Alameda County Behavioral Health

Full Service Partnership Assessment

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Introduction

In late 2023, Alameda County, Disability Rights California, and the United States Department of Justice entered into a settlement agreement addressing the provision of community behavioral health services in the County. The settlement agreement includes provisions designed to assess the need for Full Service Partnership (FSP) and mobile crisis services in order to inform the County's program development and expansion efforts. Alameda County Behavioral Health Services (ACBH) contracted with the Indigo Project (Indigo) to conduct the FSP assessment.

ACBH provides a full range of behavioral health services, ranging from crisis services through outpatient, residential, and inpatient programs to address mental health, substance use, and co- occurring disorders. Through a partnership with the Office of Homeless Care and Coordination (OHCC), ACBH also funds a range of housing options for people with behavioral health issues.

This assessment focuses on the Full Service Partnership program, specifically on the needs and gaps in FSP services for individuals ages 16 years and older. Full Service Partnerships are a model set forth by the Behavioral Health Services Act (BHSA) and are the highest level of outpatient mental health services provided in the community. **The purpose of this assessment is to estimate the number of FSP slots needed to serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.** This assessment also considers an analysis of any demographic or other variables that may influence participation in FSP programming as well as the challenges and barriers in identifying, referring, engaging, and serving individuals who need an FSP-level of care. This assessment is informed by local service utilization data, community and stakeholder input, and available literature and evidence-based practices and results in an estimate of FSP slots needed to appropriately serve individuals who meet FSP eligibility criteria.

This assessment does not include any evaluation of existing FSP programs and therefore does not assess quality and outcomes of existing FSP programs. While this assessment does use local service utilization data from hospital, crisis system of care, and community-based behavioral health services within Alameda County's continuum of services, this assessment does not include any assessment or evaluation of the capacity or quality of any other programs that an FSP-eligible individual may access, including crisis, housing, and other residential and outpatient services.

Background Information

Full Service Partnerships

The term Full Service Partnership (FSP) was coined during the drafting and passage of the Mental Health Services Act in the early 2000s. It is a term that is specific to California and is codified in the Mental Health Services Act, Welfare and Institutions Code, and Title 9 of the California Code of Regulations. The FSP Service Category is intended to provide a "whatever it takes" approach to supporting individuals with significant mental health challenges who require an intensive level of mental health and other supportive services to live safely in the community and reduce the risk and incidence of crisis, hospitalization, incarceration, and homelessness. The regulations set forth eligibility criteria for the FSP Service Category[1] [2] as well as the service expectations.[3]

FSP-eligible individuals must meet specialty mental health criteria and FSP eligibility criteria. Specialty mental health criteria include a serious mental disorder that is "severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time."[4] FSP criteria includes the following:

> *Transition Age Youth* who are unserved or underserved and homeless or at risk of homelessness; aging out of the child and youth mental health, child welfare, and/or juvenile justice systems; involved in the criminal justice system, at risk of involuntary hospitalization or institutionalization, or have experienced a first episode of serious mental illness.
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> *Adults* who are unserved and homeless or at risk of homelessness, involved in the criminal justice system, and/or frequent users of hospital and/or emergency room services as the primary resource for mental health treatment; or adults who are underserved and at risk of homelessness, involvement in the criminal justice system, and/or institutionalization.
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> *Older Adults* who are unserved and experiencing a reduction in personal and/or community functioning; homeless; or at risk of homelessness, becoming institutionalized, out-of-home care, or becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment; or older adults who are underserved and at risk of homelessness, institutionalization, nursing home or out-of-home care, frequent users of hospital and/or emergency room services as the primary resource for mental health treatment, and/or involvement in the criminal justice system.[5]

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[1] California Code, Welfare and Institutions Code - WIC § 5600.3
[2] Cal. Code Regs. Tit. 9, § 3620.05 - Criteria for Full Service Partnerships Service Category
[3] Cal. Code Regs. Tit. 9, § 3620 - Full Service Partnership Service Category
[4] California Code, Welfare and Institutions Code - WIC § 5600.3
[5] Cal. Code Regs. Tit. 9, § 3620.05 - Criteria for Full Service Partnerships Service Category

FSP programs are expected to provide a "full spectrum of community services necessary to attain the goals identified in the Individual Services and Supports Plan." This includes mental health services including mental health treatment, peer support, alternative and culturally specific treatment, personal service coordination/case management, family education, crisis intervention/stabilization, and other supportive services regarding housing, employment, and/or education. FSP services also include non-mental health services, such as food, clothing, housing, cost of healthcare, cost of co-occurring disorders treatment, and respite.[6]

FSP programs are associated with improved outcomes for people who participate, including improved access to and participation in mental health services, reduced crisis and emergency mental health services,[7] [8] reduced criminal justice involvement,[9] [10] and reduced homelessness and improved housing status.[11] [12]

Placing Full Service Partnerships in Context

Given that FSP is a term specific to California, in order to understand what the existing body of literature says about "FSP-like" programs outside of California, we must place the FSP Service Category within the larger continuum of mental health services. Specifically, we must look to programs across the nation that serve a similar population to those served in FSP—individuals with serious mental illness who have either experienced or are at risk of crisis, hospitalization, incarceration, and/or homelessness.

The FSP concept was originally based on a modified version of Assertive Community Treatment (ACT), which is an evidence-based practice for supporting people with significant mental health issues to live in the community. FSP may also be considered an intensive case management (ICM) program, which is a broader term for a collection of programs and services that support individuals who are affected by and living with serious mental illness to live in the community but may need the higher level of care.

ACT is a model that arose in the 1970s and is one of the most widely studied mental health models with consistent outcomes.[13] Often referred to as a "hospital without walls," the ACT model was designed to support individuals—who would otherwise be confined in a locked psychiatric setting—to live meaningfully within the community. The ACT model is characterized by a low 1:10 staff-to-client ratio that employs a multi-disciplinary team who practice a team-based approach to community mental health services.[14] The ACT model specifies the positions and ratios to staff the

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[6] Cal. Code Regs. Tit. 9, § 3620 - Full Service Partnership Service Category
[7] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201100384
[8] https://www.ingentaconnect.com/content/wk/mcar/2017/00000055/00000003/art00015
[9] https://mhsoac.ca.gov/wp-content/uploads/SB-465-Report-to-the-Legislature_approved_ADA.pdf
[10] https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/SFMHSA5YearReport-2010.pdf
[11] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/210805
[12] https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/SFMHSA5YearReport-2010.pdf
[13] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.51.6.759
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471983/

team, including psychiatry, nursing, and peer support, as well as a team-based approach. Unlike case management programs where an individual might work predominantly with a single staff member, all staff members of an ACT team interact with the individuals that they serve on the team. The ACT model also prescribes the intensity and frequency of services with multiple face-to-face contacts expected per week and sets forth that the majority of services should be provided outside of an office setting.

ACT teams are intended to provide all of the services an individual may need; they serve less of a case management/brokerage function and provide more direct intervention based on an individual's needs and preferences. High fidelity ACT programs are associated with reductions in psychiatric hospitalization, crisis, and homelessness.[15] Forensic ACT, which is a modified ACT team that specializes in serving individuals who are involved with the criminal justice system, is associated with reduced arrests and incarcerations.[16]

Unlike ACT, ICM does not refer to a specific model or intervention. ICM is a term used to describe a collection of programs that provide more intensive services than a typical outpatient mental health service; it does not have the same prescriptive staffing or approach as ACT.[17] ICM programs are generally characterized by approximately a 1:20 staff-to-client ratio and operate with an assigned case manager who serves as the primary point of contact to support the client in receiving needed services.[18] ICM programs may have interdisciplinary staff, but may also operate only with case management and psychiatry staff with referrals to other services. ICM programs may be predominantly field-based or office-based. Similar to ACT, ICM programs are associated with reductions in psychiatric hospitalization, crisis, incarceration, and homelessness.[19]

ACBH uses the ACT model of care to design and implement their FSP programs. ACBH also provides ICM programming through their Service Teams. ACBH's FSP programs and Service Teams are intensive, community-based mental health programs that are intended to support individuals impacted by significant mental health challenges to live successfully in the community. In alignment with the outcomes expected of FSP programs, people enrolled in ACBH FSP programs for at least one year experience reductions in crisis admissions, psychiatric hospitalizations, and incarcerations. Among individuals enrolled in ACBH FSP programs during fiscal year 22-23, the proportion of individuals who experienced crisis admissions dropped from 75% in the year prior to FSP enrollment to 49% of clients during their most recent year of FSP enrollment. The proportion of FSP clients who experienced psychiatric hospitalizations in the year prior to enrollment dropped from 49% to 25% during their most recent year of enrollment, and one third (33%) of FSP clients

[15] https://store.samhsa.gov/sites/default/files/sma08-4344-theevidence.pdf
[16] https://journals.sagepub.com/doi/full/10.1177/00938548211061489
[17] https://ps.psychiatryonline.org/doi/10.1176/ps.2007.58.1.121
[18]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6472672/#:~:text=Intensive%20Case%20Management%20(ICM)%20is%20one%20such%20intervention.,clients%20(fewer%20than%2020).
[19] Ibid.

were incarcerated at Alameda County Jail in the year prior to FSP enrollment compared to 24% during their most recent year of enrollment.

Assessment Questions

There are two primary questions that guide this assessment:

1. What are the barriers and challenges to identifying, referring, engaging, and serving individuals who need an FSP-level of care and what demographic variables influence participation?
2. How many FSP slots are needed to serve individuals[20] who meet FSP eligibility criteria under 9 C.C.R. § 3620.05?

By answering these two questions, this assessment supports the County to estimate the additional need for FSP slots, considering any barriers and challenges for eligible individuals to access and participate in the services.

The assessment includes a mixed methods analysis that leverages: 1) demographic and service utilization data about individuals who meet FSP inclusion criteria, 2) community and stakeholder input, and 3) the research and literature regarding ACT and ICM, eligible individuals, and evidence-based practices for identifying, engaging, and serving eligible individuals in intensive community-based programming. The assessment culminates in an estimate of FSP capacity, including an analysis of the barriers and challenges to FSP participation for eligible individuals.

[20] The settlement agreement specifies estimating FSP slots for individuals ages 16 and older in order to ensure the assessment includes transition aged youth (TAY). In Alameda County, TAY FSP programs serve individuals ages 18-24, while individuals under 18 are served in ACBH's child FSP program. The assessment will include analysis of ACBH Adult and TAY FSP programs, and therefore will only include individuals ages 18 and older as an analysis of child FSP programs (ages 0-17) would be outside the scope of the settlement agreement.

Assessment Question 1 Methodology

The first assessment question seeks to understand: What are the barriers and challenges to identifying, referring, engaging, and serving individuals who need an FSP-level of care as well as any demographic variables that may influence participation? The settlement agreement specifically requires the following to inform the assessment of how many FSP slots are needed to appropriately serve individuals in the County:

> *Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups.*

The purpose of this assessment question is to explore the demographics and other variables for individuals who met FSP eligibility criteria but did not receive or maintain participation in FSP services. This question focuses on exploring the group identified in the first question that are FSP-eligible but did not receive FSP services, as well as those who were enrolled in an FSP and did not sustain participation in services.

Figure 1 summarizes the methodology to address Assessment Question 1, where we first use ACBH administrative data to identify the demographic characteristics and other characteristics of individuals who were FSP-eligible but did not receive, accept, or sustain participation in services. The quantitative data findings were used to engage community stakeholders and community providers in a discussion of barriers and challenges to engagement and participation in FSP services. This included discussion around barriers and challenges to identifying FSP-eligible individuals, engaging them in services, and supporting their ongoing participation in services.

Figure 1. Assessment Question 1 Process Flow

Quantitative Methods

Quantitative data were used to:

1) Describe referrals to ACBH FSP programs and identify individuals who met FSP criteria but were not enrolled in an FSP program;
2) Identify who is and is not enrolling in ACBH FSP programs and how long it takes to get from referral to enrollment in FSP; and

3) Assess FSP service delivery and participation, including differences across sub-populations.

Indigo worked with the ACBH Data Services Team to identify and obtain aggregate data from the ACBH electronic health record (EHR) systems, including the ACCESS database, Insyst client database, and Sheriff's Office jail booking and incarceration data via the ACBH Data Warehouse.

Analyses included individuals 18 and older referred to or enrolled in ACBH FSP programs.[21] The FSP programs included in the analysis are listed below:

- **TAY FSP:** BACS PAIGE FSP, Fred Finch Youth & Family Services STAY FSP
- **Adult FSP:** Abode Greater Hope FSP, BACS HEAT FSP, Telecare Changes FSP, Telecare Strides FSP
- **Older Adult FSP:** BACS Circa60 FSP
- **Adult Forensic FSP:** BACS LIFT FSP, Telecare JAMHR FSP
- **Assisted Outpatient Treatment (AOT) & Community Conservatorship (CC) FSP:** Telecare AOT FSP; Telecare CC FSP

Indigo used descriptive statistics to study referral, enrollment, service delivery, and service participation for FSP services in Alameda County. To the extent possible, Indigo also examined differences across the following demographic characteristics: age group, race / ethnicity, gender, language, city, and housing status. Additional information about the specific data utilized and analyses performed is summarized below.

Referrals to ACBH FSP

Indigo examined all referrals for individuals ages 18 and older to ACBH FSP programs in FY21-22. Among FSP referrals, we examined: 1) the type of FSP program individuals were referred to (i.e., TAY, Adult, Older Adult, Adult Forensic, AOT/CC), 2) the referring party, 3) demographic characteristics of referred individuals, and 4) clinical profile of referred individuals. Clinical profile included:

- **Substance Use Disorder Diagnosis:** Number of individuals who had a documented substance use diagnosis in any ACBH program episode during the 5-year period from FY18-19 to FY22-23.
- **Behavioral Health Diagnoses:** Types of behavioral health diagnoses, including schizophrenia and psychotic disorders, mood disorders (depressive and bipolar disorders), trauma-related disorders, or other diagnoses.
- **Crisis Admissions & Jail Bookings:** Number of individuals who were admitted to crisis receiving centers in Alameda County (Amber House CSU, John George PES, Cherry Hill

[21] Referrals to and participation in Berkeley Mental Health FSP programs were excluded.

Sobering Center) or booked at Santa Rita Jail, as well as the average number of crisis receiving center admissions and/or jail bookings in the year prior to referral. The number of jail bookings were included as some people may be arrested and transported to jail rather than being taken to other crisis receiving centers.

- **Psychiatric Hospitalizations:** Number of individuals with a psychiatric hospitalization in the year prior to referral, including average number of psychiatric hospitalizations, average number of hospital days, and length of stay.
- **Incarcerations:** Number of individuals incarcerated in the year prior to referral, including average number of incarcerations, incarcerated days, and length of incarceration.

To determine whether there were individuals met FSP criteria but did not receive an FSP service, Indigo identified individuals who met FSP inclusion criteria but were not enrolled in and had never been referred to ACBH FSP services as part of Assessment Question 2. We explored differences in demographic characteristics between FSP clients and individuals who met FSP inclusion criteria but were never referred to FSP.

Enrollment in ACBH FSP

After identifying referrals to ACBH programs in FY21-22, Indigo assessed how many referrals enrolled in FSP services by the end of FY22-23 (June 30, 2023) and how long it took to enroll. The outreach and engagement process to get individuals to accept FSP services can sometimes take several months. To account for the outreach and engagement period, we examined enrollment up to June 30, 2023, allowing at least 1 year for referred individuals to enroll in FSP. To explore differences in enrollment across sub-populations, we compared demographic characteristics of individuals who did and did not enroll in FSP by June 30, 2023.

ACBH FSP Service Delivery and Service Participation

Indigo identified how many individuals were enrolled in ACBH FSP programs for at least one day in FY22-23. Among these individuals, Indigo assessed: 1) program enrollment length at the end of FY22-23 (June 30, 2023), 2) service frequency (i.e., average number of services per month), 3) service intensity (i.e., average length of services), and 4) level of service participation. We also examined whether there were differences in service engagement patterns across demographic characteristics.

Service frequency, intensity, and level of participation analyses examined FSP services during FY22-23 in order to standardize the time period for assessment. These analyses excluded individuals with less than one month of FSP enrollment. Service analyses assessed FSP services directly with the client (excluding collateral contacts, no shows, and cancellations). Service participation analyses assessed face-to-face FSP services directly with the client and excluded phone services. Telehealth services were included as face-to-face services. Additionally, service analyses excluded out-of-community time when individuals were not available for services (e.g., incarcerated, hospitalized).

To examine differences in service participation, we created two service participation sub-groups:

- **Active service participation:** Individuals who participated in an average of 4 or more face-to-face FSP services per month.
- **Low service participation:** Individuals who participated in an average of fewer than 4 face -to-face FSP services per month. Individuals who only participated in phone services would be included in this group.

As part of the service participation analysis, Indigo explored whether any individuals received no FSP services during FY22-23. Only one individual, with more than one month of enrollment, did not participate in any FSP services. This individual is included in the "not active participation" group. Indigo also explored whether and how many individuals stopped engaging in FSP services for a period of 90 days or longer; however, this number of individuals was small and are not reported in the findings.

Qualitative Methods

Survey and Key Informant Interviews

In order to better understand FSP program models, Indigo conducted a short survey followed by a key informant interview with staff from each FSP provider team. First, we developed and administered a short online survey to gather information from FSP teams about program capacity. The goal of this survey was to gather readily available data on contracted and available slots to inform the subsequent interview and to ensure we were starting each interview with the same information across providers.

Next, we conducted a one-hour long meeting with a representative or representatives from each FSP provider. We gathered background information to understand each provider's program model, their staffing model and current vacancies, and challenges they are facing in providing contracted services.

Focus Groups

After Indigo completed and compiled the quantitative analysis, the team conducted four focus groups with consumers, families, referring parties, and FSP service providers. The goal of the focus groups was to understand strengths and barriers to FSP services at each step in the process from identification and outreach to ongoing service delivery.

The referring party focus group included gathering information about how referring parties become aware of someone who should be referred to an FSP; reasons a referring party decides to refer or not refer a person; the referral process; and strengths and barriers to referring individuals who may need these services. Referring parties were also given the opportunity to review and react to quantitative data on referrals and services to provide additional context about quantitative findings. The referring party focus group was composed of individuals representing John George, Santa Rita Jail, Amber House, Cherry Hill, and IHOT.

The focus group with FSP services providers gathered information on FSP services from identification to discharge. Indigo asked about reasons a person may engage or not engage in FSP services, and strengths and challenges to engagement at each step in the process. Similar to the referring party focus group, FSP providers were given the opportunity to review and react to quantitative data on referrals and services to provide additional context about quantitative findings. The focus group was attended by representatives from each of the four agencies that provide FSP services in the County.

For clients and families, we asked about service experience both prior to and during service participation. Indigo inquired about how determinations were made around service delivery; factors that promoted or detracted from service engagement; and strengths and challenges to FSP service provision.

Data Limitations and Methodology Adjustments

During the assessment process, Indigo made minor methodology adjustments in response to emerging data trends as well as data limitations or availability. One of the first steps in the assessment was to confirm that existing FSP programs align more closely with an ACT level of care, while Service Teams align with an ICM model of care. This was supported by quantitative data, showing FSP clients had a more acute clinical profile and received more frequent and intensive services than Service Team clients. If FSP and Service Teams had provided a similar level of care and served a similar population, we proposed examining referrals, service delivery, and service participation for both FSP and Service Team programs. However, given the apparent differences in program model and population, findings are only reported for FSP programs. The assessment also excludes child and youth programs, and therefore only includes individuals ages 18 and older.[22] While all existing TAY FSP programming was included in the analysis, the overall TAY population may be slightly underrepresented as youth ages 16-17 enrolled in child and youth FSP programs were not included.

The assessment had initially intended to examine a 2-year period from FY21-22 to FY22-23. However, program operations were still somewhat impacted by COVID during FY21-22. In order to assess the most current operations, we adjusted the methodology to focus on clients, service delivery, and service participation in FY22-23. For the referral analysis, however, we assessed referrals made in FY21-22. As mentioned, the outreach and engagement process to get individuals to accept FSP services can take months and clients referred in one fiscal year may

[22] Behavioral health services in Alameda County for individuals ages 16-17 are within the children's system of care. While FSP and other outpatient services within the Transition Age Youth division provide services from age 18 through 25, crisis, residential, and hospital programs that serve children and youth stop at age 17, and youth ages 18 and up are served within adult services as required by state licensing agencies. Services for minors are subject to separate policy and regulatory guidance that differs from the requirements for programs that serve individuals ages 18+. This assessment does not include services within the children's system of care and therefore does not estimate need for 16-17 year olds. Additionally, 16 and 17 year olds who require FSP services would receive them through the children's system of care, and this assessment did not include an assessment of the capacity needed for children's FSP services as this would fall outside of the scope of the settlement agreement. Services for transition age youth ages 18-25 are included in the assessment.

not be enrolled until the next fiscal year. FSP program data were incomplete beyond FY22-23 due to a transition in the County's EHR. As a result, we were unable to examine enrollment for all referrals made in FY22-23, and instead focused the analysis on FY21-22 referrals.

Some quantitative data was not available or had quality concerns. FSP programs do not track outreach and engagement contacts in the EHR before the individual has enrolled in FSP. As a result, it was not possible to explore the associations between outreach and engagement and FSP enrollment quantitatively, and this was instead assessed through stakeholder interviews. Housing status is often difficult to assess from administrative datasets because many people experiencing homelessness use a mailing address, such as a friend or family member or homeless service provider location. Within the dataset available for the assessment, the housing status indicator was largely unreported for referred individuals and was unreported for one-third of FSP episodes, making it difficult to examine trends in referral, enrollment, and service participation between the housed and unhoused populations. From the data available to this assessment, it is reasonable to assume that many of the FSP clients experience homelessness.[23] Lastly, to comply with HIPAA and protect client anonymity, demographic groups with fewer than 12 clients are either aggregated or are not reported. Lastly, to comply with HIPAA and protect client anonymity, demographic groups with fewer than 12 clients are either aggregated or are not reported.

[23] It was infeasible to review other data sources that would contain more detailed information regarding housing status, such individual client charts.

What are the barriers and challenges to identifying, referring, engaging, and serving individuals who need an FSP-level of care and what demographic variables influence participation?

FSP Referrals

Who is being referred to FSPs?

In Fiscal Year (FY) 21-22 there were a total of 221 referrals made to ACBH FSP programs for adults (including Transitional Age Youth, Older Adult, and Forensic FSP programs). As shown in Table 1, among these referrals, nearly 70% were for people diagnosed with schizophrenia spectrum and other psychotic disorders (55%) or bipolar and related disorders 14%. Seven percent (7%) of referrals were for people with trauma- and stressor-related disorders, and 6% were for people with depressive disorders (17% had deferred diagnoses). Over half of referrals (57%) to FSP programs were for people with co-occurring substance use disorders.

Table 1. Mental Health and Substance Use Disorder Diagnoses of People Referred to FSP Programs in FY21-22 (N=221 Referrals)

Diagnoses	Referrals	Percent
Mental Health Diagnosis		
Schizophrenia Spectrum and Other Psychotic Disorders	121	55%
Bipolar and Related Disorders	32	14%
Trauma- and Stressor-Related Disorders	16	7%
Depressive Disorders	14	6%
Diagnosis Deferred	38	17%
Substance Use Diagnosis		
Active SUD Diagnosis	127	57%
No Active SUD Diagnosis	94	43%

Table 2 below shows that nearly half (45%) of referrals to FSP programs in FY21-22 were for people who identified as Black/African American, while approximately 20% identified as White, 13% identified as Hispanic/Latino, 9% identified as Asian American or Pacific Islander, and 13% identified as another race or did not report their race. Nearly all referrals were for people who spoke English as their first language. Over half of referrals were for men (60%) while 40% were for women. Although approximately 60% of referrals to an adult FSP were between the ages of 25 and 59, a large proportion of referrals were for transitional age youth as well (30%), and

approximately 10% of referrals were for adults ages 60 and over. Finally, most referrals to FSP programs were for people whose last known residence was in Oakland (42%), Hayward (15%), or San Leandro (15%).

Table 2. Demographic Characteristics of People Referred to ACBH FSP Program FY21-22 (N=221 Referrals)

Demographic Characteristic	Referrals	Percent
Race/Ethnicity		
Black / African American	100	45%
White	45	20%
Hispanic / Latino	29	13%
Asian / Pacific Islander	20	9%
Other or Unknown	27	13%
Age Group		
18-24	66	30%
25-59	129	58%
60+	26	12%
Gender		
Male	132	60%
Female	89	40%
City		
Oakland	92	42%
Hayward	34	15%
San Leandro	33	15%
All Other Cities	62	28%

Overall, the population referred to FSP in FY21-22 appeared to have acute needs, experiencing significant levels of crisis, hospitalization, and incarceration. Among all referrals:

- **Crisis Episodes**: 76% experienced at least one crisis episode (CSU, PES, Jail, Sobering Center) in the year prior to FSP referral, with an average of 7.3 crisis episodes each. Most crisis episodes resulted in PES admissions. Sixty-eight percent (68%) of referrals to FSP were for people admitted to PES at least once in the year prior to FSP referral, with an average of 5.3 PES admissions each.
- **Psychiatric Hospitalizations**: 54% experienced a psychiatric hospitalization in the year prior to FSP referral, with an average of 2.2 hospitalizations lasting approximately 20 days in the year prior to FSP referral.
- **Incarceration:** 37% were booked into Alameda County Jail at least once in the year prior to their FSP referral, with an average of 4.7 jail bookings and 128 days spent in jail in the year prior to FSP referral.

Where are referrals to FSP coming from?

Among the 221 referrals made to adult ACBH FSP programs in FY21-22, mental health providers such as outpatient therapists, psychiatrists, case managers, and other representatives from the ACBHD systems of care, made 54% of referrals, while 18% of referrals were self-referrals or from family and friends. Only 12% of referrals were made from law enforcement agencies, 6% were from John George PES and crisis programs (including but not limited to mobile crisis programs), 5% were from hospitals or another medical professional, and 5% came from other sources such as CPS and APS, among other community agencies.

Are there people who met FSP eligibility criteria but were not referred to an FSP program?

As described in the proceeding Assessment Question 2 Findings section, there were 1,080 people who: 1) met FSP inclusion criteria, 2) were not connected to an ACBH FSP or Service Team in FY22-23, and 3) had never been referred to an ACBH FSP program. Comparing this group with the 221 referrals to FSP in FY21-22 helps to identify characteristics associated with people who might have been referred to FSP but were not. To that end, Table 3 demonstrates that the 1,080 individuals who met FSP inclusion criteria but had never been referred to an FSP were more likely to be criminal justice involved, diagnosed with a trauma-related disorder, adult (as opposed to TAY and older adults), and male. These individuals were also less likely to have experienced non-jail crisis episodes and psychiatric hospitalizations. There were no notable differences across race/ethnicity.

Table 3. Comparison of Characteristics of People Referred to FSP in FY21-22 with People who Met FSP Inclusion Criteria in FY22-23 and were Never Referred to an FSP

	Met FSP inclusion criteria in FY22-23 & Never Referred to FSP (n=1,080)	Referrals to FSP in FY21-22 (n=221)
Justice System Involvement	55% met FSP criteria through incarceration in year prior to eligibility (4+ jail bookings and/or 28+ days in jail)	37% with one or more jail bookings in year prior to FSP referral
Mental Health Diagnosis	37% diagnosed with a trauma-related disorder	9% diagnosed with a trauma-related disorder
Gender	74% male	60% male
Age Group	85% ages 25-59	58% ages 25-59

What are the barriers to identifying and referring people for ACBH FSP Programs?

Findings from focus groups suggest that **there are groups of people who are in need of FSP services, but do not get a referral for a number of reasons including: 1) a person refusing services prior to a formal referral, 2) consumers and family members not always having knowledge about FSP services in the County, and 3) reentry planning challenges resulting in many individuals who are justice-involved not being referred to FSP upon release from**

custody. Providers reported that sometimes an individual will be asked if they are interested in FSP services, and if the person declines, the referral is never made. Data are not available to determine the extent to which people decline FSP services prior to a referral that is then never made. Another barrier to getting referred to FSP services appears to be knowledge about FSP services. In the consumer focus group, there was a large group of people who appeared to have a high level of need. Most individuals had substantial experience with crisis events, jail, hospitalization, and homelessness; yet, these people were not aware of what an FSP service was in the County. Additionally, service providers noted that it appears that many justice-involved individuals are not being referred to FSP and suggested there may be opportunities to increase referrals for these individuals.

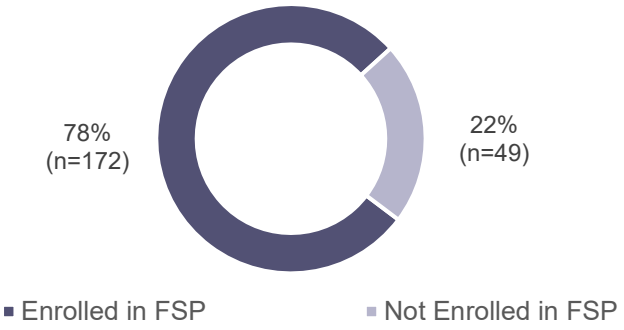
Another challenge arises when a person is already in a Service Team but needs a higher level of care. Service Teams provide a lower level of care compared to FSP; however, some people who likely need FSP remain in Service Teams for a number of reasons. Referring providers, like those at John George, explained that if a person is already enrolled with a Service Team, they are unable to refer that person to FSP; instead, the individual must be referred to FSP through their Service Team provider. Additionally, sometimes a person feels connected to their Service Team case manager and they do not want to transition to FSP. At other times, the Service Team is reluctant to refer a client to a FSP for different reasons. Providers shared that in some cases there may be reluctance to make a referral because there have been instances where someone referred to FSP did not connect to services and fell out of care. For language-specific providers, there is an added reluctance because they have had prior experiences when they referred someone to FSP and there have been language or other cultural barriers that result in the person not doing as well with the FSP as they were with the Service Team.

FSP Service Enrollment

Once referred to FSP services, who is enrolling?

Of 221 referrals for FSP in FY21-22, 78% (n=172) resulted in FSP enrollment by the end of FY22-23, while 22% (n=49) did not (Figure 2).

Figure 2. Proportion of FY21-22 FSP Referrals Resulting in FSP Enrollment (N=221)



Among the 49 referrals that did not result in an FSP enrollment, 28 were closed by the end of FY22-23 while 21 referrals remained open (and the person had not yet enrolled in services). Stark differences suggesting certain demographics groups were significantly more or less likely to enroll in FSP were not found. However, there were some slight differences in enrollment rates across demographic characteristics, noted below:

Race: Seventy-five percent (75%) of referrals for Black/African Americans resulted in FSP enrollment, compared to 78%, 79%, and 80% of referrals for White, Hispanic/Latino, and Asian American and Pacific Islanders, respectively.

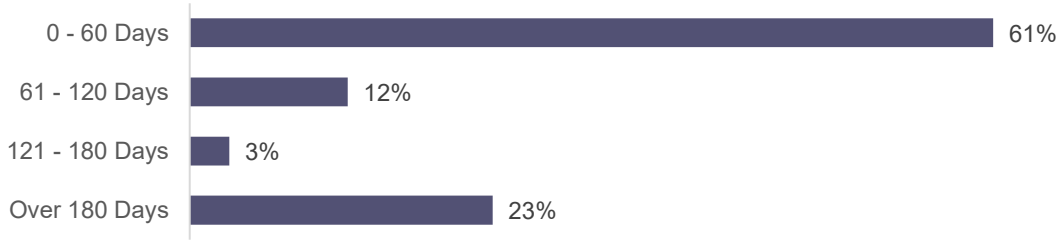
Age: A higher proportion of referrals for transitional age youth (86%) resulted in FSP enrollment than referrals for adults (75%) and older adults (69%).

Gender: A higher proportion of referrals for females (81%) than male (76%) resulted in FSP enrollment.

How long, on average, does it take for a person to get from referral to enrollment in an FSP service?

Figure 3 below shows that among referrals resulting in an FSP enrollment, 61% resulted in enrollment within 2 months. A much smaller proportion resulted in FSP enrollment within 2 - 6 months (12% in 61-120 days and 3% in 121–180 days). Notably, nearly one-quarter (23%) of referrals resulting in FSP enrollment took six months or longer to complete.

Figure 3. Number of Days from Referral to Enrollment (N=172)



Overall, there were no notable differences suggesting shorter or longer periods from FSP referral to enrollment for certain demographic groups, other than age and FSP population. Referrals for transitional age youth tended to result in enrollment more quickly than referrals for adults and older adults. Eighty-two percent (82%) of FSP referrals resulting in enrollment for transitional age youth were completed within 0 to 120 days, compared to 70% of FSP referrals resulting in enrollment for adults (ages 25-59) and 67% of referrals resulting in enrollment for older adults (age 60 or older). In addition, enrollment in Adult Forensic FSP programs took longer than other programs—only 65% of FSP referrals resulting in Adult Forensic FSP enrollment were completed within 0 to 120 days.

The differences in time periods to enrollment, specifically for those individuals who had an open referral (i.e., referral not yet closed or enrolled in FSP) for six months or more, likely indicates the individual was unavailable for enrollment (e.g., incarcerated, hospitalized, etc.) or was unable to be located and was lost to follow-up, and was then reconnected to the FSP provider when experiencing an additional crisis, admission, or jail booking because they were in a known location.

What are the barriers to engaging and enrolling people in ACBH FSP Programs?

When an FSP referral is made, it typically goes through the ACBH ACCESS program. If a person is not connected to services, providers will connect a person to ACCESS to determine what level of service they need. Referring parties mentioned that they have experienced the ACCESS line as being fairly responsive. After the referral has been made, ACCESS staff engage with an individual and determine the level of care needed. If they determine that the person needs an FSP, ACCESS staff will assign them to an FSP provider.

Because of the population, people are often hard to find and engage in services after they have been assigned to an FSP provider. However, liaisons with County staff are often helpful. Referring parties reported that they work closely with County connections to try to identify where a person may be located, and mobile outreach is often another source of support in locating a person. Providers also reported that they try to gather as much collateral information (i.e., information from family, friends, or other third parties) about a person to facilitate a smooth connection.

FSP providers reported they have similar approaches to outreach, but did not have a set standard of how many attempts at contact they will make in a referral. Some providers reported attempting outreach contacts three to five times total while others reported focusing on a timeframe of reaching out three times per week for four to six weeks. In part, this variation in outreach may be because providers receive referrals from different sources. Some programs, like those that serve transition age youth, are usually able to get a warm handoff from another provider and the linkage is often easier. Other providers get most referrals from other system partners such as the Public Defender or Parole Office.

For all providers, **warm handoffs were especially helpful in connecting with the individual to begin the outreach and enrollment process**. Often, providers reach out to the referring party to connect or meet the person at a specific location. For example, one provider reported having success with referrals from Parole officers when they can go directly to the Parole office and connect to the referred individual. Additionally, providers reported that people who are referred from an IHOT or Crisis Residential program that are being connected to an FSP may be more likely to engage because they have been stabilized in the prior service. Providers spoke of how contact with IHOT often facilitates a successful transition to FSP. **Providers reported that when a person is not connected to any other providers or system partners, outreach and engagement is often very difficult.**

When people are at John George or Santa Rita Jail, it is often easier to initially engage them in services but engagement may not last after they are released. Several providers reported that people often agree to services while hospitalized or incarcerated, but then refuse to participate when they come back into the community. For example, as one referring party mentioned, providers at Santa Rita Jail will try to connect a person to an FSP or Service Team and provide a warm handoff, but the person will not continue with those services post-release. In part this is because those that have the highest needs for an FSP service are also the ones that struggle the most to seek help. Another barrier noted by referring parties is service providers' limited ability to engage with people in-custody and build rapport to facilitate service engagement post-release. To help address this challenge, staff at Santa Rita Jail are getting tablets to be able to connect people in custody to providers remotely while also working on getting clearance for providers to see clients while they are in custody. Several providers mentioned that the ability to offer a subsidy or access to housing can be a large incentive to participate in FSP services, especially for individuals being released from jail.

FSP Service Delivery & Service Participation

How many FSP episodes were open during FY22-23 and for how long?

In FY22-23, there were 1,083 FSP episodes open (i.e., individual was enrolled in FSP) for at least one day during the year, representing 1,055 unique individuals. Of these episodes,

- 50% were open to an Adult FSP program (non-forensic)
- 22% were open to an Adult Forensic FSP program
- 13% were open to a TAY FSP program,
- 8% were open to an Older Adult FSP program, and
- 7% were open to AOT or Community Conservatorship.

At the end of FY22-23, 81% of these episodes remained open and 19% were closed. The average length of enrollment was 4 years (median 2.7 years, range: 3 days to 27 years), and overall, 29% of people were enrolled in FSP for less than one year, 30% were enrolled for 1-3 years, 27% were enrolled 3-5 years, 7% were enrolled 5-10 years, and 6% were enrolled 10+ years.

What level of services do people in FSPs receive, and what kinds of services are they receiving?

We examined 975 FSP episodes for people who spent at least 30 days in the community (not in jail, PES, or a hospital) while enrolled in FSP to assess service frequency and intensity and examine if there were differences across demographic groups. Overall, FSP clients received an average of 6.5 services per month, including 5.4 face-to-face service contacts and 1.2 phone contacts (excluding no shows, cancellations, and contacts with collateral), for an average of 9.6 hours per month. Most face-to-face contacts took place in the field (85%) and 15% occurred in an office setting. Face-to-face contacts lasted an average of 1 hour 45 minutes while phone contacts

lasted an average of 40 minutes. There were no notable differences in service frequency and intensity across demographic groups.

Are there differences in the levels of FSP service participation among different groups?

We examined the same 975 FSP episodes for people who spent at least 30 days in the community while enrolled in FSP during FY22-23 to assess the level of service participation among FSP clients.

- **Active Service Participation**: Clients who, on average, had 4+ face-to-face services with the FSP provider per month.

- **Low Service Participation**: Clients who, on average, had less than 4 face-to-face services with the FSP provider per month.

Based on these criteria, which assume that FSP clients should have at least one face-to-face contact per week, 60% of FSP clients met active service participation criteria. On average, individuals with active service participation had 8.3 service contacts (including collateral contacts) and received 12.6 hours of services per month. These included 5.9 face-to-face services and 1.3 phone contacts per month.

In comparison, 40% of FSP clients met the low service participation criteria. On average, these individuals had 3.7 service contacts and received 4.8 hours of service per month, including 2.6 face-to-face contacts and 1.1 phone contacts.

Table 4 below shows the level of service participation across demographic characteristics. Overall, there were some minor differences in level of service participation across gender and race, however there were more notable differences in participation levels across age groups, housing status, region of residence, and FSP population types.

Age Group. A higher proportion of older adults (74%) met active service participation criteria than adults aged 26-59 (58%) and transitional age youth (52%).

Housing Status: A lower proportion of unhoused FSP clients (48%) met active service participation criteria than those who were housed (62%) or in some other type of housing or treatment setting (64%). However, it is notable that housing status was unknown or unreported for 33% of clients, making it difficult to reliably identify trends across housed and unhoused clients.

Region of Residence: Fewer FSP clients live in East and South (n=85) Alameda County compared to Central (n=370) and North County (n=466) which include the cities of Oakland, Hayward, and San Leandro. Among FSP clients who do live in East and South County, a lower proportion met active service participation criteria (45%) compared to Central (68%) and North County (59%).

FSP Population Types: Not referenced in the Table above, findings also suggested that a much greater proportion of FSP clients enrolled in AOT or Community Conservatorship (82%), a

Forensic FSP (77%), or an Older Adult FSP (72%) met active service participation criteria than those in Adult (51%) and TAY (52%) FSPs.

Table 4. Service Participation Level, by Demographic Characteristics of FSP Client (N=975)

Demographic Characteristic	Active Service Participation		Low Service Participation		Total	
Race/Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**
Black / African American	269	60%	183	40%	452	100
White	152	61%	96	39%	248	100
Hispanic / Latino	51	55%	42	45%	93	100
Asian / Pacific Islander	65	66%	33	34%	98	100
Other	21	49%	22	51%	43	100
Unknown	24	59%	17	41%	41	100
Age Group						
18-24	78	52%	72	48%	150	100%
25-59	373	58%	275	42%	648	100%
60+	131	74%	46	26%	177	100%
Gender						
Male	380	62%	233	38%	613	100%
Female	202	56%	160	44%	362	100%
Housing Status						
Housed	249	62%	151	38%	400	100%
Unhoused	77	48%	84	52%	161	100%
Other Housing/Treatment Setting	56	64%	31	36%	87	100%
Unknown	200	61%	127	39%	327	100%
City						
Oakland	246	60%	167	40%	413	100%
Hayward	106	65%	57	35%	163	100%
San Leandro	133	70%	57	30%	190	100%
Other	78	50%	77	50%	155	100%
Region						
North	275	59%	191	41%	466	100%
Central	250	68%	120	32%	370	100%
East & South	38	45%	47	55%	85	100%
TOTAL	**582**	**60%**	**393**	**40%**	**975**	**100%**

What are the barriers to service engagement?

Individuals with co-occurring SMI and SUD are often difficult to engage in ongoing services. As service providers mentioned, people often want access to housing or SUD services to sustain service engagement. However, it is often a challenge to get people connected to SUD services, and not all FSP programs are able to provide SUD services directly and instead link FSP clients with SUD services. As one referring party mentioned, these challenges with service engagement point to the profound impact of addiction and a lack of affordable housing in the Bay Area, especially for a population with complex needs that may not be successful in many housing settings.

As mentioned, **having an array of housing options to meet someone's needs supports engagement.** Providers mentioned that the FSP population may struggle more in board and care type housing where they need to navigate and share space with others. Similarly, consumers also discussed how getting secure housing that met their needs was a key component to their recovery process. Family members highlighted challenges getting their loved ones into stable housing and feeling that there were not enough housing options being provided.

Providers reported that challenges with engaging people on an ongoing basis often comes from a combination of an inability to locate a person and the person being unwilling to participate in services. In some cases, assigning a peer mentor is helpful in keeping engagement levels high. This aligns closely with consumers who expressed the importance of having peers accompany clinicians. Consumers also suggested that people will engage in services if the providers are caring and compassionate towards them. Family members spoke of the importance of service providers being consistent and creative in their approach toward engagement and providing a "whatever it takes" approach to services.

Both consumers and providers mentioned that **creating a sense of community can facilitate ongoing service engagement**. Several consumers spoke of their connection to the Pool of Consumer Champions as being important. Others spoke of having goals like growing in recovery and helping others as supporting them to stay engaged in services.

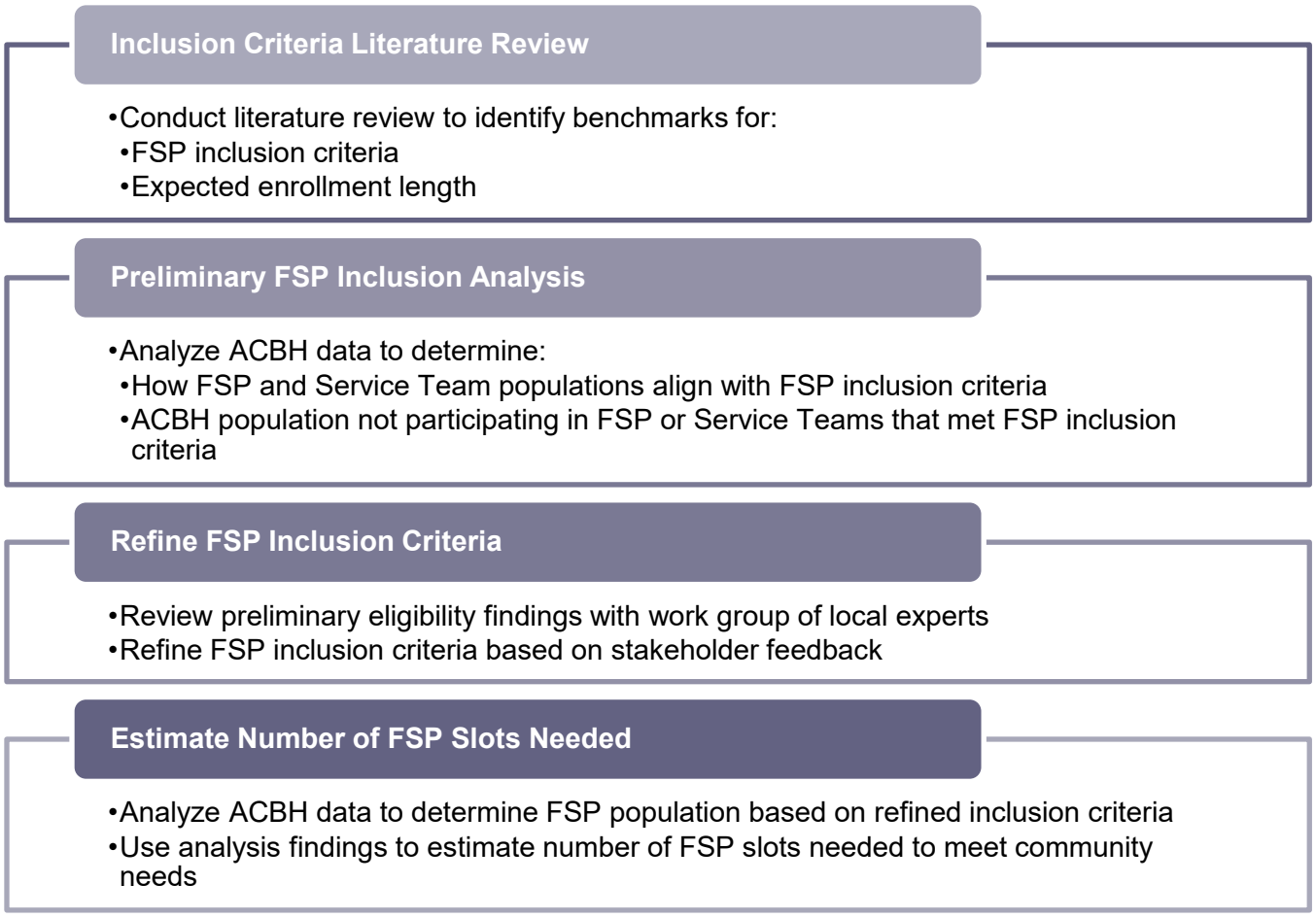
Assessment Question 2 Methodology

Assessment Question 2 aimed to answer the primary question of how many FSP slots are needed to serve individuals who meet FSP eligibility criteria under 9 C.C.R. § 3620.05. In order to answer this question, the assessment first needed to identify FSP inclusion criteria that operationalizes the FSP eligibility criteria established in state regulation. For example, FSP eligibility criteria under 9 C.C.R. § 3620.05 includes imprecise criteria such as being unserved or underserved, involved in the criminal justice system, and frequent utilization of hospital and/or emergency room services as the primary resource for mental health treatment. To identify individuals who meet state FSP eligibility criteria and determine the number of FSP slots needed, the assessment required specific, quantifiable metrics that define thresholds for imprecise FSP eligibility criteria such as criminal justice involvement and frequent utilization of hospital and emergency services. To inform the development of specific, measurable FSP inclusion criteria that align with state regulations, we conducted a literature review and benchmarking research about inclusion criteria for similar programs across the country.

We then identified the group of individuals who met FSP inclusion criteria, including examination of sociodemographic variables, clinical profile, and service utilization history. Within this FSP-eligible group, some individuals were already participating in an ACBH FSP or Service Team and some were not. Additionally, there were some individuals who participated in ACBH FSP or Service Team programs who do not meet the FSP inclusion criteria developed. Once the FSP-eligible group was identified using the criteria developed from the literature and informed by relevant regulations, Indigo assembled a group of local subject matter experts who represent the full spectrum of experiences with FSP programming and FSP-eligible individuals, including professionals and people with lived experience. This group reviewed data from the initial analysis about who met preliminary inclusion criteria and provided their guidance and expertise to refine inclusion criteria to determine what populations have an FSP-level of need. The Indigo team then re-ran the analyses with the refined inclusion criteria to estimate: 1) the total number of individuals who require an FSP level of care, and 2) the number of FSP slots needed.

Figure 4 summarizes the methodology to address Assessment Question 2 and identify the number of FSP slots needed to meet community needs.

Figure 4. Assessment Question 2: Methodology Process Flow



To address Assessment Question 1, Indigo utilized several data sources, including:

- Literature review
- Interviews with ACBH FSP and Service Teams
- Quantitative data including ACBH client data and service data

For quantitative data, Indigo worked with the ACBH Data Services Team to identify and obtain aggregate data from the ACBH electronic health record systems, including the ACCESS database, Insyst client database, and Sheriff's Office jail booking and incarceration data via the ACBH Data Warehouse.

The specific quantitative elements examined include: ACBH FSP and Service Team enrollment, admissions to crisis facilities, psychiatric hospitalizations, jail bookings and incarcerations, behavioral health diagnoses, demographic characteristics, and ACBH service and referral history.

The subsequent sections provide greater detail about the specific data sources used, questions addressed, and methods employed.

Literature Review

In order to support the development of the methodology, Indigo conducted a literature review and benchmarking research to identify: 1) inclusion criteria for FSP services based on the Welfare and Institutions Code and ACT literature, and 2) expected enrollment length in FSP based on clinical stability.

FSP Inclusion Criteria

As mentioned, the assessment required the operationalization of FSP eligibility criteria outlined in state regulations into specific, measurable FSP inclusion criteria in order to estimate the number of FSP slots needed. Most information about ACT eligibility and service need is derived from service utilization patterns and cost associated with care. Many studies define ACT eligibility by the number of hospitalizations or hospital days a person experienced and note the limitation that jail bookings or length of incarceration are not included. Given the overincarceration of people with serious mental illness,[24] it is recommended to include both psychiatric hospital and incarceration episodes and/or days in estimates of need, if data are available. For hospitalization, the literature centers around 2-3 hospitalizations[25] and/or incarcerations.[26] Other studies define eligibility or appropriateness by cost and potential cost savings, meaning that the cost of FSP services should be less than the cost of not providing FSP services (i.e., crisis, hospitalization, and incarceration).

In Alameda County, the cost of FSP programming varies by provider, but ranges from $24,000-$40,000 per year per person served.[27] Using the midpoint of the range of service costs, the estimated service costs for an individual enrolled in FSP is approximately $32,000. The rates for an inpatient psychiatric admission may cost anywhere from $523 - $1,831 per day, or an average of $1,177.[28] Using this average of $1,177 per psychiatric inpatient bed day, the average cost of FSP services and housing equals about 27 inpatient bed days.[29] The average length of stay in a psychiatric inpatient unit in California for Medi-Cal beneficiaries and indigent individuals ranges from 5.1- 9.4 days with an average of 7.25 days per stay for publicly funded individuals.[30] This suggests that FSP services that align with the ACT model would be a cost effective approach for individuals who have experienced 4 or more psychiatric hospitalizations or at least 28 inpatient bed days in a year. Given the shortage of inpatient beds across the state and the need to triage available resources to those with the most acute needs, it is reasonable to assume that individuals

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[24] https://www.americanprogress.org/article/long-term-solutions-to-the-overincarceration-of-people-with-mental-health-disabilities/#:~:text=Individuals%20with%20mental%20illnesses%20are,to%20be%20killed%20by%20police.&text=The%20overpolicing%20of%20people%20with,an%20escalating%20mental%20health%20crisis

[25] Cuddeback GS, Morissey, JP, Meyer, P. Psychiatric Services , Volume 57 , Issue 12, December, 2006, Pages 1803-1806

[26] Cuddeback GS, Morrissey JP, Cusack KJ. How many forensic assertive community treatment teams do we need? Psychiatr Serv. 2008 Feb;59(2):205-8.

[27] MHSA 2023-2026 Three-Year Program and Expenditure Plan

[28]https://www.dhcs.ca.gov/Documents/BHIN-23-038-Regional-Average-Rates-for-Non-Contract-Psych- Inpatient-Hospitals-FY-2023-24-Enclosure-1.pdf

[29] Ibid.

[30] https://hcai.ca.gov/facility/santa-barbara-psychiatric-health-facility/

who may benefit from a brief inpatient stabilization may not be hospitalized. Similarly, some individuals may be arrested and booked into jail rather than transported to psychiatric emergency services. Therefore, the FSP criteria utilized in this assessment is adjusted from 4 psychiatric hospitalizations to: 4 crisis episodes and/or jail episodes *or* 28 days in an inpatient psychiatric hospital and/or jail per year.

Clinical Stability and Expected Duration of FSP Services

While ACT was originally envisioned as a time-unlimited service, its main criticism is that it may foster dependency because of this time-unlimited expectation.[31] While a hallmark of ACT is that individuals can stay for as long as they need and that there are risks with prematurely discharging individuals to a lower level of care, the current thinking about length of ACT service participation is that there should be a year of stability prior to discharge.[32] While treatment decisions should be individualized, it is reasonable to assume that an individual will take 1-2 years to stabilize[33] and then require an additional year to solidify these gains prior to discharge.[34] Clinical stability is evidenced by no more than 1 crisis episode, hospitalization, or incarceration per year. Based on the literature, clients are likely to be clinically stable and ready to be stepped down to less intensive services after an average of 3 years of ACT treatment, recognizing some clients may need a longer or shorter time to stabilize.

Preliminary FSP Inclusion Analysis & Refining Inclusion Criteria

Preliminary FSP Criteria

Four or more crisis episodes (CSU, PES, Jail Booking, Sobering Center) or 28 days or more of psychiatric hospitalization and/or incarceration in a 12-month period.

Quantitative Data

Indigo examined how many adults met FSP inclusion criteria among three populations[35]:

1) FY22-23 ACBH FSP clients,
2) FY22-23 ACBH Service Team clients, and
3) Individuals not open to ACBH FSP or Service Teams in FY22-23.

[31] Finnerty MT, Manuel JI, Tochterman AZ, et al. Clinicians perceptions of challenges and strategies of transition from assertive community treatment to less intensive services. Community Ment Health J. 2015;51:85–95.
[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4636011/
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10447266/
[34] Rosenheck R, Kasprow W, Frisman L, Liu-Mares W. Cost-effectiveness of supported housing for homeless persons with mental illness. Arch Gen Psychiatry. 2003 Sep;60(9):940-51. doi: 10.1001/archpsyc.60.9.940. PMID: 12963676.
[35] Individuals enrolled in Berkeley FSP programs and/or Berkeley residents were excluded from analysis as these individuals are served through Berkeley Mental Health.

A small number of individuals were enrolled in both FSP and Service Team during FY22-23. For these individuals, we examined FSP inclusion criteria during their FSP enrollment period (i.e., time from FSP admission to FSP discharge).

To determine whether individuals met preliminary FSP inclusion criteria, Indigo examined the following:

1) Behavioral health crisis admissions (i.e., Amber House Crisis Stabilization Unit, John George Psychiatric Emergency Services, Cherry Hill Sobering Center)
2) Psychiatric hospitalizations, and
3) Jail bookings and incarcerations at Santa Rita Jail.

For all populations, we first examined whether individuals met preliminary FSP inclusion criteria on any day FY22-23. Individuals with at least 4 crisis episodes and/or jail bookings OR 28+ days of psychiatric hospitalization and/or incarceration in the year prior to any day in FY22-23 were determined to meet preliminary FSP inclusion criteria. To further refine whether individuals required an FSP level of care, Indigo developed additional criteria specific to each population in consultation with Subject Matter Expert group.

For FSP clients who did not meet inclusion criteria in FY22-23, we looked at the following additional factors to determine whether individuals required an FSP level of care:

- Preliminary FSP Inclusion Criteria at program enrollment
- Clinical instability in FY22-23
- FSP service frequency in FY22-23
- Participation in civil court-ordered FSP programs (i.e., Assisted Outpatient Treatment FSP and Community Conservatorship FSP)

Service Team clients were determined to need an FSP level of care only if they met inclusion criteria in FY22-23. For ACBH clients not enrolled in FSP or Service Teams in FY22-23, we additionally examined:

- How individuals met FSP eligibility criteria (i.e., incarcerations and jail bookings only, crisis admissions and psychiatric hospitalizations only, or a combination of crisis/hospitalization and incarceration)
- Type of behavioral health diagnosis
- Previous referral to an ACBH Adult or TAY FSP program
- Admission to behavioral health residential treatment (adult residential treatment, crisis residential treatment, and/or short-term residential therapeutic program) in FY22-23
- Psychiatric hospitalization in FY22-23
- Behavioral health assessments at Santa Rita Jail in FY22-23 indicating need for a high

level of behavioral health care[36] (i.e., level of care determination score of 3 or 4 indicating high functional impairment and/or high risk of self-harm, or severe functional impairment and/or imminent risk of self-harm).

After identifying how many total individuals met inclusion criteria in FY22-23, we also explored how many individuals met inclusion criteria from each FSP population, including Transition Age Youth (TAY), Adults, Older Adults, and Forensic FSP populations.

Subject Matter Expert Group

Indigo convened a diverse group of local subject matter experts over two meetings to validate and refine FSP inclusion criteria. The subject matter expert group included one or more representatives from the following groups, including ACBH staff and ACBH contract provider staff:

- ACBH Adult and Older Adult Services
- ACBH TAY Services
- ACBH Adult Forensic Behavioral Health
- ACBH FSP programs
- ACBH Service Teams
- ACBH Outpatient Clinics
- ACBH In-Home Outreach Teams (IHOT)
- ACBH ACCESS Line
- Cherry Hill Sobering Center and Detox
- ACBH Crisis System of Care
- ACBH Office of Health Equity

During the first meeting, Indigo shared findings from the initial analysis about who and how many individuals meet preliminary FSP inclusion criteria and engaged subject matter experts in discussion to get their guidance on if and how inclusion criteria should be refined to determine what populations have an FSP level of need. Based on feedback from subject matter experts, Indigo revised FSP criteria in two ways: (1) by including examination of FSP services frequency needed to maintain clinical stability and (2) by incorporating behavioral health level of care determinations at Santa Rita Jail. Indigo then re-ran analyses to estimate the total number of individuals who require an FSP level of care. During the second meeting, subject matter experts reviewed and validated the refined FSP inclusion criteria.

[36] The level of care determination used at the Santa Rita Jail is an existing measurement used to assess level of behavioral health risk and need for individuals booked into the facility.

Estimate Number of FSP Slots Needed

Quantitative Data

After determining how many individuals met FSP inclusion criteria in FY22-23 and need an FSP level of care, Indigo estimated the number of FSP slots needed based on the following factors:

- Number of existing ACBH FSP slots
- Number of individuals who need ACBH FSP services in FY22-23 based on refined FSP inclusion criteria
- The number of FY22-23 FSP clients who did not meet FSP inclusion criteria and could likely be stepped down
- Average expected duration of FSP services and discharge rate
- Expected length of time to enroll identified individuals
- Expected capacity needed on an ongoing basis

To determine the expected duration of FSP services and discharge rate, Indigo examined 1) average FSP enrollment length among all FY22-23 FSP clients, and 2) how long it took FY22-23 FSP clients (who met FSP inclusion criteria) to reach clinical stability. To further refine the number of FSP slots needed, Indigo created several analytic scenarios using different FSP enrollment lengths and discharge rates to estimate how many additional FSP slots would be needed to enroll the number of individuals who met FSP inclusion in FY22-23 criteria within 3 to 4 years. The scenarios also examined when and how many newly eligible individuals (i.e., individuals who meet FSP inclusion criteria after FY22-23) would be able to enroll in FSP each year.

Survey and Interviews with ACBH FSP & Service Teams

In order to determine the number of existing FSP slots in the County, Indigo conducted a short survey followed by a key informant interview with staff from each FSP provider to understand program capacity. Indigo also met with ACBH leadership to understand any planned expansions in FSP programming that would change FSP capacity.

Data Limitations and Methodology Adjustments

During the assessment process, Indigo made minor methodology adjustments in response to emerging data trends as well as data limitations or availability. As mentioned in Assessment Question 1, one of the first steps in the assessment was interviews with FSP and Service Team providers to understand each program model. Through these interviews, we confirmed that existing FSP programs align more closely with an ACT level of care, while Service Teams align with an ICM model of care. This was supported by quantitative data, showing FSP clients generally had a more acute clinical profile and received more frequent and intensive services than Service Team clients.

Given these differences in program model and population, the need for an FSP level of care is assessed differently for FSP and Service Team clients. As FSP clients generally had higher acuity needs and received a higher level of care, we examined additional factors beyond preliminary

inclusion criteria to determine if individuals needed to stay in an FSP level of care. In contrast, Service Team clients were determined to need FSP only if they showed a need for a higher level of care, demonstrated by meeting FSP inclusion criteria in FY22-23.

The assessment had also initially intended to examine complexity of risk factors—such as homelessness, active substance use, and difficulty participating in services—to differentiate whether individuals who met preliminary FSP inclusion criteria required an FSP level of care. However, nearly all individuals who met preliminary FSP inclusion criteria in FY22-23 experienced at least one of these risk factors—including 93% of FSP clients, 85% of Service Team clients, and 98% of ACBH clients not enrolled in FSP or Service Teams. As a result, we examined other factors determined in consultation with the subject matter expert group—such as clinical stability, service frequency, diagnoses, service history, and other factors related to clinical profile. Information about individuals who did and did not meet FSP inclusion criteria is available in Appendix A.

The assessment had initially intended to examine a 2-year period from FY21-22 to FY22-23. However, program operations were still somewhat impacted by COVID during FY21-22. In order to assess the most current operations, we adjusted the methodology to focus on clients, service delivery, and outcomes in FY22-23. For the referral analysis, however, we assessed referrals made in FY21-22. As mentioned, the outreach and engagement process to get individuals to accept FSP services can sometimes take several months and clients referred in one fiscal year may not be enrolled until the next fiscal year. FSP program data were incomplete beyond FY22-23 due to a transition in the County's EHR. As a result, we were unable to examine enrollment for all referrals made in FY22-23, and instead focused the analysis on FY21-22 referrals.

Lastly, the settlement agreement specifies estimating FSP slots for individuals ages 16 and older in order to ensure the assessment considers FSP needs for transition aged youth (TAY). In Alameda County, TAY FSP programs serve individuals ages 18-24, while individuals under 18 are served in ACBH's child FSP program.[37] The assessment includes analysis of ACBH Adult and TAY FSP programs (excluding child and youth programs), and therefore only includes individuals ages 18 and older. While all existing TAY FSP programming was included in the analysis, the overall TAY population may be slightly underrepresented as youth ages 16-17 enrolled in child FSP programs were not included as an analysis of child FSP programs (ages 0-17) would be outside the scope of the settlement agreement.

[37] As mentioned, behavioral health services in Alameda County for individuals ages 16-17 are within the children's system of care. While FSP and other outpatient services within the Transition Age Youth division provide services from age 18 through 25, crisis, residential, and hospital programs that serve children and youth stop at age 17, and youth ages 18 and up are served within adult services as required by state licensing agencies. Services for minors are subject to separate policy and regulatory guidance that differs from the requirements for programs that serve individuals ages 18+. This assessment does not include services within the children's system of care and therefore does not estimate need for 16-17 year olds. Additionally, 16 and 17 year olds who require FSP services would receive them through the children's system of care, and this assessment did not include an assessment of the capacity needed for children's FSP services as this would fall outside of the scope of the settlement agreement. Services for transition age youth ages 18-25 are included in the assessment.

How many FSP slots are needed to serve individuals who meet FSP eligibility criteria under 9 C.C.R. § 3620.05?

In the sections below, first we describe the *Populations for Analysis* and P*reliminary FSP Inclusion Criteria* used to identify people who may have an FSP level of need. Then we describe the specific criteria that were used to identify *ACBH FSP Clients with an FSP Level of Need*, *ACBH Service Team Clients with an FSP Level of Need*, and *ACBH Non-FSP/Non-Service Team Clients with an FSP Level of Need.* Finally, we describe the model that incorporates the expected average duration of services in an FSP program to determine the *Estimated Number of FSP Slots Needed to Meet the Need of Alameda County Residents* on an ongoing basis.

Estimated Number of Alameda County Residents with an FSP-Level of Need

Populations for Analysis

To determine the number of FSP slots needed to serve the residents of Alameda County, first we estimated the number of Alameda County residents with an FSP level of need. There were three populations we assessed: 1) ACBH FSP Clients, 2) ACBH Service Team Clients, and 3) Individuals open to any ACBH service (including John George Psychiatric Emergency Services, Amber House Crisis Stabilization Unit, Cherry Hill Sobering Center, and Adult Forensic Behavioral Health at the Santa Rita jail) but not enrolled in FSP or Service Teams in FY22-23. These populations are described in Table 5 below.

Table 5. Populations for Analysis

Population	Inclusion Criteria
ACBH FSP Clients	Individuals ages 18+ open to ACBH FSP Program for at least one day in FY22-23
ACBH Service Team Clients	Individuals ages 18+ open to ACBH Service Team Program for at least one day in FY22-23
ACBH Non-FSP/ Non-Service Team Clients	Individuals ages 18+: • Open to ACBH program / service in FY21-22 or FY22-23 • Alameda County Medi-Cal in FY22-23 • SMI Diagnosis in FY21-22 or FY22-23 • In community when eligibility was assessed (i.e., not in sub-acute IMD / Facility, jail)

For each population, **we examined whether individuals met preliminary FSP inclusion criteria in FY22-23 (4+ crisis episodes and/or jail bookings AND/OR 28+ days in a**

psychiatric hospital or incarcerated) as well as additional population-specific criteria. These criteria are described in greater detail in the sections below.

ACBH FSP or Service Team Clients with an FSP Level of Need

ACBH FSP or Service Team Clients with an FSP Level of Need (n=835)
Group 1: ACBH clients participating in FSP during FY22-23 who met FSP criteria in FY22-23 (n=480)
Group 2: ACBH clients participating in FSP during FY22-23 who did not meet preliminary FSP criteria in FY22-23, met preliminary FSP criteria at enrollment, and were NOT clinically stable in FY22-23 OR were clinically stable in FY22-23 but received two or more face-to-face services per week, indicating a high level of need to maintain their clinical stability (n=60)
Group 3: ACBH clients participating in an FSP while enrolled in Assisted Outpatient Treatment or Community Conservatorship in FY22-23 (n=65)
Group 4: Clients participating in a Service Team during FY22-23 who met preliminary FSP criteria in FY22-23 (n=230)

The table above summarizes the FY22-23 ACBH FSP and Service Team client population groups that were determined to have an FSP level of need based on the following inclusion criteria.

Preliminary FSP Inclusion Criteria in FY22-23. All FSP and Service Team clients who met preliminary FSP criteria in FY22-23 were determined to need an FSP level of care. Service Team clients who ***did not*** meet FSP inclusion criteria in FY22-23 were determined to not need an FSP level of care.

Preliminary FSP Inclusion Criteria at FSP program enrollment. Among FSP clients who did not meet preliminary FSP criteria in FY22-23, we examined whether they met preliminary FSP criteria at program enrollment. Among clients who met preliminary FSP criteria at enrollment, those who were not clinically stable in FY22-23 were determined to need an FSP level of care.

Clinical Instability in FY22-23. Individuals were identified as NOT clinically stable if they experienced any of the following during a 365-day period while enrolled in an FSP during FY22-23:

- 2+ crisis, incarceration, or psychiatric hospital episodes
- 1 incarceration lasting six days or longer
- 1 psychiatric hospitalization lasting four days or longer

Individuals who were in an FSP program for at least one year who did not experience this level of crisis, hospitalization, or incarceration were determined to have reached a level of clinical stability where an FSP level of care is likely not necessary to maintain ongoing stability.

Level of Service Needed to Maintain Clinical Stability.[38] Among FSP clients who were clinically stable, some needed a high level of service engagement to maintain their stability, suggesting they still have an FSP level of need. Therefore, individuals who reached clinical stability in FY22-23 who received an average of 2 or more face-to-face services per week over the most recent 6 months of enrollment were determined to have an FSP level of need.

Enrollment is Assisted Outpatient Treatment or Community Conservatorship. All clients participating in an FSP while enrolled in Assisted Outpatient Treatment or Community Conservatorship in FY22-23 were determined to meet an FSP level of need based on their legal status and the level of care they were assessed for within each program.

Utilizing the criteria outlined above, **among the 1,010 ACBH FSP clients in FY22-23, 605 were identified to have an FSP level of need. Among the 1,534 Service Team clients in FY22-23, 230 were identified to have an FSP level of need.** Appendix B includes a detailed map showing which FSP and Service Team client populations were identified to have an FSP level of need.

[38] This analysis was included based on subject matter expert feedback to ensure that people who required an FSP level of service to maintain clinical stability remained in the FSP grouping.

ACBH Non-FSP/Non-Service Team Clients with an FSP Level of Need (N=1,181)

ACBH Non-FSP/Non-Service Team clients who met preliminary FSP inclusion criteria **AND**:

Group 5: Met preliminary FSP Criteria through psychiatric hospitalizations and/or crisis episodes (n=527)

OR

Group 6: Had a psychotic or mood disorder diagnosis (n=493)

OR

Group 7: Were EVER referred to and ACBH Adult FSP or Service Team (n=53)

OR

Group 8: Were admitted to ACBH Residential MH Treatment in FY22-23 (n=33)

OR

Group 9: Were admitted to Psychiatric Hospital or JGPP PES in FY22-23 (n=18)

OR

Group 10: Were designated at Level of Care 3 or 4 at Santa Rita County Jail in FY22-23 (n=91)

The table above summarizes the Non-FSP/Non-Service Team ACBH clients population groups that were determined to have an FSP level of need.

For the Non-FSP/Non-Service Team ACBH clients[39] who met preliminary FSP inclusion criteria in FY22-23, we examined the following factors to determine whether they met an FSP level of need.

Preliminary FSP Criteria Group. All individuals who met FSP inclusion criteria through psychiatric hospitalization and/or behavioral health crisis episodes (i.e., crisis stabilization unit, psychiatric emergency services, and sobering center) were determined to have an FSP level of need.

Among Non-FSP/Non-Service Team ACBH clients who met preliminary FSP inclusion criteria through incarcerations and/or jail bookings only, we examined additional factors described below to determine whether they met an FSP level of need.

[39] In FY22-23 all clients had to be 18 years or older, have a serious mental illness diagnosis, be enrolled in Alameda County Medi-Cal, open to an ACBH program or service, and be in the community for at least one day during the fiscal year when eligibility was assessed (i.e., not in jail or a sub-acute IMD / Facility for 365 days during the fiscal year).

Type of Behavioral Health Diagnosis. Among individuals who were only served by ACBH in jail, we examined their behavioral health diagnoses to better understand whether they would likely require an FSP level of care in the community. Individuals with psychotic or mood disorders comprise a majority of people enrolled in FSP (90%), and these diagnoses are likely to be pervasive regardless of the setting they are documented in. Therefore, individuals with psychotic or mood disorders were determined to require an FSP level of care. Additional factors described below were examined for individuals with other diagnoses such as trauma, stress, or anxiety related disorders, which are more likely to be situational (i.e., symptoms are influenced by the setting within which they are determined, like a carceral setting), such that individuals who received these diagnoses in jail may not experience the same symptoms or receive the same diagnoses in the community.

Previous referral to ACBH Adult FSP or Service Team. If at any time in the past, a clinician determined that someone who met preliminary FSP inclusion criteria through incarcerations and/or jail bookings only during FY22-23 needed the highest level of outpatient care (Level 1 service need), it is reasonable to assume that their justice system involvement plus this previous clinical determination suggests they are likely to need an FSP level of care in the community.

ACBH Mental Health Residential Treatment admission in FY22-23. Similarly, if at any time in the past year an individual who met preliminary FSP inclusion criteria through incarcerations and/or jail bookings during FY22-23 was admitted to a residential treatment facility, it is reasonable to assume that their justice involvement plus this level of mental health treatment need suggests they are likely to need an FSP level of care in the community.

Psychiatric Hospitalizations in FY22-23. If someone met preliminary FSP inclusion criteria through incarcerations and/or jail bookings in FY22-23 and was also assessed to require an involuntary detention at JGPP PES or a psychiatric hospital during the fiscal year, this person likely requires an FSP level of care in the community.

Santa Rita Jail Level of Care Determinations in FY22-23.[40] If a clinician at Santa Rita County Jail assessed individuals during their most recent level of care determination in FY22-23 (not conducted at booking or conducted upon release from custody) to have high functional impairment and/or high risk of self-harm, or severe functional impairment and/or imminent risk of self-harm, they were determined to require an FSP level of care in the community.

Utilizing the criteria outlined above, **among 2,083 ACBH Non-FSP/Non-Service Team clients who met preliminary FSP criteria in FY22-23, 1,181 were identified to require an FSP level of care.** Appendix C includes a detailed map clearly demonstrating which ACBH Non-FSP/Non-Service Team clients were determined to have an FSP level of need.

[40] This analysis was added based on subject matter expert feedback to support a more thorough understanding of who from the justice-involved population should be included in the FSP grouping.

Total Number of Individuals with an ACBH Level of Need

A total of 2,016 individuals were determined to meet FSP inclusion criteria and a need for an FSP level of care, including:

- **605 ACBH FSP clients in FY22-23**
- **230 ACBH Service Team clients in FY22-23**
- **1,181 ACBH clients not open to FSP or Service Teams in FY22-23**

Of these individuals, 180 need TAY FSP, 1,615 need Adult FSP, 156 need Older Adult FSP, and 65 were in AOT or Community Conservatorship FSP. Of the TAY, approximately 50 may need Forensic FSP while approximately 900 of the adults and older adults may need Forensic FSP. Individuals were determined to need forensic FSP services if they were participating in an ACBH forensic FSP program in FY22-23 or if they met FSP inclusion criteria through jail bookings and incarceration only.

Estimated Number of FSP Slots Needed to Meet the Need of Alameda County Residents

In order to determine how many FSP slots would be needed in order to serve the 2,016 individuals identified as well as how many slots were likely needed on an ongoing basis, the assessment considered the following factors.

First, there is likely a backlog of individuals who are in need of FSP services now, but the ongoing capacity needed is likely lower. The group of 2,016 individuals identified likely reflects needed capacity over a period of years and is larger than the annual capacity needed.

Second, there are a number of individuals currently enrolled in an FSP program that are likely ready to step down to a less intensive service as evidenced by meeting the clinical stability threshold with a lower frequency of service akin to a service team or outpatient program. The estimate of the number of slots needed assumes that individuals who no longer require an FSP level of care are given the opportunity to step down into a less intensive service thereby creating capacity for new enrollments.

Third, understanding the capacity needed requires estimating what the likely length of enrollment would be for an individual. As stated previously, the expected average length of stay from the literature is about three years, and the average length of stay among all FY22-23 FSP clients in Alameda County ranges from 2.7- 4 years. The estimate of needed capacity assumes an average length of participation of 4 years, recognizing that some individuals may step down sooner and others may require a longer course of treatment.

Finally, the average number of referrals FSP referrals across FY21-23 (2-year period) was approximately 200 annually, and the average number of FSP enrollments across FY21-23 (2-year period) was approximately 250 annually. This number of referrals and enrollments, in part, likely contributed to the backlog of individuals identified who meet FSP inclusion criteria. We also

anticipate that the number of referrals and rate of enrollment is likely to increase in subsequent years suggesting a need for greater capacity on an ongoing basis than currently exists. As a result, the likely capacity needed annually is greater than what was available annually in FY21-22 and FY22-23.

During the assessment period, ACBH had a capacity of 1,000 FSP slots. In December of 2024, ACBH added an additional 100 FSP slots totaling 1,100 FSP slots. In order to answer the question of how many slots would be needed, the assessment team ran different scenarios of new FSP capacity to determine how long it would take to clear the backlog of individuals identified for FSP services by this assessment and how many slots would be available for new referrals on an ongoing basis thereafter. The results are presented in Table 6 below.

Table 6. FSP Capacity Scenarios

New Spots Added	Time Needed to Serve FSP-identified Individuals	Average Number of Open Spots on Ongoing Basis
100	4 Years	300
200	3 Years	325
300	**3 Years**	**350**
400	3 Years	375
500	2 Years	400

Based on these results, the actual total FSP capacity needed is approximately 1,400 FSP slots, this includes an additional 300 slots beyond the existing 1,100 slots. Creating 100 slots would take 4 years to serve everyone identified in this assessment whereas creating 200-400 new slots would allow for everyone identified to be served within a three year period. While creating 500 slots would allow for everyone to be served within a two year period, it likely creates too many slots on an ongoing basis, roughly doubling the referrals expected as compared to the annual referral rate from FY21-23. Approximately 300 new FSP slots balances enrolling clients in need quickly, stabilizing enrollment rates over time, and allowing sufficient openings for new clients on ongoing basis without creating excess capacity in subsequent years.

Appendix A. Populations who did and did not meet FSP Inclusion Criteria

Who and how many ACBH clients met preliminary FSP inclusion criteria at baseline?

As a first step to address how many FSP slots are needed, we explored who and how many individuals met preliminary FSP inclusion criteria at program enrollment for FSP and Service Team clients, and in FY22-23 for ACBH clients not enrolled in FSP and Service Teams.

For FSP and Service Team clients, we first examined FSP inclusion criteria at program enrollment to better understand if and what differences existed between clients who were enrolled in FSP compared to Service Teams. As shown below, over half of FSP clients met preliminary FSP inclusion criteria at program enrollment compared to only 21% of Service Team clients. Over 2,000 individuals not enrolled in ACBH FSP or Service Teams in FY22-23 met preliminary criteria, requiring further examination of additional factors to determine need for an FSP level of care.

Table 7. Number of Individuals who met FSP Inclusion criteria, by population group

Eligibility Group	FY22-23 FSP Client	FY22-23 Service Team Client	Non-FSP / Non-Service Team Client
Met Preliminary FSP Inclusion Criteria	551 (55%)	323 (21%)	2,083 (100%)
Did not meet Preliminary FSP Inclusion Criteria	459 (45%)	1,211 (79%)	N/A
TOTAL	**1,010 (100%)**	**1,534 (100%)**	**2,083 (100%)**

What is the clinical profile of ACBH FSP & Service Team clients who did and did not meet preliminary FSP inclusion criteria at program enrollment?

We examined the clinical profile of FSP and Service Team clients to further explore potential differences among FSP and Service Team populations who did and did not meet preliminary FSP inclusion criteria.

As shown below, FSP and Service Team clients who met preliminary FSP inclusion experienced far more crisis admissions, psychiatric hospitalizations, and incarcerations than clients who did not meet inclusion criteria.

Notably, FSP clients who met preliminary FSP inclusion had more crisis admissions, had more hospital days, and were more likely to be incarcerated than Service Team clients who also met preliminary inclusion criteria. This data suggests FSP clients who meet preliminary inclusion criteria tend have a more acute clinical profile than Service Team clients.

Table 8. Clinical profile of FSP and Service Team clients who did and not meet preliminary FSP inclusion criteria at program enrollment

Clinical Profile Characteristics	Met FSP Inclusion Criteria at Enrollment		Did Not Meet FSP Inclusion Criteria at Enrollment	
	FY22-23 FSP Client (N=551)	FY22-23 Service Team Client (N=323)	FY22-23 FSP Client (N=459)	FY22-23 Service Team Client (N=1,211)
Crisis Episodes				
% of Clients with Crisis Episode	**95%**	**98%**	46%	34%
Avg # Crisis Episodes	**8.2 Episodes**	**5.8 Episodes**	1.9 Episodes	1.6 Episodes
Psychiatric Hospitalizations				
% of Clients with Hospitalization	**72%**	**72%**	30%	24%
Avg # of Hospital Days	**33 Days**	**28 Days**	11 Days	11 Days
Incarcerations				
% of Clients with Incarceration	**62%**	**42%**	11%	5%
Avg # of Incarcerated Days	**108 Days**	**76 Days**	7 Days	8 Days

What is the clinical profile of individuals who met preliminary FSP inclusion criteria and were not open to FSP and Service Teams in FY22-23?

We also examined the clinical profile of ACBH clients who did not participate in FSP and Service Teams in FY22-23. As shown below, ACBH clients who met preliminary FSP inclusion criteria in FY22-23 and who did not participate in FSP and Service Teams were more likely to be incarcerated, had fewer crisis episodes, and were less likely to be hospitalized than FSP and Service Team clients who met preliminary FSP inclusion criteria at program enrollment.

Table 9. Clinical profile of ACBH clients who met preliminary FSP inclusion criteria in FY22-23 and were not enrolled in ACBH FSP or Service Teams

Clinical Profile Characteristics	Met FSP Inclusion Criteria at Baseline		
	Non-FSP / Non-Service Team Client (N=2,083)	FY22-23 FSP Client (N=551)	FY22-23 Service Team Client (N=323)
Crisis Episodes			
% of Clients with Crisis Episode	**93%**	95%	98%
Avg # Crisis Episodes	**3.7 Episodes**	8.2 Episodes	5.8 Episodes
Psychiatric Hospitalizations			
% of Clients with Hospitalization	**18%**	72%	72%
Avg # of Hospital Days	**16 Days**	33 Days	28 Days
Incarcerations			
% of Clients with Incarceration	**88%**	62%	42%
Avg # of Incarcerated Days	**105 Days**	108 Days	76 Days

Are there differences in how ACBH clients met preliminary FSP inclusion criteria?

To better understand the differences between the population groups who met preliminary FSP inclusion criteria, we examined how individuals met preliminary inclusion criteria. As shown below, individuals who were not enrolled in FSP or Service Teams and met preliminary FSP inclusion criteria in FY22-23 were most likely to meet criteria through jail bookings and incarceration only. In contrast, FSP and Service Team clients who met preliminary FSP inclusion criteria at enrollment were most likely to meet criteria through behavioral health crisis admissions and psychiatric hospitalizations.

Table 10. FSP Inclusion Criteria Groups, by Population

Inclusion Criteria Group	Met FSP Inclusion Criteria at Baseline		
	FY22-23 FSP Client (N=551)	FY22-23 Service Team Client (N=323)	Non-FSP / Non-Service Team Client (N=2,083)
Jail Bookings & Incarceration Only	145 (26%)	62 (19%)	**1,556 (76%)**
Crisis Admissions & Psychiatric Hospitalization Only	**285 (52%)**	**223 (69%)**	298 (15%)
Combination of Jail Booking / Incarceration & Crisis / Psychiatric Hospitalization	121 (22%)	38 (12%)	229 (11%)

For individuals who met preliminary FSP inclusion criteria and were not open to FSP and Service Team, are there differences in characteristics based on how individuals met criteria?

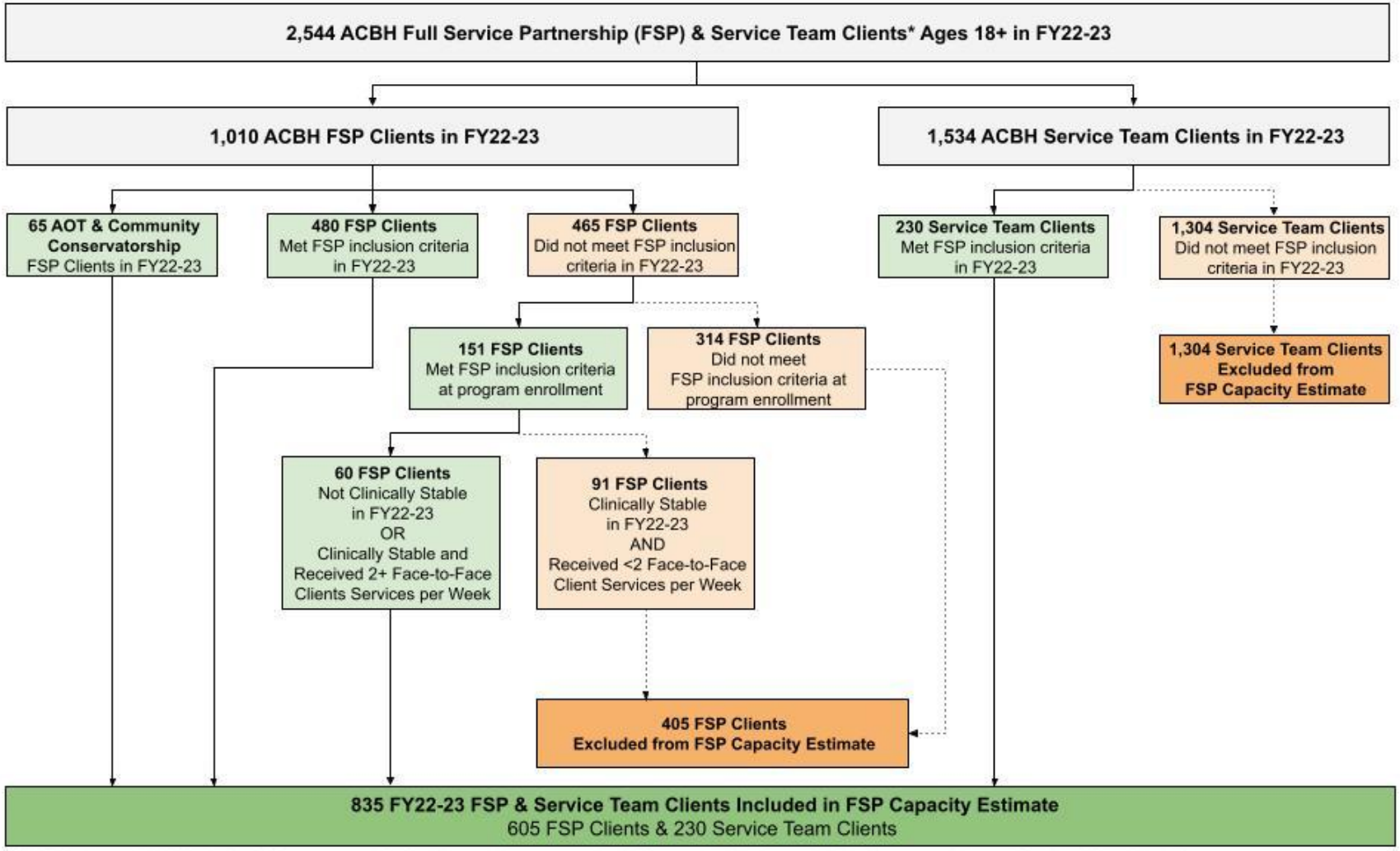
To better understand whether individuals who met preliminary FSP inclusion criteria and were not open to FSP and Service Team required an FSP level of care, we examined differences in various characteristics related to clinical profile across FSP inclusion eligibility groups (i.e., jail and incarceration only, crisis and psychiatric hospitalization only, and a combination of jail/incarceration and crisis/psychiatric hospitalization). Data are shown below.

Overall, individuals not enrolled in FSP or Service Teams who met FSP inclusion criteria through jail bookings and incarceration alone—compared to those who met criteria through crisis and psychiatric hospitalization or combination—were more likely to have trauma, stress, or anxiety disorders; more likely to have a high level of care determination during a jail booking (score of 3 or 4); and less likely to be referred to FSP or Service Teams, admitted to residential mental health treatment, or admitted to a psychiatric hospital.

Table 11. Characteristics of Non-FSP / Non-Service Team ACBH Clients who met preliminary FSP inclusion criteria, by FSP Inclusion Criteria Group

Characteristic	Non-FSP / Non-Service Team Clients who Met FSP Inclusion Criteria		
	Jail Booking & Incarceration Only (N=1,556)	Crisis & Psychiatric Hospitalization Only (N=298)	Combination (N=229)
Behavioral Health Diagnosis			
Psychotic or Mood Disorder	**29%**	57%	48%
Trauma, Stress, or Anxiety Disorder	**70%**	42%	52%
Referral to FSP or Service Team			
Ever Referred to ACBH Adult FSP or Service Team	**9%**	24%	21%
Never Referred to ACBH Adult FSP or Service Team	**91%**	76%	79%
Open to Residential Treatment			
Admitted to Residential MH Treatment in FY22-23	**8%**	42%	30%
Never Admitted to Residential MH Treatment in FY22-23	**92%**	58%	70%
Psychiatric Hospitalization & JGPP PES Admission			
Admitted to Psychiatric Hospital in FY22-23	**4%**	48%	34%
Not admitted to Psychiatric Hospital in FY22-23	**96%**	25%	28%
Santa Rita Jail LOC Determination			
LOC Determination of 3 or 4 at jail booking in FY22-23	**14%**	6%	32%
No LOC Determination of 3 or 4 at jail booking in FY22-23	**86%**	94%	68%

Appendix B. FSP and Service Team Clients in FY22-23 with an FSP-Level of Need



*Individuals enrolled in Berkeley FSP programs and/or Berkeley residents were excluded from analysis as these individuals are served through Berkeley Mental Health.

Appendix C. Non-FSP/Non-Service Team Clients in FY22-23 with an FSP-Level of Need