Full Service Partnership Outcomes

Findings From Fiscal Year 2024–2025

San Mateo County Behavioral Health and Recovery Services

Christine Walsh, PhD; Laina Serrer, MS; Meera Ragunathan; Britney Veal, PhD; Yousra Hussain; Tania Dutta, MPP, PMP
American Institutes for Research

December 2025

Contents

Exhibits

Executive Summary

The Full Service Partnership (FSP) program in San Mateo County (SMC) provides intensive, wraparound behavioral health services to support individuals with mental and behavioral health needs. These services are provided through four contracted providers: Edgewood Center and Fred Finch Youth Center (hereafter Edgewood/Fred Finch;[1] serving children, youth, and transitional age youth [TAY]) and Caminar and Telecare (serving adults and older adults). SMC Behavioral Health and Recovery Services (BHRS) (hereafter the County) has partnered with the American Institutes for Research® (AIR®) to assess how FSP enrollment promotes resilience and improves health outcomes of individuals served by these providers.

AIR conducted a mixed-methods study to evaluate the SMC FSP program for Fiscal Year (FY) 2024–2025 using data from self-reported client surveys,[2] electronic health record (EHR) utilization data, and in-depth interviews with clients and treatment team members. This annual report summarizes client outcomes, comparing the year prior to FSP enrollment with the first year of participation, and qualitative insights from client and treatment team members on their experiences with FSP during FY 2024–2025.

Key Quantitative Outcomes

Across all age groups, FSP participation is associated with significant improvements in client outcomes, including:

- Reductions in homelessness, arrests, hospitalizations, and psychiatric emergencies;

- Increased adult employment; and

- Significant declines in PES (psychiatric emergency services) utilization and hospital days.

These improvements were observed in both self-reported outcomes and EHR utilization data, highlighting a link between clients' perceived improvements in physical and mental health outcomes and measurable decreases in hospitalizations and PES use.

---

[1] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.
[2] Self-reported data for Edgewood/Fred Finch and Caminar include all clients since the FSP program began in 2006. Telecare transitioned to a new EHR system in December 2018 and was unable to provide data prior to that conversion. As a result, self-reported data for Telecare are reported separately for the period from December 2018 through June 2025.

Exhibits 1 and 2 present FSP outcomes for children (16 years and younger), TAY (16–25 years), adults (25–59 years), and older adults (60 years and older). Due to reporting system changes, the Telecare self-reported outcomes data are shown separately in Exhibit 3.

Key highlights for findings among Adults and Older Adults include:

- Six of 16 self-reported survey outcomes (Caminar) improved significantly, including increased employment and fewer arrests, detentions, and mental/physical health emergencies.

- EHR data across all FSP providers showed statistically significant decreases in hospitalizations, mean hospital days, and PES use for adults; older adults saw significant reductions in PES events.

Exhibit 1. Percentage Change in Outcomes Among Adults and Older Adults, Year Before FSP Compared with First FSP Year

FSP outcomes	Adults (25 to 59 years)			Older adults (60 years and older)		
Survey outcomes (Caminar)	*N = 118*			*N = 28*		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	48 (41%)	35 (30%)	-27%	8 (29%)	6 (21%)	-25%
Detention or incarceration	35 (30%)	22 (19%)	**-37%***	4 (14%)	3 (11%)	-25%
Employment	1 (1%)	6 (5%)	**500%***	0 (0%)	0 (0%)	--
Arrests	20 (17%)	4 (3%)	**-80%***	4 (14%)	1 (4%)	-75%
Mental health emergencies	87 (74%)	33 (28%)	**-62%***	16 (57%)	5 (18%)	**-69%***
Physical health emergencies	50 (42%)	17 (14%)	**-66%***	8 (29%)	6 (21%)	-25%
Active substance use disorder (SUD)	63 (53%)	60 (51%)	-5%	6 (21%)	5 (18%)	-17%
SUD treatment	28 (24%)	33 (28%)	18%	3 (11%)	2 (7%)	-33%

Health care utilization (All EHR data)	N = 408			N = 88		
	Yr before	Yr after	Change	Yr before	Yr after	Change
Hospitalization	122 (30%)	56 (14%)	**-54%***	22 (26%)	12 (14%)	-45%
Hospital days per client	10.9	3.2	**-71%***	9.0	3.9	-57%
PES	205 (50%)	150 (37%)	**-27%***	35 (40%)	21 (24%)	**-40%***
PES events per client	1.5	0.9	**-38%***	1.1	0.5	-54%

Note. Self-reported outcomes do not include Telecare. SUD = substance use disorder; EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Blue font indicates outcomes that significantly improved. Black font indicates outcomes that did not change or changed but the change was not statistically significant. An outcome with * indicates a change significantly different from 0 at 0.05 significance level.

Findings for Children and TAY:

- Eight outcomes of 16 self-reported survey outcomes (Edgewood/Fred Finch) improved significantly, including fewer arrests, homelessness, and school suspensions.

- Academic performance declined slightly for youth clients, with significant decreases in self-rated school performance and attendance for children.

- Health care utilization data show significant reductions in hospitalizations and PES use for both children and TAY.

Exhibit 2. Percentage Change in Outcomes for Children and TAY, Year Before FSP Compared with First FSP Year

FSP outcomes	Children (16 years and younger)			TAY (17 to 25 years)		
Survey outcomes (Edgewood/Fred Finch)	N = 249			N = 305		
	Yr before	Yr after	Change	Yr before	Yr after	Change
Homelessness	9 (4%)	8 (3%)	-11%	35 (11%)	34 (11%)	-3%
Detention or incarceration	28 (11%)	28 (11%)	0%	39 (13%)	33 (11%)	-15%
Arrests	31 (12%)	11 (4%)	**-65%***	65 (21%)	21 (7%)	**-68%***
Mental health emergencies	99 (40%)	14 (6%)	**-86%***	143 (47%)	30 (10%)	**-79%***
Physical health emergencies	20 (8%)	1 (0%)	**-95%***	60 (20%)	5 (2%)	**-92%***
Suspensions	51 (20%)	21 (8%)	**-59%***	31 (10%)	7 (2%)	**-77%***

FSP outcomes	Children (16 years and younger)			TAY (17 to 25 years)		
Survey outcomes (Edgewood/Fred Finch)	*N = 249*			*N = 305*		
School performance (self-rating)	3.29 (1%)	2.98 (1%)	**-9%***	3.24 (1%)	3.11 (1%)	-4%
School attendance (self-rating)	2.26 (1%)	1.99 (1%)	**-12%***	2.50 (1%)	2.49 (1%)	0%
Health care utilization (EHR data)	*N = 215*			*N = 227*		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	**-70%***	24 (11%)	16 (7%)	-38%
Hospital days per client	1.2	0.1	-91%	4.2	2.1	-51%
PES	52 (24%)	23 (11%)	**-56%***	92 (41%)	58 (26%)	**-37%***
PES events per client	0.5	0.2	**-54%***	1.1	0.7	**-36%***

Note. EHR = electronic health record; PES = psychiatric emergency services; Yr = year. Red font indicates a statistically significant negative percentage change. Blue font indicates outcomes that significantly improved. Black font indicates outcomes did not change or changed but the change was not statistically significant from the year before and the first year of enrollment in an FSP. An outcome with * indicates a change significantly different from 0 at 0.05 significance level.

Self-reported survey data for Telecare Clients (TAY, Adults, and Older Adults):

- Improvements in homelessness, arrests, and active substance use were statistically significant.

- Increased reports of mental health emergencies may reflect greater engagement with services, improved diagnosis, or transitional stressors during early FSP participation.

Exhibit 3. Percentage Change in Outcomes Among Telecare Clients, Year Before FSP Compared with First FSP Year

FSP self-reported outcomes	Combined Telecare TAY, adults, and older adults (*N* = 198)		
	Yr before	*Yr after*	*Change*
Homelessness	41 (27%)	10 (7%)	**-76%***
Detention or incarceration	34 (22%)	42 (28%)	24%
Employment	0 (0%)	0 (0%)	--
Arrests	45 (30%)	17 (11%)	**-62%***
Mental health emergencies	18 (12%)	54 (36%)	**200%***

FSP self-reported outcomes	Combined Telecare TAY, adults, and older adults (N = 198)		
	Yr before	Yr after	Change
Physical health emergencies	15 (10%)	24 (16%)	60%
Active SUD	96 (63%)	47 (31%)	-51%*
SUD treatment	10 (7%)	8 (5%)	-20%

Note. FSP = Full Service Partnership; TAY = transitional age youth; SUD = substance use disorder; Yr = year. Blue font indicates outcomes that significantly improved. Red font indicates a statistically significant worse change in outcome. Black font indicates outcomes did not change or changed but the change was not statistically significant. An outcome with * indicates a change significantly different from 0 at 0.05 significance level.

Exhibit 4 describes hospitalization outcomes for all FSP clients across all age groups who enrolled since 2006, completed at least 1 full year in an FSP program, and had EHR health care utilization data. We compared their mean health care utilization outcomes in the first year of FSP to the year prior to FSP. FSP clients showed significant improvement in hospitalization outcomes across all measures. Exhibits 15–18 in the report further highlight reductions in hospitalization and PES since the inception of the FSP program.

Exhibit 4. Hospitalization Outcomes for All Combined FSP Clients (N = 938)

Outcome	1 year before FSP Percentage/Mean (95% confidence interval)	Year 1 in FSP Percentage/Mean (95% confidence interval)
Percentage of clients with any hospitalization*	19% (17%–22%)	9% (7%–11%)
Mean number of hospital days*	6.8 (5.5–8.2)	2.3 (1.5–3.0)
Percentage of clients with any PES event*	41% (38%–44%)	27% (24%–30%)
Mean PES events, per client*	1.1 (1.0–1.3)	0.7 (0.6–0.8)

Note. PES = psychiatric emergency services. Significance testing was conducted using chi-square tests for percentages and t tests for means. An outcome with a * indicates result is statistically significant at the 0.05 level.

Outcomes From Key Informant Interviews With FSP Treatment Team Staff and Clients

Many FSP clients and treatment team members we interviewed said they were satisfied with the program but had specific recommendations to improve the program in the future. Exhibit 5 discusses key findings from these interviews.

Exhibit 5. Summary of FSP Treatment Team Staff and Client Interview Findings

Key client and treatment team experiences with the FSP program	
Overall experience and satisfaction with the program	• Clients noted supportive and satisfactory experiences with the FSP program, which many attributed to positive interactions with case managers and treatment team members. Their goals for program participation included improving mental health, living independently, pursuing education and employment, and enhancing family dynamics and communication. • Treatment team members reported satisfactory and rewarding experiences as staff members of the FSP program, attributing their satisfaction to effective team collaboration, connecting with clients, and opportunities for career growth. They identified the greatest needs among FSP clients to be access to housing and food assistance, substance use treatment services, and social support.
Referral process and initiation of treatment	• Clients reported positive feedback on the referral and initiation of care processes, noting feeling supported by staff in overcoming hesitations about discussing needs. Most clients felt supported by the comprehensive assistance provided by multidisciplinary treatment teams during initial meetings, although one client experienced confusion about treatment team member roles and responsibilities. • Treatment team members generally described the referral and intake processes to be smooth, emphasizing the importance of the warm handoff from the referring provider. However, they noted areas for improvement, including lack of comprehensive information from referring providers, administrative burden, housing placements, and data tracking.
Experiences with program services and care	• Clients had positive feedback about their experience with FSP case managers and providers, particularly highlighting case manager support and attentiveness. They expressed trust, comfort, and confidence in treatment team members' ability to assist with achieving program goals. However, some clients described issues with interruptions in care due to staff turnover, citing the importance of continuity and building rapport with their case managers. • Treatment team members appreciated strong collaboration and communication within their teams and praised the design of the wraparound services model, which enhanced their ability to provide comprehensive, individualized services to clients. However, they identified challenges, including understaffing, turnover, administrative burden, need for formal training documentation, and gaps in funding that impact staff well-being and client engagement.
Impact on health and quality of life	• Clients noted improvements in their mental and physical health outcomes, resilience against life stressors, and developing independence after enrolling in the FSP program. • Clients and treatment team members reported that the FSP program had a positive impact on clients' interpersonal relationships, social networks, and integration into the community.

Overall, the interviews highlight the positive influence of the FSP program on client well-being that is consistent with improvement in client outcomes seen in the quantitative data results. For example, FSP clients reported feeling more stable and independent after enrolling in the program, particularly among individuals who previously were homeless. These findings align with the decrease in homelessness among clients during their first year of FSP enrollment compared to 1 year prior to FSP enrollment.

The majority of client and provider interviewees reported being satisfied with the program; however, some noted a few areas of the FSP program that could be improved. Exhibit 6 summarizes recommendations based on these findings.

Exhibit 6. Recommendations Based on FSP Treatment Team and Client Interview Findings

Recommendations	
Recommendation 1: **Improve staff retention through team-building opportunities and legal and procedural guidance**	• Provide more regularly scheduled team-building activities, preferably at an offsite location, for treatment team members to enhance professional and personal connections. • Create a resource library to house legal and procedural guides and training materials for staff to reference. • Modify onboarding trainings to include lessons on legal terms and systems.
Recommendation 2: **Expand workforce and increase staff diversity**	• Expand the number of team members, especially case managers, and redistribute some tasks to other staff (e.g., administrative assistants). • Increase the number of multilingual staff to cater to the needs of clients. • Increase gender and ethnic diversity amongst staff to facilitate stronger, trusting relationships with clients.
Recommendation 3: **Ensure consistent team member assignments**	• Establish clear guidelines for case manager assignments and prioritize consistency. • Create and disseminate a provider-level survey before new cases are assigned to assess individual case managers' strengths and workload capacities, to be updated annually. • Develop a notification system to ensure clients and team members are promptly notified of any staff turnover, including temporary coverage arrangements.
Recommendation 4: **Increase awareness and accessibility of FSP services**	• Implement more robust strategic outreach through schools and other community channels. • Connect with county school counseling or health services to identify and refer potential clients to FSP programs.
Recommendation 5: **Enhance client engagement**	• Establish an online portal or messaging platform for clients to ask questions or request meetings with their case managers.

Background and Introduction

The Mental Health Services Act (MHSA), enacted in 2005, provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), much of this work is accomplished through FSPs. These partnerships deliver individualized, integrated mental health care, flexible funding, intensive case management, and 24/7 access to services following a "whatever it takes" approach to support recovery and wellness for people with serious mental illness (SMI) and their families.

Currently, the County has four comprehensive FSP providers:

- **Edgewood Center** and **Fred Finch Youth Center** (collectively referred to as Edgewood/Fred Finch for self-reported and EHR data), serving children, youth, and TAY

- **Caminar** and **Telecare**, serving adults and older adults

San Mateo County BHRS has partnered with AIR to evaluate how enrollment in FSPs fosters resiliency and improves health outcomes for clients living with mental illness.

Research Methodology

This year's report draws on both quantitative and qualitative data. This section provides an overview of the data sources and methodologies used to assess client outcomes in FSP programs from 2006 through June 2025.

Quantitative Methodology

Data Sources

We use two data sources to track changes in client well-being and hospitalizations over time:

- **Self-reported survey data** collected by FSP providers from clients
- **Electronic Health Records (EHRs)** obtained through the County's Avatar system

This year's report presents self-reported client data from Edgewood/Fred Finch and Caminar since the FSP began in 2006. Telecare's data from December 2018 to June 2025 is reported separately due to ongoing technical issues following a system change in 2018.

Self-Reported Data

For the self-reported data, providers collected initial survey data through an intake assessment, called the Partnership Assessment Form (PAF), which includes information on clients' well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the 12-month "lookback" window of the year prior to FSP enrollment. More details about the self-reported outcomes can be found in Appendix C.

Providers gather survey data on clients during their participation in an FSP in two ways:

- Life-changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting).

- FSP clients are also assessed every 3 months using the 3-Month (3M) forms. Changes in client outcomes are gathered by comparing data at baseline from PAF forms to follow-up data from KET and 3M forms.

EHR Data

EHR data collected through the County Avatar system contain longitudinal client-level information on demographics, FSP participation, hospitalizations, and psychiatric emergency services (PES) utilization before and after FSP enrollment. The Avatar system is limited to individuals who obtain emergency care in the County hospitals. Hospitalizations outside of the County, or in private hospitals, are not captured.

Analysis

This report presents changes in clients' self-reported and hospitalization outcomes for 2 consecutive years: (1) the baseline year, that is, the 12 months prior to enrollment in an FSP program; and (2) the first full 12 months after enrolling in an FSP. Children, TAY, adults, and older adults were included in the analysis if they had completed at least 1 full year with an FSP program by June 30, 2025 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years since inception of the program (2006) as well as annually, by year of FSP program enrollment. Appendices at the end of the report provide details about our quantitative methodology as well as detailed findings for each outcome. Appendix A provides methodology for the self-reported outcomes and EHR-based hospitalization outcomes (i.e., "quantitative methodology"). Appendix D presents additional details on residential outcomes.

Qualitative Methodology

Data Collection

The report also incorporates insights from 34 qualitative interviews—15 with FSP clients and 19 with treatment team members—representing four service providers: Caminar, Telecare, Edgewood Center, and Fred Finch.[3]

Analysis

Appendix B provides detailed information on the methodology for qualitative data collection and interviews.

Self-Reported Data Outcomes

Overview

This section presents outcomes for 898 FSP clients across four FSP providers. The results presented in this section compare the first year enrolled in an FSP with the year prior to FSP enrollment for clients completing at least 1 year in an FSP program.

- The Caminar section presents outcomes for 118 adult FSP clients (ages 26–59) and 28 older adult FSP clients (ages 60 and older) who joined and completed at least one year in an FSP since 2006.[4]

- The Edgewood/Fred Finch section presents outcomes for 249 child FSP clients (ages 16 and younger) and 305 TAY FSP clients (ages 17–25).

- The Telecare section presents outcomes for 198 FSP clients regardless of age, including youth and TAY clients. We combine findings for all age groups when reporting findings for Telecare clients.

Telecare changed its data reporting system on December 1, 2018, and was only able to provide the data after the conversion date due to data reliability issues. Because of the incompleteness of the Telecare data, we conducted a separate analysis for Telecare's self-reported data.

In this section, we present findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception, followed by findings from the analysis using Telecare data since December 2018.

---

[3] Fred Finch served fewer clients this year, and therefore our team was unable to interview clients from this FSP provider. However, our team did interview a Fred Finch team member.
[4] Caminar's self-reported data also includes 89 TAY clients; however, we excluded them from the analysis due to lack of ongoing data collection for TAY-specific outcomes.

Caminar Findings

Self-Reported Outcomes by Age Group

Adults. Exhibit 7 compares outcomes for adult clients in the year prior to FSP enrollment with their first year in an FSP. One year after enrollment, adult Caminar clients showed improvements across multiple outcomes:

- **Mental and physical health emergencies** showed statistically significant decreases in self-reported crises.

- **Incarceration and arrests** declined significantly.

- **Homelessness** decreased, though the decrease was not statistically significant.

- **Employment and substance use treatment** increased, but changes were not statistically significant.

These findings demonstrate improvements for adult clients in the first year of FSP enrollment for all outcomes and significant improvements for all except homelessness, active substance use problems, and substance use treatment.

Exhibit 7. Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 118)
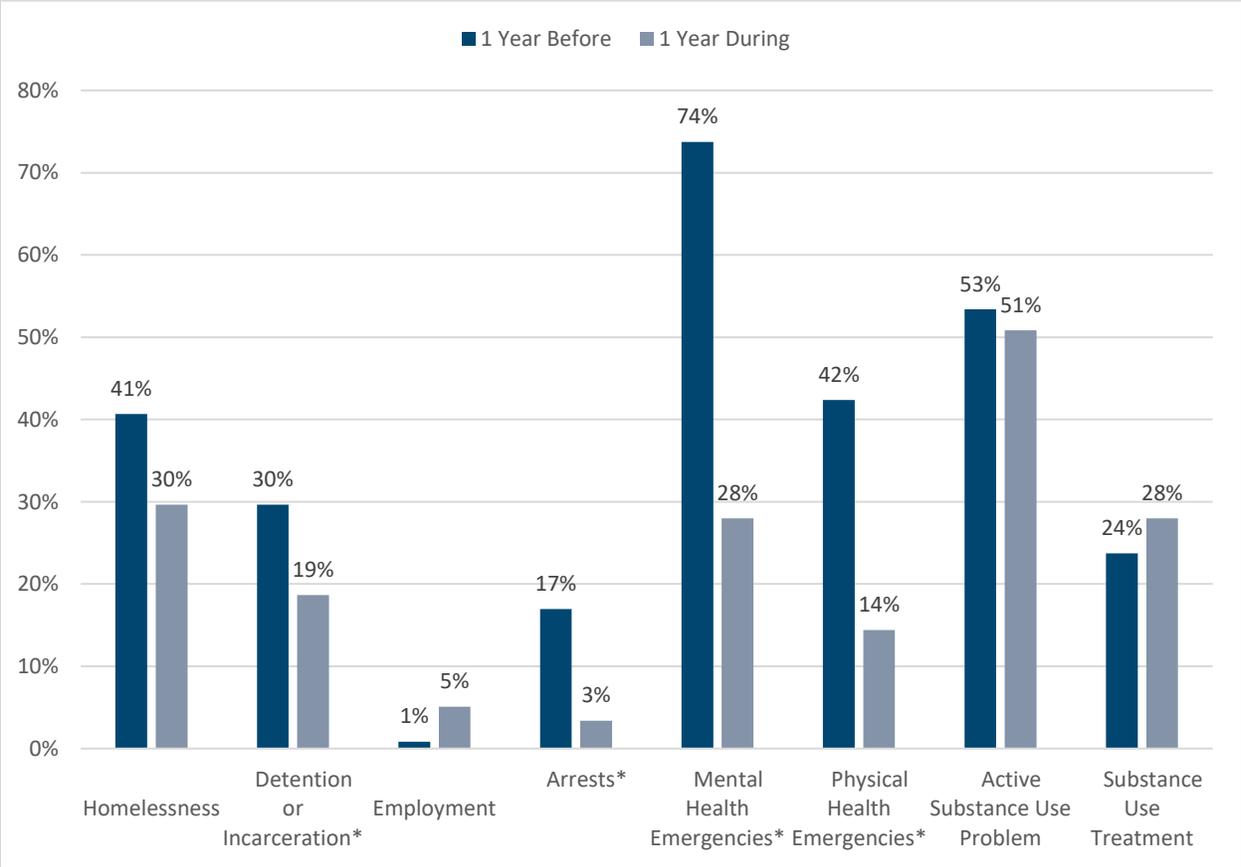
Older Adults. Exhibit 8 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult Caminar clients. Each of these outcomes demonstrated improvement for this group, though results should be interpreted with caution due to the small sample size:

- **Mental health emergencies** declined from 57% to 18%, which emerged as the only statistically significant outcome among older adults.

- **Physical health emergencies and homelessness:** Both outcomes decreased by 8% each, suggesting better health management and housing stability.

- **Substance-related outcomes:** Active substance use problems and treatment participation showed slight declines.

- **Arrests** dropped from 14% to 4%, indicating improved stability and reduced justice system involvement.

Exhibit 8. Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 28)

Note. Employment and incarceration outcomes are not presented for older adults due to insufficient observations in this age group for meaningful interpretation. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Edgewood/Fred Finch Findings

Children. Exhibit 9 shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child clients. There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in an FSP program.

- **Mental health emergencies** dropped from 40% to 6%, representing a statistically significant improvement.

- **Detention or incarceration** remained unchanged, with 11% or 28 incidents both before and during the first year of FSP enrollment.

- **Arrests** decreased after enrollment in FSP (11 in the first year with FSP compared with 31 in the year just prior).

The decreases in arrests, mental and physical health emergencies, and school suspensions were statistically significant.

Exhibit 9. Outcomes for Child Clients Completing 1 Year With FSP (N = 249)

Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Full Service Partnership Outcomes: Findings from FY 2024–2025

Exhibit 10 presents outcomes on self-rated school performance and attendance among child clients. School attendance and performance declined slightly after enrolling in an FSP program. Although modest, these decreases in performance and attendance were statistically significant.

Exhibit 10. School Outcomes for Child Clients Completing 1 Year With FSP (*N* = 249)

Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale, coded such that a higher score is better.

Transitional Age Youth (TAY). Exhibit 11 compares the outcomes for TAY clients in the year before joining FSP with their first year in the program.[5] All self-reported outcomes decreased (indicating an improved status). Outcomes for **arrests, mental and physical health emergencies, and school suspensions demonstrated statistically significant improvement.**

---

[5] The older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY-specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

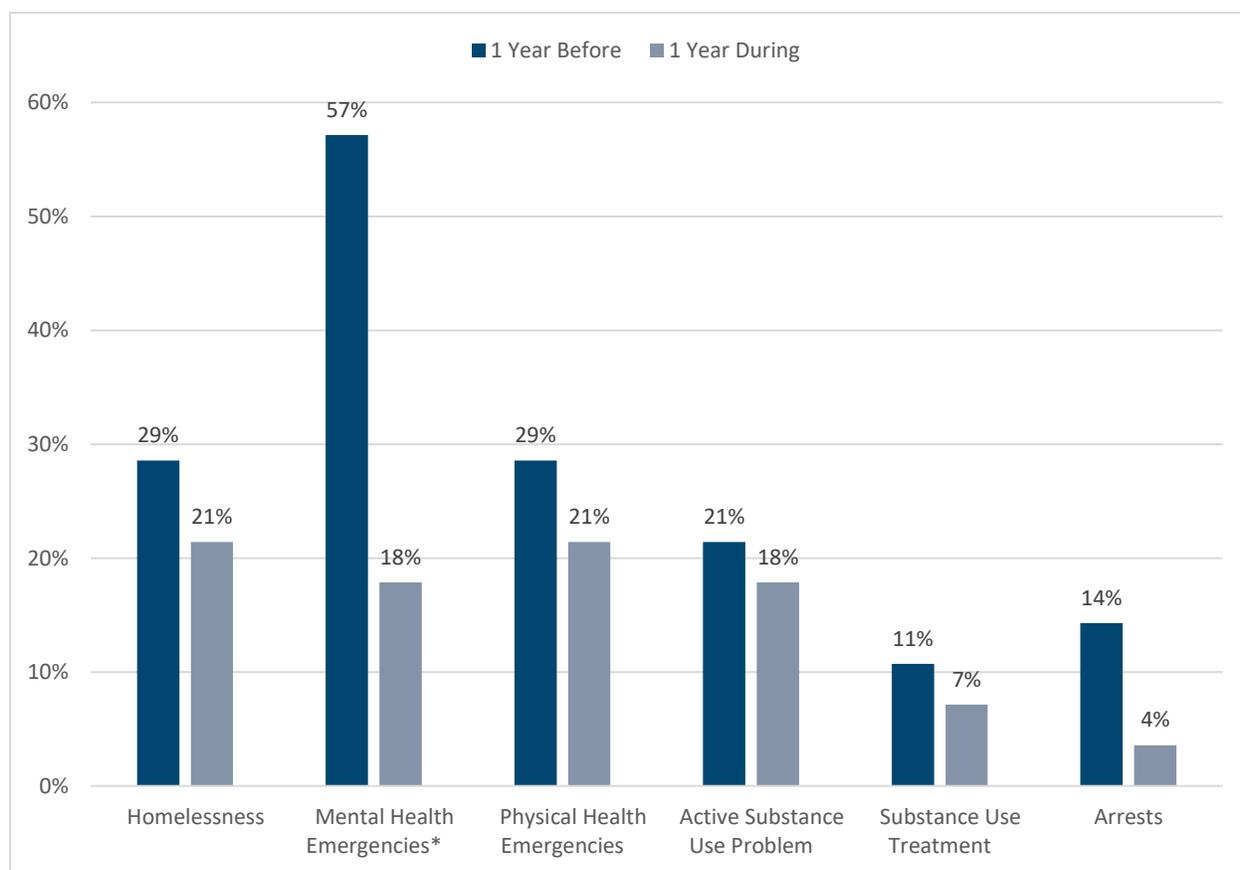**Exhibit 11. Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 305)**
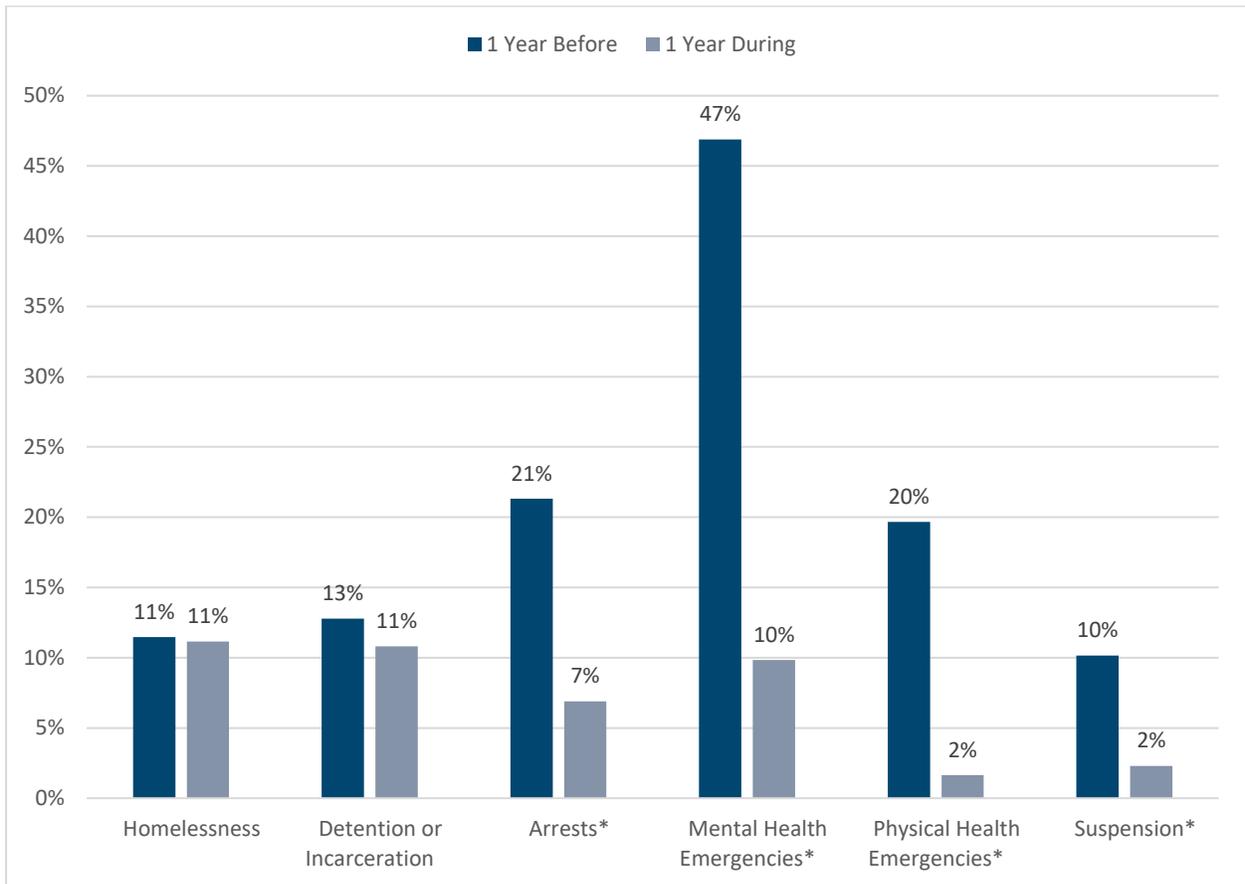
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

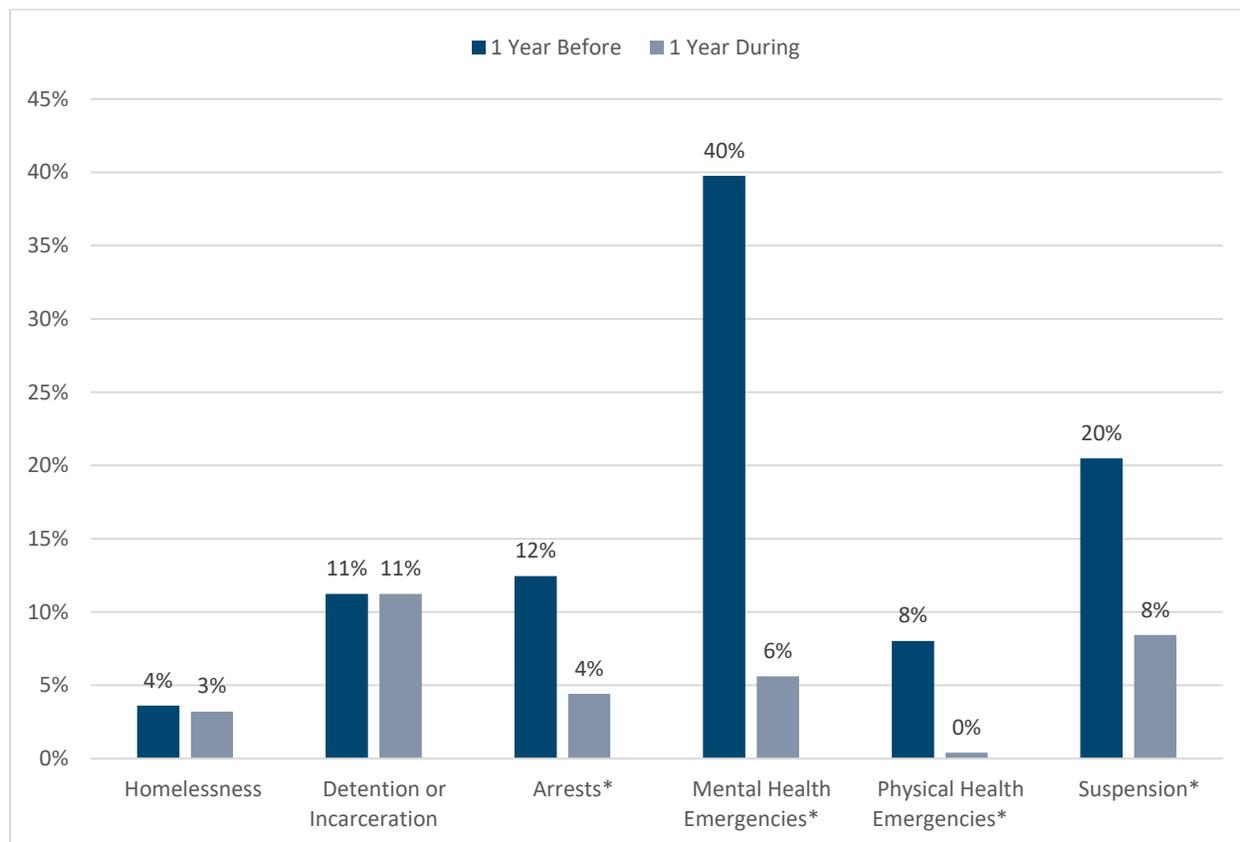Exhibit 12 shows outcomes on self-rated school performance and attendance for TAY clients. School performance and attendance showed a slight decline following enrollment in an FSP; however, neither outcome demonstrated a statistically significant change.

Exhibit 12. School Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 305)

Legend: ■ 1 Year Before ■ 1 Year During

Academic Performance: 1 Year Before = 3.24, 1 Year During = 3.11
Attendance: 1 Year Before = 2.50, 1 Year During = 2.49
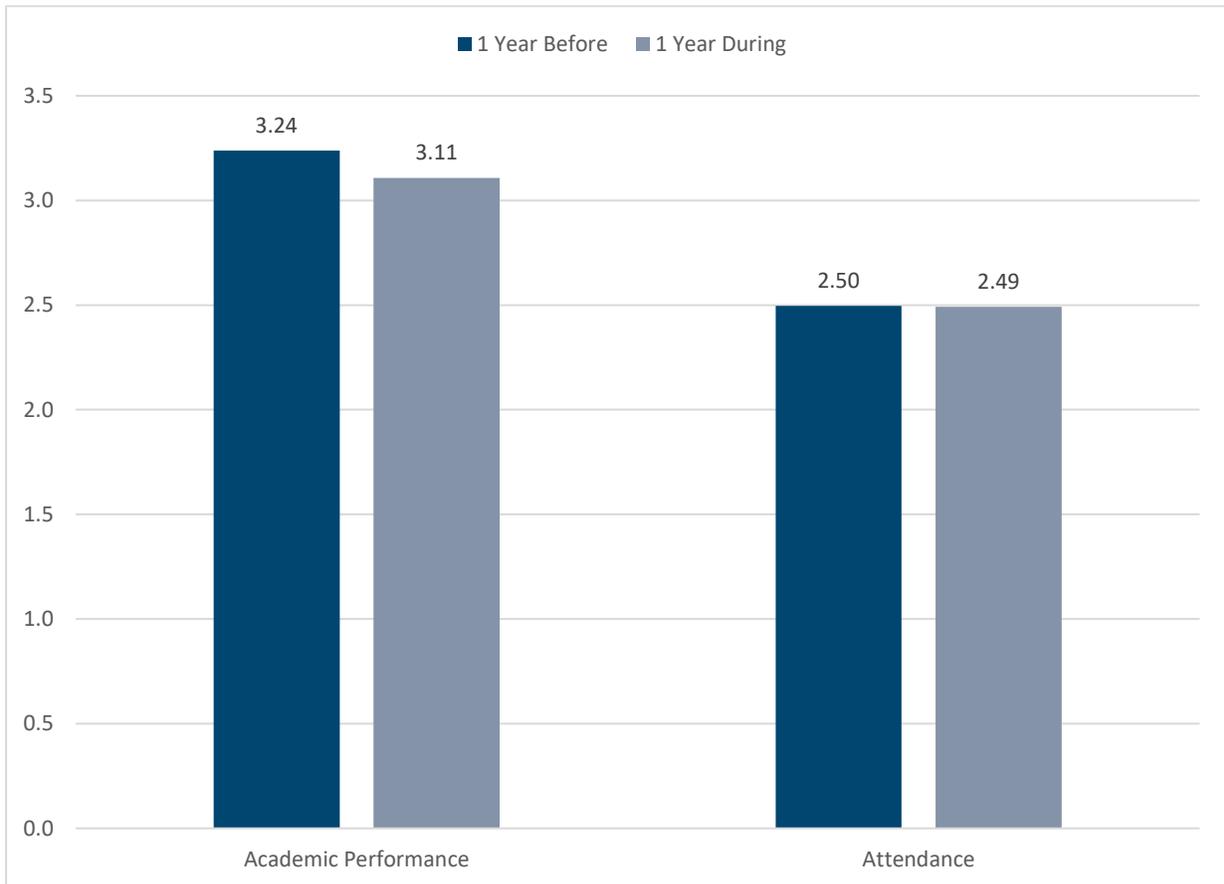
Note. The ratings are on a 1–5 scale; a higher score is better.

Telecare Findings

Self-Reported Outcomes: All Ages

Telecare data include 198 adult and older adult clients who have completed at least 1 year of FSP as of June 30, 2025. Due to the limited sample size of clients served by Telecare, results for all age groups were aggregated. Exhibit 13 shows the comparison of outcomes for all Telecare clients in the year prior to FSP enrollment with the first year in an FSP.

- **Homelessness, arrests, and substance use disorders** decreased significantly after FSP enrollment. Each of these outcomes demonstrates improvements in the first year of FSP enrollment.

- **Mental and physical health emergencies** were reported more often among Telecare clients 1 year after FSP enrollment, though only the increase in mental health emergencies was statistically significant. The increase may reflect improved

detection and reporting of acute crises as clients engage more consistently with providers.

- **Detention or incarceration** rose slightly after enrollment, but the change was not significant.

- Substance use treatment was reported less often during the first year of FSP, likely due to a **significant decline in active substance use**.
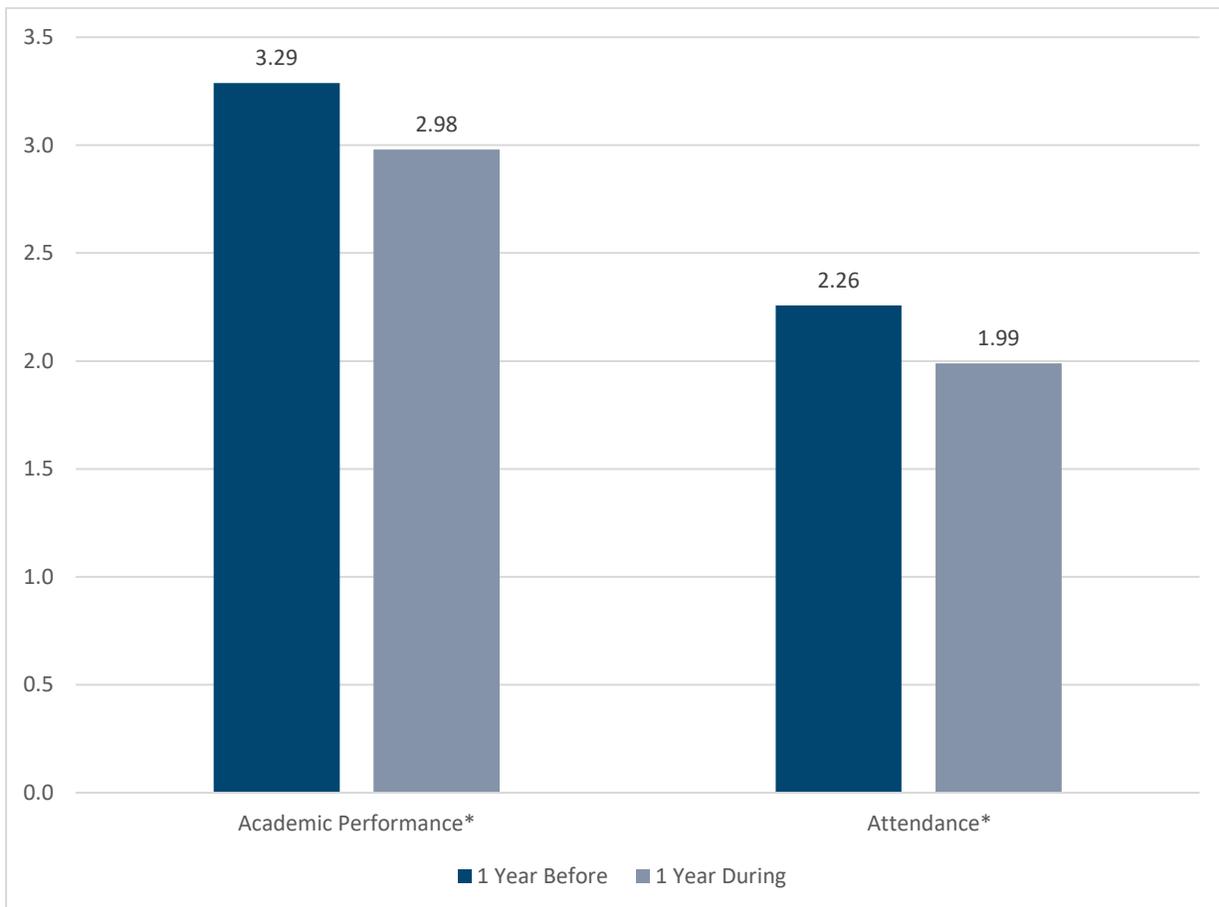
Exhibit 13. Outcomes for Telecare Clients Completing 1 Year With FSP (*N* = 198)
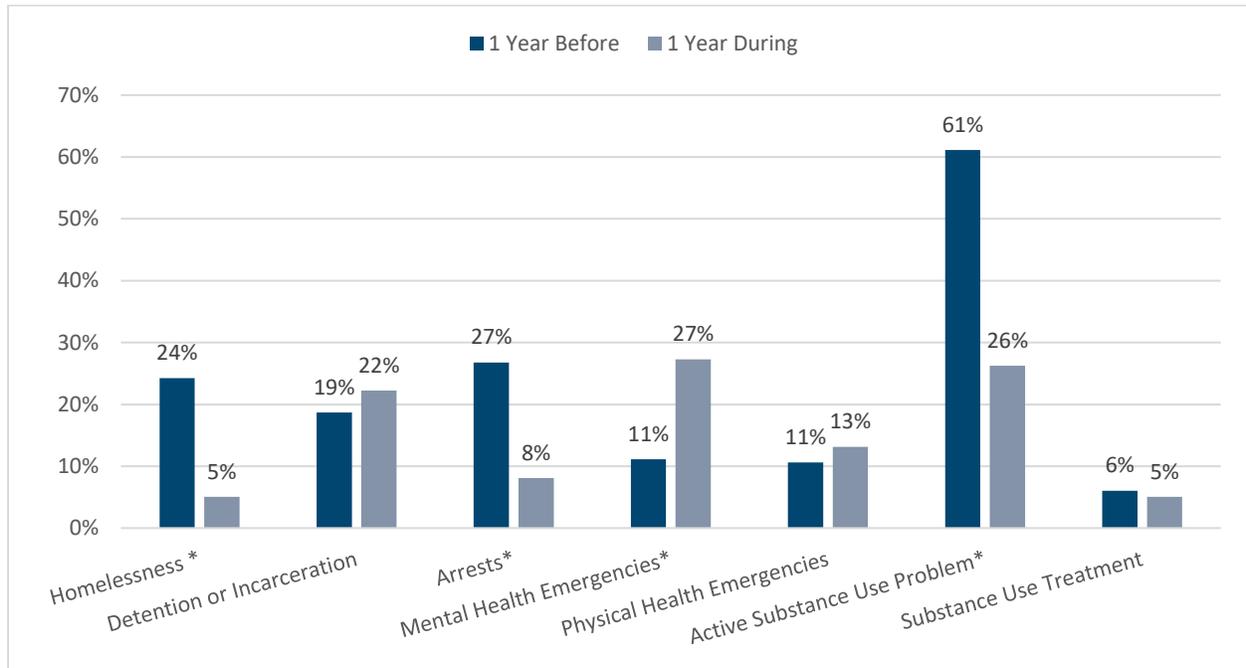
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Health Care Utilization

Overview

This section describes a) overall health care utilization across all clients from the beginning of an FSP program, b) health care utilization by age group from the beginning of an FSP program, and c) health care utilization for clients by year (2006–2024/25).

Using the County's EHR data, we present four hospitalization outcomes for 938 total FSP clients, including 215 child clients, 227 TAY clients, 408 adult clients, and 88 older adult clients:

- **Clients with any hospitalizations:** measured by any hospital admission in the past 12 months
- **Clients with any PES:** measured by any PES event in the past 12 months
- **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months
- **Average number of PES events:** the number of PES events in the past 12 months

Findings

Overall Health Care Utilization Outcomes Across All Clients

We detected statistically significant changes in outcomes from the year before FSP compared with the first year in FSP for all hospitalization outcomes (Exhibit 14). The percentage of clients with any hospitalization decreased by about half from 19% before FSP to 9% during FSP. The average number of days spent in the hospital decreased from 6.9 days before FSP to 2.3 days during FSP. The percentage of clients with any PES decreased from 41% before FSP to 27% during FSP. The average number of PES events decreased from 1.1 events before FSP to 0.7 events during FSP.

Exhibit 14. Hospitalization Outcomes Among FSP Clients (*N* = 938)

Outcome	1 year before FSP Percentage/Mean (95% confidence interval)	Year 1 in FSP Percentage/Mean (95% confidence interval)
Percentage of clients with any hospitalization*	19% (17%–22%)	9% (7%–11%)
Mean number of hospital days*	6.9 (5.5–8.3)	2.5 (1.7–3.3)
Percentage of clients with any PES event*	41% (38%–44%)	27% (24%–30%)
Mean PES events, per client*	1.1 (1.0–1.3)	0.7 (0.6–0.8)

Note. Significance testing was conducted using chi-square tests for percentages and *t* tests for means. An outcome with a * indicates result is statistically significant at the 0.05 level.

Health Care Utilization for FSP Clients by Age Group

Hospitalization outcomes are presented in Exhibits 15–18 by age group. For all four age groups, the percentage of FSP clients with any hospitalization declined after joining an FSP. This decrease was significant for children and adults and not significant for TAY or older adults. For all age groups, the percentage of FSP clients with a PES event showed a statistically significant decrease after joining an FSP. The mean number of

hospital days experienced by FSP clients decreased for all age groups. The decrease was only significant for adults. The average number of PES events had a statistically significant decrease after FSP enrollment for all age groups.

As shown in Exhibit 15 below, all outcomes for children are statistically significant except the change in mean hospital stays.

Exhibit 15. Hospitalization and PES Outcomes for Child Clients Completing 1 Year With FSP (*N* = 215)
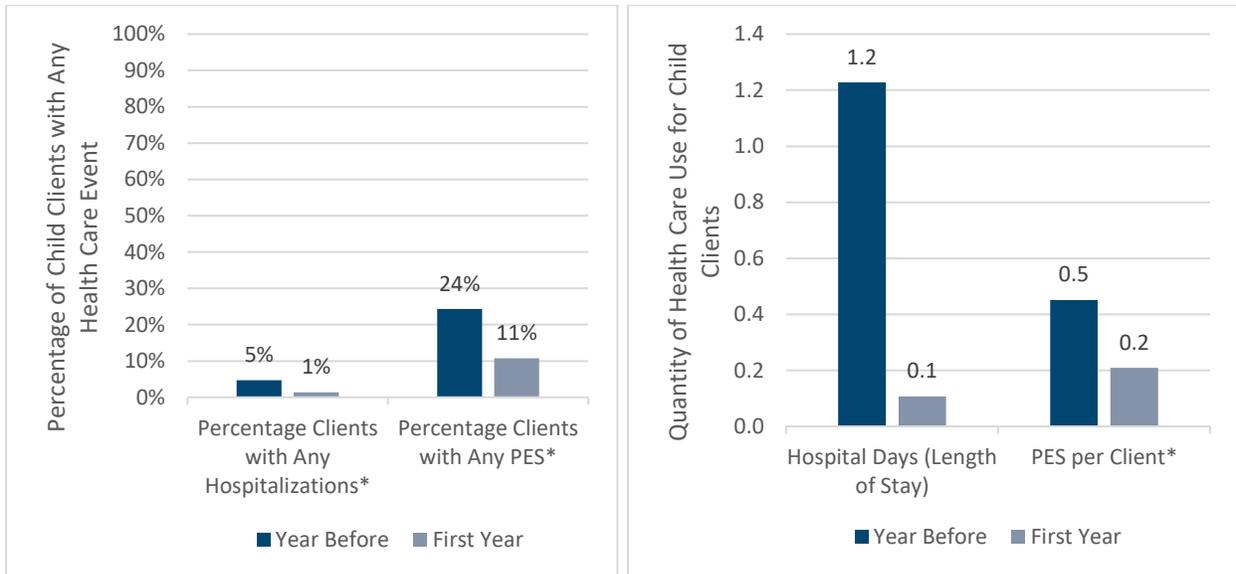
Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

In Exhibit 16 below, the change in percentage of TAY clients with PES and the change in mean number of PES events are statistically significant.

Exhibit 16. Hospitalization and PES Outcomes for TAY Clients Completing 1 Year With FSP (*N* = 227)
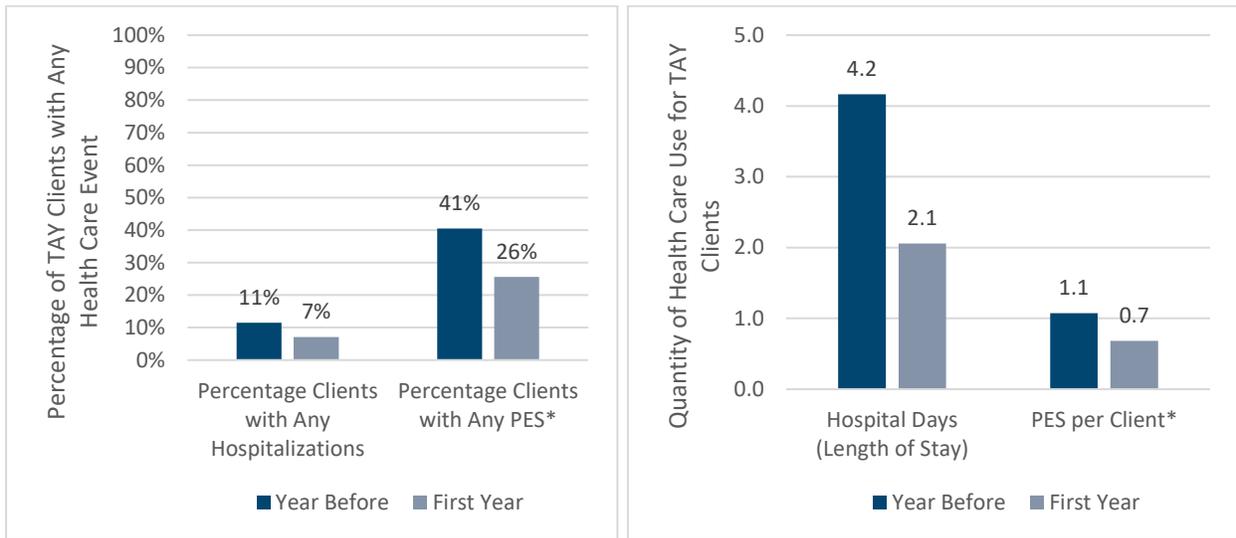
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

In Exhibit 17 below, all four outcomes are statistically significant for adults.

Exhibit 17. Hospitalization and PES Outcomes for Adult Clients Completing 1 Year With FSP (*N* = 408)
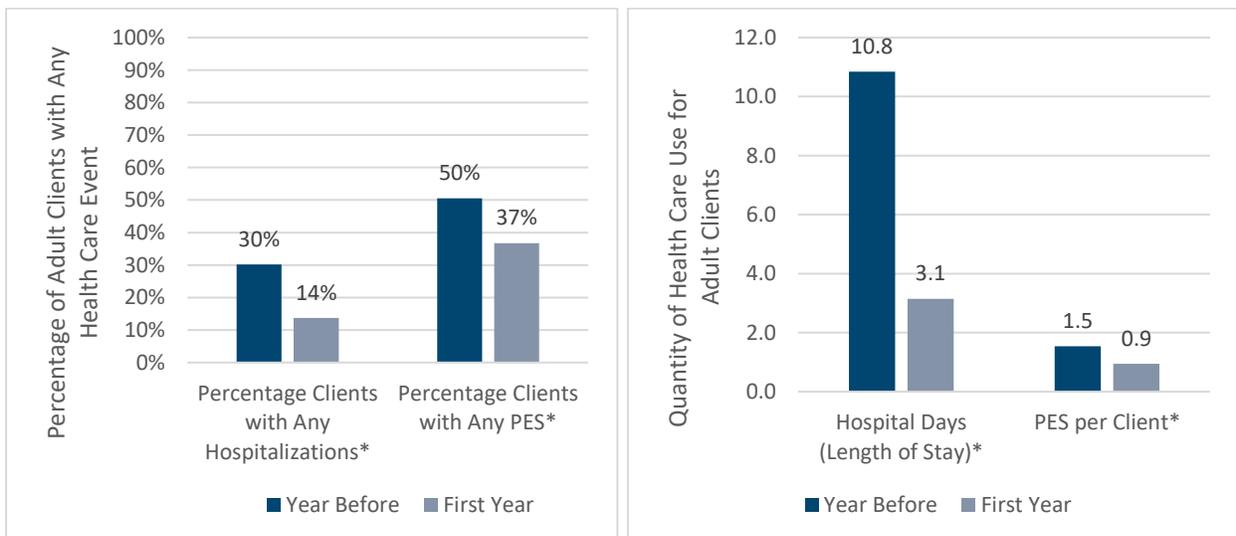
Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

As shown in Exhibit 18, for older adults, the change in percentage of clients receiving PES and the number of PES per client are statistically significant.

Exhibit 18. Hospitalization and PES Outcomes for Older Adult Clients Completing 1 Year With FSP (*N* = 88)
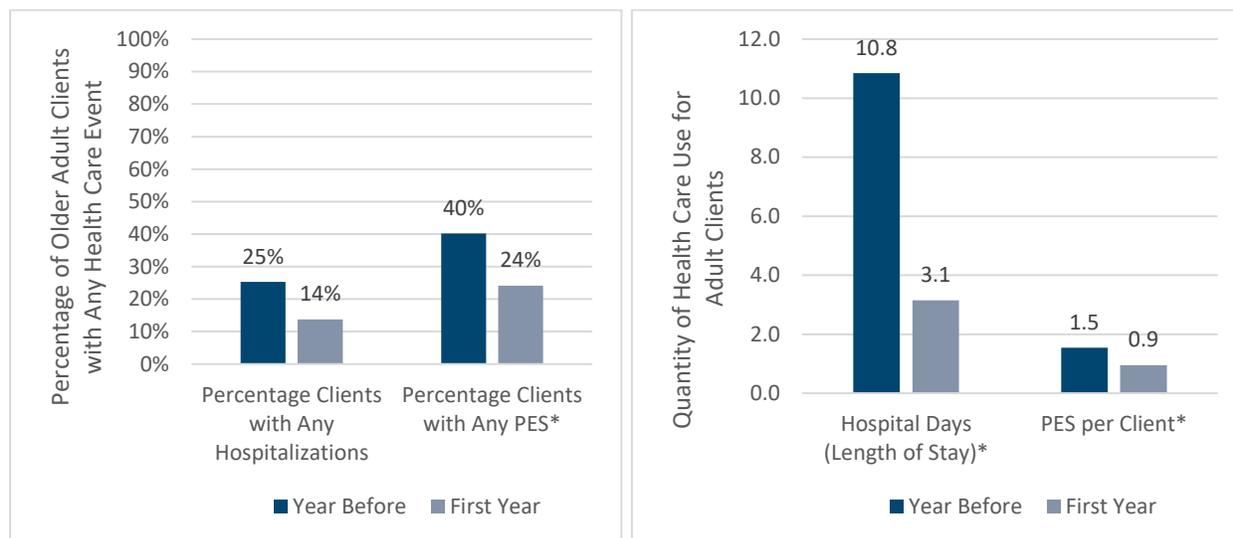
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Health Care Utilization for FSP Clients Over Time

Exhibits 19–22 show the four health care utilization outcomes, including the percentage of clients with any hospitalization, mean hospital days per client, percentage of clients using any PES, and mean PES event per client, stratified by year of enrollment. As shown in Exhibit 19, nearly every cohort shows fewer clients with any hospitalization in their first year than in the year before. The only exceptions are 2016, where the percentage remained the same; and 2022, where the percentage increased slightly but still remained low. The consistent reduction in hospitalization rates and hospital days during the first year after FSP enrollment suggests that the program is effective in promoting stability and reducing crises. Further, this trend holds across almost two decades of cohorts, demonstrating the robustness of the FSP program despite broader external factors and changes.

Exhibit 19. Percentage of Clients With Any Hospitalization by FSP Enrollment Year
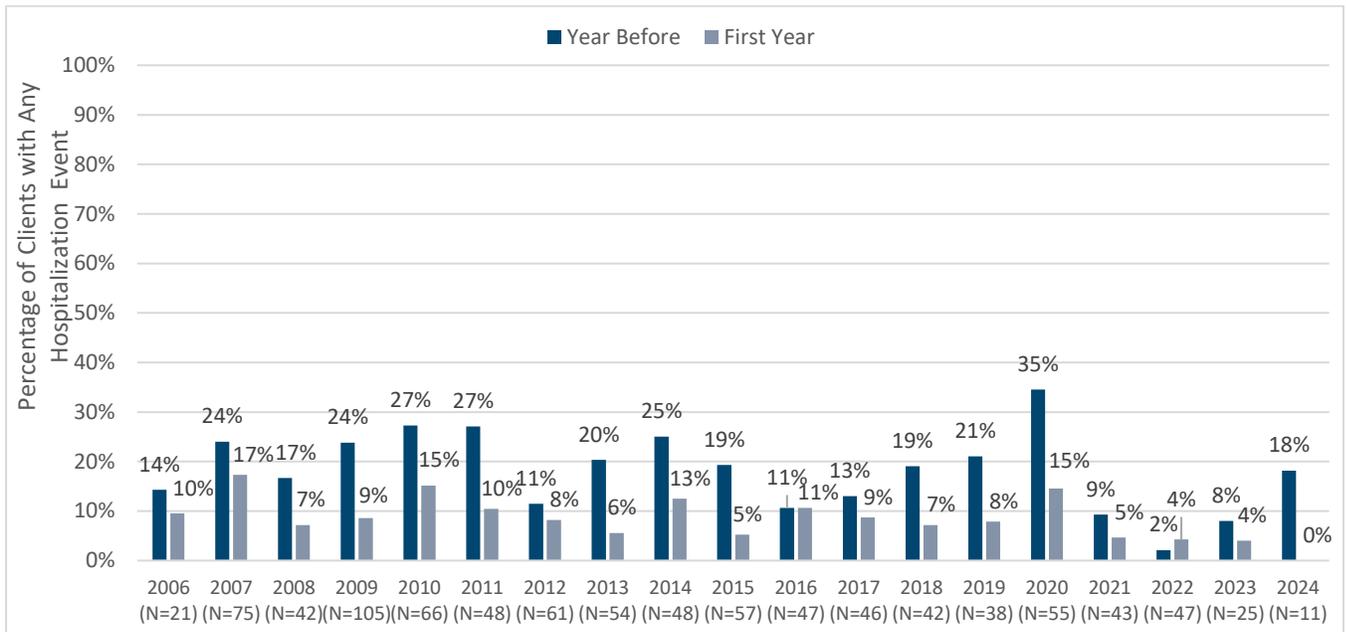
Exhibit 20 below displays the mean hospital days per client by enrollment year. Apart from the 2006, 2007, and 2022 cohorts, all other years show a decrease in the average hospital days from the year before FSP to the first year of FSP enrollment. Hospital days decreased by an average of nearly 5 days from the prior year for the 2024–25 enrollment cohort.

Exhibit 20. Mean Number of Hospital Days by FSP Enrollment Year

Full Service Partnership Outcomes: Findings from FY 2024–2025
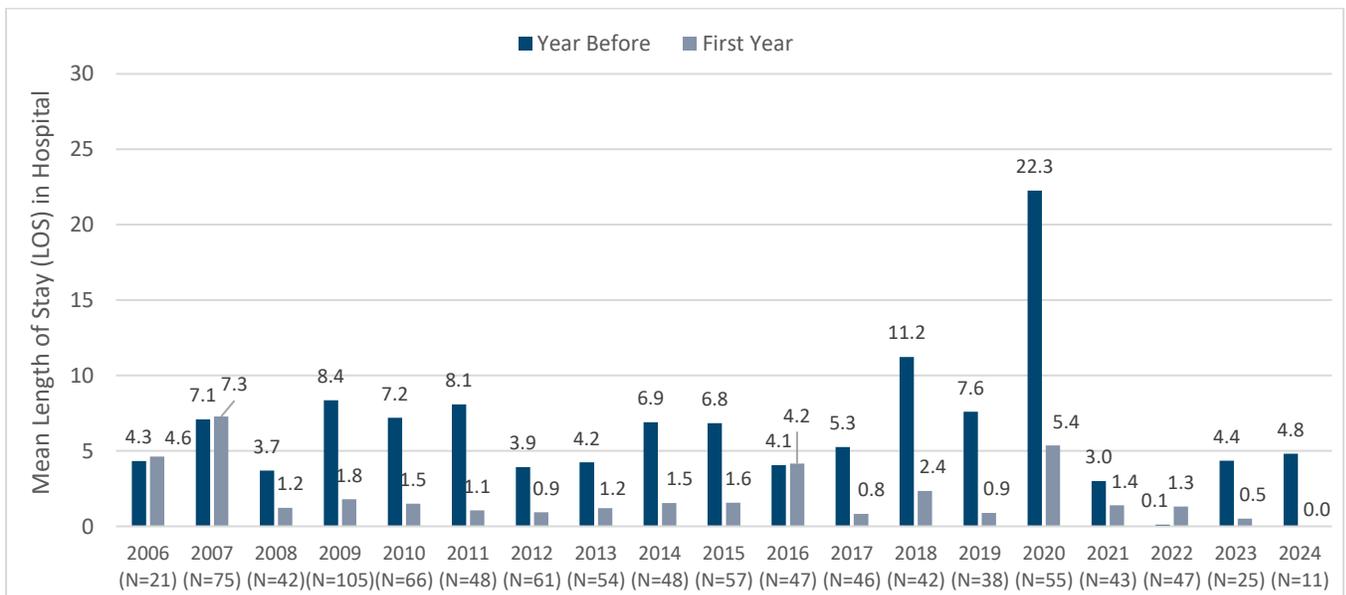
Exhibit 21 displays the percentage of clients with any PES event by the year they began FSP. Almost all cohorts experienced a decline in the likelihood of a PES event from the year before FSP to the first year of FSP enrollment. Cohorts 2021, 2023, and 2024–25 experienced no change in the likelihood of a PES event.

Exhibit 21. Percentage of Clients With Any PES Event by FSP Enrollment Year
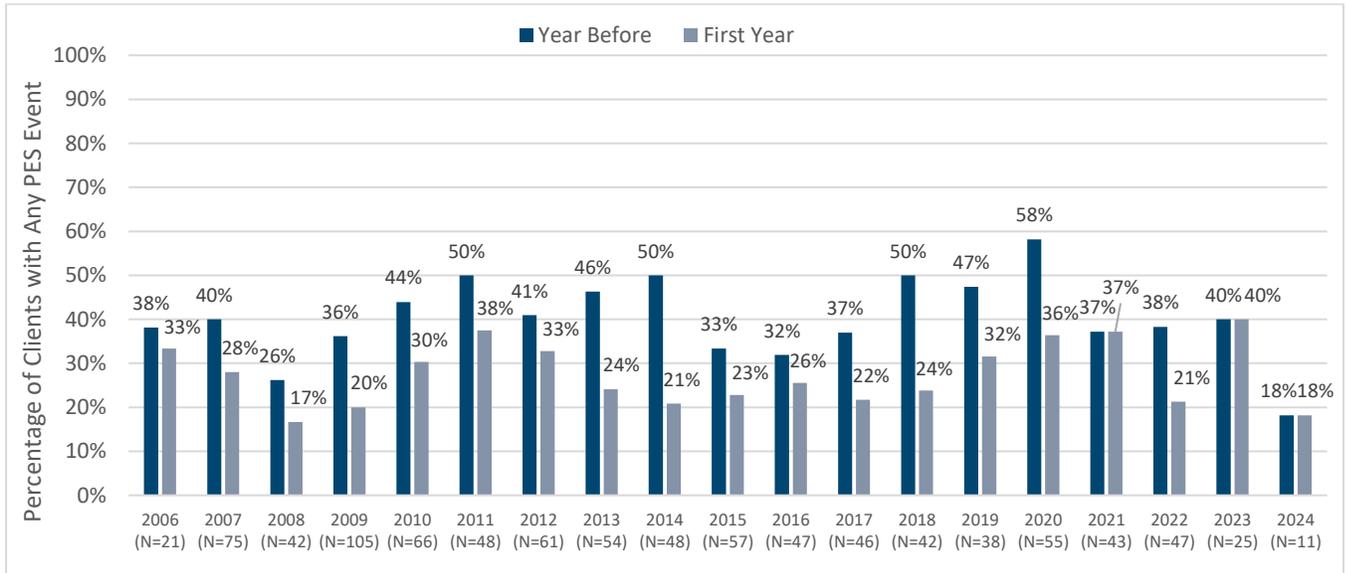
Exhibit 22 displays the mean PES events per client by FSP enrollment year. All cohorts experienced a reduction in PES events from the year before FSP to the first year of FSP enrollment, with the exception of 2024–25 where PES events slightly increased.

Exhibit 22. Mean PES Events by FSP Enrollment Year
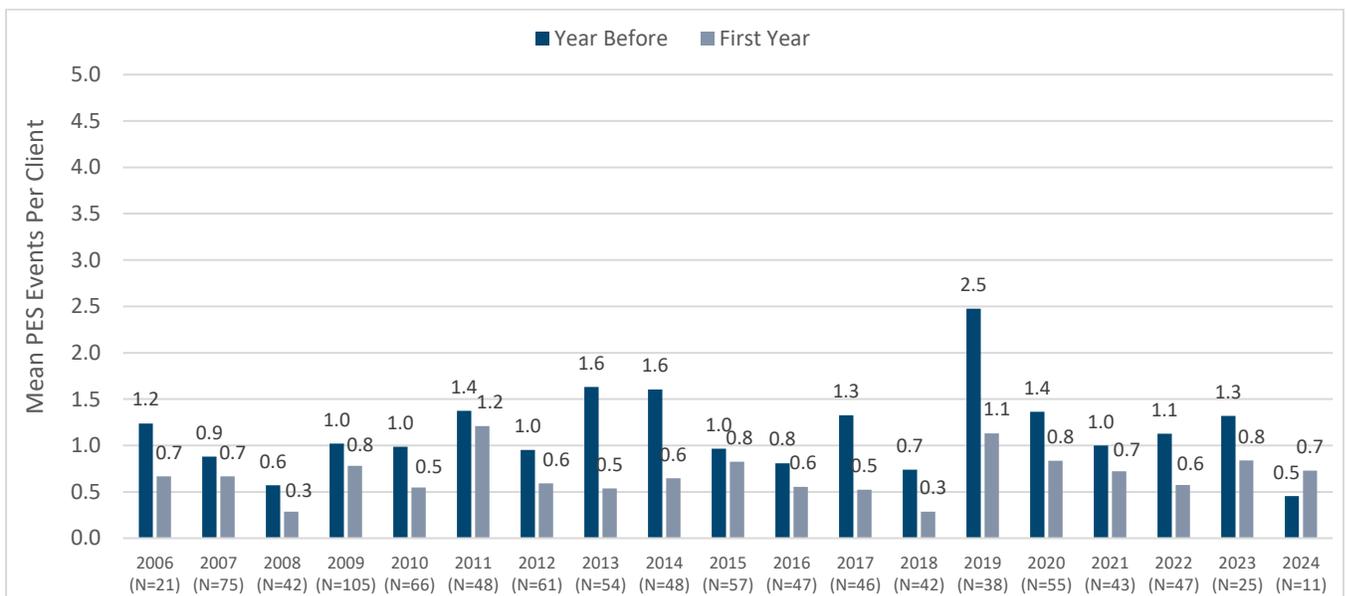
Qualitative Analysis

In addition to the quantitative assessment using self-reported and EHR data, AIR conducted qualitative data collection and analysis to complement the final evaluation for FY 2024–2025. AIR conducted key informant interviews (KIIs) with FSP clients and members of the wraparound treatment team to understand their experiences with the FSP program, perceptions of impact, and factors affecting the implementation of the FSPs in San Mateo County. Below we present the analysis results for the completed KIIs.

Qualitative Evaluation Questions

The qualitative data collection and analysis aimed to answer the following Evaluation questions.

Clients

1. Client experiences: How do clients perceive their experience with FSPs?

2. Interaction with wraparound treatment team: How is the wraparound treatment team helping clients achieve their goals?

3. Improving the FSP experience: What changes do clients recommend for improving their FSP experience?

Treatment Team Members

1. Wraparound treatment team (integrated and comprehensive) experiences: How does the wraparound treatment team perceive their experience with FSP?

2. Providing client services and outcomes: What strategies and resources are wraparound treatment team members using to address the behavioral health needs of clients they serve?

3. Improving the FSP experience: What changes do wraparound treatment team members recommend for improving the FSP program?

Findings: FSP Treatment Team and Client Interviews

This section presents findings from interviews conducted with the 15 FSP clients and 19 FSP treatment team members across the four service providers as described in Exhibit B2 in Appendix B.

Findings describe clients' and treatment team members' responses regarding the following:

- Overall experience and satisfaction with the FSP program

- Experience with FSP services and care, including strengths and areas for improvement

- Clients' greatest needs and goals for FSP participation

- Opinions about how well provided FSP services met clients' needs

- Perspectives on mental health and quality-of-life impact

- Recommendations for the FSP program

We refer to the FSP clients we interviewed, including parents of youth program clients, as "clients," FSP treatment team members as "treatment team members," and FSP service providers, (i.e., Fred Finch, Edgewood, Telecare, and Caminar) as "service providers."

Overall Experience and Satisfaction With the FSP Program

Exhibit 23. Summary of Overall Experience and Satisfaction With FSP Program

Clients	Treatment team
- Clients had overall satisfactory, supportive, and comfortable experiences with the FSP program. - Clients referenced positive interactions with case managers and other treatment team members as a reason for their high satisfaction with the program, although some mentioned difficulty with staff turnover. - The average satisfaction rating across clients was 8.9 out of 10.	- Treatment team members had overall satisfactory and rewarding experiences as staff members in the FSP program. - Treatment team members listed effective team collaboration, connecting with clients, and opportunities for career growth as reasons for their high satisfaction with the FSP program. - The average satisfaction rating across treatment team members was 8.4 out of 10.

Clients' Overall Experience

Clients shared that they had supportive and comfortable experiences with FSP staff, including case managers, therapists, and other treatment team members.

Client Satisfaction

On a scale of 0 to 10, with 0 being not at all satisfied and 10 being extremely satisfied with the program, clients rated the FSP program an average of **8.9 out of 10**.

Clients who provided scores between 8 and 10 expressed gratitude for the FSP treatment team's support for them or their family and indicated positive changes in their lives since joining the program:

> *"When, like I said, I first was there, I was so down and out that I had no confidence in myself, and since then, I knew they had built up my confidence and they helped me out in a lot of things I couldn't do myself."* (An **older adult** client)

> *"I really think that doing the family therapy, and all the support they've given us, has really turned around things for my family."* (**Parent** of a youth client)

> *"I had a really, really, great care team, and I even mentioned it several times that I was, I must have been one of the luckier people because I had a full complete care team. I had everybody that I needed, and things were good."* (An **adult** client)

One client, who gave the program a score of 7.5, shared that staff retention had affected their experience with their treatment team and "*if they could in some way reduce turnover and maintain staff retention, then that would be a great benefit … the staff that work there is really great. I really appreciate everything that they do.*" (An **adult** client)

Overall Treatment Team Experience

Treatment team members from adult and youth FSP programs reported satisfaction in their roles, highlighting rewarding experiences in the client-centered work to help clients achieve their goals, and valued opportunities for professional growth and learning. Additionally, they appreciated the supportive and effective collaboration across the treatment team.

A treatment team member emphasized the inclusive and collaborative nature of the FSP program:

> *"First thing, we're an ACT [Assertive Community Treatment] team, and so ACT team means everybody has a seat at the table. My best way to describe it is that even as a new case manager, I was always able to share my thoughts and speak my truth."* (Treatment team member from an **adult** program)

Two other treatment team members expressed similar sentiments about the rewarding nature of the work and the supportive team environment:

> *"I love the helping people part. I think the helping people, and I love especially being a lead. I love working with my team."* (Treatment team member from an **adult** program)

"I love this work. I love serving the families that we do. I've always felt really called to this line of work, and I'm really grateful … because it's a really supportive team environment." (Treatment team member from a **youth** program)

Treatment Team Satisfaction

Treatment team members were asked to rate their satisfaction with the FSP program from 0 to 10, where 0 suggested they felt not satisfied, and 10 indicated they felt extremely satisfied. More than 80% of treatment team members rated their satisfaction with the program 8 or higher. Across 19 treatment team members, the average rating for the FSP program was **8.4**.

A treatment team member, who gave their satisfaction with the program a score of 10, attributed the high score to the program's opportunities for growth and advancement:

> *"What I love about being part of this team is that I'm proof that there's advancement working in our setting. And me coming up basically starting from the ground up, the very, very bottom is something that I'm extremely proud of."* (Treatment team member from an **adult** program)

One treatment team member, who provided a satisfaction score of 9, highlighted the value of representation:

> *"If you're able to reflect yourself and see yourself in someone who has the same gender identity or the same ethnic identity, that goes a long way."* (Treatment team member from a **youth** program)

Another treatment team member, who gave a satisfaction score of 8, shared the staff's dedication to providing individualized care and building genuine connections with clients:

> *"We really strive to give each individual what they need, and rather than having a standardized mode of treatment for everyone, we just have real relationships, real human relationships with our clients."* (Treatment team member from an **adult** program)

A treatment team member who provided a satisfaction score of 7 emphasized the effect of low pay on staff turnover and client care:

> *"Staff and people are leaving mainly because of getting more money elsewhere. So I just think if something could be potentially done about that, that would really help to keep staff here for a longer time, and then that would in turn benefit the*

clients more because staff wouldn't be as burnt out and they'd get the quality care that they need." (Treatment team member from an **adult** program)

Greatest Needs and Program Goals of FSP Clients

Exhibit 24 summarizes FSP participation goals shared by clients, and treatment team members' perceptions of clients' greatest needs.

Exhibit 24. Summary of Clients' Goals and Greatest Needs

Client perceptions	Treatment team perceptions
• Adult and older adult clients shared that their goals for participating in the FSP program include improving their mental health, living independently, pursuing education, and finding employment. • Parents of youth clients said that their goals include receiving support for their child's mental well-being, improving school performance, and enhancing family dynamics and communication.	• Treatment team members stated that the greatest needs among FSP clients include assistance with finding stable housing, access to substance use treatment services, food assistance, and social support.

Clients' Goals: Client and Parent Views

On enrollment in the FSP program, adult and older adult clients reported a desire to improve their mental health, live independently and become self-sufficient, and pursue employment and education. In addition to improving mental well-being, youth clients and their parents sought to improve school performance and family dynamics and communication.

Adult and Older Adult Clients

- **Improving mental health:** Clients shared that their primary goal when joining the FSP program was to improve and stabilize their mental health and overall well-being. Specifically, they aim to process trauma, take their medication regularly, and attend doctor and therapy appointments consistently. Three clients shared the following about their goals:

  "To work on my mental health, to improve my wellness, and to get a stable medication regimen." (An **older adult** client)

  "My current goals, at my age, I've had several good jobs, and I was able to complete a college degree, now my goals are just very simple, it's to make all my doctor's appointments, make all my appointments, to take my medicine." (An **older adult** client)

"To continue the psychiatry that I'm getting now. It's called EMT, and it's really helpful for trauma. The trauma that I had when I found out that I was bipolar and how that affected my whole life. I needed medication. I needed counseling. I needed psychiatry, so it just changed my whole life." (An **adult** client)

- **Independent living:** Several clients expressed that their goal is to become self-sufficient or to start living independently. Learning how to fill out applications and forms, obtaining stable housing, or living in their own apartment were important to adult and older adult clients:

  "Well, to get myself back to a place where I can handle myself, because when I was in there first, I didn't know what to do or anything. I couldn't do anything. I couldn't even understand how to fill out an application or anything like that." (An **older adult** client)

  "To eventually get my own apartment, I mean, back to true independent living. It's been a long road for me, but I know I can do it. So yeah, basically to get back on my own, even if it's a place that they support, that I would be living on my own rather than with a group of people in the building." (An **older adult** client)

  "Getting back to being self-sufficient." (An **adult** client)

Two clients elaborated on the reasons why they would prefer independent housing over living with roommates or in a shelter:

  "They provide me with room and shelter and food and a place to do my laundry. I rent a room. I have a roommate in the room. There are challenges with that. They took my clothes and wearing them and stuff like that. It's irritating, but there's not much I can do about it besides get new clothes, I guess." (An **older adult** client)

  "For me, at least my experience in shelters, there's always a thief that'll steal your cologne or your best pair of sneakers or Air Jordans, if you have them or whatever. I've been into many, many shelters and board and care homes, but this is the first time ever that I've had my own apartment. So, I have basically privacy and security that I'm not going to get ripped off by somebody who's got sticky fingers. By sticky fingers, I mean things stick to their fingers that aren't theirs." (An **older adult** client)

- **Employment and education:** Another goal for adult and older adult clients when joining the program was to pursue employment opportunities or enroll in higher education. For example, clients wanted to return to the workforce, graduate from the peer counselor program, or obtain a college degree or certification:

"I never completed college. And now I'd like to try it again. It's never too late, they say. It's great to go back to school … I definitely want to take it seriously, take economics classes and also history classes." (An **older adult** client)

"I did the peer counseling program, and I graduated, so I'm hoping to be able to counsel others and help them become more independent." (An **adult** client)

"Well, I have been taken under the wing of my psychiatrist … I've been a therapist my whole life, and I was experienced too, when I got sick … I'm ready to get my license again. I have to just renew it. So it's taking a couple classes online, that kind of thing." (An **adult** client)

Youth Clients and Their Parents

- **Improving mental well-being:** Parents of youth clients shared that their primary goal when enrolling their child in the FSP program was to support their mental and emotional well-being and help them overcome depression and process trauma:

    "Well, that she's able to overcome the traumas she carries and the depression she's still working through, and that she can see life from a different point of view, from another perspective. And that's what matters most to me, that she can move forward without everything she's been through haunting her like a ghost in her life." (**Parent** of a youth client)

    "Well, because my son has always had emotional problems since he was little, I wanted to find help so he could stay emotionally healthy." (**Parent** of a youth client)

- **School performance:** Parents indicated that they hoped to improve their child's school performance; some have already started to see positive changes in their child's grades. Two parents shared the following about school performance:

    "Well, what happened is my daughter had many academic needs at school due to problems with her … She has a disability, she has speech problems, and, like, comprehension problems. So … held her back a lot in school." (**Parent** of a youth client)

    "What she didn't do before, she's doing very well now. Both at school and at work. She's doing a lot of really nice things right now. Through all the help and support they've given us. Well, that's great, so it's helping." (**Parent** of a youth client)

- **Improve family dynamics and communication:** Parents stated that they aimed to become better parents and improve family cohesiveness, in addition to supporting

their child's mental health. They also engaged in family therapy to facilitate communication between family members:

> *"I think just in general he could benefit from therapy … and also, the goal was to help family cohesiveness with the family therapy as well. Just help communication."* (**Parent** of a youth client)

> *"Well, I'd say to move forward with my children. To know how—how do I put it? To be able to have a better place for them and, I don't know, to be able to give them the best, well, for them."* (**Parent** of a youth client)

Clients' Needs: Treatment Team Member Views

The FSP program provides services not only with the goal of improving mental health and substance use recovery, but also to build independent living skills and resiliency to help clients transition into the larger community. When asked about clients' greatest needs, treatment team members commonly referenced assistance with accessing stable housing, food assistance, and substance use programs. The treatment plan is tailored to meet the specific needs of each client. Team members recognize the individuality of each client's needs when developing a treatment plan:

"It's very individualized care. So each case is pretty unique, but the case managers do a really good job about identifying resources to get the needs met." (Treatment team member from a **youth** program)

- **Housing assistance:** Several treatment team members described ongoing challenges in connecting clients with appropriate, stable housing. In addition to the limited availability of affordable housing, team members shared that clients living with SMI or co-occurring conditions often experience difficulty in meeting rent payments, cleanliness, and other requirements necessary to maintain housing placements. A team member also expressed concerns about how unstable housing may adversely affect a client's treatment progress:

> *"We're up against a system where they're in these places that are really depressing and not super livable, and it's hard. It's pretty hard to help people grow and advance and get better when their survival needs are just barely or inadequately provided for."* (Treatment team member from an **adult** program)

Another team member elaborated on how lack of adequate budget has led to closure of housing programs that previously helped transition young adults into more independent living situations:

> *"That was six apartments for 18- to 25-year-olds that were managing kind of on the upper end, the more successful end of that. That was super helpful, but*

unfortunately that's getting taken away because of budgets. Right? So that's an unfortunate loss, but that housing is really important." (Treatment team member from a **youth** program)

- **Access to substance use treatment services:** Treatment team members identified substance use, particularly when combined with SMI, as a significant contributor to mental health emergencies and hospitalizations among clients. Several treatment team members emphasized the complexity of treating clients with co-occurring conditions, which can make it difficult to discern the underlying cause of a crisis:

  "We have clients that come into the program with substance abuse issues that we've tried to mitigate and help them with, but that mixed with mental health is, when you see a client, you ask yourself, 'Is that the schizophrenia or is that the meth?' So you try to find balance." (Treatment team member from an **adult** program)

Another treatment team member noted that while some clients are not yet ready to stop using substances, consistent staff support and a harm reduction approach can still help prevent hospitalization or further deterioration:

  "So there are some clients where they don't use substances anymore … and there's other clients where they're just not really ready to make those changes yet, and so where it's stagnant. But they still have the support from staff and everything, so I think that could help to at least prevent hospitalizations or them from decompensating." (Treatment team member from an **adult** program)

- **Food assistance and social support:** Treatment team members shared that consistent access to food, housing, and social support services plays a critical role in improving clients' overall quality of life. Food support is usually facilitated through referrals to food banks; however, treatment team members noted that rising food prices have made it increasingly difficult to ensure clients receive proper nutrition:

  "The increase in the cost of food for our partners and our people that run our homes. They are very, very challenged to try to provide the correct nutrition for our members. And so they're working with the food banks as well as their own budgets to be able to purchase nutritional food, to be able to make sure our members are getting their sustenance." (Treatment team member from an **adult** program)

Treatment team members also emphasized the importance of addressing clients' social needs, particularly for youth who often report feeling isolated and lonely. Case managers and youth specialists work together to coordinate services that help clients build meaningful relationships and improve social engagement. One

treatment team member noted the difficulty of maintaining these social connections after clients leave the program:

> *"They have three people on their team who meet with them every week, and maybe they can go to the drop-in centers, those things, and there is some social stuff. But when they end up graduating or leaving the program, it's one of the hardest things for us to address is building that sort of social support network so they don't become isolated again once they don't have providers."* (Treatment team member from a **youth** program)

FSP Program Services Provided in Response to Clients' Needs

The following section describes information about client services, based on insights drawn from both client and team member interviews. Types of services available to clients are summarized in Exhibit 25. We also identify the types of team member roles that provide each of these services. The majority of treatment team members interviewed described a highly collaborative environment among all team member roles. Although specialist team members, such as a housing specialist, provide a specific type of service, they regularly communicate with the larger team to ensure that the client is maintaining appointments with all members of their treatment team.

Exhibit 25. Summary of Program Services Provided in Response to Clients' Needs

Services received by most clients:

- *Case management*: rehabilitative activities, motivational interviewing, crisis prevention and management, medication management, care coordination, connection to community resources, and health care advocacy
- *Mental health*: psychiatry, psychoeducation, therapeutic behavior services, and therapy that is often community-focused

Additional support available to clients:

- *Peer support*: group activities, workshops, and socializing with mentors who share similar lived experiences with clients
- *Parental and family support*: family therapists and counselors providing psychoeducation and techniques for crisis avoidance and recovery to clients' family members
- *Transportation*: for attending medical or legal appointments, for access to food pantry or groceries
- *Housing*: housing specialists/coordinators or case managers providing education, funding, or program-affiliated housing

Case Management

Clients meet with their case manager, or a rotating team of case managers, more often than with any other treatment team member. These meetings are held in person (or over the phone when necessary) and usually occur weekly, if not multiple times per

week. During these sessions, case managers utilize rehabilitative activities, including skill building, behavior modeling, mindfulness, and grounding techniques, with the goal of increasing the client's independence. They will often engage in motivational interviewing, reflective and empathic listening, and other therapeutic interventions as needed to prevent and handle crisis situations. In addition, case managers will provide targeted case management to connect clients to resources, which may include food, clothing, housing, education, employment, or specialized programs for substance use or eating disorders. They also connect clients to medical providers for medication and symptom management.

> *"Both case management and therapy are very key to the clients. The case management, because there's a lot of resources a lot of times that the clients aren't aware of or just systems that they don't know how to navigate, like getting an ID or if they can get social security or do they know anything about what's their insurance. All these kinds of things, we help them navigate those systems. So, it's really helpful because it just gets them connected to the adult world in that way, where they know those kind of responsibilities and they start to learn about it."* (Behavioral health director from a **youth** program)

Mental Health Services

Clients typically meet with a therapist once or twice per month in person. In addition to individual sessions, therapists also hold monthly family conferences and offer group sessions for multiple clients. During these sessions, therapists will utilize the therapeutic and rehabilitative techniques employed by case managers, as well as provide psychoeducation to inform clients about their symptoms, help clients heal from trauma, and reduce harm for clients with substance use disorders. Therapists provide specialized and targeted treatment for behavioral disorders identified through referrals for neurological or psychological testing. They also incorporate spiritual and religious preferences into their treatment approach and involve clients' families in the treatment program as much as the client desires and is possible. Many therapists enjoy using a community-based approach during their sessions and listed nature walks, painting, volunteering, or meeting for coffee as common activities they use to build their clients' independent living skills.

> *"I do participate in DBT [dialectical behavior therapy] group. [The therapist] can get me out of my shell. I'm very quiet. I don't really say much. And so, being in the support group is eye-opening because there's other people that are just as normal as me, and they have issues. And not everybody's disability can be seen, but it's supportive in the fact that, hey, I'm not the only one that has issues, and there are other people that have the same questions as I do or have the same thoughts."* (An **adult** client)

"We ask about what holidays they celebrate, any cultural pieces of their life that are really important to them, any rituals, any family traditions, and any cultural stress. We address cultural trauma in our assessment as well. Do these families have access to participate in aspects of their culture, or have they been restricted from that in our larger societal environment? So, we assess all of that as well and keep it in mind while delivering care." (Care facilitator from a **youth** program)

Psychiatry Services

Generally, clients will attend monthly remote sessions with their psychiatrist. During these sessions, psychiatrists will perform assessments, provide interventions, and prescribe medications for symptom management.

"PTSD is something that I never realized was so insidious … You have to really work on it … You go through the trauma with the psychiatrist, and he pinpoints areas where you need to pause. And then he repeats the REM [rapid eye movement] exercise, and it works … I've experienced it, and it's very helpful." (An **adult** client)

Peer Support Services

Many clients choose to use peer support services, which are more focused on socializing and building interpersonal skills in a relaxed environment. Peer support staff serve as mentors to clients and build relationships with them through activities such as cooking, playing video games, and taking walks. Clients are more likely to connect with and relate to peer support staff because they share similar lived experiences, which is evident in the sentiments shared by clients who regularly engage in peer support services. In addition to individualized activities, peer support services include weekly group activities and monthly workshops.

"It makes it show that somebody cares about them and that there's always somebody out there that's looking in on that, whatever struggle they might be having." (Peer support specialist from an **adult** program).

Parental and Family Support

Family therapists may meet with any number of family members in addition to the client, and the sessions are often held in the client's home. Some therapists find it helpful to meet with the client and one parent initially, with the aim of gradually including more family members. They work to reinforce boundaries among family members, teach crisis avoidance and recovery-centered techniques, and provide psychoeducation to family members to help them understand the client's situation. Sometimes, child clients are unwilling to discuss their needs with providers, so family therapists will coach parents on

how to communicate with their child. Clients and their partners may also choose to meet with family counselors.

> *"When it's hard for me to communicate with my daughter, or when I want to … talk to her and she has a hard time understanding me or listening to me, then the support from the therapist has been really helpful for me. [I] feel comfortable talking about health and other social needs."* (**Parent** of a youth client)

Transportation Assistance

Transportation assistance is available to all clients and is primarily intended for essential needs such as medical and court appointments. Case managers, peer support specialists, and therapists collaborate to provide transportation assistance to clients. However, staff noted that clients often have broader transportation needs, such as accessing community resources, attending school or work, and participating in social activities. When possible, staff try to help meet these additional needs, but resources are limited and some transportation needs may remain unmet, as reflected in client feedback.

> *"If they sit in their house all day, they could go crazy. A lot of them want to get out and do something, whether it's going to a friendship center, or to come into the office, or cashing a check at a bank, or going shopping for groceries."*
> (Peer support specialist from an **adult** program)

Housing Assistance

Clients may utilize housing assistance to find or maintain current housing. Some programs have dedicated housing specialists or housing coordinators that collaborate with case managers. Their involvement is adjusted based on the client's level of need, and the frequency of their client meetings may range from multiple visits per week to once or twice per month. Services provided may include education, funding, and building independent living skills, with the goal of maintaining a clean unit and preventing damage to property. Housing staff will involve client family members at the client's discretion and may also provide direct client care if the client is residing in an apartment complex affiliated with the FSP program.

> *"We deal with … clients in the counties that other agencies haven't been able to have success with … So, the fact that we're able to continue to engage and partner with them and have a really high success rate of keeping them housed at the end of the day, that's what we hang our hat on."* (Housing manager for **adult** clients)

Perspectives on FSP Program Referrals and Initiation of Care

Exhibit 26 summarizes the feedback received from clients and treatment team members about FSP referrals and initiation of care. Most of the clients interviewed have been receiving services from the FSP program for 5 years or more, and four of those clients have been receiving services for well over 20 years. The remainder of clients (five) joined the program within the past 2 years.

Exhibit 26. Summary of Perspectives on FSP Program Referrals and Initiation of Care

Clients	Treatment team
• Clients had extremely positive feedback about referral and initiation of care processes. • Clients felt supported by staff in overcoming hesitations about discussing needs. • Clients reported varied impact of full team presence during initial meetings.	• A majority of treatment team members said the referral and intake processes run smoothly. • Treatment team members identified a lack of comprehensive information from referring providers as a challenge. • Other areas for improvement included administrative burden, housing placements, and data tracking.

FSP Referral Process: Client Experiences

Referral sources varied for youth and adult clients interviewed as part of this year's FSP study, as shown in Exhibit 27.

Exhibit 27. Client Referral Sources

Adult clients	Youth clients
• Three were referred upon discharge from acute psychiatric institutions or a long-term residential treatment center. • Two were referred by external providers during visits to mental or behavioral health clinics. • One transitioned to the FSP program when they aged out of the foster system. • One was referred by the County's Correctional Health Services staff upon release from county jail. • One was contacted directly by FSP program staff. • One self-referred to the program. • One was referred through an existing case manager.	• Three were referred by a school psychologist or therapist. • Two were referred by social workers (through foster system or a hospital).

Many clients shared positive sentiments about their referral and transition to the program, describing first impressions of staff as generous, genuine, and informative. They recalled minimal delay in scheduling their initial appointments and receiving assistance with immediate needs such as housing and medication. Multiple clients expressed appreciation for the housing opportunities the program offered instead of remaining in a locked facility or being homeless. Both adults and parents of youth clients acknowledged overcoming difficulties during their initial appointment, including feeling embarrassment, fear, or anger toward discussing their needs and feelings with staff. However, the compassion exhibited by staff helped clients feel hopeful, safe, and confident about continuing to work with the program. Overall, clients did not identify any issues or concerns with the current referral process.

> *"Well, it was a little awkward because I didn't know anything about the topic until they started explaining to me why they were referring [us] to the team, what the purpose was, what the benefits were, and, above all, what they were most interested in was help for my daughter."* (**Parent** of a youth client)

> *"The doctors, the social workers [at the acute psychiatric ward] decided that Caminar would be, then called Mental Health Recovery, but Caminar would be suitable for me to help get back on my feet and continue with my life without being locked up in a long-term locked facility."* (An **older adult** client)

FSP Referral Process: Treatment Team Experiences

Treatment team members elaborated on the most common reasons for client referrals to FSP. Many clients have received an SMI diagnosis and are experiencing difficulty managing their symptoms or a current crisis situation. They may require assistance handling crises in their home life, maintaining housing, performing activities of daily living, obtaining employment, or accessing resources provided for families with low income. Often, referred clients have a history of multiple incarcerations in jails, prisons, or juvenile detention, or a frequent need for psychiatric emergency services or hospitalization.

> *"So for the FSP program it's, I believe it's three hospitalizations within the span of six months or maybe a year … Also court-mandated, some clients are court-mandated to be in the program."* (Treatment team member from an **adult** program)

In addition to referral through the court system, there are multiple other sources within the County that may generate a referral to FSP. These sources include county and social workers with BHRS, therapists, and other providers at county clinics. Youth clients may be referred by school therapists, Child and Family Services, Child Protective Services, or the County's foster care system. Additionally, adult and TAY clients may

refer themselves to the program by calling the ACCESS hotline or visiting a drop-in center. An intake coordinator is responsible for gathering information on potential clients, which is then discussed during weekly intake committee meetings to determine program placements. Once an FSP program receives a referral, the program director continues with the intake process to assign a treatment team and gather additional details about the client. From there, the lead case manager or care facilitator schedules the initial appointment with the client and initiates the intake paperwork.

Most treatment team members echoed clients' positive sentiments about the FSP program referral process, stating that it was generally smooth and streamlined. However, one treatment team member has experienced difficulty with a lack of detailed information included in the referral packets for potential clients, which can sometimes delay the intake process:

> *"A lot of times, we end up taking on clients and then we have to adjust on the fly because what we were told doesn't necessarily paint a full picture of who they are and what their issues may or may not be."* (Treatment team member from an **adult** program)

FSP Intake Process: Client Experiences

Most clients reported that their initial meeting with the program was held in person, either in the provider's office or the client's current place of residence. Clients shared positive experiences from their first interaction with FSP staff, revealing a strong theme of appreciation for the program and their specific treatment team. Additionally, clients found the initial meeting to be very informative, citing the introduction to the program's purpose, expectations, services, and meeting cadence to be particularly helpful. Further, this information helped alleviate the hesitation or discomfort that some clients felt about discussing their needs and feelings with treatment team members:

> *"It was a little awkward, but they were very sympathetic towards my feelings towards them, towards mental health and in general. So, they asked me my fears and whatnot. And then, I had asked them what exactly they were hoping to gain by having me as a client and what is it that I could, I guess, learn or utilize from them."* (An **adult** client)

Clients reported interacting with various treatment team members during the initial meeting. Some clients initially met with a single case manager or therapist, while other clients explained that the full treatment team, including case manager, therapist, family therapist, psychiatrist, and family partner, were present. This full-team approach seems to provide the benefit of expedited care for clients' immediate needs, such as housing, counseling, psychiatric support, and access to medication.

"I was waiting on Section 8 housing for six-and-a-half years before I finally got it. Section 8 takes a while to come through for you. But I was on the waiting list, so that helped me out, and they expedited it for me. And then I finally got an apartment off of the streets, which was really good." (An **older adult** client)

However, one client mentioned how the presence of the full team at the initial meeting led to confusion on their understanding of treatment team member roles and responsibilities:

"So during the first appointment, the care team came and visited my family in the house. It was the family partner, the therapist, clinician, and then the head of the team who I actually don't interact with a ton … He was there at the intro meeting, and then I've never seen him again. And I don't really know what his role was supposed to be that [the case manager] didn't do, or doesn't do." (**Parent** of a youth client)

FSP Intake Process: Treatment Team Experiences

Multiple treatment team members expressed satisfaction with the flow of the current intake process. One team member described that appointing a clinical manager responsible for expediting psychiatry services for newly referred clients has prevented interruptions in clients' medication availability. In addition, they discussed the benefit of conducting a warm handoff between referring organizations and the FSP program. However, some treatment team members described challenges and suggestions for improving the current intake process related to administrative burden, housing placements, and data tracking.

Multiple treatment team members across both youth and adult programs noted a concern for the administrative burden placed on clients during the initial meeting. They have perceived some clients to be overwhelmed by the volume of signatures required when reviewing consent to treatment and release of information forms. In addition, they found the collection of signatures from both conserved clients and their conservators to be redundant.

"Clients sometimes get a little overwhelmed with all the signatures and everything like reviewing of the paperwork … But SMI clients do struggle a lot with following through or just having a lot of information thrown at them all at once. It's always a little bit of a challenge for them." (Treatment team member from an **adult** program)

Other treatment team members raised concerns about staff miscommunication when determining supported housing placements for clients. They explained the benefit of

accurately portraying clients' mental health challenges on housing applications to best position clients for success:

> *"However they determine the housing for people, who goes where? I feel like that needs a little bit of revamping because putting somebody in a certain place, setting people up for success, I feel like is a very important part of it. So putting them in the correct milieu to be able to recover."* (Treatment team member from an **adult** program)

Some treatment team members identified ways to improve the data tracking process, including enhanced access to standardized neurological and psychological client assessments and more frequent reevaluation of client goals and treatment plans. Lastly, sharing a centralized client key event tracker that all treatment team members can update may equalize the administrative burden across team members and enhance the availability of the most current client information.

Clients' Experience With FSP Wraparound Services and Care

This section presents themes that emerged from clients' discussion of their experience with receiving FSP services, as summarized in Exhibit 28.

Exhibit 28. Summary of Clients' Experiences With FSP Services

Client experiences with case managers
- Clients gave positive feedback about their experience with FSP case managers, particularly highlighting case manager **support** and **attentiveness.**
  – Clients and parents feel that their case managers **go above and beyond** to help them and provide prompt assistance with their needs.
  – Clients shared that they feel very **comfortable** discussing their health with their case managers.
- Some clients mentioned issues with **interruptions in care** and a **need for continuity** with their case managers.
  – Some clients experienced disruptions in care due to **turnover** in case managers and expressed a need to **build rapport** and work with one case manager consistently.

Client experiences with treatment team staff
- Clients reported having strong **trust** in other treatment team members.
  – Clients and parents said they felt **comfortable** with their therapists and **confident** in the treatment team's abilities.
  – Clients expressed that the treatment team helped them **achieve program goals**, such as stability in their health, locating employment opportunities, and accessing housing.

Experience With Case Managers

- **Case manager support and attentiveness:** Clients expressed deep appreciation for their case managers, especially for the level of support they provide in achieving

goals. They appreciate how promptly their needs are addressed and reported feeling respected and cared for by the case managers. Two clients shared the following about case manager support:

> *"I express all my feelings and how I'm trying to meet my goals, and they've always been very supportive and listened to me. It's like, they have an ear for what I have to say, I have somebody to rely on, and I am treated with the utmost respect."* (An **older adult** client)

> *"Great. Because right now I have pneumonia and she's keeping in touch with me by phone, makes sure I don't need anything. Just what we've gotten accomplished this far since she's been my case manager. She's getting a lot of things done that I've needed to have done a long time ago. But, she's getting them done."* (An **adult** client)

- **Level of comfort with case managers:** Most parents and clients shared that they felt comfortable talking to their case managers about their health and needs. Additionally, they overcame fears about expressing themselves as they built a connection with their case manager and were able to comfortably speak to them:

  > *"They're very kind people, very dedicated to their work. And especially with me, they're very patient and very polite. The truth is, it's been a very, very beautiful experience. Because despite everything, we were like we were before, afraid to speak, to say things, and all that. Now we don't. Now we express ourselves easily, we talk to them better, and all that. I mean, it's been a very nice experience."* (**Parent** of a youth client)

  > *"Very comfortable. I know they care and they show me respect."* (An **older adult** client)

- **Interruptions in care and case management continuity:** Clients indicated that they have experienced interruptions in case management and would prefer to work with one case manager consistently. Specifically, starting over and building rapport with new case managers has been difficult for clients:

  > *"Kind of hard because, I'll be honest, I'm very, very protective of myself. And so, it's kind of hard to let them see me struggle and whatnot. And there's, well, I do trust [the service provider]. Doesn't necessarily mean that I trust the social worker, and that takes time, and I've only had them for about two weeks."* (An **adult** client)

Full Service Partnership Outcomes: Findings From FY 2024–2025

"I had one for three years and then she left recently, and then they gave me one and I had that one for one week. Now I have another one, which I really don't like. I don't feel comfortable with her." (An **older adult** client)

Experience With Other Treatment Team Staff

- **Varying perspectives on building trust:** Clients and parents shared that they generally feel comfortable with treatment team members and trust them, noting that they view treatment team members like family:

  "I realize it's like I'm talking to a family member, or let's say, to someone else you feel that kind of trust with. Honestly, I feel a very beautiful sense of trust when talking to them and telling them, 'Hey, I need this, let's see if you can help me with it.' It's a very beautiful thing." (**Parent** of youth client)

  Clients also expressed that they sometimes face barriers to building trust with treatment team members, citing staff turnover as a primary reason for this challenge. They added that consistently working with the same treatment team members makes them feel safer and more comfortable:

  "It feels like I'm worried that I may fall through the cracks, or it's a lot of stress on me because I constantly have to tell my story to multiple different people. And it's just, I don't trust people, and it takes time for me to be able to trust anybody." (An **adult** client)

  "As I get to know them, their therapy towards me is more effective. [The service provider] does have a problem with staff staying with the program very long … When they've been in the program a while and I get to know them, I feel more safe around them, and comfortable around them, and they've always treated me like I'm a regular person, that I'm not mentally ill. There's no stigma involved." (An **older adult** client)

  "At first, I was—How do I put it? Had a wall up, but now I'm more trusting, more … opened myself up more. Where I was more, like I said, I had a wall up before. I kind of let the wall down." (An **adult** client)

- **Guidance and support in achieving goals:** Clients and parents shared that treatment team members have provided ample resources and support that have helped them achieve their goals in the FSP program. Team members provided guidance to facilitate employment, transportation, access to housing, and attending appointments. Three clients shared the following about the support they received:

"They've taught me things I didn't even know existed. For example, now I know how to go to an appointment, how to go to a job interview, how to take different buses and all that." (**Parent** of youth client)

"[The treatment team provided] support, to guide her on where she can apply for jobs or recommendations, things like that." (**Parent** of youth client)

"They set me up with things that may be successful, like housing and information and transport." (An **adult** client)

- **Appreciation for increased independence:** Clients and parents expressed appreciation for their or their children's increased independence as they progress through their treatment in the FSP program. Multiple clients discussed learning about taking responsibility for their actions and being independent:

  "By making me take responsibility for my actions and for myself. That I have to do stuff for myself too … People can't do everything for you. You got to take responsibility." (An **adult** client)

  "Well, it's been helping me a lot in terms of doing things on my own. I mean, I've learned that I can't just sit around waiting for help … I have to get out and do things for myself." (**Parent** of youth client)

  "I live independently on my own. I take my own meds. I do my own cooking. I do my own laundry. Do my own cleaning. I do all that." (An **older adult** client)

Team Members' Experience Providing FSP Wraparound Services and Care

This section presents key program strengths and challenges identified by treatment team members, as summarized in Exhibit 29.

Exhibit 29. Summary of Treatment Team Members' Experiences

Key FSP strengths

- FSP team members highlighted **strong collaboration and communication within their teams**. Frequent communication through varied methods and encouraged idea-sharing foster team cohesion and support.
- Team members emphasized the importance of **meeting clients where they are and providing consistent support**, which contributes to positive client outcomes and satisfaction in their roles.
- The design of the wraparound services model was praised for allowing treatment team members the ability to provide **comprehensive, individualized services** to clients.

Challenges to providing services

- Some team members had **challenges engaging clients with high needs and their families** because some clients and families are reluctant to participate in services.
- Reported issues include understaffing, turnover, lack of formal training documentation, and insufficient pay, which can **limit staff capacity and continuity of care**.
- Team members cited that **administrative burden and lack of funding** impact client engagement and staff well-being.

Residual impact of COVID-19

- There do not appear to be any lasting residual effects of the pandemic on treatment team members' experience providing FSP services.

Perceived Program Strengths

Most FSP team members interviewed have been working at their respective FSP providers for at least a year, and several members reported working with the same provider for more than 10 years. The longest tenured treatment team member has been providing care through the FSP program for roughly 24 years. Treatment team members shared various insights into strengths of the FSP program and elements that contribute to their effectiveness.

- **Team collaboration and supportive work culture:** The most consistent strength mentioned across treatment team interviews was strong collaboration and a deep sense of mutual respect within FSP teams. Most providers noted effective teamwork where idea-sharing is encouraged, and everyone's voice is heard. Team-based care is supported through daily meetings and open communication, ensuring clients receive seamless care even when individual staff are unavailable. One treatment team member described one of the greatest strengths of the program:

  "Teamwork, because if one case manager is not there, then the other team member knows what's going on. They have daily meetings where each case manager is aware of what's going on. So if by any chance the main case manager for a client is out of town or something, the other case managers take over and support the client." (Treatment team member from an **adult** program)

  A treatment team member also highlighted a work culture that values input from all levels and described this approach as essential to effective care:

  "[We] encourage people to share their ideas or their insights and that everyone sees a different part of what we're working on and has a different role, but we have to rely on each other's information to have the whole picture and just try to encourage that." (Treatment team member from a **youth** program)

Another treatment team member spoke about the team's strong sense of empathy and dedication toward the clients:

> *"The staff is just so supportive, and they're really motivated to support these clients and there's a lot of empathy and flexibility."* (Treatment team member from an **adult** program)

This collaborative environment also creates a culture of emotional support and resilience among team members. One treatment team member reflected:

> *"We all carry the emotional weight of the work that we do and collaborate to figure out interventions that might work and make sure to leave a lot of room to give each other a lot of support too, because it is hard work. And so I feel really grateful to be a part of such a supportive team environment."* (Treatment team member from a **youth** program).

- **Compassionate and client-centered approach:** A central strength identified by more than half of treatment team members was the client-centered and family-centered approach that underpins FSP services. They emphasized the importance of building trust and therapeutic relationships with clients as a foundation for long-term success:

> *"When the client has a great therapeutic relationship with their clinician or therapist, their symptoms or their crisis, or any challenges that are happening, definitely decreases."* (Treatment team member from a **youth** program).

Treatment team members also noted the importance of working closely with clients to co-create goals that are meaningful, individualized, and sustainable. A treatment team member shared the following:

> *"The way that the caregivers can relate to them really has increased their success with them taking on feedback and maybe trying new things."* (Treatment team member from a **youth** program)

Another treatment team member shared how treating clients as friends, with dignity and familiarity, strengthens connections and improves continuity of care:

> *"I think the strengths of being a friend with clients, treating them as more than just clients … A lot of our clients know all of our case managers, not just one. So if one of them doesn't answer for a client, they might end up calling me, they know me and they want to talk to me or something."* (Treatment team member from an **adult** program)

Beyond individual rapport, staff expressed pride in how the program challenges broader systems to make services more equitable and accessible:

> *"We're willing to push back against institutionalized systems that are designed to essentially help people that look like me in ways that can really expand that access to a lot of other people, in ways that insurance companies don't always like, in ways that our funders don't always like."* (Treatment team member from a **youth** program)

- **Holistic and flexible wraparound service model:** A commonly cited strength of the FSP program was its holistic and flexible wraparound service model, which allows staff to meet a wide range of client needs beyond traditional mental health support. Providers emphasized that addressing multiple domains of a client's life (e.g., housing, education, employment) helps promote long-term stability and recovery:

> *"We're able to provide them support in different specific challenges that are happening in their life and not just the mental health piece and not just the psychiatric piece."* (Treatment team member from a **youth** program)

The wraparound model uses a team-based approach that includes clinicians, case managers, peer support specialists, and family partners. One treatment team member highlighted how this structure enables consistent and individualized support:

> *"Wraparound model is a really good model because it's a team, so it's not all just on one person to provide all of that. And it offers multiple relationships that can all work in a different way with the client."* (Treatment team member from a **youth** program)

The Assertive Community Treatment (ACT) teams extend this multidisciplinary approach into clients' homes and communities, reducing the burden of navigating systems. As one treatment team member shared:

> *"The ACT teams are multidisciplinary … We offer services in mental health treatment, vocational support, housing, and community integration. It's proactive and goes directly to individuals in their homes in the community rather than requiring them to come to a clinic. The goal is to improve the quality of life, reduce hospitalizations, and increase integration for individuals with serious mental illness."* (Treatment team member from an **adult** program)

Youth services also include creative outlets, such as drop-in centers, where clients can safely gather, build life skills, and engage socially:

"With that drop-in center, it gives them a safe place to hang out and do some crafts and basically learn some life skills during that time that they're at the drop-in center. That way, it's a safe space for our clients for primarily for our transitional age youth, who sometimes some of them are living alone or in apartments now and they're living independently, and we give them those tools to help them navigate in the world." (Treatment team member from a **youth** program)

Perceived Challenges to Providing Services

- **Engaging reluctant clients and families:** While most treatment team members reported strong rapport with clients, several described ongoing challenges engaging individuals with acute mental health needs. These clients may be in crisis, struggling with severe symptoms, or focused on basic survival needs, making therapeutic engagement difficult. As one treatment team member shared:

  "Therapeutically speaking, a lot of clients aren't ready for therapy, or the parents are ready, but the client is not, which creates difficult situations." (Treatment team member from a **youth** program)

- Team members also noted how broader and sudden structural changes can heighten the challenges in engaging reluctant clients. Without client buy-in, providers are limited in their ability to deliver sustainable care. A treatment team member shared how client participation is essential to program success:

  "I think fee-for-service has really shown that the clients have to be willing to participate in the program in order for our program to be sustainable." (Treatment team member from an **adult** program)

In addition, social and political factors can further discourage engagement, particularly among youth from marginalized communities. These concerns reflect the importance of culturally responsive care and trauma-informed approaches when supporting clients facing systemic barriers to engagement:

"There's definitely some clients who are more fearful to be out in the community. And it could be if maybe they might have family members who are undocumented or they just are worried about running into ICE or there's this fear that the world is just more aggressive and dangerous in some ways. And we have a lot of trans-identified clients in the program, so there's a lot of fear coming up from those kind of cultural, political things that are happening, and that's a barrier too." (Treatment team member from a **youth** program)

- **Staff capacity and staff turnover:** Almost half of the treatment team members interviewed reported challenges related to staff capacity and turnover. They noted understaffing, lack of formal training documentation, insufficient pay, and burnout as ongoing issues that directly impact the quality and consistency of client care. A treatment team member stated that the lack of structured training contributes to inefficiencies and increased stress, especially for newer staff:

  "Sometimes I'll meet with my supervisor, and they'll walk me through how to do something, but six months later when I need to follow that process again there aren't any step-by-step instructions for how to do it." (Treatment team member from **youth** program)

  Providers also pointed to the broader effects of turnover and layoffs, which place additional burdens on remaining staff and increase the risk of burnout. Understaffing critically threatens the continuity of care, as clients may have to restart services with new case managers, weakening therapeutic relationships and delaying progress. A treatment team member explained:

  "We do have some staff, a lot of staff who left or there were layoffs, so that just kind of puts a lot of pressure on the staff who are still currently here and who have to take on a lot more work, so that could lead to burnout." (Treatment team member from an **adult** program)

  Several treatment team members suggested funding and pay as central to improving staff retention. They emphasized that increased compensation, more leadership support, and additional staff appreciation efforts could reduce turnover and help create more sustainable, supportive work environments:

  "We're not competitively paying, I think, and I know money won't solve everything, but I think it helps compensate for the burnout." (Treatment team member from an **adult** program)

  For increased funding, a team member suggested partnerships with private companies to diversify funding sources:

  "I think in the past there was probably the idea you don't want to work for any for-profit type companies … but I think you can have a program that gets paid by them and use that money to show support across the company." (Treatment team member from **youth** program)

- **Administrative burden and resource limitations:** Administrative burden and limited resources were frequently mentioned as barriers to effective service delivery by treatment team members. One of the most common concerns was the volume of paperwork and documentation required, which team members felt could be

streamlined to reduce time spent on administrative tasks. A treatment team member described their frustration with the inefficient system, which can reduce time for client care and contribute to overall burnout:

"I think the systems that we use are outdated. We do a lot of filling in paperwork that could be automated (e.g., client information)." (Treatment team member from a **youth** program)

In addition to administrative strain, providers emphasized how limited and unevenly distributed resources create barriers for clients and contribute to staff stress. While many acknowledged the breadth of resources available, some noted challenges when clients fall through eligibility gaps:

"As much as there is a lot of resources for … almost everybody, there's always that percentage that do not qualify for certain things." (Treatment team member from an **adult** program)

Several team members also noted how resource constraints lead to reactive, rather than preventive, care and called for increased recognition of the long-term value of proactive support:

"I think counties are going to have to figure out a way to budget more support monetarily with the contracts that are coming up to be able to identify and plan for these rising costs. I think that's really the most important thing. If the County starts to recognize how much funds we save by keeping clients out of PES [psychiatric emergency services] and the costs that every time they go to PES, what that costs on the County." (Treatment team member from an **adult** program)

Residual Impact of the COVID-19 Pandemic

While treatment team members mentioned residual influence of the COVID-19 pandemic on service delivery and program staffing during FY 2023–2024, these effects were not apparent for FY 2024–2025. None of the clients or treatment team members interviewed this year mentioned a lasting effect of the pandemic on their experience receiving or delivering FSP services, respectively.

Perceived Impact of FSP Program on Quality of Life

Both clients and treatment team members shared abundantly positive ways that the FSP program affects clients' quality of life, which are summarized in Exhibit 30. Specifically, feeling safe and cared for by treatment team members has allowed clients to work toward achieving their goals, a result that treatment team members understand to be highly dependent on strong therapeutic relationships with clients. Through

discussions with clients and treatment team members, it is evident that the treatment team members are invested in the well-being of their clients.

Exhibit 30. Impact on Clients' Quality of Life

Clients reported that the FSP program had a positive impact on multiple areas of their lives, including:
- Mental and physical health outcomes
- Resilience against life stressors
- Strengthening interpersonal relationships and social networks
- Developing independence

- **Improvements in mental and physical health outcomes:** Clients discussed a multitude of positive mental and physical health changes they have experienced since entering the FSP program. They noted improved ability to manage their mental health symptoms from conditions including bipolar disorder, mania, posttraumatic stress disorder, and schizophrenia. Improved symptom management led to reductions in self-harm, depression, suicidal ideation, and aggression, combined with enhanced self-confidence, motivation, emotional strength, and positivity. They referenced improved sleeping habits, decreased hospitalizations, and the ability to discontinue some medications:

  "Well, her way of thinking has changed, and I see more motivation to move forward. Well, she no longer thinks about hurting herself." (**Parent** of a youth client)

  "Not as depressed, just overall better. So I was able in that safe environment to really work towards getting off those antidepressants, and I did. So that was a really amazing thing." (An **older adult** client)

  "I was more depressed before. Now I feel like I have depression, but I feel like I can control it. I do everything they tell me about breathing, everything related to mental health, how it affects health, being in a situation, thinking only about the negative. Well, all of that, like everything they've told me, mostly about breathing for anxiety, for the moments of fear that come, then the anxiety attacks come. So, myself, it's like what's happening, how to recognize everything that's happening to me, I already know how … how to resolve it." (**Parent** of a youth client)

- **Resilience against life stressors:** Many clients described how the FSP program has improved their ability to handle stressors. The most commonly identified stressors included limited finances, unstable housing, and providing for children and family members:

"I say I can endure whatever on the street and all that, but my kids can't … It really does affect me a lot because I start to think and ask myself, 'What am I going to do [if we lose our housing]?' And then negative thoughts start coming into my life, like telling myself, 'I'm not a good mother, I'm not good for anything.'" (**Parent** of a youth client)

Other clients noted experiencing stress over lack of sleep or other physical health challenges but appreciated the support that treatment team members have provided to manage those stressors. Clients transitioning from jail into the community noted the challenges of limited housing options and living in a shelter. However, they expressed gratitude for program staff's ability to quickly secure safe housing and support in continuing to obey laws and prevent future interactions with law enforcement:

"Well, it's been 15 years since I was ever in trouble with law enforcement, and I try and keep my nose clean, so to speak, and obey all laws. And the transition to Caminar really helped in that. And I just try and be, like I said, one of my goals was to try and be a good guy, and not rock the boat, and I've learned to do that, with Caminar giving me a great deal of help." (An **older adult** client)

- **Improvements in familial and interpersonal relationships:** Clients expressed gratitude for improved family dynamics and ability to interact with others. Some parents of youth clients noted that they feel better equipped to handle family conflicts and to provide for their children. Another parent noted that the communication strategies they learned through therapy have decreased the number of arguments in their home and enhanced relationships among family members.

  "I've rented my own apartment, and I have friends that I can talk to that I've met through Caminar, and I have an improved relationship with my family." (An **adult** client)

  "Well, I'm able to interact with people better, people that are so-called not mentally ill, where they have a stigma towards mental illness. I feel I'm able to interact with other people who are not involved in a mental health program at all. It's just 'normal' people. And I get the feeling that they don't even notice I have a problem, any mental illness at all, and I rarely have to let them know that." (An **older adult** client)

  "The therapy, when we're all able to get there together and have guided, mediated conversations about our feelings. And working on how we communicate with each other when, like communication strategies for when the therapist isn't also there. That's been invaluable." (**Parent** of a youth client)

- **Integration into community and social networks:** Many clients opened up about their fear of isolation and difficulties connecting with others. However, they described how program staff have empowered them to become more involved in their community, such as returning to work or school, joining a community center, attending Alcoholics Anonymous meetings, and assisting other clients through the peer support program. Clients expressed appreciation for the opportunities to socialize and make friends internal and external to the FSP program:

  "Well, they have meditation in each group that we go to for five minutes. Sometimes I'm inclined toward isolation, so just maintaining my ability to get out of the house and be active in the community is one goal I have." (An **adult** client)

  "I think at its best, it's wildly transformative of people's lives. I've seen people go from inability to string coherent thoughts together as a result of unmedicated schizophrenia and unhoused status and substance use to telling me all about their significant other and their apartment they're living in and this job that they've been working for a year." (Treatment team member of a **youth** program)

  However, one client who identifies as transgender reported continued difficulty connecting to others:

  "I don't feel connected to others. I am constantly trying to figure out who's friend or foe, especially in this environment and me being trans, so it scares the hell out of me." (An **adult** client)

Conclusions

The evaluation of the FSP program demonstrates meaningful improvements across populations served. Quantitative data show significant reductions in homelessness, arrests, hospitalizations, and psychiatric emergencies, along with increased adult employment. These trends are consistent over time, with notable improvements in both self-reported and EHR outcomes. While most outcomes improved, the most recent data show youth academic performance declined slightly, and Telecare clients reported more mental health emergencies from the year prior to enrollment through the first year of FSP participation.

The qualitative findings reinforce these results, highlighting enhanced client mental health, independence, and quality of life, as well as strong satisfaction with the FSP program among both clients and staff. Interviews emphasize the program's holistic, wraparound approach, supportive relationships, individualized care, and team collaboration as key strengths. However, challenges such as staff turnover, administrative burden, and resource limitations persist, underscoring the need for continued investment to sustain accessibility and effectiveness. ***Overall, the data***

underscore the effectiveness of FSPs in enhancing client well-being and reducing reliance on emergency care, while signaling areas for further attention, including youth academic outcomes and early mental health crises.

Recommendations

This section presents recommendations for improving implementation of the FSP program based on the quantitative and qualitative findings. While there is consistent evidence of improved client-level outcomes each year, the interviews help illuminate some challenges and possible solutions. Additionally, the data collection process over the past year provided critical insights into existing gaps and methodological strengths, informing targeted recommendations to enhance the rigor and relevance of both qualitative and quantitative analyses moving forward.

Like last year's recommendations, this year's recommendations again prioritize staff retention through enhanced training, mental health resources, and incentives. A new emphasis is placed on offering ongoing education and specialized training for treatment teams to better serve a diverse clientele. Furthermore, the recommendations for this year emphasize the importance of maintaining consistent team member assignments and establishing a structured process for communicating team transitions. Finally, it underlines the need to raise awareness and make FSP services easier to access for all.

Improve Staff Retention Through Team-Building Opportunities and Legal and Procedural Guidance

The treatment team is the backbone of the FSP program, and continued investment in team members is crucial to creating and maintaining effective relationship-building with clients. Interviews with treatment team members highlighted concerns about limited staff bandwidth and capacity. To address the challenges noted above, we recommend a multifaceted approach that focuses on providing treatment team members with enhanced team-building opportunities and legal and procedural knowledge-sharing.

To strengthen staff capacity and promote long-term retention, we recommend a two-pronged approach focused on fostering team cohesion and providing accessible legal and procedural resources.

Enhance Team-Building Opportunities

- Organize regularly scheduled team-building activities, preferably offsite, to encourage personal and professional connections among treatment team members.

- These activities should aim to improve collaboration across diverse personalities and backgrounds, boost morale, and equip staff to deliver high-quality client services.

- Continue supporting flexible work arrangements and maintain effective communication channels (e.g., Zoom, email, phone, in-person meetings) while supplementing them with opportunities for in-person social engagement.

Provide Legal and Procedural Guidance

- Develop a centralized resource library containing standard operating procedures, legal guides, and training materials for staff reference.

- Modify onboarding and annual trainings to include practical lessons on navigating legal systems and interpreting court terminology to reduce delays in client care.

- Ensure ongoing access to crisis prevention, intervention, and culturally responsive care training to maintain high standards of service delivery.

Implementing these measures will help address staff concerns related to workload, collaboration, and procedural clarity, ultimately improving retention of treatment team members.

Expand Workforce and Increase Diversity

Many treatment team members discussed challenges they have faced related to understaffing when handling large caseloads, raising the concern of burnout and eventual staff turnover. Many clients reported satisfaction with the attentiveness and support they receive from their treatment teams, but it is crucial to be mindful of workload challenges in relation to employee well-being to ensure delivery of high-quality client care. To ensure high-quality client care and support staff well-being, we recommend the following actions:

Address Staffing Challenges and Workload Management

- **Recruit Additional Personnel:** Collaborate with service providers to hire case managers and administrative assistants to reduce caseloads and alleviate pressure on existing staff.

- **Streamline Documentation Processes:** Conduct a review of current documentation requirements to identify opportunities for automation and process improvements. Distribute documentation responsibilities across all treatment team members to ensure accuracy and reduce administrative burden on case managers.

Increase Workforce Diversity

- **Hire Bilingual Staff:** Expand recruitment efforts to include bilingual professionals to better serve clients whose primary language is not English.

- **Promote Representation:** Prioritize diversity in gender and ethnic identities within the workforce to strengthen trust and foster culturally responsive care.

These measures will help mitigate burnout, improve operational efficiency, and enhance the quality and inclusiveness of services provided to clients.

Ensure Consistent Team Member Assignments

Another theme that emerged from the interviews is inconsistent case manager assignments. Treatment team members shared difficulties with the high staff turnover rate, and clients reflected on how these changes affect their care quality and continuity. Specifically, many clients described challenges in building rapport with newly assigned case managers, noting a hesitance to display vulnerability and discuss their needs.

Establish Clear Assignment Guidelines

- Develop and implement standardized protocols for case manager assignments to maintain consistency whenever possible.

- Limit caseload redistribution to situations where staff are managing excessive cases or crises that compromise service quality.

Create a Centralized Assignment Database

- Design and maintain a database that captures treatment team strengths and workload capacities, updated annually through structured surveys.

- Require program directors to review this database prior to assigning new cases to ensure balanced workloads and informed decision-making.

Enhance Communication During Transitions

- Provide timely notifications to clients regarding any changes in case manager assignments to preserve trust and minimize disruption.

- Prioritize continuity by reducing unnecessary transitions and fostering long-term client-staff relationships.

Increase Awareness and Accessibility of FSP Services

Clients had a positive experience with the FSP program, some noting a desire for more individuals and families living with mental health challenges to be aware of available services. One parent of a youth client recalled speaking with a group of mothers who were unaware of FSP services and could potentially benefit from them.

To maximize the reach and impact of FSP programs, we recommend implementing strategies to enhance community awareness and accessibility.

Expand Outreach and Visibility

- Develop a comprehensive outreach plan to promote FSP services through trusted community channels, including schools, county libraries, YMCA locations, faith-based organizations, and other community hubs.

- Utilize culturally responsive and multilingual materials to ensure inclusivity and accessibility for diverse populations.

Strengthen School Partnerships

- Collaborate with school counseling and health services to identify and refer individuals and families who may benefit from FSP programs.

- Position schools as central points for distributing information about youth and family mental health resources.

Leverage Community Networks

- Engage local organizations and parent groups to share information and encourage referrals.

- Explore opportunities for community events and informational sessions to increase program visibility.

These efforts will help ensure that individuals and families living with mental health challenges are aware of available resources, fostering early engagement and improved outcomes.

Enhance Client Engagement

To strengthen client experience and improve access to services, we recommend implementing measures that facilitate timely and effective communication between clients and treatment teams.

Develop Digital Communication Platforms

- Create a secure online portal or messaging system that allows clients to submit questions, request appointments, and communicate directly with their case managers.

- Ensure the platform is user-friendly, confidential, and accessible across multiple devices.

Provide Alternative Communication Options

- Maintain non-digital methods, such as phone calls and in-person meetings, for clients without access to technology.

- Guarantee equitable communication channels to meet the needs of all clients.

These enhancements will streamline interactions, reduce delays in service delivery, and promote stronger engagement with FSP programs.

Appendix A. Quantitative Methods

Methodology for Full Service Partnership Survey Data Analysis

Service providers collect the Full Service Partnership (FSP) survey data through discussions with clients and should thus be viewed as self-reported outcomes. Among the service providers included in these analyses (Edgewood Center and Fred Finch Youth Center [hereafter, Edgewood/Fred Finch], Caminar, and Telecare), 898 clients completed a Partner Assessment Form (PAF) at intake and completed a full year with FSP since program inception.

In general, three data sets were used for this report: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. All providers submitted their data sets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey, in which the data structure and variable names were different from before. Because of data reliability issues, Telecare only provided the data after its data system change, with data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch clients, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child and transitional age youth (TAY) clients. Caminar and Telecare serve primarily adult and older adult clients, and a small number of older TAY clients. Caminar's older TAY clients ($N = 89$) are excluded from the TAY-specific self-reported outcomes because Caminar does not reliably complete the ongoing program surveys for this age group (i.e., KET, 3M). Exhibit A1 reports the number of clients in each age group completing at least 1 full year of FSP from 2006 to 2025 by provider. For Telecare, these data include December 2018 through June 2025.

Exhibit A1. Age Distribution of Clients With a Minimum of 1 Full Year of FSP Participation, by Provider

Age group	Edgewood/ Fred Finch	Caminar	Telecare	Total[a]
Child (ages 16 and younger)	249	—	—	249
TAY (ages 17–25)	305	—	30	335
Adult (ages 26–59)	—	118	134	252
Older Adult (ages 60+)	—	28	34	62

Age group	Edgewood/Fred Finch	Caminar	Telecare	Total[a]
Total	554	146	198	898

[a] Telecare clients in the analysis include only those who joined the FSP after December 1, 2018, due to data availability. Telecare clients were not reported in the survey outcomes by age group. A separate analysis was conducted for Telecare clients; it combines all age groups because of the small sample size.

A comprehensive assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the state's documentation.

Client type (child, TAY, adult, and older adult) is determined by the PAF data.

- For Caminar and Edgewood/Fred Finch, records with the following specific Age Group codes were selected:

  – Caminar: Selected records with Age Group codes of "7" (TAY client, ages 17 to 25), "4" (adult client, ages 25 to 59), and "10" (older adult client, ages 60 and older).

  – Edgewood/Fred Finch: Selected records with Age Group codes of "1" (child client, ages 16 and younger) and "4" (TAY client, ages 17 to 25).

  – In both cases, Age Group codes were confirmed using the data file's continuous *Age* variable.

- For Telecare data, clients were given an age-appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF," "Adult_PAF," and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2025.

All data management and analysis were conducted in Stata. Code is available upon request.

Additional details on the methodology for each outcome are presented below.

Residential Setting

- Residential settings were grouped into categories as described in Exhibit A2.

The baseline data were populated using the variable PastTwelveDays (Caminar and Edgewood/Fred Finch) or res_past12m_days_int (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.

The client's first residential status after they joined FSP is determined by the variable Current (Caminar and Edgewood/Fred Finch) or res_curr_dsr (Telecare) collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there was one residence with a later date (as indicated by the variable DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]), this residence was the first residential setting. If the residences were marked with the same date, both were considered part of the client's first year in an FSP.

Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (DateResidentialChange [Caminar and Edgewood/Fred Finch] or main_resident_date [Telecare]) occurring within 1 year of the FSP partnership start date. If no residential data were captured after the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit A2. Residential Setting Categories and Corresponding Classification Values Used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with nonrelative	5
Homeless or emergency shelter	
Emergency shelter	6
Homeless	7

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Levels 0–11)	11
Group home (Levels 12–14)	12
Community treatment	13
Residential treatment	14
Inpatient facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't know	
Don't know	18
Other	17

[a] Setting names determined by the following guide: FSP User Manual.

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

- The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a nonzero, nonblank value for one of the following variables (note that variable names differ slightly by data set):

  a. Any competitive employment in the past 12 months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

  b. Any other employment in the past 12 months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in an FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

- The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the client was assumed to have zero arrests in the year prior to FSP.

Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET file contained no information on arrests, the client was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

- The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* [Caminar and Edgewood/Fred Finch] or *emr_mental_p12* [Telecare]) and physical health emergencies (*PhysRelated* [Caminar and Edgewood/Fred Finch] or *emr_physical_p12* [Telecare])*,* respectively. If either of these fields were blank, the client was assumed to have had zero emergencies of that type in the year prior to FSP.

Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, if the date was within the first year of an FSP as determined by the partnership date. The type of emergency

was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1" = physical; "2" = mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year of an FSP.

Substance Use Disorder

- Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* [Caminar and Edgewood/Fred Finch] or *sub_co_mh_sa_probl_past* [Telecare]) and participation in substance use disorder treatment and recovery services (*AbuseServices* [Caminar and Edgewood/Fred Finch] or *sub_sa_services_now* [Telecare]). If these fields were blank, the client was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.

- Ongoing substance use disorder data were populated using the 3-month data variables of the same name. Any record of an active substance use disorder or participation in a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for County EHR Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain emergency care in the San Mateo County (the County) hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 938 clients who were both a) included in the County's EHR system and b) completed 1 full year or more in an FSP program by the June 2025 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2025.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and psychiatric emergency services (PES) admissions, we relied on the Avatar *view_episode_summary_admit* table.

Exhibit A3 shows the corresponding program codes. In addition, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit A3. Program Codes Among Clients Ever in an FSP

Program code	Program value
Psychiatric hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric emergency services	
410702	Z410702 SMMC PES-termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Note. Data represent all utilization from FSP clients for these codes, as pulled from Avatar in October 2025.

Client type (child, TAY, adult, and older adult) was determined by the client's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode history* table.

As we have discussed in the previous year's report, the distribution of clients by age group is different between the County's EHR data and the FSP survey data. This disparity is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the client was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the County's EHR data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

Appendix B. Qualitative Methods

Methodology for Full Service Partnership Interviews

This section outlines the qualitative methods used by AIR to evaluate the Full Service Partnership (FSP) programs in the County. It includes an overview of the providers, participants, interview format, and analytic approach. Exhibit B1 provides an overview of the four FSP service providers included in this evaluation.

Exhibit B1. FSP Service Providers

Service provider	Description	Population served
Edgewood Center	Edgewood's FSP provides services to help clients stabilize and maintain current placements, while offering comprehensive mental health services.	Children, youth, and transitional age youth (TAY)
Fred Finch Youth Center	Fred Finch Youth & Family Services FSP serves foster youth and provides an array of services to promote wellness, resilience, and stability in the youth's home. Services include safety planning and behavioral interventions, as well as family and individual support.	
Caminar	Caminar FSP provides services to individuals who are among those in most need in San Mateo County and integrates streamlined, holistic health care utilizing the best-practice model of assertive community treatment. The team includes the added benefit of medical clinic services and a 24-hour on-call emergency response service.	Adults and older adults
Telecare	Telecare's FSP provides integrated service delivery to the County's residents who have symptoms commonly associated with a profound psychiatric disability (or disabilities) and who may also have co-occurring disorders (such as substance use or medical conditions) and serious life stressors (such as problems obtaining or maintaining housing or involvement with the legal system).	

Participants

AIR worked with the County's BHRS staff and the four FSP service providers (Exhibit B1) to recruit clients and wraparound treatment team members for key informant interviews. The mix of clients and team members was determined in collaboration with the San Mateo County BHRS team to ensure representation across FSP providers and client age groups. We aimed for saturation, where additional interviews are unlikely to

yield new themes, while prioritizing diversity in team member roles and engaging both English- and Spanish-speaking clients.

Exhibit B2 presents the number and categories of clients and treatment team members that we interviewed and included in this analysis across the FSP service providers. Client age categories include children (16 years and younger), TAY (16–25 years), adults (26–59 years), and older adults (60 years and older). We were not able to recruit any client participants from Fred Finch as staff indicated that they only had one current client at the time of recruitment. The client's family denied participation in the evaluation due to scheduling constraints and a need to prioritize other responsibilities.

Exhibit B2. Summary of Interviewees

Service provider	Clients	Wraparound treatment team
Edgewood Center	**5 parents** whose children have accessed services through FSP in the last year or are currently accessing services through FSP	**8 team members** including: • Program directors (2) • Program coordinators (2) • Clinical supervisor (1) • BH clinicians (2) • Crisis response worker (1)
Fred Finch Youth Center	**None**	**1 team member** including: • Care facilitator[6] (1)
Caminar	**6 clients** who accessed FSP in the last year or are currently accessing services through FSP	**5 team members** including: • Program directors (2) • Lead case manager (1) • Clinician trainee (1) • Peer support specialist (1)
Telecare	**4 clients** who accessed FSP in the last year or are currently accessing services through FSP	**5 team members** including: • Housing manager (1) • Intake coordinator (1) • Clinical supervisor (1) • Case managers (2)
Total interviewees (34)	**15 clients**	**19 team members**

Interview Format and Length

Each interview lasted roughly 35 minutes and was conducted virtually using Microsoft Teams software. The video call feature was utilized for participants who provided a valid email address, and the dial-out feature was utilized to contact participants who provided

---

[6] The care facilitator role is similar to the role of a case manager.

a phone number. A trained, bilingual interviewer with Spanish as their primary language conducted the interviews with Spanish-speaking participants. Interviewers obtained consent and permission from all participants before starting the recording.

Analysis

All interviews were recorded and transcribed, except for one where technical difficulties with Microsoft Teams required the interviewer to take manual notes instead. All interviews except one were recorded and transcribed. For the interview that was not recorded, we used the notes from the interview for the analysis. An inductive method was used to code the transcripts. We then conducted a thematic analysis of the concepts, exploring similarities and differences between participants.

Appendix C. Self-Reported Outcomes

Outcomes Assessed

Key self-reported outcomes include incidents of homelessness, detention/incarceration, employment, arrests, mental and physical health emergencies, and substance use disorder and treatment participation. For children and transitional age youth (TAY), additional outcomes include school suspensions, self-rated attendance, and academic performance. Most of these outcomes are aggregated by age group. Note that employment, homelessness, arrests, and incarceration outcomes are not presented for adults ages 60 or older, due to insufficient observations in this age group for meaningful interpretation.

- **Clients with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (sources: PAF and KET)

- **Clients with any reported detention or incarceration incident:** measured by residential setting indicating jail or prison (sources: PAF and KET)

- **Clients with any reported employment:** measured by employment in past 12 months and date of employment change (sources: PAF and KET)[7]

- **Clients with any reported arrests:** measured by arrests in past 12 months and date when arrested (sources: PAF and KET)

- **Clients with any self-reported mental health emergencies:** measured by mental health emergencies in past 12 months and date of mental health emergency (sources: PAF and KET)

- **Clients with any self-reported physical health emergencies:** measured by acute medical emergencies in past 12 months and date of acute medical emergency (sources: PAF and KET)

- **Clients with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)

- **Clients in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular 3-month updates (sources: PAF and 3M)[8]

---

[7] Employment outcome is not applicable to child and TAY clients.
[8] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with

In addition, we also examined three outcomes specific to child and TAY clients:

- **Clients with any reported suspensions:** measured by school suspensions in past 12 months (source: PAF) and date suspended (source: KET)

- **Average school attendance self-rating:** an ordinal ranking (1–5) indicating overall school attendance with 1 indicating lower attendance and 5 indicating higher attendance; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

- **Average school grade self-rating:** an ordinal ranking (1–5) indicating overall grades with 1 indicating lower grades and 5 indicating higher grades; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

---

needed care. However, if more partners have substance use disorder, there would be more partners reporting receiving treatment.

Appendix D. Detail on Residential Outcomes

Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High-risk settings are defined as homelessness, incarceration, or in a hospitalized setting. A list of all residential settings and categories is presented in Appendix A, Exhibit A2 with the methodological approach.

Mental and Physical Health Emergencies by Living Situation

Mental and physical health emergencies were analyzed in relation to clients' residential status during their first year in FSP for adults and older adults. We used self-reported data from Caminar for Exhibit D1 and self-reported data from Telecare for Exhibit D2.

Exhibit D1 shows the mental and physical health emergencies in adult and older adult Caminar clients living in advantageous versus higher risk living situations in the first year of participating in an FSP. Both mental and physical health emergencies were more common among individuals in a high-risk residential setting in their first year of FSP participation.

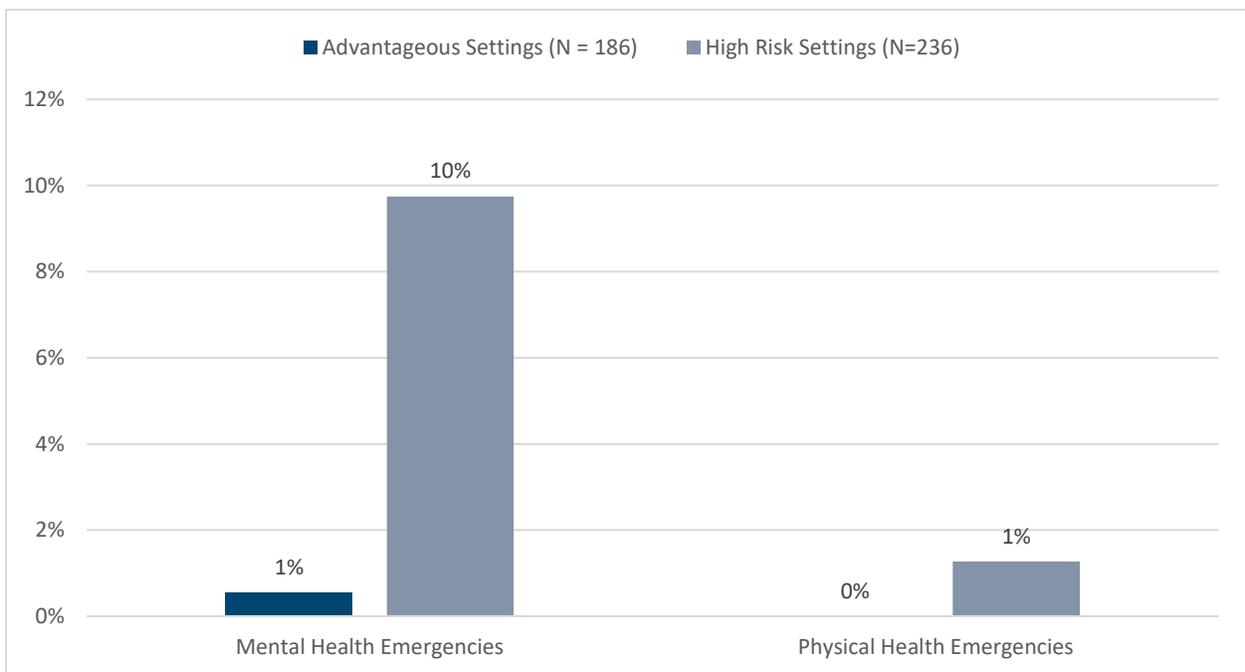### Exhibit D1. Emergency Outcomes Grouped by Residential Setting – Caminar

Exhibit D2 shows the mental and physical health emergencies in adult and older adult Telecare clients living in advantageous versus higher risk living situations in the first year of an FSP. Mental health emergencies only occurred in individuals who lived in an advantageous living situation in their first year of FSP participation, with all reporting a mental health emergency. Physical health emergencies also only occurred in individuals who lived in advantageous settings in their first year of FSP participation, with half reporting a physical health emergency. Nevertheless, because the sample sizes for both the advantageous and high-risk subgroups are extremely small, these results should be viewed cautiously as they may be subject to bias and not be representative of the broader population.

Exhibit D2. Emergency Outcomes as a Function of Residential Setting Among Telecare Clients
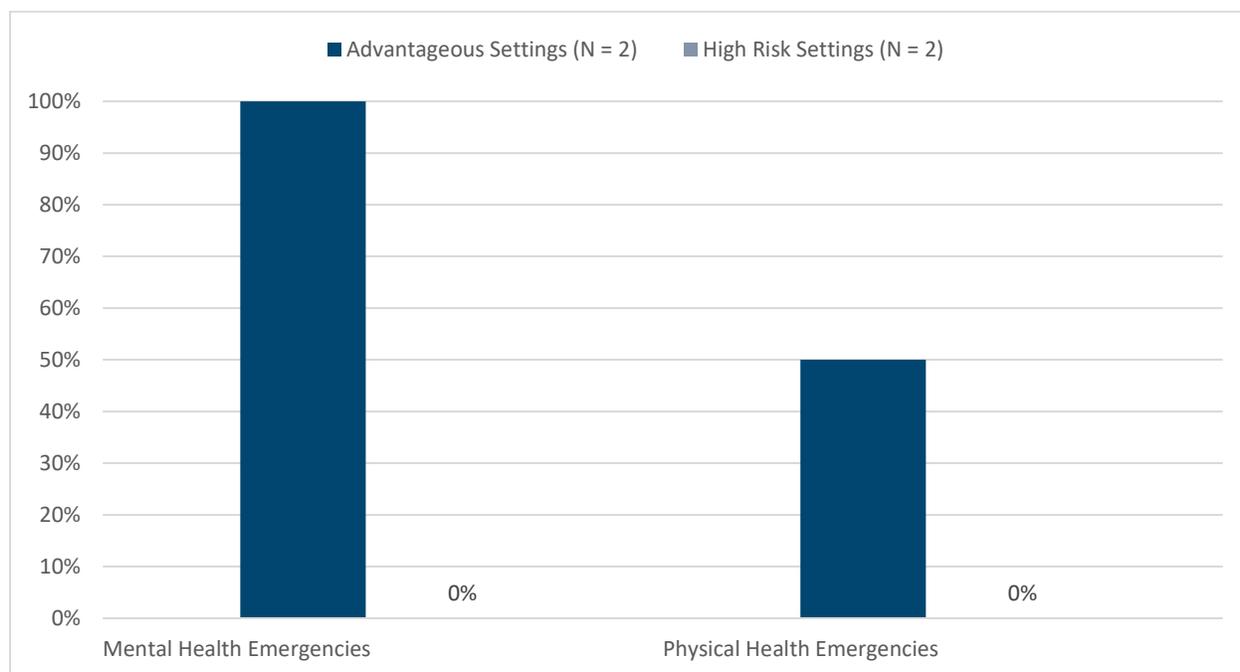

Additional Detail on Residential Settings

For residential setting outcomes by FSP provider, we present all the categories of living situations and compare the percentages of any clients spending any time in various residential settings the year prior to FSP and in the first year of FSP participation.

We used self-reported data from Caminar for Exhibit D3, data from Edgewood/Fred Finch for Exhibit D4, and data from Telecare for Exhibit D5. As shown in Exhibits D3–D5, the percentage of clients reporting any time in an inpatient clinic or living with parents decreased. Further, the percentage of clients who were homeless or living in a

Full Service Partnership Outcomes: Findings From FY 2024–2025

shelter decreased for Caminar and Telecare and remained the same for Edgewood/Fred Finch clients. In contrast, the percentage of clients who reported any time living alone or with others and paying rent increased. In general, there appears to be a shift in living situations from institutional settings (clinics, shelters, detention centers) toward living alone or with others in group homes, signaling improvement in independence after FSP enrollment. The emphasis on housing assistance in the FSP programs may help clients establish more stable living situations, which in turn can reduce stress, support recovery efforts, and deter behaviors that might otherwise lead to arrests or homelessness.

Inconsistent outcomes across providers were observed for clients reporting any time in assisted living, group home, or community care environments: the percentage for Caminar and Telecare clients increased between the two consecutive years, while the percentage for Edgewood/Fred Finch clients significantly decreased. For Caminar and Edgewood/Fred Finch, there were reductions in the percentage of clients reporting any time in detention or incarceration facilities, whereas the percentage increased among Telecare clients.

Exhibit D3. Percentage of Caminar Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 235)
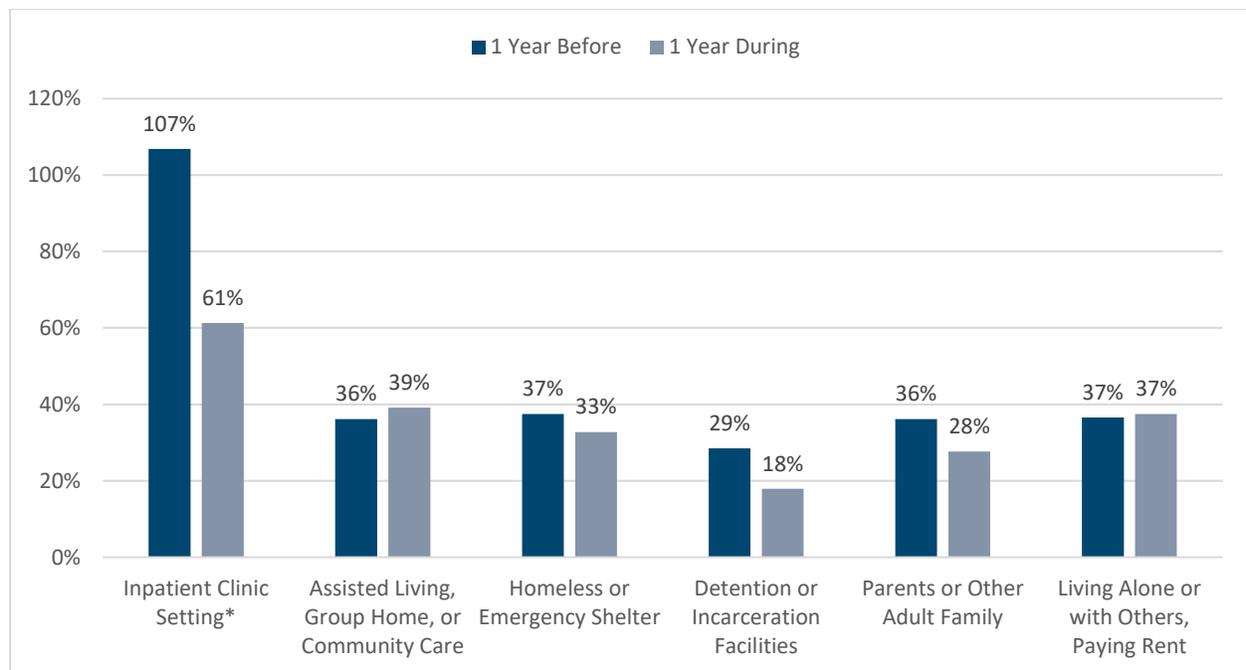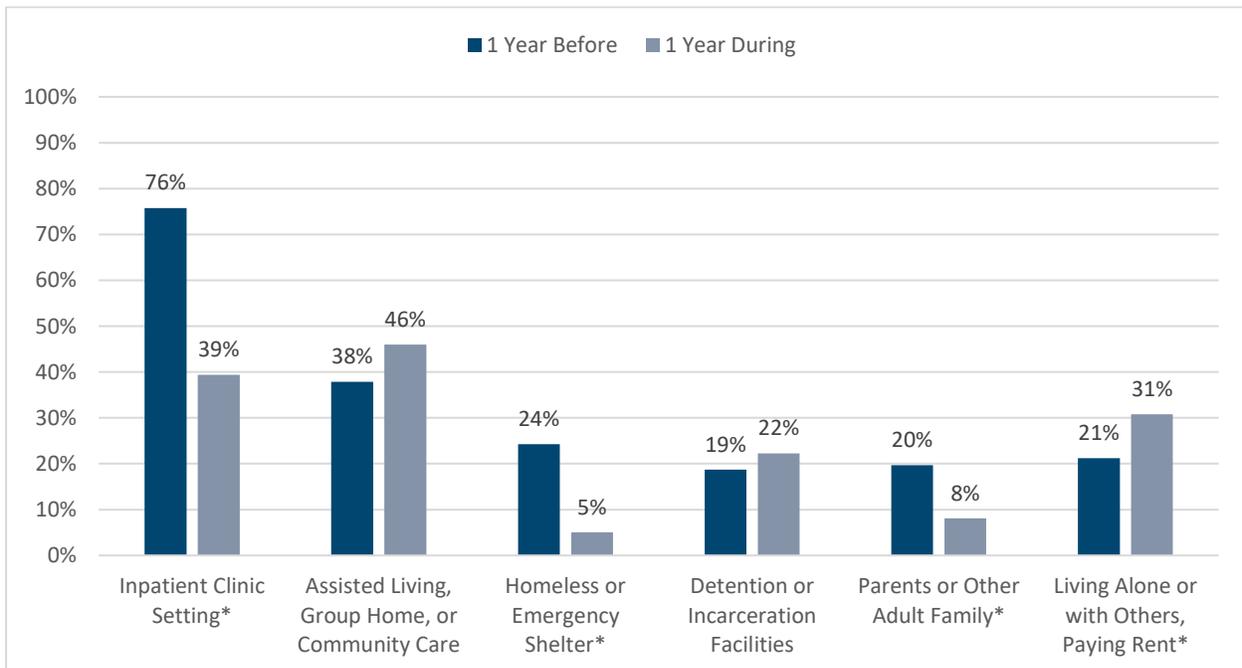

Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit D4. Percentage of Edgewood/Fred Finch Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 554)
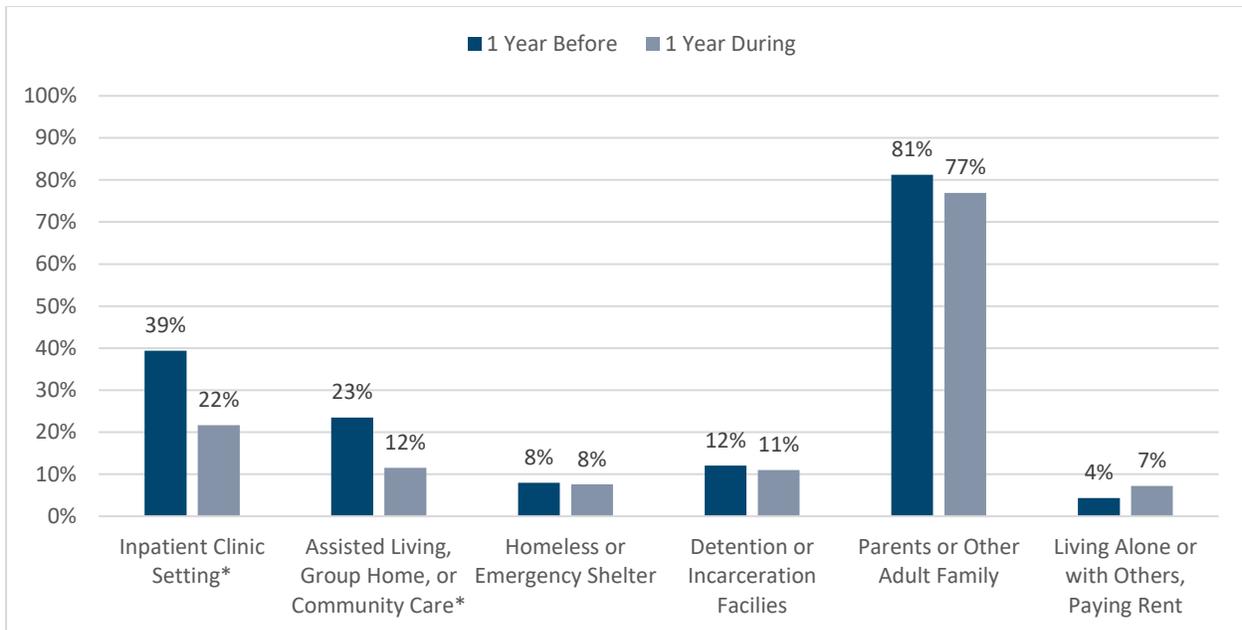
Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit D5. Percentage of Telecare Clients Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 198)

Note. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Full Service Partnership Outcomes: Findings From FY 2024–2025

About the American Institutes for Research®

Established in 1946, the American Institutes for Research® (AIR®) is a nonpartisan, not-for-profit institution that conducts behavioral and social science research and delivers technical assistance both domestically and internationally in the areas of health, education, and the workforce. With headquarters in Arlington, Virginia, AIR has offices across the U.S. and abroad. For more information, visit www.air.org.

AIR® Headquarters
1400 Crystal Drive, 10th Floor
Arlington, VA 22202-3289
+1.202.403.5000 | **AIR.ORG**