FULL SERVICE PARTNERSHIP SERVICE DELIVERY MODEL

This document outlines requirements for Full Service Partnership collaborations and can be found in its entirety at http://www.dmh.ca.gov/MHSA/docs/CSSfinal_8.1.05.pdf.

Full Service Partnerships (FSP) are designed as a partnership between enrollees and the service provider. The FSP service delivery ethic incorporates recovery and cultural competence into the services and supports offered to consumers. In this partnership, the service provider commits to do "whatever it takes" and to "meet the client where they are" in order to assist the enrollee achieve their personal recovery/resiliency and wellness goals.

1. The Target Population is consistent with the population identified in the Fresno County MHSA Community Planning Process

The target population must meet requirements for SMI/SED diagnosis; and must address reduction of specific ethnic disparities, as indicated in the MHSA Community Services and Supports proposal on which the RFP is based.

The target population will include individuals who are not currently served ***and*** meet one or more of the following criteria:

- Homeless
- At risk of homelessness – such as youth aging out of foster care or
- persons coming out of jail
- Involved in the criminal justice system (including adults with child
- protection issues)
- Frequent users of hospital and emergency room services

or are so underserved that they are at risk of:

- Homelessness – such as persons living in institutions or nursing homes
- Criminal justice involvement
- Institutionalization

Diagnoses that serve as criteria for inclusion in the target population will be based on definitions found in 5600.3 California Welfare and Institutions code defining severe mental disorder. The operational definition of "diagnosis" for programs serving the chronically homeless may also include: co-occurring disorders, personality disorders, general anxiety/mood disorders, and Post Traumatic Stress Disorder).

2. FSP Program Components:

All MHSA FSP Programs must include the following in their program descriptions

- **Providers who are part of the multidisciplinary, community based "treatment" teams serve as an ally to the consumer's recovery process.** The partnership allows clients and family members opportunities for informed choice
    - The team description must demonstrate commitment and capacity to do "whatever it takes" to assist the enrolled member, specifically:
        - Low staff to client ratio (approximately 1:12; or the ratio that has been specified in the RFP's statement of work)
        - 24/7 availability of the multidisciplinary team;

- Team culture is created where each member of the team knows each client and the clients are familiar with each member of the team.
- Members of the team speak the client's language, are familiar with community resources that reflect the healing beliefs of the client's culture, and are positioned to assist the client make meaningful connection with those resources.
- Crisis response comes from a person known to the client.
- Staff is given the administrative flexibility and flex-funding to connect consumers with non-mental health services and same day needs. Examples include: Housing; Primary Care; Dual Disorder Services, Education Services and Supports; Vocational services and supports; Payee services/benefits advocacy; Community recreational activities (YMCA classes, libraries, movie theaters); Social Services, Food, Transportation, and Clothing.
- Availability of Integrated Dual Diagnosis Treatment or other dual recovery intervention that will provide effective treatment for the target population.

- **Outreach and engagement.** The team's outreach and engagement strategy must be voluntary and driven by the values of client culture. This means that consumers will be engaged "where they are" in terms of their community location, their need for clinical and non-clinical services/supports and their phase of recovery. Outreach workers will have culturally competent language skills and will function as an ally to the consumer's decision to receive services. Peer Support will be included in the outreach and engagement of new clients.
- **Procedures for enrollment and dis-enrollment will be easily understood, clearly communicated and non-coercive**. Enrollment is voluntary. A condition of enrollment is that the client indicates that they want services from the assertive-community treatment model team.
- **Each adult, older adult, and transition age youth enrollee must have a Personal Service Coordinator (PSC).** The PSC is an ally to the enrollee and acts as a "single point of responsibility" within the multidisciplinary team for coordinating services and supports. *"Personal Service Coordinators (PSCs) for adults – case managers for children and youth – must have a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can give the individual served and/or family member considerable personal attention… PSCs/case managers must be culturally competent, and know the community resources of the client's racial ethnic community."* (Source: DMH Planning Requirements, Section III Identifying Populations for Full Service Partnerships, Aug 2005)
- **Each enrollee must have an Integrated Services and Supports Plan that is developed with their Personal Services Coordinator**. This ISSP is a planning tool that builds on the consumer's strengths. It includes goals and provides a map of the steps that the enrollee identifies as necessary to move along his/her recovery path. "*Integrated Services and Supports Plans must operationalize the five fundamental concepts*(identified listed in section three of this Exhibit*) and should reflect community collaboration, be culturally competent, be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family. In addition, the ISSP will be person/child-centered, and give individuals and their families' sufficient information to allow them to make informed choices about the services in which they participate. Services should also include linkage to, or provision of, all needed services or benefits as defined by the client and or family*

in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed ." (Source: DMH Planning Requirements, Section III Identifying Populations for Full Service Partnerships, Aug 2005)

- **Peer support services will be made available to the client.** At least two staff (a minimum of 1 FTE) who act in peer support roles will be employed in each MHSA program.
    - The enrollee is given significant access to peer recovery and self-help services. Tools such as Advanced Directives are made available to adult and older adult clients, and Wellness Recovery Action Plans (WRAP) are made available to adult, transition age youth and older adult clients.
    - Peer Counselors are included as equal partners in the multidisciplinary team, and play a critical role in developing the recovery culture and client orientation of the team.

3. The Five (5) Core MHSA Concepts are embedded in each program

Concept 1: Recovery/resiliency orientation:
FSPs will embody the values of recovery and resiliency (i.e., hope, personal responsibility, self-advocacy, choice, respect) and the program principles of recovery and resiliency, including:

- Client-driven goal setting and Individualized Services and Supports Plans
- Providers are allies to the client's recovery process.
- A harm-reduction approach to substance abuse that encourages recovery and abstinence but does not penalize consumers or withdraw help from them if they are using.
- A built in understanding and expectation of setbacks as part of recovery.
- Links to a range of services that are part of the consumers "pathway to wellness" (i.e., employment, health care, peer support, housing, medications, food and clothing)

FSPs will collaborate with the MHSA Family Education Center which makes support services available to family members and the MHSA Wellness Recovery Resource Hub which makes wellness recovery training and technical assistance available to FSP staff.

Concept 2: Cultural Competence Orientation: The program's structure, staffing and service delivery values will reflect the cultural values and orientation of the program's target populations.

The FSP program will embody principals of cultural competence including:

- Diverse staff, representative of the primary ethnic groups to be reached through the program
- Staff trained regarding common access barriers for racial and ethnic groups targeted (including the impact of housing discrimination)
- Links to community-based organizations that share the healing beliefs and practices of ethnic communities served by the FSP.

The FSP program must also be able to deal with gender and sexual orientation diversity. Training in sensitivity to gender and sexuality issues is a key component for staff on the Team.

Concept 3: Community Collaboration: FSP Collaborations ensure that community resources are made available to enrollees. These collaborations include subcontracts between the vendor and other agencies, memoranda of understanding with community non-profits and businesses regarding providing services to clients, and informal relationships built between FSP staff and community stakeholders that result in improved access and decreased discrimination.

Concept 4: Client/Family Driven program: In FSPs, the Integrated Services and Supports Plan (ISSP) is used by adult clients and families of children and youth to identify their needs and preferences which lead to the services and supports that will be most effective for them. Providers work in full partnership with clients to develop these ISSPs. Their needs and preferences drive the policy and financing decisions that affect them.

Concept 5: Integrated Service Experience: FSP programs were incorporated into the MHSA to ensure that these dollars funded "integrated service experiences." This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults.