

Mental Health Services Act (MHSA)

FSP Workgroup Meeting #2 – 10/7/21

Summary

- **What is Full Service Partnership (FSP):**
 - It is a “whatever it takes” consumer-centric approach to supporting clients in achieving their goals as identified in their Individual Services and Supports Plan (ISSP).
 - Services include therapy, psychiatric services, peer supportive services, case management and life skills development.
 - MHSA mandates the majority of Community Services and Supports (CSS) component funds to FSP programs.
- **What is the Multi-County FSP Project:**
 - Statewide collaboration with 6 Counties to share learnings and best practices and provide FSP improvements that are data driven.
- **Stakeholder Engagement to-date:**
 - 13 clients during planning and 14 during implementation
 - 8 provider staff during planning and 14 during implementation
 - Input is informing the new Request for Proposal service exhibit and policies and procedures.

Larger Group Input

- **Stakeholder Engagement:** Astounded as small number of individuals sampled. Some family members were interviewed but for the most part all three were living in silos without natural supports. Selected 8 individuals who have ever received services and provided their feedback. Some refused to respond, which is not useful. Can we look beyond the sample? I am connected to families that received FSP services in the past. Many of the issues that existed then still are showing up in this sample. How can we get the real data to move real change?
 - We reached out to a lot more than who we ended up interviewing. There were challenges getting in touch with folks.
 - The work was not meant to be a robust evaluation but about incorporating the voice of consumers and their families in the conversation.
 - While a small sample size, it is a good start and continuous improvement will be part of this process. How can we continue to conversations?
 - Third sectors efforts are a slice of the feedback that is gathered MHSA-wide. This FSP Workgroup is intended to do just this – supplement the input we have received to-date.
- **Early Psychosis Resources:** One of the comments from the FSP providers was that they did not have resources to treat individuals with psychosis. We have early psychosis programs and should have these resources available to the youth and TAY population. Why is this even an issue highlighted? Some staff don’t know that Felton Institute exists because it is listed as a deficit.
 - Felton Institute offer (re)MIND and BEAM programs for young adults. Clients from TAY FSP work in collaboration with Felton Institute. For young adults we have the Youth-to-Adult Transition Committee, which includes BHRS, Felton Institute, Edgewood and other partners. There is collaboration amongst the programs. Even though it’s a stand-alone service for early psychosis, there is collaboration.

- **Therapy Services:** There was a statement about there not being enough funding in the contract to cover provision of therapy, is that the problem?
 - It's both a funding and contracting issue... it needs to be in the scope and there needs to be funding for it. It is also an issue about staff turnover and having the appropriate funding to retain staff.
 - Individual therapy is something that is consistently provided to youth clients in the FSP programs.
 - Edgewood has embedded clinicians, psychiatrist and nurse practitioners in-house. Is some of this feedback about access related to contracting amounts to be able to retain clinicians and/or hire psychiatrists.
 - By having these resources, I can function well and contribute to my community... the more resources, the more feedback we get from clients that can provide it.
 - My son has been in and out of FSP programs and he has never had a therapist available to him. The bulk of people in FSP do not have therapy available to them and it puts a burden on medication alone, given by a doctor who sees a client for 10 minutes once a month. The notion of FSP has a long way to go to live up to the meaning of the term. We have to find a way to create opportunities to evidence-based services. Why can't we find the way to adequately fund this program?

- **Peer Support Services:** This is absolutely essential service, it is evidence-based, and it does not have a huge price tag but there are not enough peer specialists available to families. The turnover is high because they are paid so little and have little job security, of course they will move on. We need to fund our contractors appropriately or we will not have continuity and expertise of years in serving. This is not an equity approach to both those providing the care and receiving the care.

- **Nutrition Services:** There are effective, low-cost services that are proven to positively impact depression and other mental health outcomes including nutrition, physical activity, EMDR. It is a small investment that can have a big impact

Child/Youth/TAY FSP breakout room: additional feedback / insights (1/2)

Eligibility Criteria

consideration for intergenerational trauma; screen for ACEs, get a baseline for where the family is at. understand who needs which services at the start and for whom - the whole family needs

Care Coordination

more education with police, other institutions to understand SMI. Educate schools more generally

capacity to flex on hours and meet family needs (before work, etc) & multiple family members (other siblings, etc)

coordination with the providers who are meeting the other needs of the consumer; interconnection with other programs (including early psychosis programs); addressing needs of *whole* person

continued flexibility! That has been great.

Cultural Relevance

especially challenging to retain staff who meet these skills; pipeline challenges here. Need to validate peer supports & ensure compensation & benefits for retention

building natural supports so that then can move on from FSP. Whole person readiness for graduation

building independence of consumer to help themselves (get their own refills, follow up appointments)

make sure housing isn't impacted with graduation

Transfer / Graduation

Child/Youth/TAY FSP breakout room: additional feedback / insights (2/2)

Direct service requirements

desire for ongoing dialogue -- BHRS as a conduit, but where is the larger community wrap? break down silos, not BHRS as an intermediary.

peer supports - essential to youth to hear it from someone their age. not be siloed in how that happens

family support group, multiple languages - enhancing natural supports

peer supports - essential to youth to hear it from someone their age. not be siloed in how that happens

therapy

need to beef up capacity for substance use issues

lower caseloads, bigger teams so there is less burnout. absorb the trauma of this work

how to balance family services and the services they do / don't want to the contract/billing challenges?

[Other]

DBT jeopardy! fun ways to learn about DBT for the family; educational opportunities for the family community education around SMI through FSP contract; reducing stigma

pay rates & benefits. impacts whether people feel valued

education on harm reduction

3 year limited term contracts are challenge

community education around SMI through FSP contract; reducing stigma;

education for parents on how to advocate for their kids of all

knowing the signs; how to help someone in crisis, bullying, text hotline, resources for their age group

need bandwidth for training, apprenticeship, as a pipeline

recruitment & retention of staff (esp. staff of color, bilingual) -- had to retrain. salary is an issue

things that support people who receive care also support caregivers. employee & client support. work through trauma on both / all sides. "not just a paycheck but an environment. "

Adult FSP breakout room: additional feedback / insights

Eligibility Criteria	<p>Don't wait until individuals are homeless or in crisis to connect them to FSP -- we know mental health varies day to day.</p>	<p>Limited # of FSP slots by county -- how is this determined?</p>	<p>If a client is ineligible for FSP, refer them to other services where they CAN go.</p>	<p>Defining "success" for clients is also mediated by culture. Clients probably prefer to receive services from staff who share their culture.</p>	<p>"Skill-building" can also include rituals and healing practices</p>	<p>[x]</p>	Cultural Competency
	Care Coordination	<p>Individuals who are at risk of homelessness are most vulnerable when in transition (e.g. from foster care, incarceration)</p>	<p>SMC doesn't have a "housing first" model, and that's a huge loss.</p>	<p>Individuals who are not eligible for housing vouchers experience added hardship.</p>	<p>Need better ongoing communication between staff teams and clients</p>	<p>Care coordinator role could do this. Ideally a case manager could play this role, but they don't have capacity.</p>	
Direct service requirements		<p>peer therapy +2 therapy</p>	<p>Quality of FSP services also includes food and life skills training</p>	<p>Clear theme of scarcity of housing and staff -- this impacts everything else. Housing is a bedrock to recovery, as much of a human need as therapy or other clinical services.</p>	<p>Contractor rates need to be updated (operating on recession-era rates) -- need a plan in place, so they have more stability</p>	<p>For next discussion: data (priority outcomes) should capture the individual's understanding / assessment. Could consider getting anonymous client feedback.</p>	<p>Stepdown is difficult: how are we measuring success? "Success" can vary a lot and is nonlinear.</p>
	<p>Can FSP clients have consultations with their doctors by email?</p>						