Only when we are no longer afraid do we begin to live.

Dorothy Thompson
# Table of Contents

**Preface** .................................................................................................................. 4  
**Acknowledgements** ................................................................................................. 6  
**Terminology** ............................................................................................................. 10  
**Domain #1: Philosophy** ............................................................................................ 11  
  “Whatever It Takes” ...................................................................................................... 12  
  Ensuring Cultural Responsiveness of Interventions ...................................................... 14  
  Being Fully Served, Ensuring Integrated Experience ................................................... 17  
  Tailoring Service Coordination to Client Stage of Recovery ....................................... 21  
  Outreach and Engagement ......................................................................................... 24  
  Welcoming Environments .......................................................................................... 29  
  Harm Reduction and Stage of Readiness for Change ................................................. 32  
  Client-Centered Treatment Planning and Service Delivery ....................................... 34  
  Fostering Independence, Self-Determination, and the Transition  
    to Community Supports .............................................................................................. 37  
  Community Capacity Building .................................................................................... 39  
  Resource Guide ........................................................................................................... 42  
  Resources ..................................................................................................................... 43
Domain #2: Service Array ................................................................. 48
  Use of a Strength-Based Approach ............................................... 49
  Client Self-Management ................................................................ 51
  Integrated Services for Clients with Co-Occurring Substance Use and
    Mental Health Disorders ................................................................. 56
  Role of Medication and Psychotherapy .......................................... 59
  Reconnecting with Family ............................................................... 62
  Increasing Social Supports .............................................................. 64
  Education, Employment, and Volunteering .................................... 66
  Community Integration ................................................................. 71
  Reducing Involvement in the Criminal Justice System .................... 73
  Linkage to and Coordination of Health and Dental Care ................ 75
  Crisis Intervention and 24/7 Availability ....................................... 78
  Coordination of Inpatient Care ..................................................... 80
  Resource Guide ............................................................................. 83
  Resources ...................................................................................... 84

Domain #3: Team Structure ............................................................... 91
  Team Service Approach and Meeting Structure .............................. 92
  Peer Staff as Part of the FSP Team ................................................ 94
  Assertive Community Treatment (ACT) ......................................... 96
  Resource Guide ............................................................................. 98
  Resources ...................................................................................... 99

Domain #4: Housing ........................................................................ 100
  Creating An Array of Readily Available Housing Options ............... 101
  Supportive Housing and Housing First Models ............................ 104
  Use of FSP Funds for Non-Mental Health Services and Supports .... 106
  Resource Guide ............................................................................ 108
  Resources .................................................................................... 109
Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although they have been in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support the ongoing development of the programs and integration of practices. This publication series encompasses a Tool Kit for each age group — children, transition-age youth, adults, and older adults — in recognition of the programmatic differences that exist across the four age groups.
The Tool Kit has numerous unique characteristics that include:

- Development with close involvement of diverse, statewide advisory committees that represented all of California’s public mental health constituents, including clients, family members, counties, and mental health service providers

- Identification not only of service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships

- Reference and access to website links that offer additional in-depth information on the majority of practices included in the Tool Kit

- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery
This Tool Kit is dedicated to all the people with lived experience, whether children and their families, transition-age youth, adults or older adults, who continually demonstrate their belief in possibilities.

This project was funded through California’s Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, and partner agencies — participated via meetings, conference calls, and interviews.
Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.

### Acknowledgements (cont’d)

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We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning across all age groups. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, provided us guidance through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation.
The *Philosophy* domain of the Adult Full Service Partnership (FSP) Tool Kit presents an overview of the basic tenets of an Adult FSP. It emphasizes the Mental Health Act (MHSA) core principles as they are integrated into the FSP model: client and family-driven mental health services within the context of a partnership between the client and provider; accessible, individualized services and supports tailored to a client’s readiness for change that leverage community partnerships; delivery of services in a culturally competent manner, with a focus for wellness, outcomes and accountability.
“Whatever It Takes”

Purpose
To guide the actions and motivation of full service partnership staff regardless of the array of services provided.

Definition
Whatever it takes means finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. This concept may include innovative approaches to “no-fail” services in which service provision and continuation are not dependent upon amount or timeliness of progress, or on the client’s compliance with treatment expectations, but rather on individual needs and individual progress and/or pace on their path to recovery. Clients are not withdrawn from services based on pre-determined expectations of response.
Implementation Strategies

Using the following strategies, FSP teams can develop interventions based on individualized needs, utilizing the creativity of the entire team to identify client needs and offer options and choices that best respond to the identified needs throughout all arrays of services. Interventions should be based on a “whatever it takes” approach, which means that that FSP teams do not rely on traditional, pre-prescribed menus of services. Rather, they focus on the specific needs and strengths of the client and then develop new interventions that utilize those strengths to meet the needs.

- Create a “no fail” rule in order for staff to find ways to work with clients who present unique challenges yet need FSP assistance.
- Create an expectation that goal setting at the beginning of treatment is not limited to short term goals but that embedded in long term goals and associated objectives is the belief that recovery can and does occur. Goals should reflect an eventual transition to lower levels of service and ultimately, for many, a transition to natural community supports outside of the mental health system.
- Do not place time limits on the engagement phase of FSP services. Failure is not likely to occur as long as staff members keep trying.
- Develop Individual Services and Supports Plans (ISSP) with clients that contain not only symptom reduction goals but also quality-of-life goals that reflect the client’s cultural values. These goals may focus on living arrangements, social supports, education, and employment.
- Use the expertise of various team members when working with difficult-to-engage clients.
- Use a recovery scale to gauge progress toward recovery from mental illness.
Purpose
To present strategies for developing a culturally responsive approach for working with diverse clients in FSPs.

Definition
Cultural responsiveness means the ability to work effectively and sensitively within various cultural contexts. *Ensuring cultural responsiveness of interventions* entails promoting a set of congruent behaviors, attitudes, and policies in a system, agency or among client providers, family member providers, and professionals that enable them to work effectively in cross-cultural situations.¹

The effective engagement of diverse communities requires a dedicated, long-term, multidisciplinary approach. Some initial strategies for promoting cultural competence in FSPs at the organizational, systemic, provider and client levels are listed below.

**Organizational and Systemic Level**

- Recruit and train at all levels, a workforce that is reflective of the cultural groups in the county.
- Develop leadership capacity for employees from diverse cultural groups.
- Ensure that all materials are furnished in threshold and other languages, and that an effective and timely system for translation services is in place.
- Require contracting agencies to demonstrate a standard of cultural competence in service delivery.
- Collect data including race, ethnicity and language of clients to enable systems to identify unserved communities and address disparities.
- Involve target communities in leadership roles in planning, developing, and implementing FSP programs.

**Provider Level**

- Create opportunities and training for providers to develop:
  - **Awareness** — Providers must have an awareness of their own cultural experiences and background, and the ways in which these affect their beliefs, values and behaviors in the clinical setting.
  - **Knowledge** — Providers must have knowledge about the historical background and cultural worldview of communities served.
Implementation Strategies (cont’d)

- **Skills** — Providers must have skills in communicating effectively, understanding nonverbal and verbal communication differences, and building rapport in cross-cultural interactions.

**Client Level**

- Be aware that distrust and fear of mental health systems prevent many ethnic and cultural minority clients from seeking care and advocating effectively for the services they need.
- Empower clients of all cultures to be active participants in planning their care, and to obtain care that is consistent with their cultural values and beliefs.
- Develop strategies to assist clients in navigating systems of care, such as client navigator and parent partner programs.
Purpose
To understand and adopt comprehensive and integrated services and supports that meets the needs of clients throughout the recovery spectrum.

Definition
The concepts of being fully served and ensuring integrated experience are inherent aspects of the carefully selected phrase full service partnership. Their principles must be understood and embraced in order to apply FSP practices constructively.

Fully served as defined by the California Code of Regulations (CCR), Section 3200.160 means "clients, and their family members, who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client’s recovery, wellness, and resilience."
The practical application of being “fully served” is defined in CCR Section 3620 et seq. and California Department of Mental Health ... Letter 05-05 (the document that originally set forth the processes of FSP)² in the following ways:

- Each FSP client must have a single point of responsibility — a Personal Service Coordinator (PSC).

- The PSC should have a caseload low enough so that:
  1) their availability to the client 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 client served and/or family member considerable personal attention.

- Services must include the ability of the PSC or team members known to the client or family member to respond to clients and family members 24 hours a day, seven days a week. This “best practice” service strategy is intended to enable immediate ”after-hours” interventions that will reduce negative outcomes for clients including, but not limited to, unnecessary hospitalizations, incarcerations or evictions. Exceptions may be made for small counties, which may meet the 24/7 criteria requirement through peers or community partners known to the client or family rather than exclusively through the PSCs or team members. While the regulations address peer support as a small-county strategy, integrating peers into services, including crisis response is a good practice regardless of county size.

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Definition (cont’d)

Full spectrum of community services is defined by the CCR, Section 3200.150, as "the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client’s family, in order to advance the client’s goals and achieve outcomes that support the client’s recovery, wellness and resilience."

Full spectrum of services as defined by the CCR, Section 3620, means “services to be provided for each client with whom the County has a full service partnership agreement may include the Full Spectrum of Community Services necessary to attain the goals identified in the Individual Services and Supports Plan [ISSP]. The services to be provided may also include services the County, in collaboration with the client, and when appropriate the client’s family, believe are necessary to address unforeseen circumstances in the client’s life that could be, but have not yet been included in the ISSP.”

Full service partnership as defined by the CCR, Title 9, Division 1, Chapter 14, Section 3200.130, is "the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.” Inherent in the term full service partnership is the idea of being fully served and providing an integrated service experience.
Implementation Strategies

- Create teams with staff from multiple disciplines, backgrounds, and cultures, including establishing opportunities for peers as providers.

- Develop plans with clients to reduce the need for after-hours crisis response, including:
  - Using Wellness Recovery Action Plans. (Refer to Domain #2 Service Array, Tool: “Client Self-Management.”)
  - Helping clients to identify positive and useful coping strategies.
  - Identifying early signs or precursors of an increase in symptoms.
  - Assisting clients in receiving support from other clients or peer providers.
  - Pairing a licensed staff member with other staff members, such as a peer provider or specialist, in responding to after-hours crises.

- Create an integrated approach to services that can help clients by developing personal relationships with organizations in the community:
  - Disabled student centers of local colleges.
  - Health clinics.
  - Vocational rehabilitation programs.
  - Substance abuse programs.
  - Community-based agencies.
  - Faith-based organizations.

- Offer provider on-site support to these programs so that expertise is mutually shared.
Purpose
To identify and to define levels of service and support that create a continuum of services based on the client’s stage of recovery, to ensure that clients are fully served.

Definition
*Tailoring service coordination* involves establishing a process for identifying a client’s level of recovery. Determining “stage of recovery” requires identifying degree of recovery in risk, engagement, skill mastery, and self-responsibility. While recovery scales vary on specific terms, they usually cover the same general areas. Services then focus on those recovery elements.
Definition (cont’d)

An overall framework must be established to indicate how services should flow from one level to the next. Levels of service refer to a guideline for determining the level of care that a client may need. The levels of service listed below constitute an example of a service continuum designed to meet clients’ needs as they recover.

➢ Level 4: Intensive services and supports for clients imminently at risk of institutionalization or homelessness.
➢ Level 3: Focused on strategic services for clients who generally engage at some level with the mental health system and natural supports but are minimally to moderately coping.
➢ Level 2: Services geared toward self-management, with less reliance on the mental health system. Services are more peer-based and focused on wellness.
➢ Level 1: Community-based, often peer-run services, geared toward clients who have achieved relative independence from the mental health system.

## Implementation Strategies

- Create a seamless set of services at each level of service that focus on the milestones associated with each level of service.
- Obtain training for and use a recovery scale to assist FSP teams in determining a client’s level of recovery and associated services.
- Review client recovery scores on a regular basis, tracking client and program progress.
- Tailor services to client needs, interests, and level of recovery in the following ways:
  - **Clients at extreme risk**
    - Refer to Domain #2 — Service Array
    - Reducing Involvement in the Criminal Justice System
    - Crisis Intervention and 24/7 Team Availability
    - Coordination of Inpatient Care
  - **Unengaged clients**
    - Refer to Domain #1 — Philosophy
    - Outreach and Engagement
    - Welcoming Environments
  - **Clients who are building skills and mastery**
    - Refer to Domain #2 — Service Array
    - Use of Strength-Based Approach
    - Client Self-Management
    - Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders
    - Role of Medication and Psychotherapy
    - Increasing Social Supports
    - Education, Employment, and Volunteering
    - Community Integration
    - Linkage to and Coordination of Health and Dental Care
    - Refer to Domain #4 — Housing
    - Creating an Array of Readily Available Housing Options
    - Supportive Housing and Housing First Models
    - Use of FSP Funds for Non-Mental Health Services and Supports
Outreach and Engagement

Purpose
To form the foundation of a partnership by bringing clients successfully into an FSP as well as to retain clients in an FSP while they need services.

Definition
*Outreach and engagement* as codified by the CCR, Section 3200.240, means to “reach, identify and engage unserved clients and communities in the mental health system and reduce disparities identified by the county.”
Using the state’s definition as a starting point, FSP programs must practically apply the elements of reaching and identifying clients, and engaging them in services. Operationally, engagement involves establishing a trusting relationship, and is a critical component of the outreach process.

Further, outreach and engagement have been described as a dance, in the sense that each step in the outreach and engagement process is contingent upon the client’s response to the previous set of actions.⁴

### Implementation Strategies

- Identify the unserved adults with serious mental illnesses who meet the eligibility criteria of candidates for outreach services in the community as indicated in the Welfare and Institutions Code (WIC) 5600.3(b). This eligibility list may include ethnic and cultural groups who have historically faced barriers to accessing services. It also includes homeless people, people cycling in and out of psychiatric hospitals or emergency rooms, those frequently incarcerated, or people living precariously with family members.

- Determine the key issues and needs, as well as the barriers faced by these groups, and create a plan for outreach services that includes:
  - Deciding which staff members will conduct outreach services, and defining the role of peer outreach workers. Those with lived experience who are participating in outreach functions for specific populations are essential to the successful development and implementation of outreach and engagement.

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In addition, employing staff members who have constructive relationships with specific ethnic and cultural communities and have bilingual capabilities that enable them to work with groups who have limited English proficiency is critical for reducing barriers to engagement.

- Establishing which outreach staff will maintain primary responsibility for outreach and engagement, or if they will follow clients into FSP services. The answer, in part, may depend upon the strengths and interests of outreach staff members. Some staff members have particular skills and are comfortable working in specific field-based environments.
- Considering separate outreach and engagement from ongoing services and supports if some staff have particular skills and are comfortable working in specific field-based environments.
- Minimizing transitions between key staff with clients being involved in transitional decisions is important.
- Specifying locations where teams will perform outreach.
- Being aware that some clients may not access services due to fear of disclosing their identities. For example, some clients may risk legal consequences if they access services. Other clients may face violence and harassment if their sexual identity is discovered. Efforts should be made to maximize client safety and confidentiality.
- Considering resources available and collaborations to develop and to ensure success.
- Identifying existing community resources such as faith-based organizations, community-based agencies that have established relationships with target communities, and traditional or spiritual healers.
- Identifying and obtaining resources needed to meet the basic needs of each population. This could include recommendations such as how to furnish emergency shelter, food, clothing, medications, or legal assistance before or after enrollment in an FSP.
Using Motivational Interviewing (MI) to build rapport. “MI is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.”

Consider adopting the following outreach strategies by:

- Valuing the outreach client as a person.
- Understanding the cultural and belief system of each client. For example, homeless clients often feel much safer and in control on the streets than in a shelter or in housing. Therefore, outreach strategies must take into account the beliefs the client has about mental illness, social services, and changes to one’s daily activities.
- Using an approach that is responsive to cultural differences. Understanding the ways in which culture may affect the client’s willingness to seek help, attitudes about his or her illness, and attitudes toward treatment.
- Displaying respect for the outreach environment and the clients for whom outreach services are designed.
- Having and expressing hope.
- Being patient, persistent and non-threatening.
- Identifying client strengths, including survival skills.
- Creating opportunities for client empowerment and self-determination by presenting clients with choices.

Provide orientation and training to staff in the following areas:

- Knowing field safety.
- Understanding the characteristics of the specific populations that are the focus of outreach, including ethnic and cultural minority groups.

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Implementation Strategies (cont’d)

- Recognizing co-occurring substance use and mental health disorders.
- Knowing the criminal justice system, public assistance benefits, and available resources in the community.
- Understanding abuse reporting laws (particularly when working with children, families, and dependent adults).
- Identifying engagement strategies and relationship development.
- Engaging community and family members in recovery planning and process.
- De-escalating and establishing a framework for outreach services that includes boundaries and limits to the work.
Welcoming Environments

Purpose
To convey a sense of welcoming to clients that reflects the belief in recovery. The healing and recovery process will not truly begin until a client feels welcomed and accepted into the services and supports of an FSP team.

Definition
Welcoming refers to the positive and accepting attitude conveyed by team members. It also is an expression of the environment where the team provides services and supports and the degree to which team members believe in the recovery philosophy.
Consider the potential barriers to creating a welcoming environment that exist in the clinic setting, along with potential solutions that achieve the purpose the barrier served, yet contribute to a positive and accepting environment.

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<thead>
<tr>
<th>POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT</th>
<th>POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT</th>
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<tbody>
<tr>
<td>Having a security guard.</td>
<td>Creating a safe and secure environment is critical to any program’s success. The role of safety is not limited just to the presence of security guards. Staff and clients must be empowered to assume responsibility for ensuring a safe environment as well. If a county or agency must have security guards present, consider having the guards function as part of the overall team and knowing FSP clients by name. Ask clients what they like most and least about the presence of guards, and how they could be used most effectively.</td>
</tr>
<tr>
<td>Using metal detectors to provide environmental safety and security.</td>
<td>What is the purpose of the metal detector? Is it effective? How do clients and family members perceive it? How do team members perceive it? Can you devise a better way to achieve the purpose of the metal detector? Whether providing a service in the office or the community, consider the power of observation of team members and clients, coupled with a good therapeutic relationship or alliance, to determine when clients are acting in ways that might place themselves or others at potential risk.</td>
</tr>
<tr>
<td>Posting multiple signs depicting rules and regulations generally telling clients what they cannot do.</td>
<td>What does the team want to convey, and what is the best strategy to convey it? What is the role of peer specialists or peer greeters in conveying these messages?</td>
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### POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT

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<th>POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT</th>
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<tr>
<td>Locking a door that causes separation between team members, and clients between the entry or waiting room and service areas.</td>
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<tr>
<td>Determine which areas of the site require controlled access and why. Examine team beliefs regarding the need for separation between themselves and clients. If some restrooms are designated only for team use, why is that? What are the underlying assumptions and beliefs about sharing restrooms or space with clients?</td>
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<tr>
<td>Lack of cultural diversity among staff members</td>
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<td>For many clients of diverse ethnicities, entering an agency in which the staff is composed primarily of a different ethnicity can be threatening and perceived as unwelcoming. The environment can be improved by: Increasing staff diversity and bilingual capabilities. Ensuring that language minority clients are respected and receive translation services promptly. Posting signs in several languages. Choosing décor reflecting diverse cultures. Advertising local cultural events. Providing waiting room materials (magazines, children’s books, videos) in several languages.</td>
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Debbie Innes-Gomberg, PhD, District Chief – MHSA Implementation Unit, Los Angeles County DMH

- Adopt strategies for developing staff and client relationships and communication. Inherent in the name “full service partnership” is the partnership between the client and the team. As with any partnership, the client and team must make joint decisions. Developing a partnership involves:
  - Understanding the client’s culture, the way in which he or she makes decisions and the involvement of family members or community in the client’s recovery.
Implementation Strategies (cont’d)

- Establishing an investment in a relationship that, at times, requires more from one partner than from the other partner.
- Knowing that because the healing or therapeutic relationship is equal, it may encompass hierarchical service aspects.
- Developing the capacity for team members and clients to share decision making with regard to care. In order to facilitate client self-responsibility and coordination, clients must be equal partners in treatment decisions.
- Instilling and maintaining hope for the client.
**Harm Reduction and Stage of Readiness for Change**

**Purpose**
To effect change by focusing interventions based on a client’s motivation toward changing behaviors in that area of his or her life.

**Definition**
*Harm reduction* is the process of reducing the detrimental consequences of drug or alcohol use or other behaviors based on the client’s level of readiness for change. It requires acceptance that, for a variety of reasons, a client may not be able to abstain from drug or alcohol use, or change other maladaptive behaviors. Quality of life and well-being, rather than abstinence and mandatory behavior change, become the focus points of success. Harm reduction occurs within the context of a client’s readiness for change.
Five stages of change\(^7\) that have been identified include:

- Pre-contemplation: not currently considering change or a need for change.
- Contemplation: ambivalent about change.
- Preparation: attempts are being made to change.
- Action: change has been made, new behaviors are being practiced.
- Maintenance: commitment to sustained change and new behaviors.

**Implementation Strategies**

- Use a “readiness for change” approach to service delivery, assessment, and goal development.
- Utilize Motivational Interviewing (MI) strategies, based on a client’s stage of change, that identify the harmful effects of the maladaptive behavior and the benefits of reducing or stopping the behavior.
- Balance contingency-focused services (through which the client receives a service or benefit contingent upon a successful behavior change) with an overall approach to behavior change based on a client’s readiness to change that behavior, and on longer-term approaches to attaining the ultimate goal of behavior change.
- Explore alternative, safer behaviors that minimize risk.
- Praise small successes with meaningful reinforcements such as gift cards, tokens associated with progress, or acknowledgement in group activities.

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Client-Centered Treatment Planning and Service Delivery

Purpose
To promote a foundation for healing through the relationship between the client and Personal Services Coordinator (PCS) or FSP team.

Definition
*Client-centered treatment planning and service delivery* involve services that are individualized to the needs, interests, and strengths of each client. The client-centered approach involves an equal relationship between provider and client. This type of relationship may be difficult to establish, especially if clients have the cultural expectation that providers are “experts.”
Implementation Strategies

- Take care when providing orientation to this approach — particularly for clients of diverse cultures, who may expect a more hierarchical relationship with their provider.
- Approach assessment and service delivery within the context of establishing and building a relationship that will result in healing and recovery.
- Conduct a thorough assessment of each client that results in the development of an integrated summary or clinical formulation based on the client data.
- In partnership with the client, develop a clinical formulation, assessment, and service plan based on the client’s unique cultural attributes, strengths, age, gender, sexual orientation, and readiness for change. Interventions are then based on the uniqueness of each client.
- Approach service planning and delivery as a collaboration of the Personal Services Coordinator and the client.
- Refer to the table below that illustrates the differences between a client-centered approach and that of a more traditionally used illness-centered approach.

<table>
<thead>
<tr>
<th>ILLNESS-CENTERED APPROACH</th>
<th>CLIENT-CENTERED APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>The diagnosis is the foundation.</td>
<td>The relationship is the foundation.</td>
</tr>
<tr>
<td>It begins with an illness assessment.</td>
<td>It begins with welcoming — outreach and engagement.</td>
</tr>
<tr>
<td>Diagnosis and treatment are needed to determine the services provided.</td>
<td>Personal suffering and help needed determine the services provided.</td>
</tr>
<tr>
<td>Services work is defined within the context of illness reduction goals.</td>
<td>Services work is defined in terms of quality-of-life goals.</td>
</tr>
</tbody>
</table>
## ILLNESS-CENTERED APPROACH vs. CLIENT-CENTERED APPROACH

<table>
<thead>
<tr>
<th>ILLNESS-CENTERED APPROACH</th>
<th>CLIENT-CENTERED APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment is symptom driven, and rehabilitation is disability driven.</td>
<td>Treatment and rehabilitation are goal driven.</td>
</tr>
<tr>
<td>Recovery from the illness sometimes results after the illness and then the disability are treated.</td>
<td>Personal recovery is the objective of a client-centered approach from beginning to end.</td>
</tr>
<tr>
<td>Track illness progress toward symptom reduction and cure.</td>
<td>Track personal progress toward recovery.</td>
</tr>
<tr>
<td>Use techniques that promote illness control and reduction of risk of damage from the illness.</td>
<td>Use techniques that promote personal growth and self-responsibility.</td>
</tr>
<tr>
<td>Services end when the cure to the illness occurs.</td>
<td>Services end when clients manage their own life and attain meaningful roles.</td>
</tr>
<tr>
<td>The relationship exists only to treat the illness, and must be carefully restricted throughout to maintain a professional relationship.</td>
<td>The relationship may change and grow throughout the process, and may continue even after services end.</td>
</tr>
</tbody>
</table>

Source: Mark Ragins, MD, Mental Health America of Los Angeles
Fostering Independence, Self-Determination and the Transition to Community Supports

Purpose
To assist clients in becoming more engaged in their recovery, in order to reduce reliance on the mental health system, as mental health interventions become less necessary.

Definition
Fostering independence, self-determination and the transition to community supports involves availability of interventions and approaches that focus on clients assuming more responsibility for their recovery and their daily life and changing their role from that of a client in a mental health system to a community member.
Implementation Strategies

- Create opportunities for shared decision making between Personal Service Coordinators and clients by using shared decision-making aids that can help clients weigh risks and benefits associated with various types of treatment and service, and make informed decisions.
- Help clients interested in physical activity, crafts, or reading find opportunities in their community to engage in those activities instead of creating groups at the mental health center.
- Acknowledge and respond to difficulties that unserved and underserved groups encounter when trying to access services.
- Identify programs that provide culturally appropriate supports and services and that adequately help members of unserved and underserved groups cope with difficulties they experience.
- Minimize the need to transport clients by helping them learn to take public transportation when available. Encourage clients to explore group transportation options.
- Provide community-based services to help clients become accustomed to accessing community resources.
- Encourage the use of self-help services and supports in order to self-manage symptoms.
- Hire clients as part of the FSP team.
- Consider the role of faith-based organizations and other naturally occurring groups in supporting clients in the community.
- Use program and client outcome data wherever possible as part of a larger strategy to facilitate joint or shared decision-making regarding client transitions.
- Assist clients in creating a sense of community based on client interests and strengths, or ways in which clients identify ethnically or culturally.
Community Capacity Building

Purpose

- To assist clients in managing and living productive lives in their community.
- To reduce unnecessary client reliance on the mental health system.
- To increase capacity within the system to serve new clients.

Definition

*Community capacity* means the “ability of community members to use the assets of its residents, associations, and institutions to improve quality of life.”

*Community capacity building* involves finding or creating opportunities that enable clients, as they recover, to rely on services and supports from the community rather than the mental health system.

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Generally, community capacity building has five elements: 9

1. Knowledge building within the community — to assist communities in understanding the needs of diverse populations that exist within the community, such as those recovering from mental illness and striving to live independently.
2. Leadership — to identify and support a collective vision and interest of all community stakeholders and develop a strategic direction.
3. Network building — to enable formation of partnerships and strategic alliances for the benefit of the community.
4. Valuing of community — to recognize importance of the distinctive qualities of the community that support an investment of effort to work together.
5. Supporting information and analysis — to track and report on data and outcomes of community integration efforts and the mental health program.

Implementation Strategies

Build community capacity by facilitating trust of mental health clients within communities by:

- Educating the community about mental illness, including resource information and speakers bureau composed of clients, family members, and non-clients, to illustrate inclusion and recovery.

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Implementation Strategies (cont’d)

- Collaborating with Prevention and Early Intervention (PEI) programs targeting PEI programs with non-mental health community-based agencies, programs, and faith-based groups.
- Reducing the stigma of mental illness through the process of de-bunking myths that persons diagnosed with mental illness are violent or unpredictable.
- Establishing partnerships between mental health programs and community organizations such as the YMCA, local parks or recreational establishments, gyms, health-care organizations, businesses, community-based organizations, traditional or spiritual healers, and advocacy groups.
- Establishing a positive presence by becoming partners with the community. Providers should strive to build constructive relationships with their communities by attending community events and cultural celebrations. In addition, providers may consider serving on local committees and governing boards. Mental health providers should strive to receive as much support from the community as is given to the community.
- Assisting in establishing community “safety nets” for residents and clients.
- Assisting in establishing, developing, and supporting community or neighborhood coalitions that are empowered to solve community-level problems.
- Identifying existing official and “non-official” resources in communities, and making that information widely available and easily accessible.
- Creating networking opportunities for existing resource providers to encourage warm hand-off referrals from resource to resource.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 44–48. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whatever It Takes</td>
<td>10, 11, 12, 13</td>
</tr>
<tr>
<td>Ensuring Cultural Responsiveness of Interventions</td>
<td>4, 17, 21</td>
</tr>
<tr>
<td>Being Fully Served, Ensuring Integrated Experience</td>
<td>15</td>
</tr>
<tr>
<td>Tailoring Service Coordination to Client Stage of Recovery</td>
<td>8, 9, 10, 11</td>
</tr>
<tr>
<td>Outreach and Engagement</td>
<td>1, 6, 14, 16</td>
</tr>
<tr>
<td>Welcoming Environments</td>
<td>26</td>
</tr>
<tr>
<td>Harm Reduction and Stage of Readiness for Change</td>
<td>2, 5, 14, 20, 24, 25</td>
</tr>
<tr>
<td>Client-Centered Treatment Planning and Service Delivery</td>
<td>3, 18</td>
</tr>
<tr>
<td>Fostering Independence, Self-Determination and the Transition to Community Supports</td>
<td>19, 22, 23</td>
</tr>
<tr>
<td>Community Capacity Building</td>
<td>7, 15, 16</td>
</tr>
</tbody>
</table>
**Resources**

**Articles**


**Books**


Resources (cont’d)


✓ Newsletter


✓ Policy Guideline


✓ Recovery Scales


Resources (cont’d)

✓ Recovery Scales (cont’d)


✓ Reports and Research Papers

13. California Department of Mental Health — MHSA Community Services and Supports (CSS) plan three-year program and expenditure plan requirements. Letter on August 1, 2005. Retrieved from http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf


Resources (cont’d)

✓ Reports/Research Papers (cont’d)


✓ Websites

18. CalMEND — Resources for Mental Health Care Organizations and Providers of Mental Health: http://www.calmend.org


22. SAMHSA Mental Health Decision Aids: http://www.samhsa.gov/consumersurvivor/pdf/SAMHSA_Decision_Aid_Chart_Jan08.pdf

Resources (cont’d)

✓ Websites (cont’d)

24. Stages of Change: UCLA Center for Human Nutrition: 
   http://www.cellinteractive.com/ucla/physcian_ed/stages_change.htm

25. Transtheoretical Model, Cancer Prevention Research Center: 
   http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm

✓ Workbook

The Service Array domain identifies the specific practices, tools and interventions associated with adult FSP programs. These practices place the Philosophy domain into operation.
Purpose

To help a client identify and use his or her individual strengths in treatment as an effective way to help achieve goals and believe that recovery is possible.

Definition

A strength-based approach involves development of an assessment, treatment plan, and service delivery through a collaborative partnership between the client and treatment team. This approach capitalizes on a client’s strengths, a holistic view of the client, and the belief that recovery is achievable. For many clients, particularly clients of ethnic and cultural minority groups, the relationships may not be only with the client but also with the extended family, traditional or spiritual healers, and other community members important to the client.
Implementation Strategies

- Explore with each client his or her strengths, as they relate to each goal, while acknowledging mental health barriers. Also include what the client — and in some cases, the client’s family and support network — bring to the treatment process, including identifying client interests, talents, abilities, and resources.

- Assist the client in identifying and using the types of “capital” he or she brings to services: personal (values, skills, and knowledge), family or social, community (resources and culture), and physical and financial health.

- Identify and build upon cultural strengths, such as a positive and strong ethnic identity, sexual orientation, traditional cultural customs and heritage, tribal traditions, and cultural celebrations.
Client Self-Management

**Purpose**
To help clients learn to assume more responsibility for their overall care by becoming more involved in decision making and successfully managing their symptoms.

**Definition**
*Client self-management* is the process by which clients increase their involvement in decisions about their care and recovery.
Implementation Strategies

Client self-management strategies vary in their use of peers and mental health staff, but all focus on educating and empowering clients to make decisions and actions that support their recovery. Among the universe of strategies to enhance client self-management, consider the following:

**Shared Decision Making**

This collaborative process between a mental health professional and a client is intended to help clients understand the advantages and disadvantages of mental health treatment options, with the goal of creating decision aids to guide clients in making informed choices.

- Place computers in waiting rooms or resource areas of mental health programs, and encourage clients to access on-line information and decision aids that can assist them in making decisions related to their care.
- Create opportunities for clients and staff to discuss decision-making strategies, individually, in groups, or using technology.
- Consider reviewing client data (outcome, recovery level, or client-completed questionnaires) with clients to create opportunities for clients and FSP team members to discuss progress.
- Provide information in a variety of languages.
Wellness Recovery Action Planning (WRAP)

WRAP is an approach to client self-management, facilitated by trained WRAP leaders who usually are clients in recovery. In this approach, clients help clients by developing:

- Daily maintenance plans that list the characteristics of clients when they are feeling well, daily activities that maintain wellness, and additional activities that would contribute to wellness.
- Wellness toolboxes that could be a notebook or container where daily maintenance plans, triggers, trigger plans, and plans for crisis and post-crisis are kept.
- Ways to identify early warning signs that symptoms are increasing.
- An action plan defining what to do when triggers develop.
- A crisis plan that identifies what the client is like when he or she is feeling well; symptoms that indicate that others need to take over full responsibility for care and make decisions on their behalf; who those trusted individuals are and how to contact them; medications and supplements the client takes, including preferences and those that must be avoided; treatments that reduce symptoms and those that should be avoided; and preferred treatment facilities.
- A post-crisis plan indicating the signs or symptoms that the crisis plan no longer needs to be utilized.

- Develop a training and implementation plan that involves the role of all team members and that focuses on what WRAP uniquely brings to the services that already are being provided. Involve the client’s community and family support network in the implementation plan.
- Use WRAP strategically to assist clients in transitions — for example, in living independently, obtaining employment, returning to school, or making the transition from mental health services.
Peer Support

A peer’s presence can signal hope that recovery can, and does occur, and lends legitimacy to the program more convincingly than the assertions of staff members without lived experience.

- Target efforts to increase the cultural and linguistic diversity of peer staff to improve the effectiveness of peer support programs.
- Be aware that, depending on the varied needs of clients on the team, peer support may take different forms and may consist of paid peer staff members, volunteers, or clients helping other clients.
- Consider the following specific roles for peers:
  - Having peers initially act as outreach workers and welcomers as clients consider entering the system.
  - Accompanying clients to appointments.
  - Assisting clients in obtaining needed services.
  - Lending a hand in looking for housing or grocery shopping.
  - Serving to assist clients in crisis.
  - Offering alternatives to crisis, such as staffing warm lines.
  - Providing peer counseling.
  - Assisting clients in seeking crisis residential programs and other outpatient alternatives to hospitalization.
Implementation Strategies (cont’d)

**Illness Management and Recovery (IMR)**

Ilness Management and Recovery (IMR) is a SAMHSA evidence-based practice for teaching clients, either individually or in groups, how to identify and manage symptoms effectively. Approaches include relapse prevention training, psychoeducation, coping skills training, and social skills training.

- Provide 5 to 12 months of weekly or twice-weekly sessions focused on recovery strategies, facts on mental illness, building social support, using medication effectively, reducing relapse, coping with stress, coping with symptoms and problems, and fulfilling needs within the mental health system.
- Have clients set personal recovery goals.
- Remember, the client is the expert, with the FSP staff facilitating the client’s learning in a partnership.
Integrated Services for Clients with Co-Occurring Substance Use And Mental Health Disorders

Purpose
To integrate substance abuse and mental health services into one treatment plan. Doing so is critical to the recovery process for both disorders.

Definition
The concept of integrated services for clients with co-occurring substance abuse and mental health disorders (COD) means “providing both substance use and mental health interventions concurrently and in relation to each other, as part of one treatment plan provided by one team or within a network of services with shared goals. These integrated services must appear seamless to the individual and family participating in services.”

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Implementation Strategies

Developing the Capacity for Integrated Services

- Consider hiring a Dual Diagnosis Specialist who assists and leads the team with developing COD services.
- All team members should participate in specialized dual recovery training initially and at least annually.
- All staff members should be trained in and practice Motivational Interviewing (MI) and stage-wise treatment.

Integrated Service Strategies

- Begin the integrated services process with an assessment of a client’s patterns of use of alcohol and other substances and their impact on mental illness.
- Use a stages of change model, such as Prochaska and DiClemente’s Stages of Change model, or a similar model, as a way to match a client’s stage of change to intervention strategies. Approach services from the perspective of the client and his or her degree of perception that substance abuse is a problem and is crucial to address.
- Coordinate and match interventions and services to the client’s readiness or willingness to change.
- Use MI, after identifying a client's stage of change. MI can serve as a strategy to stimulate conversation about readiness for change and therapeutic commitments.
Implementation Strategies (cont’d)

- Offer an array of services options. Services should range from outpatient individual and group COD services, 12-Step programs, sober living homes and residential drug treatment programs. These options are often useful living arrangements as long as alignment exists between the client’s agreement to the approach and the treatment strategies.
- Develop integrated assessments, service plans and crisis plans that promote recovery.
Purpose
To understand the potential role and value of psychotherapy as a treatment modality within an FSP, and to identify strategies for FSP teams to work collaboratively with clients regarding psychiatric medications.

Definition
_Medication and psychotherapy_ are therapeutic interventions designed to reduce the symptoms associated with a serious mental illness and improve a client's quality of life by helping a client gain insight into behaviors and symptoms and adopting behaviors that contribute to recovery goals. While the goals of both cognitive behaviorally based psychotherapies and the administration of psychiatric medication are not always explicitly grounded in the language of recovery, both are elemental in the recovery process.
Helping clients to make the connection between these interventions and the recovery process is critical to the success of these interventions.

Common diagnoses for FSP populations include depression, anxiety, and/or psychotic disorders. It is strongly recommended that counties use evidence-based practices as part of the FSP service array. These may include but are not limited to:

- **Cognitive Behavioral Therapy (CBT).** CBT is an efficacious, evidence-based practice used in individual or group treatment. The basis for CBT is the assumption that negative thoughts can lead to negative emotions and behaviors. By helping people change the way they think (cognitive) and the way they act (behavior), CBT can help people resolve problems that would otherwise interfere with daily living.

- **Dialectical Behavior Therapy (DBT).** Like CBT, DBT is an evidence-based practice targeting emotional dysregulation. DBT augments the techniques of CBT by helping the client acquire skills in mindfulness and non-judgmental acceptance.

- In order to review more commonly used evidence-based practices, refer to SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) or a similar source of evidence-based practices.¹¹

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Implementation Strategies

- Identify clinicians interested in obtaining training in empirically supported treatments such as CBT or DBT. Treatment teams should be well-versed in the overall approach of the psychotherapies being offered in order to support and make referrals for interventions.
- Use daily team meetings to facilitate referrals for psychotherapy and medication issues.
- Consider the use of shared decision models and decision aids to assist a client in making a responsible and informed choice regarding psychiatric medications.
- Take care to explore the attitudes of team members, including the client and his or her support network, regarding these approaches to treatment and to respect the client’s experience and values. Attitudes toward medication and psychotherapy vary across cultures. For some clients, particularly those from unserved and underserved groups, these interventions may seem oppressive or harmful.
- Provide an orientation, when appropriate and particularly for those clients with little exposure to the mental health system, to the process, benefits, and risks of medication and psychotherapy.
- Respect a client’s choice regarding taking psychiatric medication, and use Motivational Interviewing (MI) approaches where appropriate.
- Identify delivery strategies for clients who cannot easily access pharmacies to routinely obtain their medication.
Reconnecting with Family

Purpose
To facilitate the recovery process and add an element of social support to the client. Participation of the family in services is contingent upon the wishes of the client.

Definition
*Family* refers to “anyone committed to the care and support of the person with mental illness, and does not have to be a blood relative”\(^\text{12}\) as identified by the client. The role of the family in the recovery process may also be a function of the cultural context. For example, in many Latino families, family obligations, roles, and family bonds and ties continue to exert a strong influence into adulthood. For many Native Americans, the treatment of the client often is seen as a process involving the entire community.

Definition (cont’d)

Care should be taken to explore the cultural context of recovery for the client, and identify a level of family and community participation that reflects the client’s wishes and is culturally congruent.

Implementation Strategies

- Establish the client’s wishes for family involvement in services. If the client initially declined, periodically check to see if the client has changed his or her mind and now wishes to establish a connection with family and involve them in the care. A client’s definition of family may encompass friends who have significant and supportive relationships with the client.
- Be aware and respectful of differing cultural roles, communication, decision-making processes, and expectations within diverse families.
- Include key community members, per client wishes and when culturally appropriate, in developing and implementing the recovery plan.
- Use family psychoeducation, involving engaging families in and offering ongoing education about the illness, to develop problem solving and coping skills and to create social supports.
- Implement other educational supports for family members.
- Attend local National Alliance on Mental Illness (NAMI) groups, and advise family members about NAMI services that are available.
Increasing Social Supports

Purpose
To increase clients’ social networks and increase opportunities to meet new people. Doing so can help make recovery seem achievable.

Definition
*Social supports* encompass ongoing social, nonprofessionally oriented interactions with people who act as supports for clients, yet who are not mental health staff members.
Implementation Strategies

- Create opportunities for social networking by creating bulletin boards and posting social activities.
- Link clients to natural social networking opportunities, including those based in the community (for example, book clubs and hiking clubs) and on-line resources (such as Facebook and Twitter).
- Create non-professionally led groups based on interests, such as weight loss and cooking programs.
- Identify resources and activities for unserved and underserved clients, such as support groups, recreational programs, older adult activity groups, cultural ceremonies, spiritual celebrations, and musical festivals.
Education, Employment, And Volunteering

Purpose
To engage in activities that are meaningful, create self-sufficiency and give back to the community. These are critical elements of recovery.

Definition
*Education, employment and volunteering* are activities that are meaningful to clients, contribute to their personal well-being, and help them transcend their role as a client of the mental health system. Supported employment has the following principles: (1) employment is based on client choice, rather than on provider belief of client readiness; (2) services are integrated with comprehensive mental health services; (3) competitive employment is the goal; (4) job searches start as soon as the client expresses an interest in working; (5) follow-along supports are continuous, and generally gradually decrease over time; (6) client preferences are important.
Implementation Strategies

EDUCATION

- Promote returning to school by advertising or publicizing opportunities in newsletters or posters in the building.
- Establish relationships with a range of local academic programs and institutions.
- Achieve a thorough understanding of the unique needs of the clients as they consider returning to school, including key educational pursuits. When composing a strategy, consider the following questions:
  - Can the educational program tailor courses to the needs of clients with certain specific interests?
  - How closely associated is the educational program with local employers?
  - What other services does the educational program offer? Are enriching experiences such as gym memberships, groups, and other opportunities available by which students can attain greater community integration?
  - Does the mental health program require a certain type of job classification and can the educational program develop a set of classes resulting in a certification that qualifies clients for the job classification, thus creating career opportunities?
Implementation Strategies (cont’d)

EMPLOYMENT

- Create a vision for client employment opportunities within and outside the mental health system, based on the principles and goals of supported employment (SE) and recruit a lead employment specialist with designated job functions.
- Form one or more advisory groups to identify and remove bureaucratic barriers and inform the program of findings. Ideally, advisory groups would include members of unserved and underserved groups, because guidance in developing resources for ethnic and cultural minority clients is critical to the success of these programs.
- Establish program standards.
- Identify and resolve any financial insufficiencies or other problems. Explore the use of non-mental health services and support funds for use in paying salaries for jobs. (Refer to Domain #4 Housing, Tool: “Use of FSP Funds for Non-Mental Health Services and Supports.”)
- Develop a training structure.
- Monitor the program and its outcomes.
- Develop collaborative relationships with other agencies (state and local), thereby leveraging capital to support a client employment program.
- Consider establishing shared procedures for referrals and providing ongoing support for mutual clients.
- Create part-time and full-time hiring and promotional opportunities within the local mental health system. Clients interested in a career within mental health, as a peer specialist, peer advocate or other position, may benefit from the following functions:

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Implementation Strategies (cont’d)

➢ Exploring any opportunities the county’s Workforce, Education and Training (WET) Plan may offer related to funding for client mental health career pathways or other relevant components of WET. For more information on WET, consult the CCR, Title 9, Division 1, Articles 2, 3, 5 and 8.
➢ Developing a plan for peers to enter county or contract agency mental health programs as employees, including specific positions and a career ladder.
➢ Developing and implementing training or certification for peers to gain the essential skills to enter the mental health workforce.
➢ Establishing specific, targeted recruitment activities for ethnic and cultural minority clients.
➢ Linking certification completion with the employment application process.
➢ Conducting ongoing educational support for peers as they enter the mental health workforce, perhaps through the resources of the county's WET Plan, including establishing a loan assumption program or a scholarship program.
➢ Establishing and funding mental health career pathway programs in the mental health system for clients currently employed, whether full-time or part-time, who want to increase their skills and scope of responsibility. Encourage participation of clients within populations and communities that have been identified as unserved or underserved by the public mental health system.
➢ Establishing policies and parameters on peer employment within the same setting where clients received mental health services.
➢ Developing educational opportunities for interested peer staff members, and encourage them to apply.
➢ Overcoming benefit-related barriers — such as changes in SSI benefits as a result of working — that can impede clients from seeking employment.
➢ Referring clients to Social Security benefits counselors as a way to help them understand how employment may affect benefits.
VOLUNTEERING

Clients who are uninterested in seeking employment or returning to school may find volunteering — either within the mental health system, in other organizations or in general community settings — an appealing way to contribute to a sense of well-being and recovery.

- Help clients identify opportunities for meaningful volunteering through peer support groups or by creating volunteer opportunities posted on bulletin boards or websites created by clients.
- Consider creating volunteer positions within FSP teams, including clerical support, assisting clients in completing annual satisfaction surveys, and other tasks as identified by the FSP team.
Purpose
To shift client supports and activities from the mental health system to those in the community as the client’s recovery progresses.

Definition
Community integration occurs when friends, colleagues, and others take a more active role in the life of a client who is undergoing the transition from the primary support of the mental health system. The role of an FSP team shifts to supporting the client in initiating activities and taking further responsibility for recovery and community integration through “interpersonal connectedness and citizenship.”

Implementation Strategies

- Assist clients in using the Internet or other community guides to plan activities.
- Help clients identify ways and opportunities to meet people, by defining their interests, strengths, hobbies, and cultural and ethnic affiliations.
- Be aware of and responsive to differing cultural attitudes regarding the disclosure of mental illness in public settings.
- Identify recreation centers, community centers, faith-based and spiritual supports, advocacy groups, and ethnic organizations that may provide support and social activities for clients.
- Assist the client’s support network (family and community members) in developing a plan to integrate the client into traditional celebrations and cultural activities.
- Focus peer support toward community engagement activities.
- Encourage clients to celebrate holidays in their own apartment, rather than at a mental health center or at community organizations.
- Motivate clients to organize their own trips and outings rather than confining themselves to those that the mental health program may conduct.
- Assist clients in identifying low-cost or no-cost organizations they may join in their community.
Reducing Involvement in the Criminal Justice System

**Purpose**
To minimize client contact with law enforcement agencies, as a means of improving client quality of life.

**Definition**
*Reducing involvement in the criminal justice system* can be achieved through strategies designed to minimize client contact with law enforcement, including detainment and arrests.
Implementation Strategies

- In partnership with the client, determine whether he or she has been issued any outstanding warrants or unpaid tickets that could result in an arrest. Assist the client in resolving these infractions to reduce the likelihood of criminal justice involvement for activities that occurred before the partnership.
- Engage in proactive, advocacy-related work with the court when clients do become involved in the criminal justice system. Depending upon circumstances and history, a judge may suspend or reduce a sentence for a client who is enrolled in an intensive program.
- Conduct advocacy and education activities to help counter the stigmatization and discrimination that confront mental health clients in the criminal justice system.
- Establish relationships or partnerships with local probation offices. Such collaborations can identify individuals with a mental illness who are involved in the criminal justice system and may benefit from a referral to a FSP team.
- Consider involvement of mental health courts where they exist and when appropriate.
- Consider involving the probation officer, with client consent, as part of the FSP team.
- Issue identification cards for interested clients, requesting law enforcement or psychiatric mobile response personnel to contact the FSP team in the event the client is in need or in trouble. Use of these cards is voluntary and at the discretion of the client.
Purpose
To ensure access for all FSP clients to needed health and dental care. Access to these services is particularly critical because mental health clients often have undiagnosed and untreated medical conditions that result in chronic medical conditions and premature death.

Definition
*Linkage to and coordination of health and dental care* entail engaging in activities that result in a client-patient relationship with a primary-care physician for health care and with a dentist for dental care.
Determine which health-related services the FSP team will offer. Such functions may include health screenings, health promotion and prevention activities, on-site diagnostic and treatment services, and assistance in understanding the interactions between medical and psychiatric medications.

Identify prevalent health conditions among the FSP client population, and create education, prevention, and linkage services to help resolve them.

Develop collaborative relationships with local health-care organizations that accept clients without a payor source or those with Medi-Cal. Identify local community clinics that accept clients without a payor source.

Identify the role of a nurse, nurse practitioner or psychiatrist on the FSP team when determining the health needs of clients. Such an individual may act as a liaison to primary-care programs.

Consider different strategies that convey to clients the importance of paying attention to health status, including the presence of groups focused on managing health conditions, smoking cessation, weight loss, and healthy eating and living.

Assist clients in developing health literacy: knowing how to communicate with health-care providers, navigating the health-care system, asking the right questions, and receiving adequate translation services when appropriate.

Accompany clients to their first medical appointments and subsequent appointments, as necessary.

Attend dental appointments with clients, with the understanding that it may have been the client’s first dental appointment in years.

Consider adding healthy living activities, such as handing out dental floss and teaching clients about proper flossing.

Prepare clients for the information they will need to present to their primary-care provider regarding their medical histories.
Implementation Strategies (cont’d)

- Ask the client to sign releases of information and authorization, as a matter of practice, to help initiate comprehensive, integrated health and mental health treatment and to ensure that information on health and mental health care is shared appropriately. Authorizations should be specific to a primary-care physician to achieve coordination of care and in accordance with HIPAA regulations.
Purpose
To ensure that someone known to the client is available to respond during a crisis 24 hours per day, seven days per week.

Definition
Providing crisis intervention and 24/7 availability is the responsibility of the Personal Services Coordinator (PSC) and the entire FSP team. The team shares responsibility for each client but the PSC is immediately accountable for 24/7 response to client needs. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. The team ensures that a PSC is available 24/7 to respond to crisis needs if and when they arise. This team approach to around the clock availability helps to minimize the impact of staff absences or turnover and assure that a PSC, who is known by the client, is always available.
Implementation Strategies

- In team meetings, identify clients who are likely to need response during the workday or after hours.
- Develop plans with clients to reduce the need for after-hours crisis response, including:
  - Using Wellness Recovery Action Plans. (Refer to Domain #2 Service Array, Tool: “Client Self-Management.”)
  - Helping clients to identify positive and useful coping strategies.
  - Identifying early signs or precursors of an increase in symptoms.
  - Assisting clients in receiving support from other clients or peer providers.
- Ensure that bilingual staff members are available to meet the needs of clients with limited English-language proficiency.
- Consider use of 23-hour urgent care centers associated with FSP programs to manage crises after hours. These programs can treat clients for up to 23 hours, 59 minutes, and can provide crisis services, medication, and linkage to immediate needs such as housing or outpatient mental health services. Be aware of language limitations at the centers, and prepare for potential linguistic complications before they occur.
- Consider creating crisis respite centers with staffs composed of peers who can furnish care support and housing during a mental health crisis.
Coordination of Inpatient Care

**Purpose**
To ensure coordination of services when an FSP client is in a psychiatric hospital.

**Definition**
*Coordination of inpatient care* is the process by which the FSP team ensures continuity of care while a client is hospitalized, and manages a seamless transition to ongoing self-care once the hospital discharges the client.
Implementation Strategies

Before a Hospitalization Occurs

- Develop relationships with local psychiatric inpatient units to help achieve continuity of care.
- Assist each client in identifying a plan for the care of children, pets, or housing in the event of a psychiatric hospitalization. Document these needs in the client’s medical record.

Once a Hospitalization Occurs

- Contact the attending psychiatrist and discharge planner immediately, after obtaining appropriate releases and authorizations, when a psychiatric hospitalization occurs without the knowledge or involvement of the FSP team.
- Make sure that the hospital staff understands the services associated with the FSP team and has pertinent information related to the client’s care.
- Visit each client regularly while he or she is in the hospital, and meet with the discharge planner and treatment team to coordinate discharge. Help family members, when appropriate, and other support team members to visit the client in the hospital.
- Meet the client’s emergent needs. (Refer to the second bullet item in “Before a Hospitalization Occurs” above.)
**Implementation Strategies (cont’d)**

**At the Conclusion of a Psychiatric Hospitalization**

- Pick up the client, furnish transportation to his or her place of residence, ensure that the client’s supply of medication is adequate, and confirm that the team is prepared to render follow-up care.
- Review with the client any precursors that may have contributed to the hospitalization, and develop strategies to avert future incidents or episodes. Include the family in that review process (when applicable to the client’s wishes), and engage the support team in developing a plan to prevent future hospitalization.
- Modify the treatment plan as needed.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 85–91. This guide lists and links pertinent resources within each tool name.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of a Strength-Based Approach</td>
<td>3, 7, 14, 15</td>
</tr>
<tr>
<td>Client Self-Management</td>
<td>1, 4, 23, 25, 27, 33, 36, 39, 44</td>
</tr>
<tr>
<td>Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders</td>
<td>2, 8, 18, 20</td>
</tr>
<tr>
<td>Role of Medication and Psychotherapy</td>
<td>11, 13, 28, 37, 38</td>
</tr>
<tr>
<td>Reconnecting with Family</td>
<td>17, 30, 40</td>
</tr>
<tr>
<td>Increasing Social Supports</td>
<td>16</td>
</tr>
<tr>
<td>Education, Employment and Volunteering</td>
<td>19, 29, 43</td>
</tr>
<tr>
<td>Community Integration</td>
<td>3, 12, 42</td>
</tr>
<tr>
<td>Reducing Involvement in the Criminal Justice System</td>
<td>9, 10, 24</td>
</tr>
<tr>
<td>Linkage to and Coordination of Health and Dental Care</td>
<td>5, 31, 32, 34, 35, 41</td>
</tr>
<tr>
<td>Crisis Intervention and 24/7 Availability</td>
<td>21</td>
</tr>
<tr>
<td>Coordination of Inpatient Care</td>
<td>6, 22, 44</td>
</tr>
</tbody>
</table>
 ✓ **Articles**


Resources (cont’d)

✓ Articles (cont’d)


Resources (cont’d)

✓ Articles (cont’d)


✓ Books


Resources (cont’d)

✓ Handout


✓ Tool Kits

17. Family Psychoeducation Evidence-Based KIT from SAMHSA. Retrieved from http://store.samhsa.gov/product/SMA09-4423


✓ Treatment Improvement Protocol


✓ Video

Resources (cont’d)

✓ Websites

22. Assertive Community Treatment:
   http://store.samhsa.gov/pages/product/advSearchResult/?keyword=assertive%2Bcommunity%2Btreatment&pubNumber=&selectedTerms=Kit&pubDate=200

23. CalMEND: http://www.calmend.org

24. CMHS National GAINS Center: http://www.gainscenter.samhsa.gov

25. Common Ground:
   http://www.patdeegan.com/AboutCommonGround.html

26. Consumer/Survivor Mental Health Information, from SAMHSA’s Center for Mental Health Services:
   http://mentalhealth.samhsa.gov/consumersurvivor

27. Dartmouth Psychiatric Research Center:
   http://www.dartmouth.edu/~prc/

28. Dialectical Behavior Therapy Information and Training:
   http://www.behavioraltech.org


30. Family to Family:
   http://store.samhsa.gov/pages/searchResult/Family+Psychoeducation+Evidence+Based+KIT
**Resources (cont’d)**

**✓ Websites (cont’d)**


33. Illness Management and Recovery, from SAMHSA’s National Mental Health Information Center: [http://www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)

34. National Association of State Mental Health Program Directors: [http://www.nasmhpdo.org](http://www.nasmhpdo.org)


41. The National Council, for information about integrating health and mental health care: [http://www.thenationalcouncil.org](http://www.thenationalcouncil.org)
Resources (cont’d)

✓ Websites (cont’d)

42. University of Pennsylvania, Collaborative on Community Integration:  
   http://www.upennrrtc.org/

43. Working While Receiving Benefits:  
   http://www.socialsecurity.gov/work/receivingbenefits.html

44. WRAP: Mary Ellen Copeland — Mental Health Recovery and WRAP:  
   www.mentalhealthrecovery.com
Team Structure

The term *Team Structure* refers to the staffing, operations, decision-making, and organization of adult FSP teams, and to their overall approach to the coordination of client care.
Team Service Approach and Meeting Structure

**Purpose**
To use the FSP team as a cohesive entity in treatment and service planning, and to maximize use of team meetings.

**Definition**
A *team service approach and meeting structure* is an essential element of a team-based approach to service planning and delivery in an assertive community treatment context.
Implementation Strategies

- Devote certain team meetings to conducting a review of short and longer term goals for particular clients and group service planning. Some teams find that a helpful approach is using a large dry erase white board in a secured area to organize service planning, staff priorities, and daily assignments.

- Review level of client recovery (through the use of the MORS, LOCUS, and other means) routinely during team meetings. Parameters can include aggregate recovery scores for all clients on the team to determine what percentage of clients are at particular recovery stages.

- Use team meetings to ensure outcome Key Event Tracking (KET) and 3-Month Assessment Updates (3Ms) are completed, thus maintaining up-to-date monitoring of outcomes. As changes occur in a client’s status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail, complete KET during the team meeting.

- Use team meetings to prioritize outreach and engagement services, and identify and develop plans for clients who are likely to use after-hours services.
Purpose
To identify meaningful roles for peer employees as part of an FSP team. Employing clients is transformational and not only helps clients give back to the system that helped them recover, but also — if done with care — will reduce the stigma associated with mental illness.

Definition
_Peer staff_ are clients with lived mental health service experience who serve as a member of the FSP team in the role of a peer advocate; a peer bridger (assisting FSP clients with the transition from institutional or psychiatric inpatient settings to the community); a peer provider or specialist; or as a Personal Services Coordinator.
Implementation Strategies

- Determine staffing qualifications for peer employees.
- Determine initial and ongoing training and support needs, including whether a training certification process is necessary as a qualification for employment.
- Identify roles for clients in recovery on an FSP team, including:
  - Accompanying clients to appointments.
  - Assisting clients in obtaining needed services.
  - Assisting clients in locating housing or shopping for groceries.
  - Serving to assist clients in crisis.
  - Offering alternatives to crisis, such as staffing warm lines for clients to call when needing non-emergent support.
  - Providing peer counseling.
  - Considering peers as equal team members when integrating them within an FSP team with a particular specialization or background.
  - Developing career pathways for clients in recovery, perhaps by utilizing MHSA Workforce, Education, and Training opportunities.
Purpose
To consider the elements of ACT within the context of creating a team structure for comprehensive and coordinated services that support and promote recovery. Adoption of select ACT program elements will help FSP teams achieve the team structure referenced in the MHSA regulations.

Definition
*Assertive community treatment* encompasses field-based, comprehensive, team-based services characterized by a small and shared caseload, time-unlimited services with flexible service delivery, a fixed point of responsibility for each client, and crisis management services available 24 hours per day, seven days per week. The elements of ACT listed next have been highly researched and demonstrated to be effective in achieving favorable quality-of-life outcomes for clients.
To establish and enrich an FSP program as defined in the MHSA regulations, consider incorporating the following essential elements:

- Team approach to services, affording clients access to any team member.
- Small caseload of one staff member per 10 clients.
- Nurse assigned to each team.
- Psychiatrist (or prescribing professional) assigned to each team.
- Housing and employment specialists.
- Shared caseloads.
- Daily team meetings.
- 24-hour availability.
- Capacity for frequent contacts.
- Coordination of services when a client enters an institutional setting.

Select practices that support the outcomes that FSP teams and their clients wish to achieve.
Each of the tools listed below has specific resources that you can locate in the general resource section on page 100. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Service Approach and Meeting Structure</td>
<td>3</td>
</tr>
<tr>
<td>Peer Staff as Part of the FSP Team</td>
<td>1</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>2, 3, 4, 5</td>
</tr>
</tbody>
</table>
## Articles


## Toolkit

5. Assertive Community Treatment (ACT) KIT: [http://store.samhsa.gov/product/SMA08-4345](http://store.samhsa.gov/product/SMA08-4345)
Domain #4

Housing

The Housing domain identifies approaches to establishing an array of housing options for adult FSP clients, including approaches to creating permanent, supported housing. Non-Mental Health Service and Support strategies are also identified as ways to fund housing and the supports necessary for recovery.
Creating an Array of Readily Available Housing Options

Purpose
To establish safe, affordable, and permanent housing for each client, one of the most important practices in an FSP. Such living arrangements will greatly contribute to desirable client outcomes, including reductions in emergency room and hospital visits, with corresponding increase in use of primary-care and substance abuse services, as well as participation in employment services.

Definition
An array of readily available housing options includes access to emergency and short-term housing such as shelter beds, hotel rooms, and transitional housing, as well as access to affordable apartments, houses and other long-term, stable housing accommodations.
Implementation Strategies

- Recruit and train for the FSP team a dedicated housing specialist to develop community-housing options. That individual would be responsible for developing relationships with property owners to increase rental options. The housing specialist also would work directly with clients to help them obtain housing, including completing rental assistance and other housing applications. Peer specialists often make excellent housing specialists because they act as sources of hope and models for other clients to emulate. Peers also uniquely understand the barriers to housing and strategies to overcome them.

- Use FSP funding to subsidize a variety of housing options. Subsidies could include a portion of fees for rentals, utilities, first and last month’s rent, eviction prevention, and purchase of household goods.

- Develop an array of housing options including shelter beds, motels and other emergency housing provisions, as well as accommodations for sharing of apartments, single-family homes and other forms of permanent housing. Also, develop relationships with local housing authorities that may be willing to set aside Homeless Section 8 housing vouchers and Shelter Plus Care certificates for clients with psychiatric disabilities and their families.

- Consider evidence from a Pathways Housing First project in New York and other studies that have demonstrated the benefit of “housing first” approaches to assisting clients and building trust.\(^\text{15}\)

- Use MHSA Housing Program units which provide permanent supportive housing specifically for MHSA-eligible clients.

- Identify opportunities to partner with housing developers to create additional housing with units for clients who have psychiatric disabilities, and for their families.

Implementation Strategies (cont’d)

- Identify clients who are living in board-and-care facilities but, with appropriate supports, could make the transition to independent living. Develop a clinical and a fiscal plan to facilitate those transitions.
- Create roommate groups or networking opportunities for clients interested in congregate or completely independent living.
Supportive Housing and Housing First Models

Purpose
To assist and support clients in finding and maintaining permanent housing of their choice.

Definition
Supportive housing and housing first models support clients in finding residential accommodations and in becoming good tenants, neighbors, and community members. Regardless of the level of recovery, the team will assist clients who seek safe and affordable permanent housing. Both models emphasize and require collaboration between the client, FSP team, and landlord. Both also include community-based (not clinic-based) services geared toward building the skills and supports necessary for living in the community.
Implementation Strategies

- Ensure that funding and housing options are available at the time the client expresses an interest in obtaining housing.
- Teach clients about the expectations of tenancy and lease agreement requirements, and encourage them to pay rent on time, maintain cleanliness and upkeep in their unit, and remain courteous and peaceful in consideration of other tenants.
- Engage in case management to support residential stability.
- Assist clients in accessing and using non-mental health resources.
- Teach clients about tenant rights and responsibilities.
- Direct support that emphasizes fulfilling the needs of the client rather than focusing on specific housing facilities to enable a smooth transition in case the client decides to relocate.
- Integrate stage-specific services for clients who have co-occurring substance use and mental health disorders, matching client readiness for change with interventions.
- Assist clients with vocational and employment services.
- Assist with money management.
- Support community building and tenant advocacy.
- Arrange for peer support. Research indicates that clients often require approximately six weeks of peer support, within the context of supported housing, before they can see a change in themselves.
- Develop a self-sufficiency plan or agreement before subsidizing client rent in order to reduce ongoing, long-term dependence on housing subsidies. Over time, clients would assume more responsibility for the monthly rent or lease payment. A self-sufficiency plan, coupled with a focus on benefits establishment, employment, and education, will help clients work toward complete housing self-sufficiency.
Use of FSP Funds for Non-Mental Health Services and Supports

Purpose
To understand the Mental Health Services Act California Code of Regulations, Title 9, Section 3620,(a)(1)(B), authorizing use of a portion of FSP funds for non-mental health services and supports. These funds are part of an approach to doing “whatever it takes” to help clients achieve their recovery goals.

Definition
Non-mental health services and supports encompass funding for food; clothing; housing, including, but not limited to, rent subsidies, house payments, residence in drug or alcohol rehabilitation programs, and transitional and temporary housing; health-care treatment; and treatment for co-occurring substance abuse disorders, such as substance abuse and respite care.
Implementation Strategies

- Determine what portion of FSP funds should be dedicated for this purpose.
- Balance the use of these funds with the ability of each client to provide for himself or herself. In using these funds, teams should help clients identify ways to attain self-sufficiency.
- Consider the following key uses for these funds:
  - Client housing support expenditures: housing subsidies, master leases, motel and other housing vouchers, rental security deposits, first and last month’s rental deposits.
  - Client flexible support expenditures: food, clothing, items necessary for daily living, travel and transportation, medication, respite services for caretakers, goods necessary for caretaking, medical and dental expenses, school or vocational supplies, furniture, and household products and appliances.
  - Other non-Medi-Cal client support expenditures: costs of salaries and benefits for employment specialists, housing specialists or peer support staff who do not bill for their services.
Each of the tools listed below has specific resources that you can locate in the general resource section on page 110. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating an Array of Readily Available Housing Options</td>
<td>1</td>
</tr>
<tr>
<td>Supportive Housing and Housing First Models</td>
<td>2, 3</td>
</tr>
<tr>
<td>Use of FSP Funds for Non-Mental Health Services and Supports</td>
<td></td>
</tr>
</tbody>
</table>
✓ Article


✓ Websites

2. Housing First: http://www.beyondshelter.org