect outcomes?
7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

Primary Purpose: Increase the quality of services, including better outcomes

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

Mental health treatment providers in Stanislaus County are seeing a great proportion of people with severe mental illness and co-occurring substance use disorders (SUDs). These co-occurring SUDs are substantially interfering with the effectiveness of their clients' mental health treatment. In Fiscal Year 2013/2014, 61% of adult Full Service Partnership (FSP) clients received a substance abuse/dependency diagnosis. While all adult FSPs work with this population and should have the capability to diagnose and treat SUDs (e.g. IDDT), there are some individuals for whom the extreme extent of their SUD behavior creates challenges and reduces the effectiveness of the FSP. As a result, this population is unserved or underserved. In fact, during the MHSA Stanislaus County Stakeholder process, "Treatment options for people struggling with both substance abuse and mental illness" was one of the priority mental health adaptive dilemmas that should be addressed in an innovative manner because it is a persistent mental health challenge that has not been successfully addressed by more traditional methods.

But what would happen if a combination of strategies were in place as part of a new FSP that, ultimately, could increase the quality of mental health services? This Innovation project has several elements, when combined, that could produce better outcomes and create a promising practice for residents suffering from severe mental illness and SUD. Many of these individuals are also involved with the criminal justice system, often directly related to their mental health and SUD symptoms and behaviors. Many are also homeless, at risk of homelessness, at risk of institutionalization, and/or frequent users of emergency services. Therefore, there is overlap with other existing adult FSPs. However, there is a gap in our continuum of FSP programs that this Innovation Project would address, and coordination with existing FSPs will be a key component to this project.

Mental health treatment and SUD treatment are similar and overlap each other. But there are some areas that are significantly different in approach, training, and philosophy. These areas include, but are not limited to, engagement versus enabling, abstinence versus meeting the client where they are at in their life, hopefulness for recovery versus the desire to drink or use drugs without consequence, empowerment of the individual versus acceptance of the individual's powerlessness over drugs and alcohol use. Through this Innovation project, our belief is that a client-centered, stage-based approach to mental health and SUD treatment and treatment planning, with a focus on shared understanding amongst staff and with client, will create a theoretical and practical framework that allows for both approaches to be fully tested and utilized.

Stanislaus County is proposing to test the efficacy of an FSP providing co-occurring disorder services by evaluating not only *what* is provided,"housing first" and primary care access on an SUD treatment and recovery campus, but *how* services are provided. The co-occurring disorder will be the first "lens" through which this Innovative FSP project views the clients' recovery needs and strengths. The primary focus will be on creating shared understanding and vision amongst staff and with clients through a client-centered, stage-based approach, enriched with primary care and housing services. We expect to learn whether this approach can make a true difference in the lives of people with mental illness and SUDs. This would make the Innovation project unique and different from other FSPs with the potential to advance knowledge and contribute something new to the field of mental health.

This Innovative approach would create a unique FSP that integrates primary care access, a "housing first" approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and practice.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

This Innovation project makes a change to an existing mental health practice that has not yet been demonstrated to be effective for the population experiencing both a serious mental illness as well as a co-occurring SUD. The FSP will be operated by Behavioral Health and Recovery Services and is expected to serve fifty (50) individuals at any one time.

Though BHRS currently has a small Co-occurring Treatment Program (COT), which is a primary substance use disorder treatment program with adjunct mental health services for clients in SUD residential and IOT, this new program will focus on the treatment team process(es) in testing/applying stage based engagement/treatment strategies at every level of client contact for both mental health and SUD with the goal of client recovery and wellness. In addition, the FSP model will address potential risks that all FSPs are designed to address: reduce homelessness, involvement with the criminal justice system, acute psychiatric hospitalizations, and institutionalization.

Additionally, this FSP will be co-located on an SUD treatment site in Ceres, California, where clients will have access to recovering peers and supports integrated primary care, and a dedicated "Housing First" approach. Again, an emphasis will be on using the Stage Based Treatment framework for both mental health and SUD concurrently and deliberately, addressing the sometimes contradictory strategies indicated for each stage separately.

These are the primary components of this Innovative FSP that substantively change the existing FSP model in our County:

Stage Based Treatment: Stage based treatment encompassing Mental Health Recovery Treatment assessment stages known as MHRTS and the Substance Abuse Treatment Scale known as SATS will be used for this at-risk population. We hope to discover that these dual stages and the strategies associated with each of them can impact individuals with co-occurring disorders. It is believed that once engaged, this population would benefit from stage-based mental health treatment and stage-based substance use disorder treatment concurrently and integrated. Too often, mental health treatment and substance use disorder treatment are provided sequentially, allowing progress to be undermined by issues stemming from the untreated aspect. Beginning where the client is in their stage of change process, whether that is more mental health related, or more substance use related, treatment will be guided by data that reflects that specific client's readiness for treatment in both areas. Using peers who are in recovery as well as the SUD recovery environment and group-based treatment is expected to be particularly effective with this population. Staff will be trained in the Integrated Dual Diagnosis Treatment protocol. Ultimately, this approach should create positive change.

Primary Care: This FSP will integrate primary care in the continuum of care for this population. Broadening the focus beyond behavioral health to encompass physical health is becoming an expected standard of care in the health industry and is designed to reduce the silos that have often characterized behavioral and physical healthcare. Well-documented research has indicated that untreated behavioral health conditions lead to early death in individuals with mental health and/or substance abuse conditions. In addition, it is believed that the inclusion of physical health care in this INN project is a way to engage individuals that are resistant to behavioral health treatment. The experience of our outreach teams supports this assumption given that many individuals want assistance with health issues which are less stigmatizing. However they are engaged, many individuals are then more receptive to dealing with the root causes of their physical health issues.

Housing: A 'housing first' approach is also critical to engage this population and begin the treatment process. Experience in our other FSPs has demonstrated that clients often continue harmful substance use behaviors despite efforts to eliminate them. Consequently, they appear in temporary housing under the influence and, ultimately, lose the housing because the continued substance use has put the other clients in the housing at risk of relapse and using substances themselves. This FSP will develop housing engagement strategies that deal with continued substance use without resulting in the client losing their housing. At the same time, this will protect other clients from this behavior. It has been shown in other states that offering housing that does not require sobriety to begin with has resulted in the client actually working toward sobriety, i.e., engaging in treatment.

The learning goal of the project is to increase the effectiveness of an FSP program dedicated to difficult to engage individuals with severe mental illness and co-occurring SUDs by integrating primary care access, a "housing first" approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and practice. What we learn from this project can be applied to other FSPs to successfully engage clients in treatment to addresses both their physical and behavioral health needs. In addition, it is expected that this innovative combination of services will yield better health and behavioral health outcomes for this population at risk of disabling conditions affecting the quality of their lives as well as the length of their lives.

The overarching learning outcome is to help inform the behavioral health field about what combination of strategies and services are most effective at the different concurrent mental health and SUD recovery stages.

ATTACHMENT 3

FSP Co-Occurring Disorders Innovation Project

Facilitated Group Learning Debrief Questions

1. What worked well in creating shared understanding and vision of this program amongst your team? *(What did you do – meetings/emails/consultation?)*

2. How did the concurrent use of stage-based approaches improve your ability to identify, engage, and treat the co-occurring population? *(Did this approach help to discover combinations of effective strategies and services?)*
   - How did the MHRTS and SATS tools help? *(or not) successes/challenges)*
   - Did the data from the tools reflect the observed changes for the clients?

3. How did clients benefit from using stage-based mental health treatment and substance use disorder treatment concurrently?
   - What processes/practices were most effective? *(What worked from your perspective? Did you receive feedback, negative or positive, from clients?)*

4. How did the co-location of the FSP on an SUD/Co-occurring treatment site positively affect:
   a. Peer Support?
   b. Follow-through to SUD treatment?
   c. Linkage to MH and SUD resources?

5. What is the most impactful insight you learned from this Innovation Project?

6. Challenges

Mental Health Recovery Treatment Stages (MHRTS)

Assess the stage of mental health treatment that best matches where the consumer is in their treatment and recovery and best matches the recovery milestones they have achieved. (CHOOSE ONE)

0 **No mental health problems reported.**

1 **Pre-Engagement** ---The person does not have contact with a mental health service provider or substance abuse service provider.

2 **Engagement / Outreach**--- May have a lack of regular contact with treatment provider or lack of a working alliance. May have some beginning awareness of the problem, but not fully willing to accept help or not knowing where to get the right help. Possibly beginning to recognize inner distress, but unable to identify what is causing it.

3 **Contemplation / Exploration**--- Seeks help and/or has regular contact with treatment provider. Working relationship is beginning to be established. Willing to discuss problem and starting to accept help. Beginning to examine distress with the help and support of others. Increasing openness to information about the illness.

4 **Recovery Awareness**---Beginning to believe that recovery is possible. Becoming hopeful about the possibility of getting better. Increased willingness to discuss the illness. Increased awareness of the illness and of recovery.

5 **Stabilization / Beginning Recovery**---Those symptoms identified by the consumer as interfering with their recovery are becoming managed sufficiently to allow the consumer to examine their life circumstances. They are able to self-identify and prioritize which symptoms are important to be addressed. These symptoms are becoming stabilized, possibly with medication and symptom management skills, and learning from others how they are managing their symptoms. Abstaining from alcohol or other drug use if use is problematic. Consumer is actively participating in his or her own treatment and recovery. Setting recovery goals and taking action steps. Increased awareness of physical/mental/social/spiritual needs.

6 **Active Recovery**---Actively participates in mutual aid, peer support and/or treatment. Begins to experience the benefits of recovery. Practices the tools of recovery. Shares own experiences with others. Links with recovering peers and builds support system. Able to make relapse prevention plans. Responsible for taking own medication.

7 **Relapse Prevention**---Takes ownership/responsibility for own recovery. Follows relapse prevention plans and strategies. Increased ability to advocate for oneself. Communicates clearly with provider about what is helping in recovery process and with symptom management. Increased use of recovery principles related to illness. Increasing independence and self-sufficiency.

8 **Maintaining Recovery**---Continued recovery strengthened by generosity toward others and being of service to others. Strong relapse prevention strategies continue to be used. Increased support provided to others. Balances activity with rest, nutrition and recreation. Demonstrates healthy boundaries in relationships. Increased use of recovery principles in all areas of life.

9 **UNABLE TO RATE**

Mental Health				Stages of Change:
Co-occurring Strategies (Approach)-*5	**Consumer Identified Milestones in Recovery** (Measurement)-*4	**Mental Health Treatment Strategies** (Approach)	**MHRTS (MH Recovery Treatment Stages)** (Measurement)-*1	
• Outreach • Trusting relationship • Practical support • Harm reduction • Assessment • Peer outreach	1. I begin to recognize my inner distress but may be unable to identify what it is	• Establish Therapeutic Alliance (staff, program, peers) by: Validating strengths, re-framing negative views of self, ask how client was able to get through difficult situations they describe, reflect back what client says, roll with resistance to change (avoid reacting), ask non-judgmental questions • Stabilize critical life area's (food, housing, financing, clothing etc.) by providing case management • On going assessment/contact that is hopeful and empathic	1. Pre-engagement 2. Engagement / Outreach	Pre-Contemplation
• Motivational interviewing • Ambivalence is normal • Pay-off matrix • Education • Peer recovery • Medications tried	2. I begin to examine my distress with the help of others	• Persuade client to become aware of the problems created by untreated mental disorder • Establish motivation to increase/establish regular treatment for mental disorder by: becoming curious about clients short/long term goals and provide assistance in reaching those goals • Highlight obstacles towards reaching these goals, including untreated mental disorder. Discuss inconsistencies with goals and active psychiatric symptoms • Assist client in stating or writing positives and negatives of active symptoms of untreated mental disorder • Become curious about the positives and seek information about them to inform you about client's resistance to stabilizing psychiatric symptoms • Reflect back your understanding about the ways resistance to stabilizing psychiatric symptoms helps the client; ask if there are other ways to achieve those same things (ie. Not taking medications or getting treatment for mental disorder helps client to feel like his/her peers and not "crazy or weird", and asking if the untreated symptoms help client fit in with their peers or ways to fit in while taking medication or getting treatment.)	3. Contemplation / Exploration	Contemplation And Preparation
	3. I choose to believe that hope exists	• Increase discussion of inconsistencies between goals and unstable symptoms through Motivational Interviewing • Highlight differences in what the client seeks in life (goals) and interference with untreated disorder • Review treatment progress with client • Normalize change as a gradual process	4. Recovery Awareness	

		• Offer to try a group offered at the program • Offer the option of a NAMI or other support group in the community		
• Skill building • Social support / Peer support • Cognitive behavioral interventions • Medications / side-effects actively managed • Integrated timelines (AOD, MH, and trauma) • Other therapeutic interventions	4. I start overcoming those symptoms that keep me from examining what is important to me in life 5. I voluntarily take some action toward recovery 6. I start to enjoy the benefits of mutual recovery	• Focus on increasing treatment contact for MH symptoms (towards goal of stabilization) • Focus on skill building like recognizing symptoms onset, managing triggers & medication education and management • Encourage positive peer support • Assist with establishing above peer support • Goal setting that will lead to incremental successes • Provide hope and confidence in client's ability to grow • Validate successes • Investigate and analyze any return to MH symptoms or behavior • Educate and identify Thinking Errors (all or nothing thinking, overgeneralization, awfulizing, mind-reading etc.) • Educate and work on Cognitive Restructuring • Continued Focus on skill building like anger management, feelings management, time management, goal setting • Role-play and/or writing assignments on above skills • Educate on healthy communication (Assertiveness Training) • Continue to encourage self-help support (strengthening peer support)	5. Beginning Recovery and Stabilization 6. Active Recovery	Action
• Planning • Recovery lifestyle • Social support	7. I am responsible for my own recovery 8. Yes, helping others strengthens my recovery	• Focus existing skills and supports to maintain stability • Develop a Relapse Prevention Plan by: identifying triggers and writing out a plan of action for each one identified, what support people will be called, how often, self-care plan (8 hrs sleep, 3 meals a day, 3 meetings per week, school, job, social contacts) • Continued hopeful support and encouragement • Assist client with new goals for enhancing quality of life • Continue to emphasize and encourage positive support system	7. Relapse Prevention 8. Maintaining Recovery	Maintenance

SUBSTANCE ABUSE TREATMENT SCALE (SATS)
(McHugo, Drake, Burton, Ackerson)

This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last SIX months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. **Pre-engagement:** The person (not client) does not have contact with a case manager, mental health counselor, or substance abuse counselor.

2. **Engagement:** The client has had contact with an assigned case manager or counselor, but does not have regular contacts. The lack of regular contact implies lack of a working alliance.

3. **Early Persuasion:** The client has regular contacts with a case manager or counselor, but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. **Late Persuasion:** The client is engaged in a relationship with a case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g. Antabuse) may be involved in reduction.

5. **Early Active Treatment:** The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal even though he or she may still be abusing.

6. **Late Active Treatment:** The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.

7. **Relapse Prevention:** The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days or problematic use are allowed.

8. **In Remission or Recovery:** The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.

Stages of Change:	Alcohol and Other Drugs		
	SATS (Substance Abuse Treatment Scale) Stages (Measurement)-*2	**AOD Treatment Strategies** (Individual and Group Options)	**AOD Treatment Phases** (Approach)-*3
Pre-contemplation	1. Pre-engagement		
	2. Engagement "The courts think I have a problem with alcohol because I got a DUI"	• Establish Therapeutic Alliance (staff, program, peers) by: Validating strengths, re-framing negative views of self, ask how client was able to get through difficult situations they describe, reflect back what client says, roll with resistance to change (avoid reacting), ask non-judgmental questions • Stabilize critical life area's (food, housing, financing, clothing etc.) by providing case management • On going assessment/contact that is hopeful and empathic • Increase information about the self and the clients' problems. "To make the unconscious conscious" – Freud, by asking questions in group or 1/1 setting. Do you think you have a SA problem? Who in your life has told you this? How many times have you denied it? Who still thinks that they don't have a problem? Ask for interpretations about their SA: what does it mean to you, how do you view yourself, how do others view you? Describe a day in your life and how SA plays a role.	
Contemplation And Preparation	3. Early Persuasion (Motivating contemplation) "I want help getting a job".	• Persuade client to become aware of the problems created by substance use. • Establish motivation to reduce (Harm Reduction) or stop substance use by: becoming curious about clients short/long term goals and provide assistance in reaching those goals • Highlight obstacles towards reaching these goals, including substance use. Discuss inconsistencies with goals and active substance use. • Assist client in stating or writing positives and negatives of substance use (pro's and con's) • Become curious about the positives and seek information about them to inform you about client's continued use • Reflect back your understanding about the ways substance use helps the client; ask if there are other ways to achieve those same things (ie. Substance use helps with socializing and coping with stress, and asking if there have been other ways client has handled stress and socialize in the past	Phase 1-Motivational
	4. Late Persuasion (Motivating preparation) "I want a plan to help me with smoking pot and still working."	• Increase discussion of inconsistencies between goals and substance use consequences through Motivational Interviewing • Highlight differences in what the client seeks in life (goals) and interference that substance use causes • Review treatment progress with client • Normalize change as a gradual process • Offer to try a group offered at the program aimed at reducing/eliminating substance use • Offer the option of a 12 step or other support group in the community • Self Re-evaluation - (Does SA conflict with personal values?) What part of my life would be better if I was not using drug? • Educate - Stages of Addiction, Categories of Substances, Dependence VS Abuse, Triggers	Phase 2-Willingness
Action	5. Early Active Treatment I have problems using if my friend offer it to me."	• Focus on reducing substance use (towards goal of abstinence) • Focus on skill building like managing triggers and cravings, refusal skills • Encourage positive peer support (self-help groups – 12 Step) • Assist with establishing above self-help support • Goal setting that will lead to incremental successes • Provide hope and confidence in client's ability to grow	Phase 3-Open Mindedness Phase 4-Honesty

		• Validate successes • Investigate and analyze any relapses with client • Use pro and con list to find alternatives to using behavior	Phase 5-Introspcetion
	6. Late Active Treatment "I want to use if I am bored or alone."	• Educate and identify Thinking Errors (all or nothing thinking, overgeneralization, awfulizing, mind-reading etc.) • Educate and work on Cognitive Restructuring • Continued Focus on skill building like anger management, feelings management, time management, goal setting • Educate on healthy communication (Assertiveness Training) • Continue to encourage self-help support (strengthening peer support, get a sponsor)	Phase 6-Detachment Phase 7-Acceptance Phase 8-Identifying addictive thoughts, feelings and actions
Maintenance	7. Relapse Prevention "I am worried about relapsing when my Dad gets out of prison."	• Focus existing skills and supports to maintain sobriety • Develop a Relapse Prevention Plan by: identifying triggers and writing out a plan of action for each one identified, what support people will be called, how often, self-care plan (8 hrs sleep, 3 meals a day, 3 meetings per week, school, job, social contacts) • Continued hopeful support and encouragement • Assist client with new goals for enhancing quality of life	Phase 9-Changing addictive thoughts, feelings and actions

ATTACHMENT 6

FSP Co-Occurring Disorders Project
Choose Journal Format.

Name: _____ Choose Date Format._____

Learning Questions:

1. Will clients be successfully engaged by receiving a combination of services through this new FSP?
2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?
4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?
5. Will access to integrated primary care positively affect outcomes?
6. Will employing an integrated "Housing First" approach positively affect outcomes?
7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support and linkages to mental health resources?

Successes:

Challenges:

Areas of Improvement:

Practices / Processes:

Additional Information / Other Comments/ Reflections:

ATTACHMENT 7

DHCS California Department of HealthCareServices

ADULT SURVEY FALL 2019

ADULT ENGLISH Age 18-59

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.**

EXAMPLE: **Correct** ● ■ **Incorrect** ✓ ✗ ⊘ ⊖

MHSIP Consumer Survey*

Please answer the following questions based on the **last 6 months** OR if services have not been received for 6 months, just give answers based on the services that you have received so far. Indicate if you ***Strongly Agree***, ***Agree***, are ***Neutral, Disagree,*** or ***Strongly Disagree*** with each of the statements below. If the question is about something you have not experienced, fill in the circle for ***Not Applicable*** to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	○	○	○	○	○	○
2. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
3. I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4. The location of services was convenient (parking, public transportation, distance, etc.).	○	○	○	○	○	○
5. Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
6. Staff returned my calls within 24 hours.	○	○	○	○	○	○
7. Services were available at times that were good for me.	○	○	○	○	○	○
8. I was able to get all the services I thought I needed.	○	○	○	○	○	○
9. I was able to see a psychiatrist when I wanted to.	○	○	○	○	○	○
10. Staff here believe that I can grow, change and recover.	○	○	○	○	○	○
11. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
12. I felt free to complain.	○	○	○	○	○	○
13. I was given information about my rights.	○	○	○	○	○	○
14. Staff encouraged me to take responsibility for how I live my life.	○	○	○	○	○	○
15. Staff told me what side effects to watch out for.	○	○	○	○	○	○
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	○	○	○	○	○	○
17. I, not staff, decided my treatment goals.	○	○	○	○	○	○
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○	○
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	○	○	○	○	○	○
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	○	○	○	○	○	○

*The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

OFFICE STAFF COMPLETE THIS SECTION

County Code: 5 0 CN:

Today's Date: 1 1 / / 2 0 1 9 Sub-Unit:

DOB: / /

Reason (if applicable):

○ Ref ○ Imp ○ Lan ○ Oth

CONTINUED ON NEXT PAGE . . .

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I deal more effectively with daily problems.	○	○	○	○	○	○
22. I am better able to control my life.	○	○	○	○	○	○
23. I am better able to deal with crisis.	○	○	○	○	○	○
24. I am getting along better with my family.	○	○	○	○	○	○
25. I do better in social situations.	○	○	○	○	○	○
26. I do better in school and/or work.	○	○	○	○	○	○
27. My housing situation has improved.	○	○	○	○	○	○
28. My symptoms are not bothering me as much.	○	○	○	○	○	○
29. I do things that are more meaningful to me.	○	○	○	○	○	○
30. I am better able to take care of my needs.	○	○	○	○	○	○
31. I am better able to handle things when they go wrong.	○	○	○	○	○	○
32. I am better able to do things that I want to do.	○	○	○	○	○	○

For Questions #33-36, please answer for relationships with persons other than your mental health provider(s).

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
33. I am happy with the friendships I have.	○	○	○	○	○	○
34. I have people with whom I can do enjoyable things.	○	○	○	○	○	○
35. I feel I belong in my community.	○	○	○	○	○	○
36. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○

Please answer the following questions to let us know how you are doing.

1. Approximately, how long have you received services here?

- ○ This is my first visit here.
- ○ I have had more than one visit but have received services for less than one month.
- ○ 1 - 2 months
- ○ 3 - 5 months
- ○ 6 months to 1 year
- ○ More than 1 year

Please answer Questions #2-4, below, if you have been receiving mental health services for ONE YEAR OR LESS. If you have been receiving services for "MORE THAN ONE YEAR" please SKIP to Questions #5-7.

2. Were you arrested since you began to receive mental health services? ○ Yes ○ No

3. Were you arrested during the 12 months prior to that? ○ Yes ○ No

4. Since you began to receive mental health services, have your encounters with the police . . .

- ○ been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
- ○ stayed the same
- ○ increased
- ○ not applicable (I had no police encounters this year or last year)

SKIP to Question #8

Please answer Questions #5-7 only if you have been receiving mental health services for "MORE THAN ONE YEAR".

5. Were you arrested during the last 12 months? ○ Yes ○ No

6. Were you arrested during the 12 months prior to that? ○ Yes ○ No

7. Over the last year, have your encounters with the police:

- ○ been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
- ○ stayed the same
- ○ increased
- ○ not applicable (I had no police encounters this year or last year)

CONTINUED ON NEXT PAGE . . .

Please answer the following questions to let us know a little about you.

8. **What is your gender?** ○ Female ○ Male ○ Other

9. **Are you of Mexican / Hispanic / Latino origin?** ○ Yes ○ No ○ Unknown

10. **What is your race? (Please mark all that apply)**
    - ☐ American Indian / Alaskan Native
    - ☐ Asian
    - ☐ Black / African American
    - ☐ Native Hawaiian / Other Pacific Islander
    - ☐ White / Caucasian
    - ☐ Other
    - ☐ Unknown

11. **What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See example.)**

Date of Birth (mm-dd-yyyy)

			/		/				
0	○	○	○	○	○	○	○	○	
1	○	○	○	○	○	○	○	○	
2	○	○	○	○	○	○	○	○	
3	○	○	○	○	○	○	○	○	
4	○	○	○	○	○	○	○	○	
5	○	○	○	○	○	○	○	○	
6	○	○	○	○	○	○	○	○	
7	○	○	○	○	○	○	○	○	
8	○	○	○	○	○	○	○	○	
9	○	○	○	○	○	○	○	○	

1. Write in your date of birth →
2. Fill in the corresponding circles →

EXAMPLE: **Date of birth on April 30, 1967:**

Date of Birth (mm-dd-yyyy)

	0	4	/	3	0	/	1	9	6	7
0	●	○		○	●		○	○	○	○
1	○	○		○	○		●	○	○	○
2	○	○		○	○		○	○	○	○
3	○	○		●	○		○	○	○	○
4	○	●		○	○		○	○	○	○
5	○	○		○	○		○	○	○	○
6	○	○		○	○		○	○	●	○
7	○	○		○	○		○	○	○	●
8	○	○		○	○		○	○	○	○
9	○	○		○	○		○	●	○	○

12. **Were the services you received provided in the language you prefer?** ○ Yes ○ No

13. **Was written information (e.g. brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer?** ○ Yes ○ No

14. **What was the primary reason you became involved with this program? (Mark one):**
    - ○ I decided to come in on my own.
    - ○ Someone else recommended that I come in.
    - ○ I came in against my will.

15. **Please identify who helped you complete any part of this survey (Mark all that apply):**
    - ☐ I did not need any help.
    - ☐ A mental health advocate / volunteer helped me.
    - ☐ Another mental health consumer helped me.
    - ☐ A member of my family helped me.
    - ☐ A professional interviewer helped me.
    - ☐ My clinician / case manager helped me.
    - ☐ A staff member other than my clinician or case manager helped me.
    - ☐ Someone else helped me. Who?: _____

16. **Please provide comments here and/or on the back of this form, if needed. We are interested in both positive and negative feedback. Also, if there are areas which were not covered by this questionnaire which you feel should have been please write them here.**

Thank you for taking the time to answer these questions!

ATTACHMENT 8

DHCS California Department of HealthCareServices

OLDER ADULT SURVEY FALL 2019

OLDER ADULT ENGLISH Age 60+

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.**

EXAMPLE: **Correct** ● ■ **Incorrect** ✓ ✗ ⊘ ⊖

MHSIP Consumer Survey*

Please answer the following questions based on the **last 6 months** OR if you have not received services for 6 months, just give answers based on the services that you have received so far. Indicate if you ***Strongly Agree, Agree,*** are ***Neutral, Disagree,*** or ***Strongly Disagree*** with each of the statements below. If the question is about something you have not experienced, fill in the circle for ***Not Applicable*** to indicate that this item does not apply to you.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	○	○	○	○	○	○
2. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
3. I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4. The location of services was convenient (parking, public transportation, distance, etc.).	○	○	○	○	○	○
5. Staff were willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
6. Staff returned my calls within 24 hours.	○	○	○	○	○	○
7. Services were available at times that were good for me.	○	○	○	○	○	○
8. I was able to get all the services I thought I needed.	○	○	○	○	○	○
9. I was able to see a psychiatrist when I wanted to.	○	○	○	○	○	○
10. Staff here believe that I can grow, change and recover.	○	○	○	○	○	○

*The MHSIP Consumer Survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

OFFICE STAFF COMPLETE THIS SECTION

County Code: 5 0 CN:

Today's Date: 1 1 / / 2 0 1 9 Sub-Unit:

DOB: / /

Reason (if applicable):

○ Ref ○ Imp ○ Lan ○ Oth

CONTINUED ON NEXT PAGE . . .

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
11. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
12. I felt free to complain.	○	○	○	○	○	○
13. I was given information about my rights.	○	○	○	○	○	○
14. Staff encouraged me to take responsibility for how I live my life.	○	○	○	○	○	○
15. Staff told me what side effects to watch out for.	○	○	○	○	○	○
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	○	○	○	○	○	○
17. I, not staff, decided my treatment goals.	○	○	○	○	○	○
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	○	○	○	○	○	○
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	○	○	○	○	○	○
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	○	○	○	○	○	○

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I deal more effectively with daily problems.	○	○	○	○	○	○
22. I am better able to control my life.	○	○	○	○	○	○
23. I am better able to deal with crisis.	○	○	○	○	○	○
24. I am getting along better with my family.	○	○	○	○	○	○
25. I do better in social situations.	○	○	○	○	○	○
26. I do better in school and/or work.	○	○	○	○	○	○
27. My housing situation has improved.	○	○	○	○	○	○
28. My symptoms are not bothering me as much.	○	○	○	○	○	○
29. I do things that are more meaningful to me.	○	○	○	○	○	○
30. I am better able to take care of my needs.	○	○	○	○	○	○
31. I am better able to handle things when they go wrong.	○	○	○	○	○	○
32. I am better able to do things that I want to do.	○	○	○	○	○	○

For Questions #33-36, please answer for relationships with persons other than your mental health provider(s).

As a direct result of the services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
33. I am happy with the friendships I have.	○	○	○	○	○	○
34. I have people with whom I can do enjoyable things.	○	○	○	○	○	○
35. I feel I belong in my community.	○	○	○	○	○	○
36. In a crisis, I would have the support I need from family or friends.	○	○	○	○	○	○

CONTINUED ON NEXT PAGE . . .

Please answer the following questions to let us know how you are doing.

1. Approximately, how long have you received services here?

- ❍ This is my first visit here.
- ❍ I have had more than one visit but have received services for less than one month.
- ❍ 1 - 2 months
- ❍ 3 - 5 months
- ❍ 6 months to 1 year
- ❍ More than 1 year

Please answer Questions #2-4 if you have been receiving mental health services for <u>ONE YEAR OR LESS</u>. If you have been services for "MORE THAN ONE YEAR," please SKIP to Questions #5-7.

2. Were you arrested since you began to receive mental health services? ❍ Yes ❍ No

3. Were you arrested during the 12 months prior to that? ❍ Yes ❍ No

4. Since you began to receive mental health services, have your encounters with the police . . .

- ❍ been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
- ❍ stayed the same
- ❍ increased
- ❍ not applicable (I had no police encounters this year or last year)

SKIP to Question #8 on next page

Please answer Questions #5-7 only if you have been receiving mental health services for "<u>MORE THAN ONE YEAR</u>".

5. Were you arrested during the last 12 months? ❍ Yes ❍ No

6. Were you arrested during the 12 months prior to that? ❍ Yes ❍ No

7. Over the last year, have your encounters with the police . . .

- ❍ been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program)
- ❍ stayed the same
- ❍ increased
- ❍ not applicable (I had no police encounters this year or last year)

Please answer the following questions to let us know a little about you.

8. What is your gender? ❍ Female ❍ Male ❍ Other

9. Are you of Mexican / Hispanic / Latino origin? ❍ Yes ❍ No ❍ Unknown

10. What is your race? (Mark all that apply)

- ❒ American Indian / Alaskan Native
- ❒ Asian
- ❒ Black / African American
- ❒ Native Hawaiian / Other Pacific Islander
- ❒ White / Caucasian
- ❒ Other
- ❒ Unknown

CONTINUED ON NEXT PAGE . . .

11. What is your date of birth? (Write it in the boxes AND fill in the circles that correspond. See example.)

Date of Birth (mm-dd-yyyy)

			/		/				
0	○	○	○	○		○	○	○	○
1	○	○	○	○		○	○	○	○
2	○	○	○	○		○	○	○	○
3	○	○	○	○		○	○	○	○
4	○	○	○	○		○	○	○	○
5	○	○	○	○		○	○	○	○
6	○	○	○	○		○	○	○	○
7	○	○	○	○		○	○	○	○
8	○	○	○	○		○	○	○	○
9	○	○	○	○		○	○	○	○

1. Write in your date of birth →
2. Fill in the corresponding circles →

EXAMPLE: **Date of birth on April 30, 1955:**

Date of Birth (mm-dd-yyyy)

	0	4	/	3	0	/	1	9	5	5
0	●	○		○	●		○	○	○	○
1	○	○		○	○		●	○	○	○
2	○	○		○	○		○	○	○	○
3	○	○		●	○		○	○	○	○
4	○	●		○	○		○	○	○	○
5	○	○		○	○		○	○	●	●
6	○	○		○	○		○	○	○	○
7	○	○		○	○		○	○	○	○
8	○	○		○	○		○	○	○	○
9	○	○		○	○		○	●	○	○

12. Were the services you received provided in the language you prefer? ○ Yes ○ No

13. Was written information (e.g. brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ○ Yes ○ No

14. What was the primary reason you became involved with this program? (Mark one):

- ○ I decided to come in on my own.
- ○ Someone else recommended that I come in.
- ○ I came in against my will.

15. Please identify who helped you complete any part of this survey (Mark all that apply):

- ☐ I did not need any help.
- ☐ A mental health advocate/volunteer helped me.
- ☐ Another mental health consumer helped me.
- ☐ A member of my family helped me.
- ☐ A professional interviewer helped me.
- ☐ My clinician / case manager helped me.
- ☐ A staff member other than my clinician or case manager helped me.
- ☐ Someone else helped me. Who: _____

16. Please provide comments here and/or on the back of this form, if needed. We are interested in both positive and negative feedback. Also, if there are areas which were not covered by this questionnaire which you feel should have been please write them here.

Thank you for taking the time to answer these questions!

Full Service Partnership (FSP) PAF Form – Page 1/10

Adult PAF
10/20/19

Adult: 26-59 Years

Partnership Assessment Form (PAF)

Partnership Information

* Date Completed (mm/dd/yyyy):	

* County: _____

CSI County Client Number (CCN): _____

County Partner ID (optional): _____

* Partner's First Name: _____

* Partner's Last Name: _____

* Partnership Date (mm/dd/yyyy): _____

* Partner's Date of Birth (mm/dd/yyyy): _____

Who Referred the Partner? (Choose One)

- ○ Self
- ○ Family Member (e.g. parent, guardian, sibling, aunt, uncle, grandparent)
- ○ Significant Other (e.g. boyfriend / girlfriend, spouse)
- ○ Friend / Neighbor (i.e., unrelated other)
- ○ School
- ○ Primary Care/Medical Office
- ○ Emergency Room
- ○ Mental Health Facility /Community Agency
- ○ Social Services Agency
- ○ Substance Abuse Treatment Facility / Agency
- ○ Faith-based Organization
- ○ Other County / Community Agency
- ○ Homeless Shelter
- ○ Street Outreach
- ○ Juvenile Hall / Camp / Ranch / Division of Juvenile Justice
- ○ Acute Psychiatric / State Hospital
- ○ Other

Administrative Information

Partnership Status

Provider Number/ NPI: _____

* Full Service Partnership (PSP) Program ID: _____

* Partnership Service Coordinator (PSC) ID: _____

Program Information

In which additional program(s) is the Partner involved?	**Currently** (mark all that apply)
1. AB2034	☐
2. Governor's Homeless Initiative (GHI)	☐
3. MHSA Housing Program	☐

Residential Information – Includes Hospitalizations and Incarcerations

Residential Setting	Tonight (Choose one)	Yesterday As of 11:59 pm The day before partnership (Choose one)	During the past 12 months Indicate the total # of occurrences	During the past 12 months Indicate the total # of days (Column must = 365 days)	Prior to the last 12 months (Mark all that apply)
General Living Arrangement					
1. In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate(must hold lease or share in rent/mortgage)	○	○	____	____	☐
2. With one or both biological /adoptive parents	○	○	____	____	☐
3. With adult family member(s) other than parents - non-foster care	○	○	____	____	☐
4. Single Room Occupancy (must hold lease)	○	○	____	____	☐
Shelter/Homeless					
5. Emergency Shelter/Temporary Housing (includes living with friends but not paying rent)	○	○	____	____	☐
6. Homeless (includes living in their car)	○	○	____	____	☐
Supervised Placement					
7. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)	○	○	____	____	☐
8. Assisted Living Facility	○	○	____	____	☐
9. Unlicensed but supervised congregate placement (includes group living homes, sober living homes)	○	○	____	____	☐
10. Licensed Community Care Facility (Board and Care)	○	○	____	____	☐
Hospital					
11. Acute Medical Hospital	○	○	____	____	☐
12. Acute Psychiatric Hospital/ Psychiatric Health Facility (PHF)	○	○	____	____	☐
13. State Psychiatric Hospital	○	○	____	____	☐

Residential Program

14. Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)	○	○	_____	_____	☐
15. Skilled Nursing Facility (physical)	○	○	_____	_____	☐
16. Skilled Nursing Facility (psychiatric)	○	○	_____	_____	☐
17. Long-Term Institutional Care (Institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC))	○	○	_____	_____	☐
Justice Placement					
18. Jail	○	○	_____	_____	☐
19. Prison	○	○	_____	_____	☐
Other					
20. Other	○	○	_____	_____	☐
21. Unknown	○	○	_____	_____	☐

Education

Highest Level of Education Completed: Choose One

- ○ No High School Diploma / No GED
- ○ GED Coursework
- ○ High School Diploma/ GED
- ○ Some college/ Some Technical or Vocational Training
- ○ Associate's Degree (e.g. A.A., A.S./ Technical or Vocational School)
- ○ Bachelor's Degree (e.g. B.A., B.S.)
- ○ Master's Degree (e.g. M.A., M.S.)
- ○ Doctoral Degree (e.g., MD., Ph.D.)

For the Education Settings below, indicate where the Partner		
Educational Setting	**Was During the Past 12 Months** # of Weeks	**Is Currently** (mark all that apply)
1. Not in school of any Kind	_____	☐
2. High School / Adult Education	_____	☐
3. Technical / Vocational School	_____	☐
4. Community College / 4 year College	_____	☐
5. Graduate School	_____	☐
6. Other	_____	☐

Recovery Goals		
○ **Yes**	○ No	Does one of the Partner's current recovery goals include any kind of education at this time?

Employment Information

Employment During Last 12 Months

Indicate the partner's employment status:	# of Weeks (Column must = 52 Weeks)	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	_____	$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. **AND** 2. Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the partner's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	_____	$_____
Unemployed	☐		

Current Employment

Indicate the Partner's Employment Status:	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. **AND** 2. Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community..	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the partner's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	$_____

☐	**Unemployed:** Check if the Partner is not employed at this time.

○ **Yes**	○ **No**	Does one of the partner's current recovery goals include any kind of employment at this time?

Sources of Financial Support

Indicate all the sources of financial aid used to meet the needs of the partner:	During the Past 12 Months (mark all that apply)	Currently (mark all that apply)
1. Partner's Wages	☐	☐
2. Partner's Spouse/ Significant Other's Wages	☐	☐
3. Savings	☐	☐
4. Other Family Member/Friend	☐	☐
5. Retirement/ Social Security Income	☐	☐
6. Veteran's Assistance Benefits	☐	☐
7. Loan/Credit	☐	☐
8. Housing Subsidy	☐	☐
9. General Relief/General Assistance	☐	☐
10. Food Stamps	☐	☐
11. Temporary Assistance for Needy Families (TANF)	☐	☐
12. Supplemental Security Income/ State Supplementary Payment (SSI/SSP) Program	☐	☐
13. Social Security Disability Insurance (SSDI)	☐	☐
14. State Disability Insurance (SDI)	☐	☐
15. American Indian Tribal Benefits (e.g., per capita revenue sharing, trust disbursements)	☐	☐
16. Other	☐	☐
17. No Financial Support	☐	☐

Legal Issues/ Designations

Arrest Information		
Indicate the number of times the partner was arrested DURING THE PAST 12 MONTHS		☐
○ Yes	○ No	**Prior 12:** Was the partner arrested any time PRIOR TO THE LAST 12 MONTHS?
Probation Information		
○ Yes	○ No	**Currently:** Is the partner CURRENTLY on probation?
○ Yes	○ No	**Past 12 Months:** Was the partner on probation DURING THE PAST 12 MONTHS?
○ Yes	○ No	**Prior 12 Months:** Was the partner on probation any time PRIOR TO THE LAST 12 MONTHS?
Parole Information		
○ Yes	○ No	**Past 12 Months:** Was the partner on any kind of parole DURING THE PAST 12 MONTHS?
○ Yes	○ No	**Prior 12 Months:** Was the partner on any kind of parole any time PRIOR TO THE LAST 12 MONTHS?
Conservatorship Information		
○ Yes	○ No	**Currently:** Is the partner CURRENTLY on conservatorship?
○ Yes	○ No	**Past 12 Months:** Was the partner on conservatorship DURING THE PAST 12 MONTHS?
○ Yes	○ No	**Prior12 Months:** Was the partner on conservatorship any time PRIOR TO THE LAST 12 MONTHS?
Payee Information		
○ Yes	○ No	**Currently:** Does the partner CURRENTLY have a payee?
○ Yes	○ No	**Past 12 Months:** Did the partner have a payee DURING THE PAST 12 MONTHS?
○ Yes	○ No	**Prior 12 Months:** Did the partner have a payee any time PRIOR TO THE LAST 12 MONTHS?

Custody Information

Indicate the total number of children the partner has who are CURRENTLY:

_____ Number placed on W & I Code 300 Status: (dependent of the court)

_____ Number placed in Foster Care

_____ Number legally Reunified with partner

_____ Number Adopted Out

Emergency Intervention

Indicate the number of emergency interventions (e.g., emergency room visit, crisis stabilization unit) the partner had DURING THE PAST 12 MONTHS that were:

_____ Physical Health Related

_____ Mental Health / Substance Abuse Related

Health Status

○ Yes	○ No	**Current PCP**:	Does the partner have a Primary Care Physician (PCP) CURRENTLY?
○ Yes	○ No	**Past 12 Months PCP**:	Did the partner have a Primary Care Physician (PCP) DURING THE PAST 12 MONTHS?

Substance Abuse

○ Yes	○ No	**Ever Issue:**	In the opinion of the Partnership Service Coordinator (PSC), has the partner ever had a co-occurring mental illness and substance use problem?
○ Yes	○ No	**Current Issue:**	In the opinion of the Partnership Service Coordinator (PSC), does the partner currently have an active co-occurring mental illness and substance use problem?
○ Yes	○ No	**Current Services:**	Is the partner currently receiving substance abuse services?

County Use Questions

To be tracked on the KET form:	Values
County Use Field # 1	
County Use Field # 2	
County Use Field # 3	
To be tracked on the 3M form:	**Values**
County Use Field # 1	
County Use Field # 2	
County Use Field # 3	

Full Service Partnership (FSP) KET Form – Page 1/7

Adult KET
10/20/19

Adult: 26-59 Years

Key Event Tracking (KET)

Partnership Information

* Date Completed (mm/dd/yyyy):	

* County: _____

CSI County Client Number (CCN): _____

County Partner ID (optional): _____

* Partner's First Name: _____

* Partner's Last Name: _____

* Partnership Date (mm/dd/yyyy): _____

* Partner's Date of Birth (mm/dd/yyyy): _____

Changes in Administrative Information -- Skip this section if there are no changes

Date of Provider Number/ NPI change (mm/dd/yyyy):	
NEW Provider Number/NPI:	
Date of Full Service Partnership (PSP) Program ID change (mm/dd/yyyy):	
NEW Full Service Partnership (PSP) Program ID:	
Date of Partnership Service Coordinator (PSC) change (mm/dd/yyyy):	
NEW Partnership Service Coordinator (PSC) ID:	

New Partnership Status -- Skip this section if there are no changes

Date of Partnership Status Change (mm/dd/yyyy):	

○ **Discontinuation** / Interruption of Full Service Partnership and/ or Community Services/ Program

○ **Reestablishment** of Full Service Partnership and/or Community Services/ Program

If there is a **Discontinuation / Interruption** of Full Service Partnership and / or Community Services/ Program, indicate the reason (choose one)	
○	Target Criteria: Target population criteria are not met
○	Partner Discontinued: Partner decided to discontinue Full Service Partnership participation after partnership established
○	Moved: Partner moved to another County/ service area
○	Not Located: After repeated attempts to contact Partner, s/he cannot be located
○	Residential / Institutional Mental Health Services :Partner's circumstances reflect a need for Residential/ Institutional Mental Health Services at this time (such as State Hospital)
○	Jail: Community Services / Program interrupted
○	Prison: Community Services / Program interrupted
○	Met Goals: Partner has successfully met his/her goals such that the discontinuation of Full Service Partnership is appropriate
○	Deceased: Partner is deceased

Program Information

Program Name	Date of Program Change (mm/dd/yyyy)	Currently Involved (Indicate status below)
1. AB2034		○ Now enrolled in the AB2034 Program ○ No longer participating in the AB2034 Program
2. Governor's Homeless Initiative (GHI)		○ Now enrolled in the GHI Program ○ No longer participating in the GHI Program
3. MHSA Housing Program		○ Now enrolled in the MHSA Housing Program ○ No longer participating in the MHSA Housing Program

Residential Information – Includes Hospitalization and Incarceration

Skip this section if there are no changes

Date of Residential Status Change (mm/dd/yyyy):	
General Living Arrangement	
○	1.In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate(must hold lease or share in rent/mortgage)
○	2. With one or both biological /adoptive parents
○	3. With adult family member(s) other than parents
○	4. Single Room Occupancy (must hold lease)
Shelter / Homeless	
○	5. Emergency Shelter/Temporary Housing (includes living with friends but not paying rent)
○	6. Homeless (includes people living in their car)
Supervised Placement	
○	7. Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants)
○	8. Unlicensed but supervised congregate placement (includes group living homes, sober living homes)
○	9. Licensed Community Care Facility (Board and Care)
Hospital	
○	10. Acute Medical Hospital
○	11. Acute Psychiatric Hospital/ Psychiatric Health Facility (PHF)
○	12. State Psychiatric Hospital
Residential Program	
○	13. Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs)
○	14. Skilled Nursing Facility (physical)
○	15. Skilled Nursing Facility (psychiatric)
○	16. Long-Term Institutional Care (Institution for Mental Disease (IMD), Mental Heals Rehabilitation Center (MHRC))

Justice Placement	
○	17. Jail
Other	
○	18. Other
○	19. Unknown

Education Information -- Skip this section if there are no changes

Date of Grade Level Completion (mm/dd/yyyy):	

Highest Level of Education Completed: Choose One

- ○ No High School Diploma / No GED
- ○ GED Coursework
- ○ High School Diploma/ GED
- ○ Some college/ Some Technical or Vocational Training
- ○ Associate's Degree (e.g. A.A., A.S./ Technical or Vocational School)
- ○ Bachelor's Degree (e.g. B.A., B.S.)
- ○ Master's Degree (e.g. M.A., M.S.)
- ○ Doctoral Degree (e.g., MD., Ph.D.)

Education Setting Information -- Skip this section if there are no changes

Date of Educational Setting Change (mm/dd/yyyy):	

If there are any Educational Setting Changes, indicate ALL new and ongoing statuses including those previously reported.

Education Setting	Currently (mark all that apply)
1. Not in school of any kind	☐
2. High School / Adult Education	☐
3. Technical / Vocational School	☐
4. Community College / 4 year College	☐
5. Graduate School	☐
6. Other	☐

○ **Yes**	○ **No**	If the Partner is stopping school, did the Partner complete a class and/or program?
○ **Yes**	○ **No**	Does one of the Partner's current recovery goals include any kind of education at this time?

Employment Information -- Skip this section if there are no changes

Date of Employment Change (mm/dd/yyyy):	

Current Employment

If there are any changes to the Partner's employment status, indicate ALL new and ongoing statuses including those previously reported:	Average Hours Per Week	Average Hourly Wage
Competitive Employment: Paid employment in the community in a position that is also open to individuals without a disability.	_____	$_____
Supported Employment: Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.	_____	$_____
Transitional Employment/ Enclave: Paid jobs in the community that are: 1. Open only to individuals with a disability. **AND** 2. Are either time-limited for the purpose of moving to a more permanent job. **OR** Are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.	_____	$_____
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. ***A Sheltered Workshop*** usually offers sub-minimum wage work in a simulated environment. ***A Work Experience*** (Adjustment) *Program* within an agency provides exposure to the standard expectations and advantages of employment. ***An Agency-Owned Business*** serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.	_____	$_____
Non-paid (Volunteer) Work Experience: Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.	_____	
Other Gainful / Employment Activity: Any informal employment activity that increases the Partner's income (e.g., recycling, gardening, babysitting) OR Participation in formal structured classes and / or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).	_____	$_____

☐	**Unemployed:** Check this box if the Partner is not employed at this time.	
○ **Yes**	○ **No**	Does one of the Partner's current recovery goals include any kind of employment at this time?

Legal Issues / Designations -- Skip this section if there are no changes

Justice System Involvement

Arrest Information:
Date Partner Arrested (mm/dd/yyyy)

Probation Information:
Date of Probation status change (mm/dd/yyyy)

Indicate new Probation status

- ○ Removed from Probation
- ○ laced on Probation

Conservatorship Information

Conservatorship / Information:
Date of new Conservatorship status change (mm/dd/yyyy)

Indicate new Conservatorship status change:

- ○ Removed from Conservatorship
- ○ Placed on Conservatorship

Payee Information:
Date of Payee status change (mm/dd/yyyy)

Indicate new Payee status:

- ○ Removed from Payee status
- ○ Placed on Payee status

Emergency Intervention -- Skip this section if there are no changes

Date of Emergency Intervention (mm/dd/yyyy):

Indicate the type of Emergency Intervention:

(e.g. emergency room visit, crisis stabilization unit)

- ○ Physical Health Related
- ○ Mental Health/ Substance Abuse Related

County Use Questions -- Skip this section if there are no changes

To be tracked on theKET form:	Date of Change mm/dd/yyyy	New Value
County Use Field # 1		
County Use Field # 2		
County Use Field # 3		

Adult 3M
10/20/19

Full Service Partnership (FSP) 3M Form – Page 1/2

Adult: 26-59 Years

Quarterly Assessment Form (3M)

Partnership Information

* Date Completed (mm/dd/yyyy):	

* County: _____

CSI County Client Number (CCN): _____

County Partner ID (optional): _____

* Partner's First Name: _____

* Partner's Last Name: _____

* Partnership Date (mm/dd/yyyy): _____

* Partner's Date of Birth (mm/dd/yyyy): _____

Sources of Financial Support

Indicate all the sources of financial aid used to meet the needs of the Partner	**Currently** (mark all that apply)
1. Partner's Wages	☐
2. Partner's Spouse/ Significant Other's Wages	☐
3. Savings	☐
4. Other Family Member/Friend	☐
5. Retirement/ Social Security Income	☐
6. Veteran's Assistance Benefits	☐
7. Loan/Credit	☐
8. Housing Subsidy	☐
9. General Relief/General Assistance	☐
10. Food Stamps	☐
11. Temporary Assistance for Needy Families (TANF)	☐
12. Supplemental Security Income/ State Supplementary Payment (SSI/SSP) Program	☐

Full Service Partnership (FSP) 3M Form — Page 2/2

13. Social Security Disability Insurance (SSDI)	☐
14. State Disability Insurance (SDI)	☐
15. American Indian Tribal Benefits (e.g., per capita revenue sharing, trust disbursements)	☐
16. Other	☐
17. No Financial Support	☐

Legal Issues/ Designations

Custody Information	

Indicate the total number of children the partner has who are CURRENTLY

_____ Number placed on W & I Code 300 Status: (dependent of the court)

_____ Number placed in Foster Care

_____ Number legally Reunified with partner

_____ Number Adopted Out

Health Status

○ **Yes**	○ **No**	**Current PCP**:	Does the partner have a Primary Care Physician (PCP) CURRENTLY?

Substance Abuse

○ **Yes**	○ **No**	**Current Issue:**	In the opinion of the Partnership Service Coordinator (PSC), does the partner currently have an active co-occurring mental illness and substance use problem?
○ **Yes**	○ **No**	**Current Services:**	Is the partner currently receiving substance abuse services?

County Use Questions

To be tracked on the 3M form:	New Value
County Use Field # 1	
County Use Field # 2	
County Use Field # 3	

Referral Resources

Mental Health Services

- Josie's Place
- Parent Resource Center
- Center for Human Services (CHS)
- Sierra Vista
- El Concilio
- Aspiranet
- The Bridge
- Turning Point Empowerment Center -MH
- Behavioral Health Recovery Services (BHRS)
- Juvenile Justice (BHRS)
- Other

Community Resources

- Red Shield
- Police Activities League (P.A.L)
- Maddux Center
- West Modesto King Kennedy Community Center
- Boys & Girls Clubs of Stanislaus County
- Patterson Teen Center
- Grayson Community Center
- Faith Based Organizations
- Stanislaus County Office of Education (SCOE)
- Comeback Kids
- Promotores
- Community Hospice
- Peer Recovery Art Project
- NAMI
- The Rock Church
- Catholic Charities
- DMV, Social Security, Birth Certificate
- Department of Rehabilitation
- Immigration Support Services
- Haven Women's Center
- Other Social Services
- Other

SUD Services

- AA / NA
- Last Resort
- Juvenile Drug Court (JDC)
- Steps to Freedom
- Nirvana Residential
- Center for Human Services (SUDTY)
- Other

Employment Services

- Alliance Network
- BHRS Employment
- Empowerment Center - Employment
- Project Y.E.S. (Youth Employment Services)
- Other

Shelter & Housing

- Hutton House (CHS)
- Community Housing and Shelter Services
- Gospel Mission
- Salvation Army Shelter
- Pathways (CHS)
- BHRS Housing
- Paradise Room & Board
- Garden Gate Respite
- Rodeway Inn
- Sober Living
- Other Motel
- Rest House
- Other

Healthcare

- Aspen Medical
- Golden Valley Health Center
- Golden Valley Health Center - Dental
- Health Services Agency (HSA)
- Quest Diagnostics
- Other

Stanislaus County
Striving to be the Best

State Semi-Annual BHRS Adult MHSIP

May 2017

Date Printed: 07/07/2017

Provider: Stanislaus County

		Total Answered	Total Agree	% Favorable
Overall	n = 890	29483	23922	81 %
Subscales				
Access		5048	4168	82 %
Quality and Appropriateness		7484	6512	87 %
*Outcomes		6266	4651	74 %
Participation in Treatment Planning		1638	1368	83 %
General Satisfaction		2626	2346	89 %
*Perception of Functioning		3996	3009	75 %
Perception of Social Connectedness		3217	2420	75 %
Access				
4. Services Location		868	705	81 %
5. Staff willing to help		872	772	88 %
6. Staff returned calls 24hrs		819	675	82 %
7. Service times good		871	765	87 %
8. Received services needed		870	734	84 %
9. Saw Psychiatrist as needed		748	517	69 %
Quality and Appropriateness				
10. Staff believed I could change		860	780	90 %
12. Felt free to complain		854	699	81 %
13. Given info. about rights		865	773	89 %
14. Staff encouraged me to take responsibility		859	777	90 %
15. Side effects to watch for		805	670	83 %
16. Staff respected info privacy		821	738	89 %
18. Sensitive to cultural background		805	682	84 %
19. Staff helped get me info so I could take charge		806	691	85 %
20. Encouraged to use consumer-run programs		809	702	86 %

Stanislaus County
Striving to be the Best

State Semi-Annual Adult MHSIP

May 2017

Date Printed: 07/07/2017

Provider: FSP COD Project - COD FSP MH ACT **SU: 3122**

Continued Page 2 of 2:

	Total Answered	Total Agree	% Favorable
***Outcomes**			
21. Deal effectively with daily problems	11	8	72 %
22. Able to control life	12	8	66 %
23. Able to deal with crisis	11	8	72 %
24. Get along better with family	12	7	58 %
25. Better in social situations	11	7	63 %
26. Better in school/work	11	6	54 %
27. Housing situation has improved	11	5	45 %
28. Symptoms not bothering as much*	11	5	45 %
Participation in Treatment Planning			
11. Felt comfortable to ask questions about Treatment and Meds	12	11	91 %
17. I directed treatment goals	12	8	66 %
General Satisfaction			
1. Like services received	13	12	92 %
2. Still would choose this agency for service	12	9	75 %
3. Recommend this agency to family or friends	13	10	76 %
***Perception of Functioning**			
28. Symptoms not bothering as much*	11	5	45 %
29. I do things that are more meaningful to me	11	7	63 %
30. I am better able to take care of my needs	11	6	54 %
31. I am better able to handle things when they go wrong	11	8	72 %
32. I am better able to do things that I want to do	11	8	72 %
Perception of Social Connectedness			
33. I am happy with the friendships I have	11	8	72 %
34. I have people with whom I can do enjoyable things	11	9	81 %
35. I feel I belong in my community	10	8	80 %
36. In a crisis, I would have the support I need from family or friends	10	8	80 %

*Note: Question # 28 is utilized in two sub-scales (Outcomes and Perception of Functioning).

Stanislaus County
Striving to be the Best

State Semi-Annual BHRS Adult MHSIP

May 2018

Date Printed: 06/13/2018

Provider: Stanislaus County

		Total Answered	Total Agree	% Favorable
Overall	n = 455	15216	11993	79 %
Subscales				
Access		2608	2231	85 %
Quality and Appropriateness		3859	3309	85 %
*Outcomes		3243	2209	68 %
Participation in Treatment Planning		849	697	82 %
General Satisfaction		1338	1214	90 %
*Perception of Functioning		2059	1388	67 %
Perception of Social Connectedness		1666	1180	70 %
Access				
4. Services Location		443	376	84 %
5. Staff willing to help		445	397	89 %
6. Staff returned calls 24hrs		421	356	84 %
7. Service times good		439	402	91 %
8. Received services needed		444	382	86 %
9. Saw Psychiatrist as needed		416	318	76 %
Quality and Appropriateness				
10. Staff believed I could change		444	394	88 %
12. Felt free to complain		436	354	81 %
13. Given info. about rights		436	383	87 %
14. Staff encouraged me to take responsibility		438	389	88 %
15. Side effects to watch for		417	328	78 %
16. Staff respected info privacy		423	379	89 %
18. Sensitive to cultural background		419	350	83 %
19. Staff helped get me info so I could take charge		421	367	87 %
20. Encouraged to use consumer-run programs		425	365	85 %

Stanislaus County
Striving to be the Best

State Semi-Annual Adult MHSIP

May 2018

Date Printed: 06/13/2018

Provider: FSP COD Project - COD FSP MH ACT **SU: 3122**

Continued Page 2 of 2:

	Total Answered	Total Agree	% Favorable
***Outcomes**			
21. Deal effectively with daily problems	11	8	72%
22. Able to control life	11	8	72%
23. Able to deal with crisis	10	8	80%
24. Get along better with family	11	9	81%
25. Better in social situations	11	8	72%
26. Better in school/work	11	6	54%
27. Housing situation has improved	10	7	70%
28. Symptoms not bothering as much*	11	7	63%
Participation in Treatment Planning			
11. Felt comfortable to ask questions about Treatment and Meds	11	10	90%
17. I directed treatment goals	10	7	70%
General Satisfaction			
1. Like services received	11	11	100%
2. Still would choose this agency for service	11	11	100%
3. Recommend this agency to family or friends	11	11	100%
***Perception of Functioning**			
28. Symptoms not bothering as much*	11	7	63%
29. I do things that are more meaningful to me	11	8	72%
30. I am better able to take care of my needs	11	8	72%
31. I am better able to handle things when they go wrong	11	7	63%
32. I am better able to do things that I want to do	11	6	54%
Perception of Social Connectedness			
33. I am happy with the friendships I have	11	8	72%
34. I have people with whom I can do enjoyable things	11	10	90%
35. I feel I belong in my community	10	5	50%
36. In a crisis, I would have the support I need from family or friends	11	8	72%

*Note: Question # 28 is utilized in two sub-scales (Outcomes and Perception of Functioning).

OUTREACH AND ENGAGEMENT: "TO GO BEYOND"

Outreach vs Engagement

Outreach

- Increase exposure beyond traditional means
- Engaging and educating the community about the organization and its goals
- Activity of providing services to any population who may not otherwise access them
- In location where those in need are; not stationary, ***mobile***

Engagement

- **NOT** compliance; a broader concept than compliance
- Involves the participation of both the people who deliver services and those who seek or are in need of services
- Centered on the goals of the individual being engaged
- The ways in which we enable people to influence and be involved in decisions and services
- Interactions through the sharing of experiences
- Activities that focus on building trust, gathering information and meeting basic needs as identified by the individual
- Developing relationship of trust between staff and individual
- Where and when the individual specifies
- Individual is the director of the helping process
- Increase in utilization of community services

Skills:

- Friendly
- Active listening
- Open-minded
- Compassionate
- Eye contact
- Empathy/ empathetic responses
- Conversation skills; informal chatting vs interrogation
- Information gathering
- Focused on individual's thoughts and feelings
- Finding commonality; What do you already know about this person?
- Genuineness/ Authenticity
- Body language
- Tone of Voice
- Knowing the audience; ability to judge mindset of individual
- Offering choices
- Persistence
- Finding strengths: What is working well despite challenges individual faces?

OUTREACH is finding the people, ***ENGAGEMENT*** is working towards the need

Stanislaus County

Behavioral Health and Recovery Services

MHSA

Representative Stakeholder Steering Committee

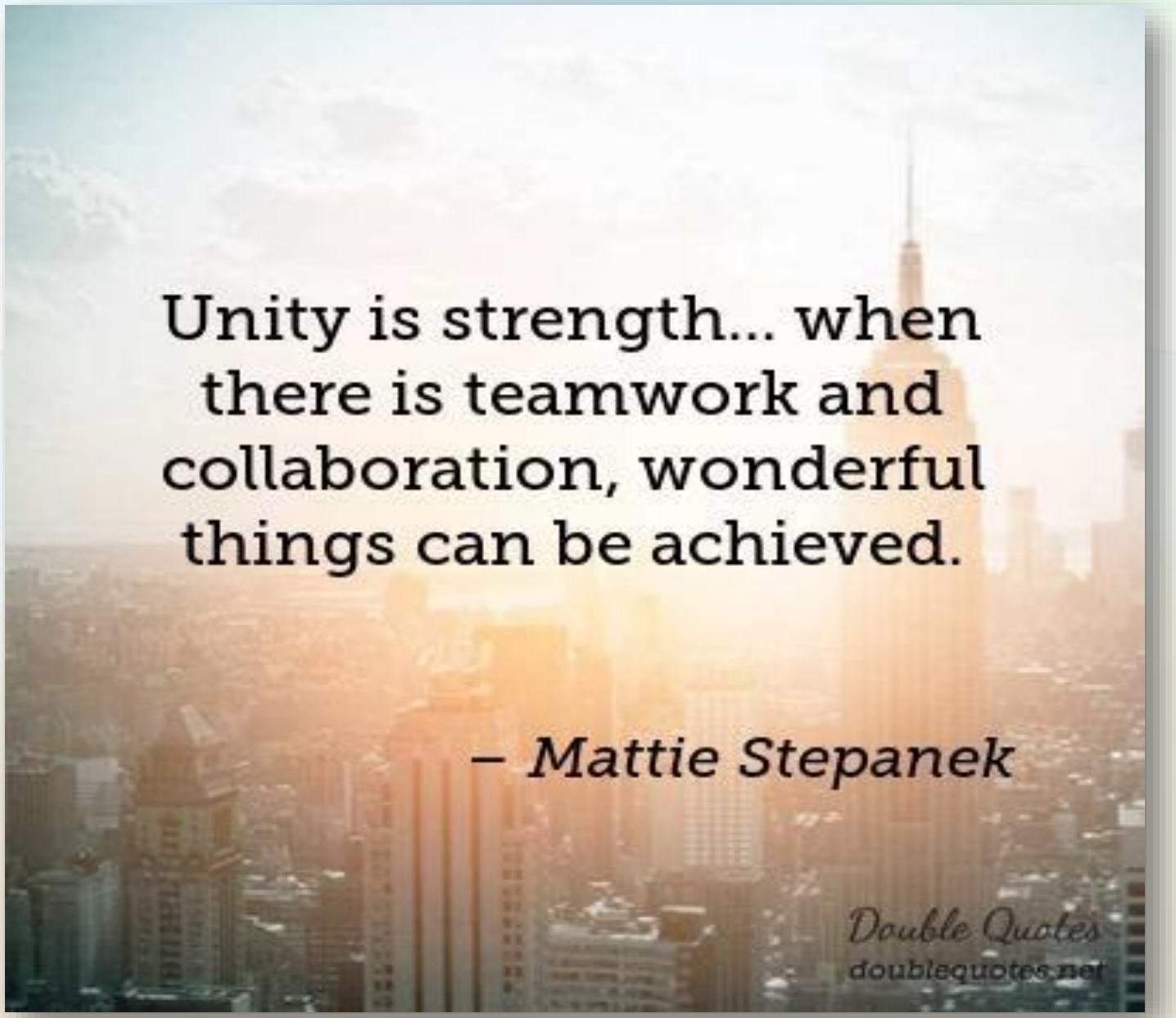
Behavioral Health and Recovery Services
Mental Health Services Act
February 1st 2019

Leng Power
MHSA Manager

ATTACHMENT 16

MHSA Representative Stakeholder Steering Committee

Welcome & Introductions

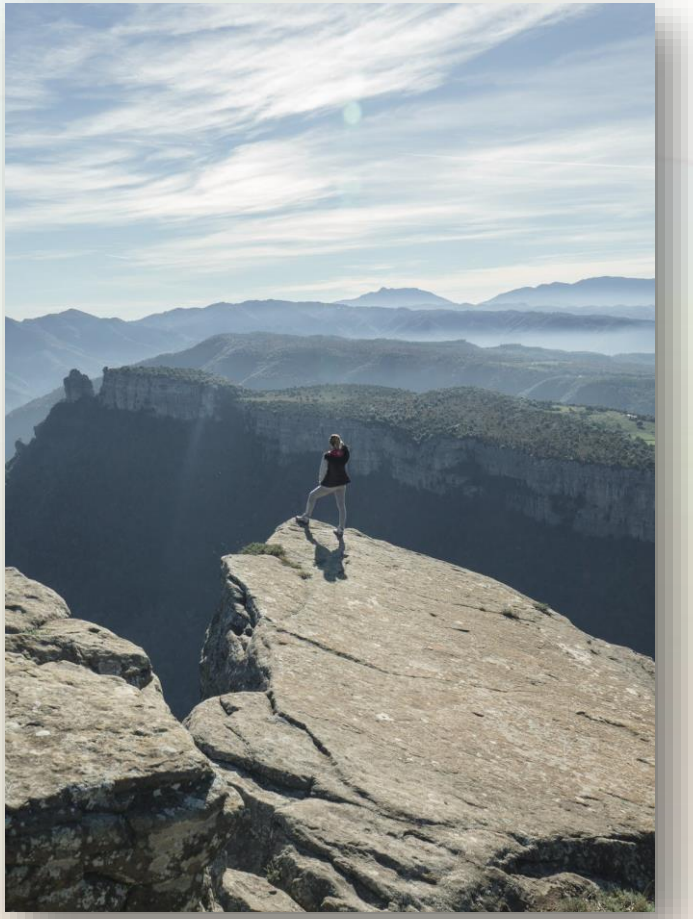

Unity is strength... when there is teamwork and collaboration, wonderful things can be achieved.
– Mattie Stepanek
Double Quotes
doublequotes.net

Agenda

1. MHSA Overview
2. Updates
3. New/Expanded
4. Reflections
5. What's Next

Overview: MHSA Point In Time

Where are we now and where are we headed?



Focus of Efforts

2018

- Plan for Innovations
- Launch AOT Pilot
- Deliver MHSA Annual Update 19/20 in corresponding fiscal year
- Continuous communication with Stakeholders

2019

- Finalize Innovation planning/begin implementation
- Strengthen Stakeholder engagement and capacity
- Continue MHSA oversight to ensure compliance

Overview: Context For Planning

Fiscal

MHSA funds may only be used for approved plans

Stakeholder input and local planning processes are necessary

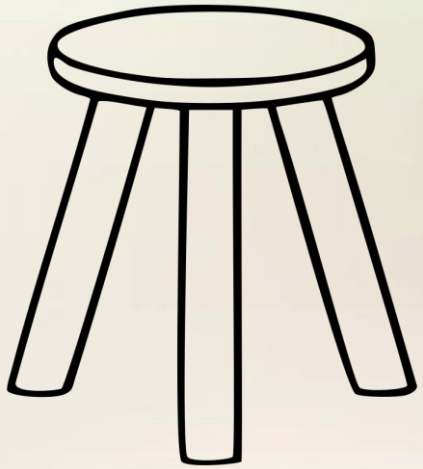
Supplantation of existing state or county funds with MHSA funds is not allowed

Processes

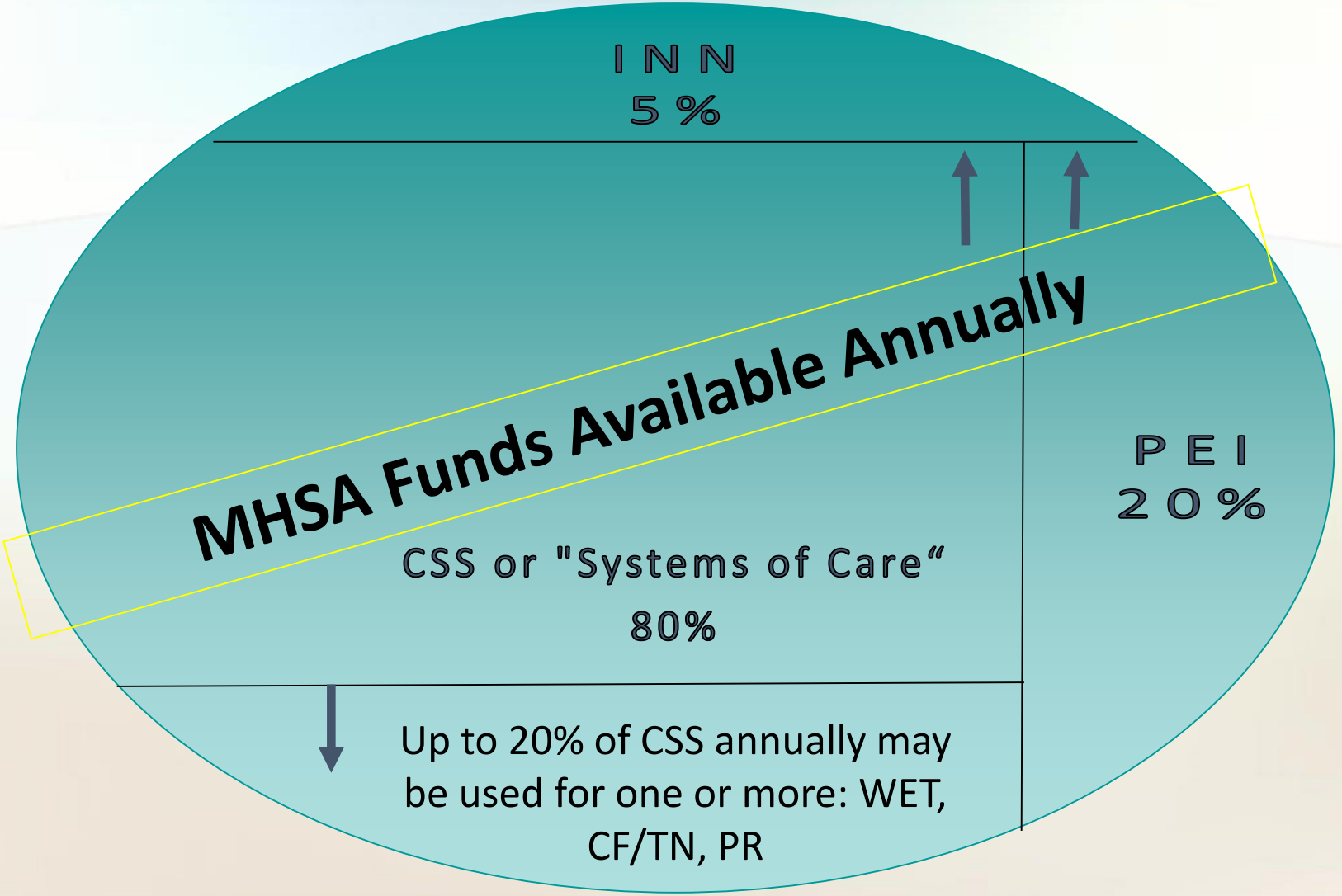
MHSA Statute, Regulations, and Guidelines

Meaningful Stakeholder Input

BHRS Capacity to implement new/expanded programs



Overview: MHSA Funding



Overview: MHSA Essential Elements

1. Community Collaboration
2. Cultural Competence
3. Client/Family driven mental health system
4. Wellness Focus – Recovery and Resilience
5. Integrated Service Experiences for clients and their families

Updates

1. Legislative Landscape
2. Innovation Projects
3. Annual Update FY 19-20
4. AOT

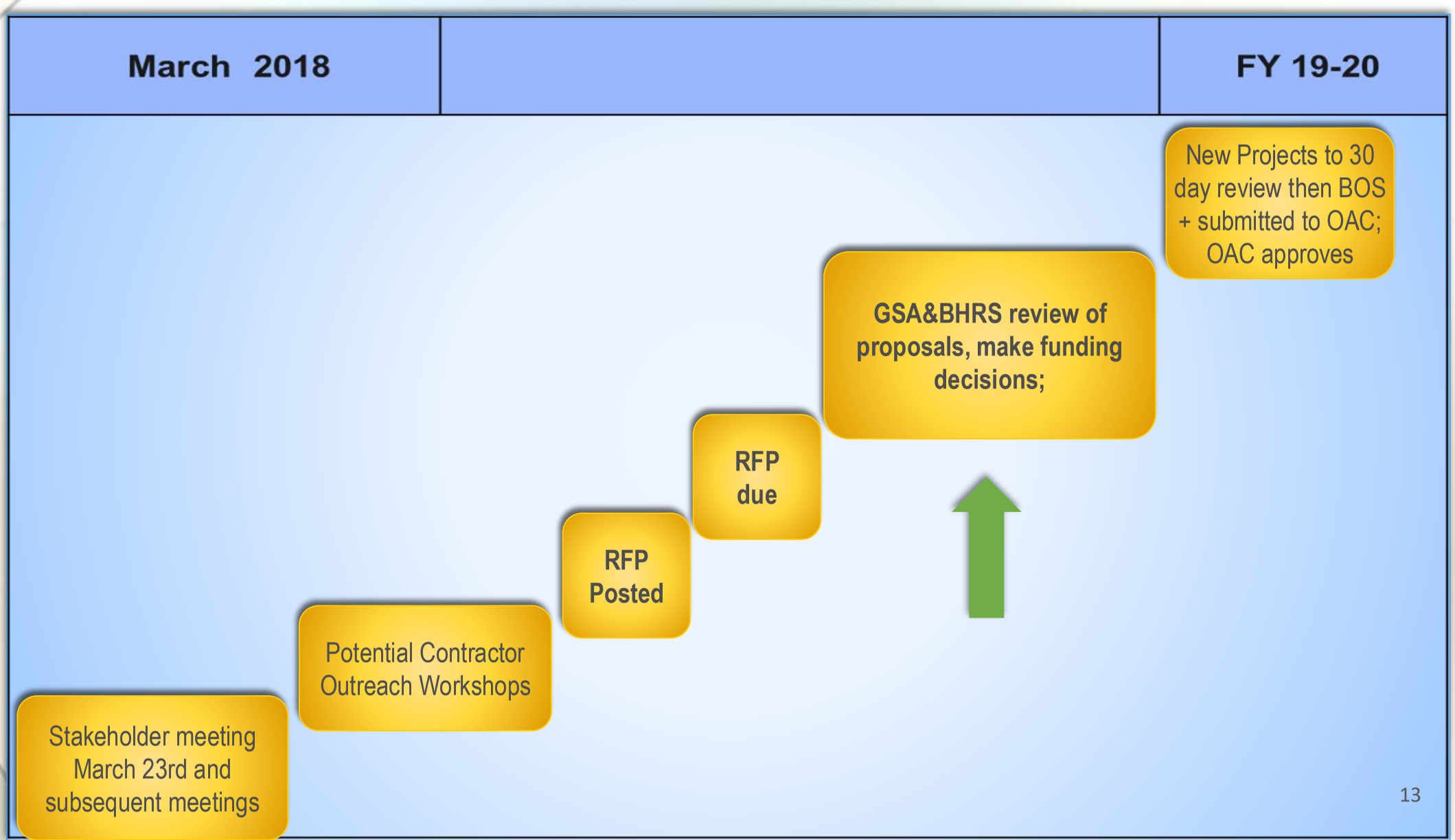
Updates: Legislative Landscape

- No Place Like Home Act of 2018
  - Prop 2 passage and implications to MHSA funds
  - Stanislaus County BHRS and partners proposal submission
- SB 1004-Prevention and Early Intervention
  - SB 1004 would create more oversight in how MHSA funds are spent and require counties to focus their PEI funds on five overarching categories:
    - Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
    - Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the life span.
    - Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
    - Culturally competent and linguistically appropriate prevention and intervention.
    - Strategies targeting the mental health needs of older adults.

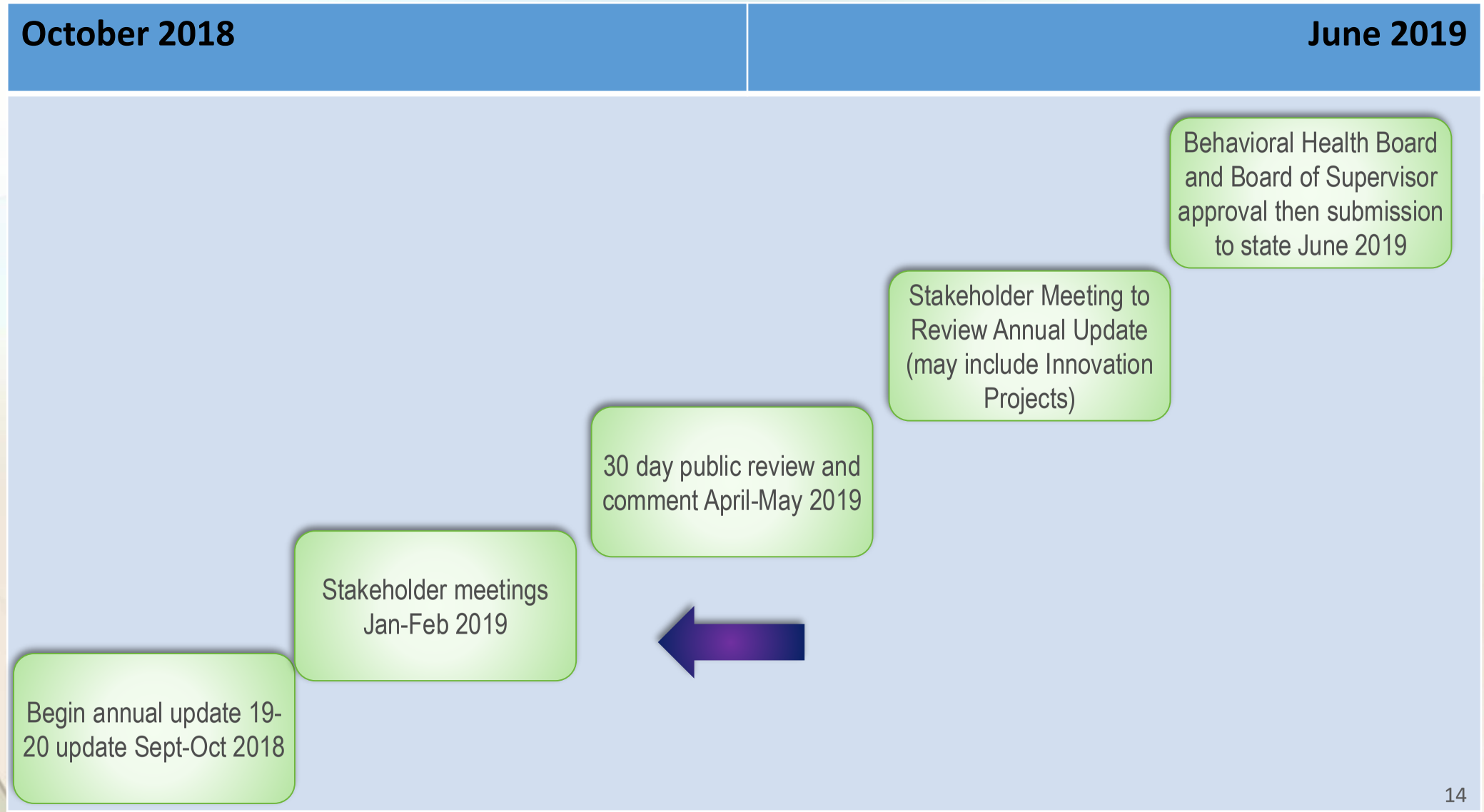
Updates: Innovation Projects

- Current Projects
  - Co-Occurring Full Service Partnership
  - Suicide Prevention Innovation Project
- New Projects
  - Timeline and status

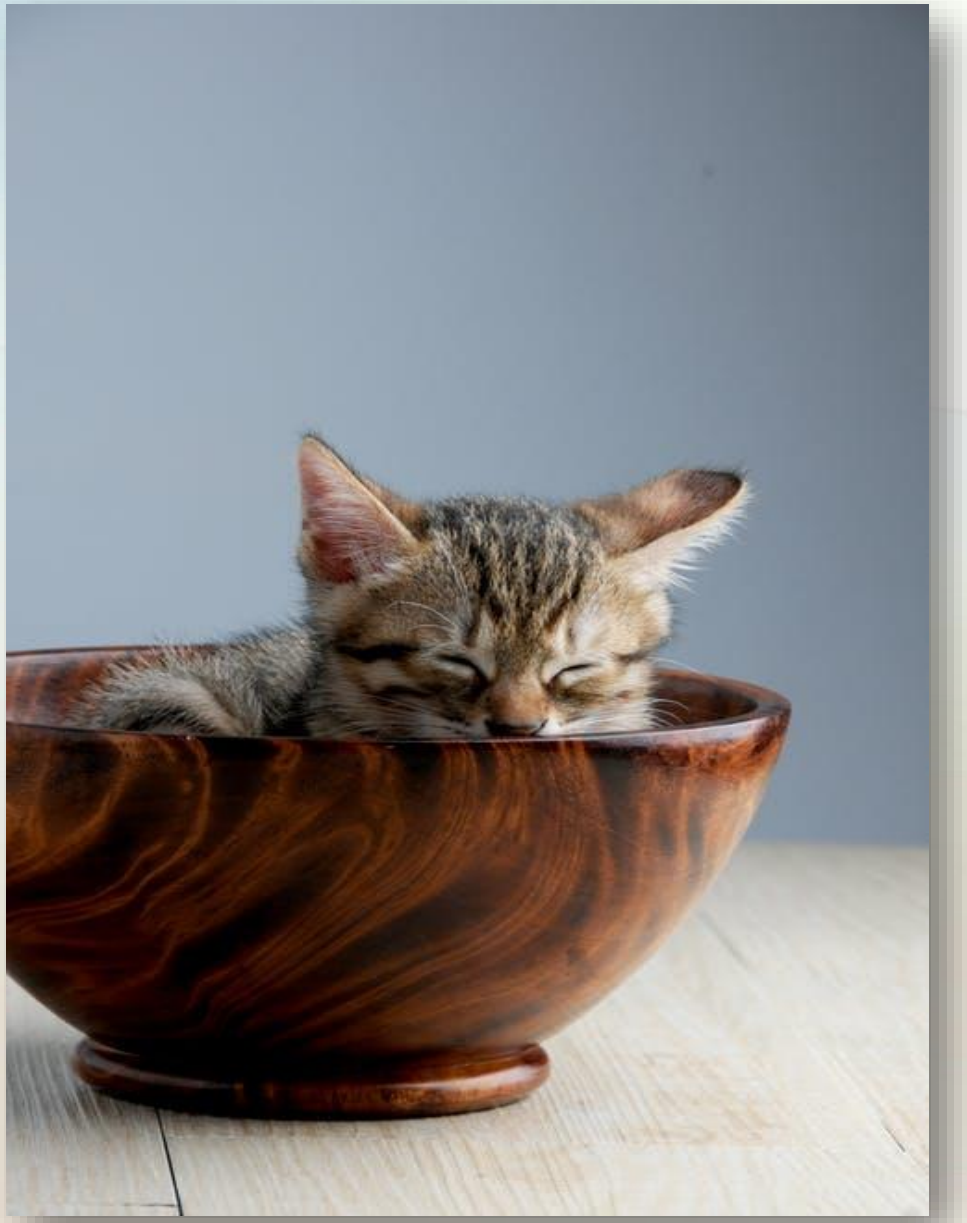
Update: Innovation Timeline



Update: MHSA Annual Update FY 19-20



Break



Update: AOT

- Assisted Outpatient Treatment
  - Three year pilot
  - Approved as part of Annual Update FY 18-19
  - Full team in place
  - Officially launched in October of 2019
  - Operations Oversight Committee

New and Expanded in CSS

- Co-Occurring Disorders
  - Supported Housing

Co-Occurring Disorders Project: Learnings

1. Will clients be successfully engaged by receiving a combination of services through this new FSP?

2. Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?

3. What engagement strategies and interventions will emerge from this concurrent stage-based approach that are most effective for this population?

4. While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?

5. Will access to integrated primary care positively affect outcomes?

6. Will employing an integrated "Housing First" approach positively affect outcomes?

7. Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support and linkages to mental health resources?

Co-Occurring Disorders Project: Learnings

"Getting a Better Picture"

Dialogue

with Dawn Vercelli

Chief, Substance Use Disorders Services

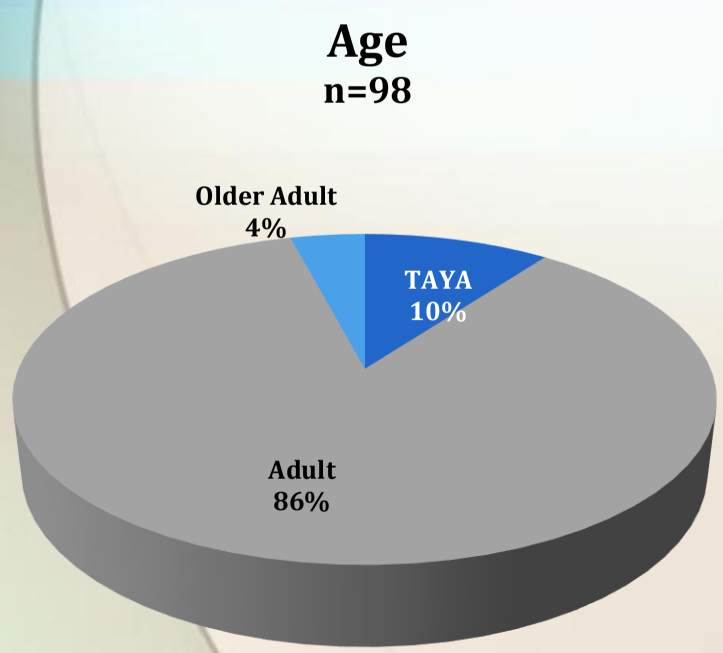
&

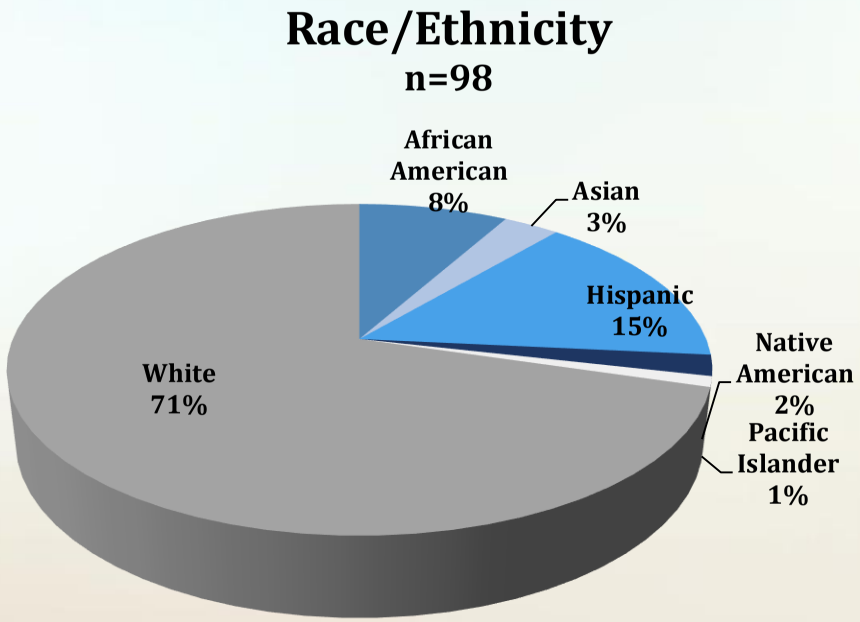
Melissa Hale,

Mental Health Coordinator

Co-Occurring Disorders Project: Data

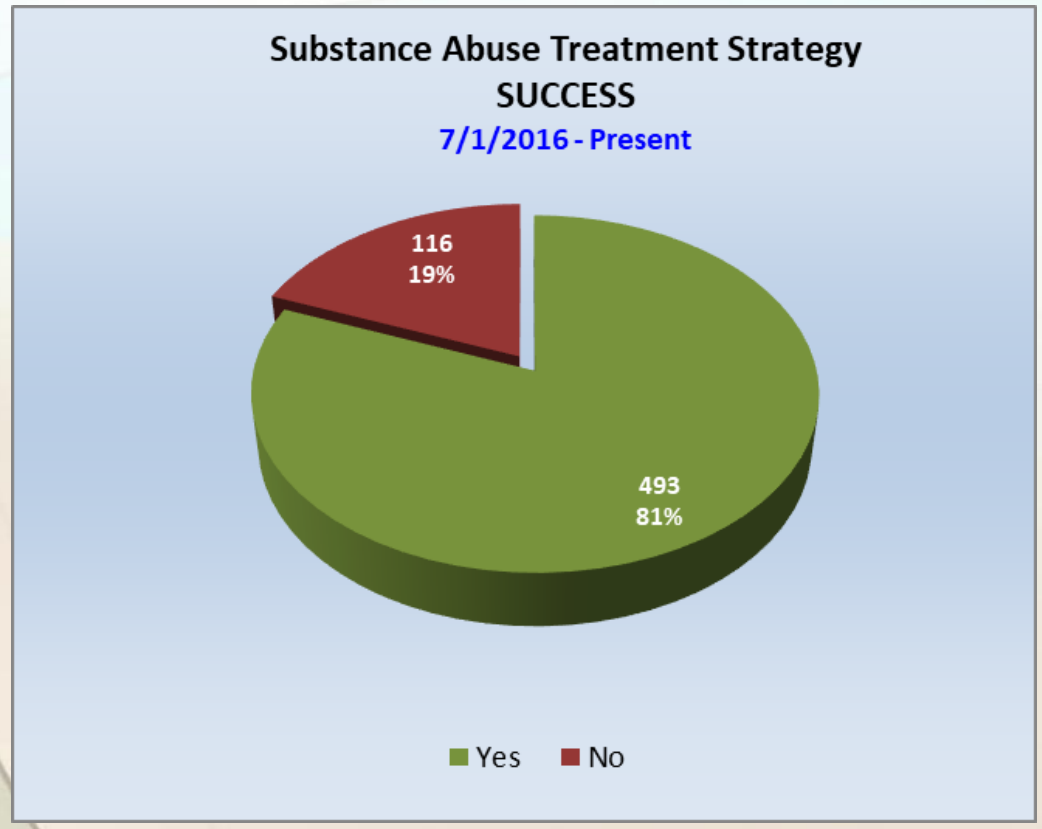
Clients Served:98

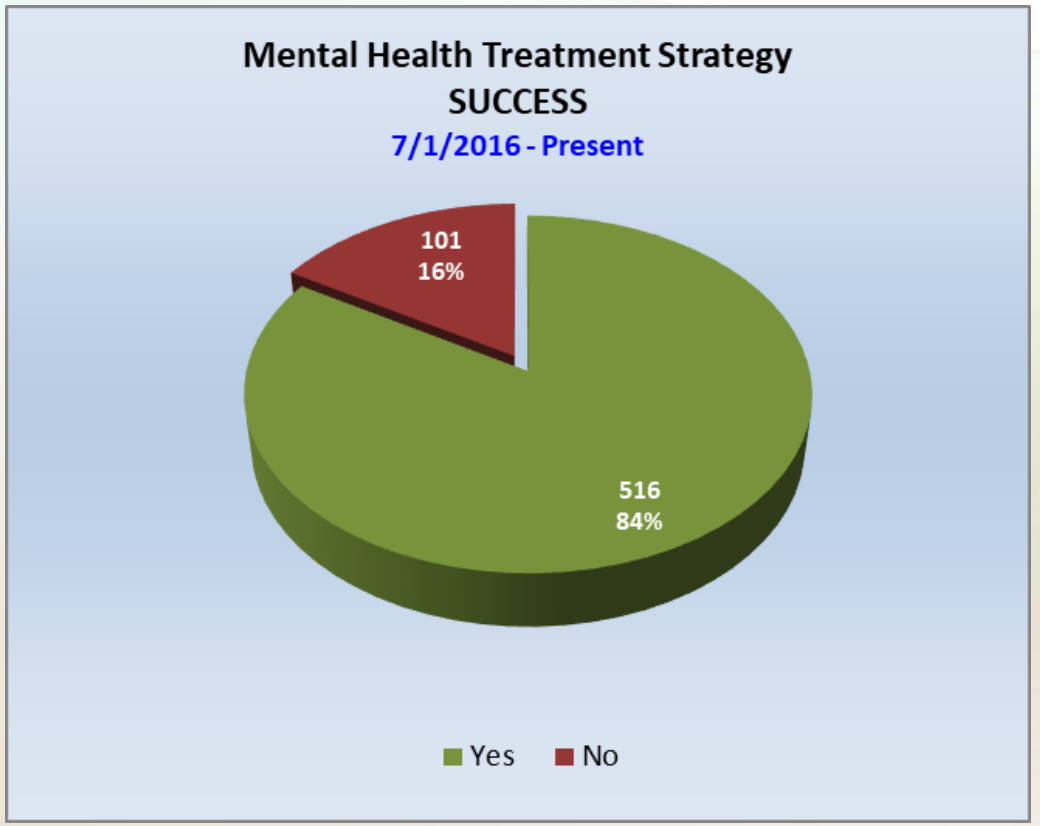




Mental Health Recovery Treatment Stages (MHRTS)

Substance Abuse Treatment Scale (SATS)

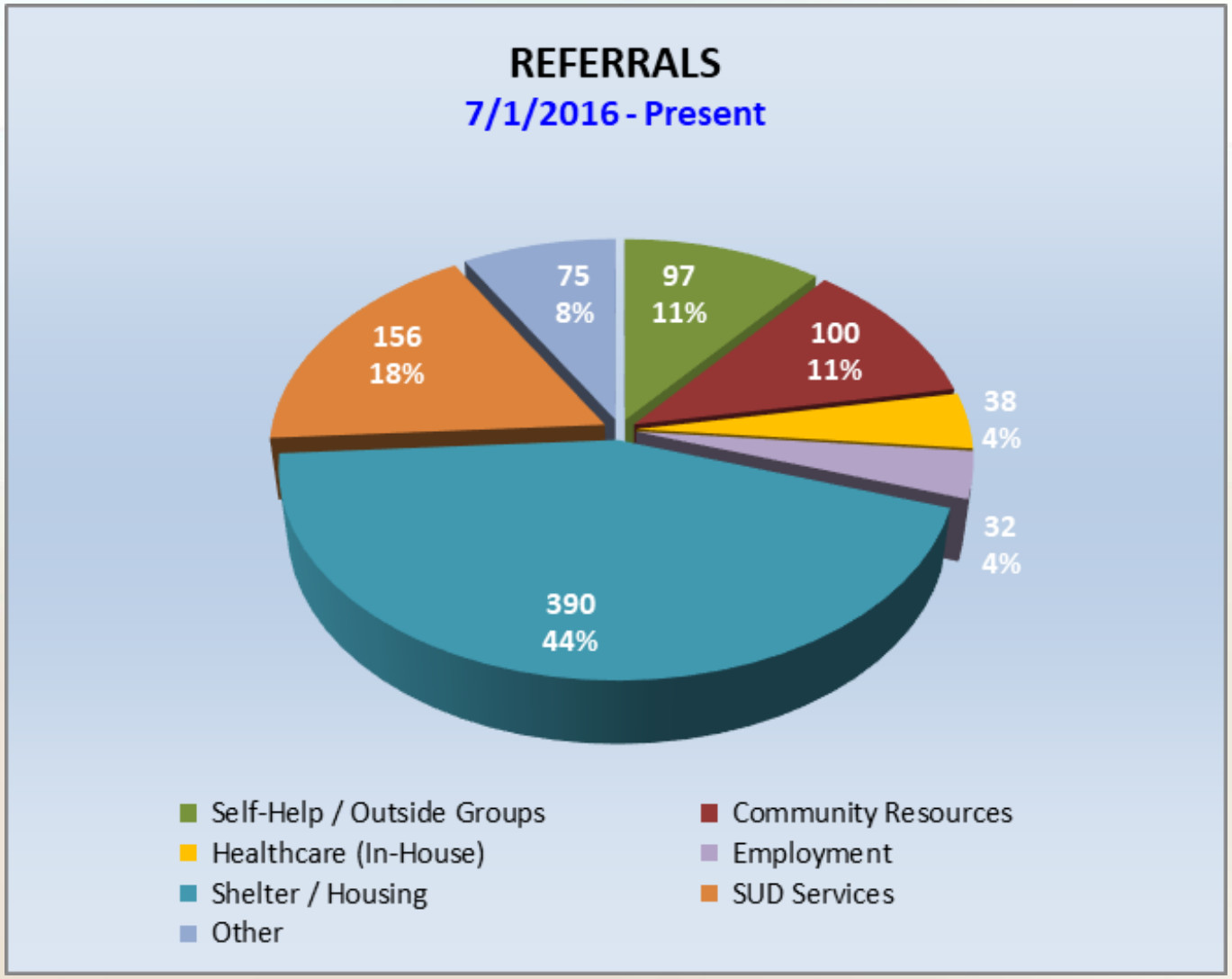




Co-Occurring Disorders Project

Total # Referrals: **888**

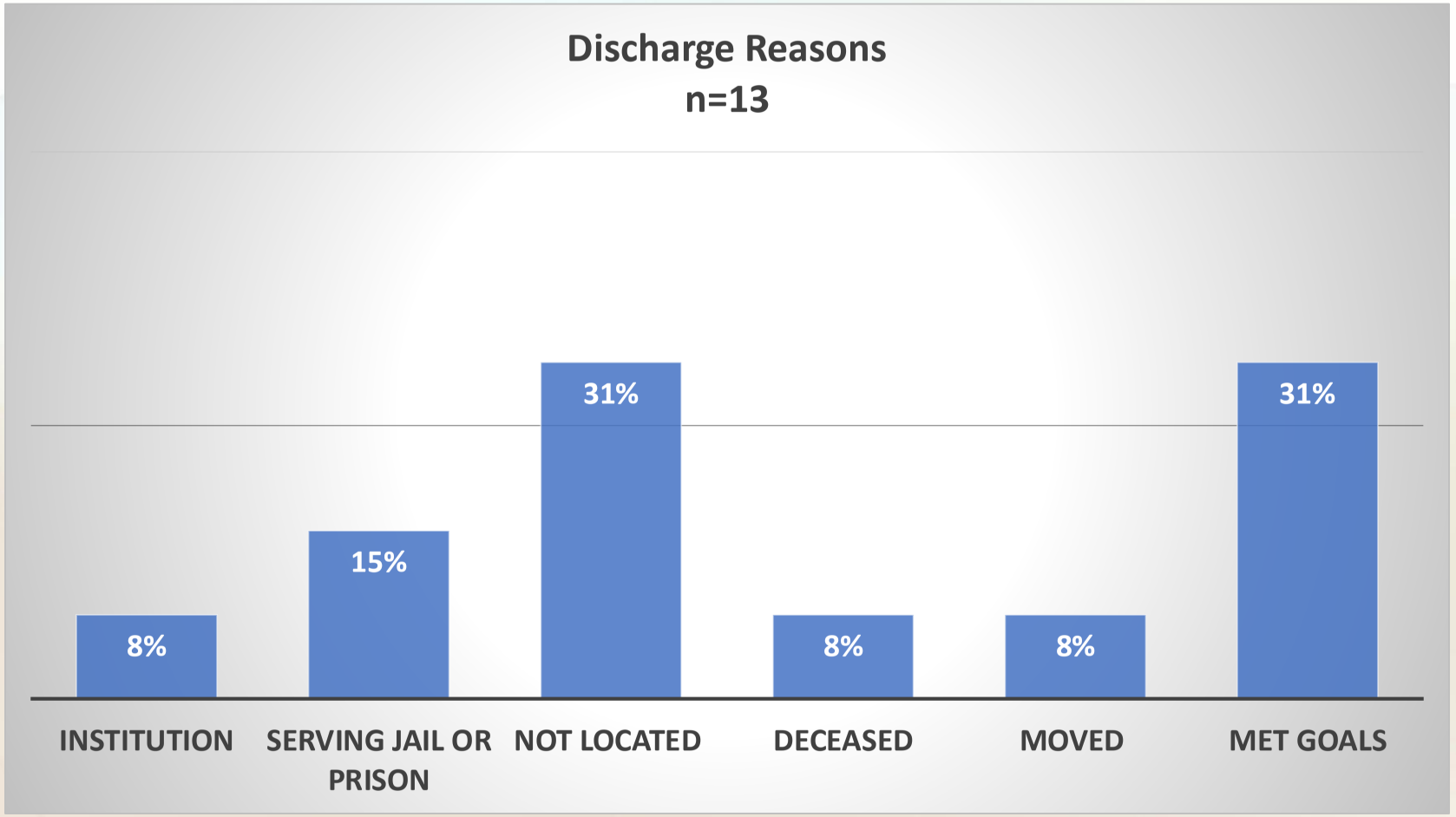
50% resulted in a successful linkage



Outcomes for Clients in Assertive Community Treatment (ACT) Level

Outcomes for Partners After One Year in COD FSP n=32		
	Partners	***Days***
Homelessness	↓29.4% (from 17 to 12)	↓55.2% (from 2,593 to 1,162)
Incarcerations	↓50.0% (from 12 to 6)	↓30.9% (from 601 to 415)
Acute Medical Hospitalizations	↓40.0% (from 5 to 3)	↓78.9% (from 109 to 23)
Acute Psych Hospitalizations	↓32.0% (from 25 to 17)	↓5.8% (from 516 to 486)
State Psychiatric	↓100% (from 3 to 0)	↓100% (from 480 to 0)

Outcomes for Clients in Assertive Community Treatment (ACT) Level



Supportive Housing

- No Place Like Home Housing Projects: $326,892
- Housing Staff: $383,146
  - Mental Health Clinician (1)
  - Behavioral Health Specialist (2)
- Allocation towards increasing contracts to transitional board and care facilities: 1.7 million

No Place Like Home Projects

- Three Projects – “Scattered Site”
- Partnership with Housing Authority of Stanislaus County
- Total increase of 19 units
  - 1143 Park Ave. Turlock- eight new units and three rehabilitated units
  - 513 N. Palm Ave.- four new units
  - 400 block, Vine Ave. Modesto- four, one bedroom cottages

What did you hear?

What are you excited about?

What do you wonder about?

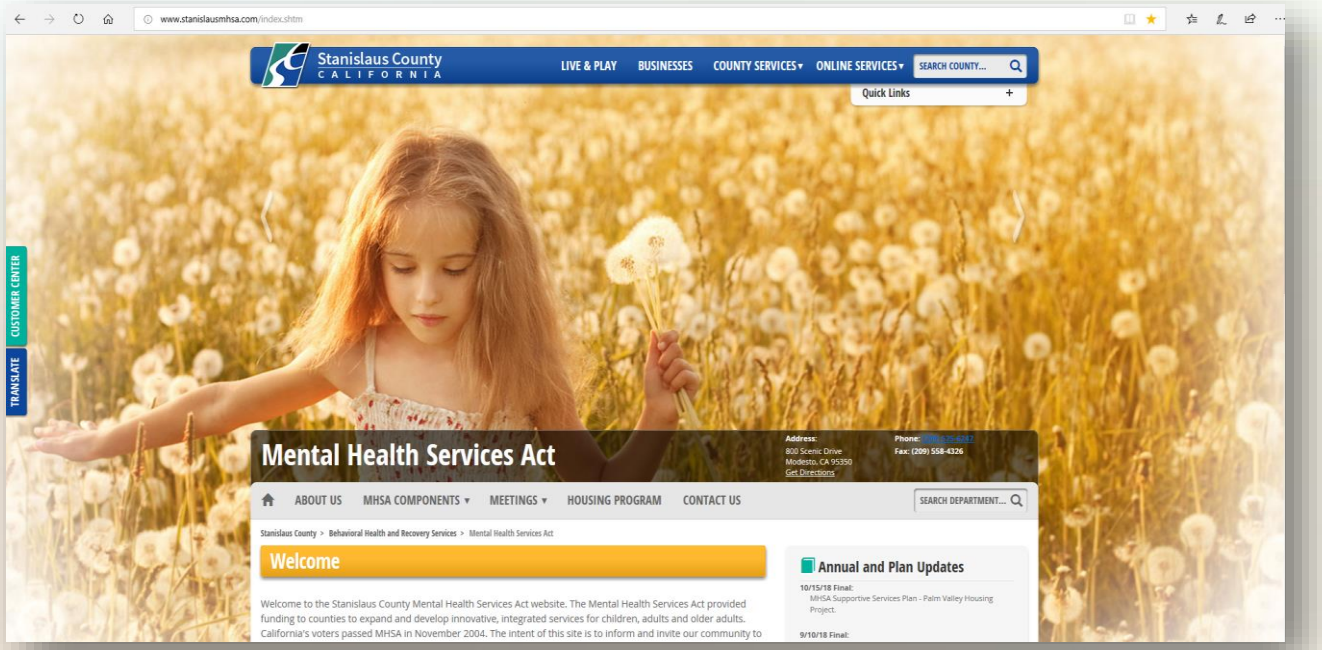
What's Next

- Annual Update FY 19-20 Production
- Representative Stakeholder Meeting April 19th

Close

- Reflections
- Feedback forms

www.stanislausmhsa.com



Thank you for your partnership!

Behavioral Health And Recovery Services