County of Los Angeles – Department of Mental Health

Mental Health Services Act

Full Service Partnership (FSP) Guidelines

Version 0.9
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Countywide Programs Administration
- Children
- Transition-age Youth
- Adults
- Older Adults

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INTRODUCTION

We are pleased to provide you with this preliminary edition of the Los Angeles County Department of Mental Health (DMH) **Full Service Partnership Guidelines** (Version 0.9). The Guidelines are intended to support the implementation of Full Service Partnership (FSP) programs for all age groups.

The documents which follow address numerous aspects of FSP operations. You will note that we have chosen to call this version of the FSP Guidelines Manual "0.9" to acknowledge that it is a work in progress that is not yet complete. The shaded items on the Table of Contents indicate the topics we are currently working on that will be included in the forthcoming "1.0 Version" of the manual to be released early next year. In addition, although we attempted to address the most pressing aspects of FSP operations, some key areas may have been overlooked. As an important stakeholder in the FSP programs, your input and participation in the development and refinement of this manual is vital. It is important to recognize that our protocols will evolve over time as we gain experience in the actual operation of these new programs. Your feedback about program operations that work well – and those that can be improved – will be of critical importance to us.

Should you have any questions, comments or suggestions regarding the information in this manual, please direct your calls or e-mail to Lisa Wicker at (213) 738-2217 or LAWicker@lacdmh.org .

Thank you.

FSP Guidelines Committee
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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

			FULL SERVICE PARTNERSHIP GUIDELINES VERSION 0.9 (12/2006) TABLE OF CONTENTS	Child	TAY	Adult	Older Adult
I.			**Outreach and Engagement**				
	A.		For Clients in Institutions				
		1.	Discharge Planning from an Institution				
	B.		For Individuals and Families in the Community				
II.			**Eligibility Criteria**				
	A.		Focal Populations per Age Group				
	B.		Operational Definitions and Examples				
	C.		Exclusionary Issues				
		1.	Medicare HMO			√	√
		2.	Third Party-Insured	√	√	√	√
		3.	Parolees		√	√	√
	D.		Family Support Services	√			
III.			**Referral, Authorization and Enrollment**				
	A.		Referral Procedures and the Role of the Impact Unit	√	√	√	
		1.	Older Adult Centralized Impact Unit				√
		2.	Older Adult Referral Guidelines				√
	B.		Procedure for Filing Appeals Related to Enrollment, Disenrollment or Transfer				
IV.			**Special Program Designation for Single Fixed Point of Responsibility on the Integrated System**				
V.			**Special Circumstances After Enrollment**				
	A.		Disclosure of Protected Health Information for Housing and Employment				
	B.		Interruption of Service Due to Institutionalization				
	C.		Transfer of Clients Between FSP Programs				
VI.			**Quality Assurance**				
	A.		Documentation Policy				
	B.		DMH Responsibility for Program Monitoring				
VII.			**Outcomes and Data Collection**				
	A.		Outcomes Data Collection				
	B.		Outcomes Data Certification				
	C.		DMH Responsibility for Data Review and Program Monitoring				
	D.		Performance-based Criteria				
VIII.			**Disenrollment**				
IX.			**24/7 Crisis Coverage**				
X.			**DMH Contacts**				
XI.			**Forms**				
	A.		Community Outreach Services				
	B.		Referral and Authorization				
		1.	Children (ages 0-15)	√			
		2.	Transition-age Youth (ages 16-25)		√		
		3.	Adult (ages 26-59)			√	
		4.	Older Adult (ages 60+)				√
	C.		Appeal (Related to Enrollment, Disenrollment and Transfer)				
	D.		Authorization for Use or Disclosure of Protected Health Information				
	E.		Certification of Accuracy of Data				
	F.		Disenrollment Request				
	G.		Transfer Request				
	H.		Disenrollment/Transfer Request Supplemental				
	I.		Transfer/Assignment of Coordinator				
XII.			**References**				
	A.		"To Dance With Grace: Outreach & Engagement to Persons on the Street"				

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
OUTREACH AND ENGAGEMENT FOR CLIENTS IN INSTITUTIONS	**I.A.**	**5/11/2007**	**1 of 3**

PURPOSE: To inform agencies with the following intensive services programs, Assertive Community Treatment (ACT), AB 2034, Full Service Partnership (FSP), and Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS), of the outreach and engagement expectations for referrals of clients residing in institutions.

DEFINITION:

1. Outreach and engagement are services provided to potential FSP clients prior to enrollment in a FSP program. Outreach and engagement services are used to build a relationship between the FSP program and potential client and to determine if the potential client is appropriate for FSP services.

    a. Outreach is defined as the initial step in connecting, or reconnecting, an individual or family to needed mental health services. Outreach is primarily directed toward individuals and families who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved. Outreach is a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept.[1]

    b. Engagement is defined as the process by which a trusting relationship between a service provider and an individual or family is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering the services. The engagement period can be lengthy; the time from initial contact to engagement can range from a few hours to two years or longer.[1]

2. Institution includes county or fee-for-service (FFS) hospitals; Institutions for Mental Disease (IMD); Skilled Nursing Facilities (SNF); State Hospitals (SH); Psychiatric Health Facilities (PHF); Community Treatment Facilities (CTF); jail; juvenile hall; Probation camps; California Youth Authority (CYA); and Level 12-14 group homes.

GUIDELINES: Clients referred to an agency while residing in an institution must be provided with outreach and engagement services prior to discharge and enrollment in an intensive services program.

1. Upon receiving a referral for a client in an in-patient hospital, emergency room or urgent care center, agency staff shall

conduct a face-to-face assessment within twenty-four (24) hours of receiving the referral to determine eligibility. For clients in all other institutional settings, agency staff shall conduct a face-to-face assessment within seventy-two (72) hours of receiving the referral to determine eligibility (see II. Eligibility Criteria)

2. Once eligibility is determined, the agency will begin outreach and engagement services, which include:

    - Regular Client Contact – The agency staff must maintain regular contact with the client and, if a minor, his/her parent/guardian. Regular client/family contact should occur as often as necessary, but not less than once a week.

    - Contact With Institutions – In order to ensure continuity of care, the agency staff must maintain regular contact with those responsible for overseeing the client's care while in the institution. Regular contact is a weekly phone call or personal visit, at minimum.

        - For minor clients residing in Probation camps, the designated contact staff will generally be the DMH TAY System Navigators deployed in the Probation camps and responsible for linkage to aftercare resources.

        - For minor clients who are court dependents or wards, this also includes regular contact with responsible individuals from other county departments, such as Children and Family Services (Children's Social Worker), Probation (Deputy Probation Officer) and/or Mental Health (Children's Countywide Case Manager), if applicable.

    - Discharge Planning – The agency staff must work cooperatively with the institution to coordinate discharge. The agency staff shall assist with locating residential placement/housing, assuring the client has adequate prescriptions or medication supply upon discharge*****, and with the transportation of the client from the institution to their pre-arranged residential placement/housing. (For

minor clients, this may also include assistance with educational placement.) These activities should be done in collaboration with the institution treatment staff, DMH liaisons, conservators and families. *****Refer to the DMH Medical Director's WebLink below for important prescription guidelines for uninsured clients.

- For clients residing in IMD's, the FSP agency staff shall be responsible for locating residential placement/housing and for transporting the client from the institution to their pre-arranged residential placement/housing.

3. Upon discharge from the institution, the agency may begin the enrollment process. If the client consents to services, a Full Service Partnership Referral and Authorization Form must be submitted (see III. Referral, Authorization and Enrollment). The enrollment date must be effective after the client is released from the institution.

4. Services provided to potential FSP clients prior to enrollment must be claimed through Community Outreach Services (COS) using a special Community Outreach Services claim form in the Integrated System (IS). Outreach and engagement services typically fall under the COS category of "Community Client Services" (refer to DMH *Community Outreach Services Manual* for service definitions, codes and claiming instructions).

FORMS:

- Full Service Partnership Referral and Authorization Form
- Community Outreach Services claim form

REFERENCES

- [1]Erickson, S. & Page, J. (1998). *To Dance With Grace: Outreach & Engagement to Persons on the Street.* Paper prepared for the National Symposium on Homelessness Research, United States Department of Health & Human Services.
- http://www.rshaner.medem.com →Pharmacy→Fund-One Initiative: Letter and Information (posted 4/20/07)→*Changes in DMH Pharmacy Operation That Affect Prescriptions Involving Potential Polypharmacy With Specific Highly Expensive Antipsychotic Medications.*
- Community Outreach Services Manual (pending release 1/07)
- http://dmh.lacounty.info/hipaa/r3COS.htm (COS claim tutorial on IS)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OUTREACH AND ENGAGEMENT FOR INDIVIDUALS AND FAMILIES IN THE COMMUNITY	**I.B.**	**11/1/2006**	**1 of 4**

PURPOSE: To inform Full Service Partnership (FSP) agencies of the outreach and engagement expectations for individuals and families residing in the community.

DEFINITION: Outreach and engagement are services provided to potential FSP clients prior to enrollment in a FSP program. Outreach and engagement services are used to build a relationship between the FSP program and potential client and to determine if the potential client is appropriate for FSP services.

1. Outreach is defined as the initial step in connecting, or reconnecting, an individual or family to needed mental health services. Outreach is primarily directed toward individuals and families who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved. Outreach is a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept.[1]

2. Engagement is defined as the process by which a trusting relationship between a service provider and an individual or family is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering the services. The engagement period can be lengthy; the time from initial contact to engagement can range from a few hours to two years or longer.[1]

GUIDELINES:

1. There are three circumstances under which an FSP agency may provide outreach and engagement services to individuals or families residing in the community:

    a. Agency-initiated Outreach to FSP Focal Populations – FSP agencies may choose to conduct outreach and engagement services to individuals or families that appear to meet FSP focal population criteria (see II.A. Focal Populations per Age Group for criteria).

        i. The FSP agency will outreach to the prospective client until such time a determination is made as to

the individual's appropriateness for, and interest in, a FSP program.

ii. If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall ensure linkage to other appropriate services, as needed.

iii. If the individual/family meets FSP age, focal population and level-of-service criteria and agrees to FSP services, the FSP agency will submit a completed Full Service Partnership Referral and Authorization Form to the appropriate Impact Unit requesting pre-authorization to enroll (see III. Referral, Authorization and Enrollment for procedure).

b. Walk-in/Self-referral – Prospective FSP clients seeking mental health services may present themselves to an FSP agency. If during the agency's screening process the individual or family appears to meet FSP focal population criteria (see II.A. Focal Populations per Age Group for criteria), the FSP agency may choose to conduct outreach and engagement services to the prospective client.

i. The FSP agency will outreach to the prospective client until such time a determination is made as to the individual's appropriateness for, and interest in, a FSP program.

ii. If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall ensure linkage to other appropriate services, as needed.

iii. If the individual/family meets FSP age, focal population and level-of-service criteria and agrees to FSP services, the FSP agency will submit a completed Full Service Partnership Referral and Authorization Form to the appropriate Impact Unit requesting pre-authorization to enroll (see III.

Referral, Authorization and Enrollment for procedure).

c. Referral from Impact Unit/Service Area Navigator – Referrals for outreach and engagement to a potential FSP client will be sent to the FSP agency by the Impact Unit staff. The Impact Unit staff will have completed the Full Service Partnership Referral and Authorization Form to the extent possible and the Impact Unit Coordinator will have pre-authorized FSP enrollment based upon preliminary information about the individual (and family, if appropriate).

   i. Upon receiving a referral from the Impact Unit for a potential FSP client residing in the community, agency staff shall initiate outreach and engagement services within seventy-two (72) hours to determine the individual's appropriateness for, and interest in, a FSP program. Discussions related to the extent and duration of outreach activities shall be held in Impact Unit meetings based the specific needs of the potential FSP client.

   ii. Once a determination has been made, the FSP agency will notify the Impact Unit of the outcome of the outreach activities by completing the "FSP Agency" section under "Disposition" on Page 4 of the original Full Service Partnership Referral and Authorization Form and submitting it to the Impact Unit that made the referral.

   iii. If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall collaborate with the Impact Unit staff to ensure linkage to other services.

   iv. If the FSP agency declines to enroll the eligible individual who has been pre-authorized for enrollment, the agency shall follow III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer.

v. If the individual/family agrees to FSP services and the agency confirms their intent to enroll, the Impact Unit will forward the completed Full Service Partnership Referral and Authorization Form to Countywide Programs Administration for enrollment authorization (see III. Referral, Authorization and Enrollment for procedure).

2. Services provided to potential FSP clients prior to enrollment must be claimed through Community Outreach Services (COS) using a special Community Outreach Services claim form in the Integrated System (IS). Outreach and engagement services typically fall under the COS category of "Community Client Services" (refer to DMH *Community Outreach Services Manual* for service definitions, codes and claiming instructions).

3. The DMH has developed a one-page brochure for each of the four FSP age groups which describes the services that are available through the FSP program. The brochure includes standardized advisement providing information about the HIPAA Privacy Practices Notice and how information that is received by the DMH will be handled and maintained. The brochure will be provided by DMH staff to potential FSP clients when, in the opinion of the outreach worker or other staff, it is appropriate and not contraindicated in the process of outreach and engagement to the potential client. The provision of a brochure or similar notification is important to ensure that all prospective clients are aware of the scope of services provided under FSP.

FORMS:

- Community Outreach Services claim form
- Full Service Partnership Referral and Authorization Form

REFERENCES:

- [1]Erickson, S. & Page, J. (1998). *To Dance with Grace: Outreach & Engagement to Persons on the Street.* Paper prepared for the National Symposium on Homelessness Research, United States Department of Health & Human Services.
- Community Outreach Services Manual (pending release 1/07)
- http://dmh.lacounty.info/hipaa/r3COS.htm (COS claim tutorial on IS)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
ELIGIBILITY CRITERIA – FOCAL POPULATIONS PER AGE GROUP	**II.A.**	**5/16/2007**	**1 of 5**

PURPOSE: To establish Full Service Partnership (FSP) eligibility criteria based on focal populations identified in the Mental Health Services Act and developed by the Department of Mental Health and its Stakeholders.

DEFINITION:

1. Child Focal Population (ages 0-15)

    a. Zero to five-year-old (0-5) with serious emotional disturbance (SED)[1] who is at high risk of expulsion from pre-school, is involved with or at high risk of being detained by Department of Children and Family Services, and/or has a parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders.

    b. Child/youth with SED who has been removed or is at risk of removal from their home by DCFS and/or is in transition to a less restrictive placement.

    c. Child/youth with SED who is experiencing the following at school: suspension or expulsion, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation.

    d. Child/youth with SED who is involved with Probation, is on psychotropic medication, and is transitioning back into a less structured home/community setting.

    [1]A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely affects his/her functioning:

    (1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
    (2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
    (3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;
    (4) A general pervasive mood of unhappiness or depression;
    (5) A tendency to develop physical symptoms or fears associated with personal or school problems. [34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

2. Transition-age Youth (TAY) Focal Population (ages 16-25)

   A transition-age youth must have a serious emotional disturbance (SED) or a severe and persistent mental illness (SPMI)[2] and meet one or more of the following criteria:

   a. Homeless or currently at risk of homelessness.

   b. Youth aging out of:

      - Child mental health system
      - Child welfare system
      - Juvenile justice system

   c. Youth leaving long-term institutional care:

      - Level 12-14 group homes
      - Community Treatment Facilities (CTF)
      - Institutes for Mental Disease (IMD)
      - State Hospitals
      - Probation camps

   c. Youth experiencing first psychotic break.

   d. Co-occurring substance abuse issues are assumed to cross-cut along the entire TAY focal population described above.

   [2]For transition-age youth, severe and persistent mental illness (SPMI) may include significant functional impairment in one or more major areas of functioning, (e.g., interpersonal relations, emotional, vocational, educational or self-care) for at least six (6) months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

3. Adult Focal Population (ages 26-59)

   To be considered for enrollment, prospective FSP clients must have a current Axis I DSM-IV diagnosis of a major psychiatric disorder *and* demonstrate a need for an intensive FSP program by virtue of their history and current level of functioning.

   Prospective FSP clients must also meet *one or more* of the following criteria:

   a. Homeless – Client must have been homeless a total of 120 days during the last 12 months.

   b. Jail – Client must have been incarcerated on two (2) or more separate occasions that total at least 30 days during the last 12 months and must have a documented history of mental illness prior to incarceration.

   c. Acute/Long Term Psychiatric Facilities:

      - Institutions of Mental Disease (IMD) – Client must have been admitted to an IMD for a minimum of 6 months during the last 12 months.
      - State Hospital – Client must have been admitted to a State Hospital for a minimum of 6 months during the last 12 months.
      - Psychiatric Emergency Services (PES) – Client must have at least 10 episodes of emergent care in the past 12 months.
      - Urgent Care Center (UCC) – Client must have at least 10 episodes of urgent care in the past 12 months.
      - County Hospital – Client must have been hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.
      - Fee For Service Hospital (FFS) – Client must have been hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.

d. Family Dependent – Client must have at least one (1) year living with family with minimal contact with the mental health system and would be at risk of institutionalization without the family's care.

4. Older Adult Focal Population (ages 60+)

To be considered for enrollment, prospective FSP clients must have a current Axis I DSM-IV diagnosis of a major psychiatric disorder *and* demonstrate a need for an intensive FSP program by virtue of their history and current level of functioning.

A minimum of 30% of enrolled FSP clients must also meet *one or more* of the following criteria:

a. Homelessness – Client was homeless a total of 120 days during the last 12 months.

b. Incarceration – Client was incarcerated on two (2) or more separate occasions that total at least 30 days during the last 12 months and must have documented history of mental illness prior to incarceration.

c. Hospitalizations – Client was hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.

Additional priority populations include:

d. Imminent risk of homelessness, (e.g., at risk of eviction due to code violations), or;

e. Risk of going to jail, (e.g., multiple interactions with law enforcement over 6 months or more), or;

f. Imminent risk for placement in a Skilled Nursing Facility (SNF) or nursing home, or being released from SNF or nursing home, and without intensive services would not be able to be maintained/released into the community, or;

g. Presence of a co-occurring disorder, (e.g., substance abuse, developmental, medical and/or cognitive disorder), or;

h. Recurrent history or serious risk of abuse or self-neglect, including individuals who are typically isolated, (e.g., APS-referred clients), or;

i. Serious risk of suicide (not imminent), or;

j. Current clients who are aging up in the system, (e.g., clients who have suffered from severe mental disorders in earlier years who are now becoming senior citizens, perhaps currently in an ACT or AB2034-like intensive services program).

GUIDELINES:

1. FSP enrollment is contingent upon potential clients meeting FSP eligibility criteria, including focal population and level-of-service requirements. To avoid supplantation of services, clients already linked to intensive mental health services, such as Assertive Community Treatment (ACT), AB 2034, Children's System of Care (SOC), Wraparound, Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS), and Day Treatment are not eligible for the FSP program.

2. Upon determining a client meets both focal population and level-of-service criteria, complete a Full Service Partnership Referral and Authorization Form and submit it to the Impact Unit in the desired Service Area (see III.A. Referral Procedures and the Role of the Impact Unit).

FORMS:

- Full Service Partnership Referral and Authorization Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
ELIGIBILITY CRITERIA – OPERATIONAL DEFINITIONS AND EXAMPLES	**II.B.**	**11/1/2006**	**1 of 2**

PURPOSE: To provide operational definitions and examples of Full Service Partnership (FSP) eligibility criteria identified in the Mental Health Services Act and established by the Department of Mental Health and its Stakeholders.

DEFINITION:

1. Level of Service

   a. Unserved – Those who are not receiving mental health services, particularly those who are from racial/ethnic populations that have not had access to mental health services.

   b. Underserved – Those who are receiving some mental health services, though they are insufficient to achieve desired outcomes. For example, Client X has been receiving general out patient services for several years but continues to be homeless and in and out of jail and the hospital. Due to high case loads the staff is unable to provide the necessary services. Clinic Y case managers and clinicians have attempted to meet Client X's frequent requests for assistance with her ancillary needs, which include substance abuse treatment, legal issues, housing, etc. However, the assistance needed to accomplish the above-mentioned ancillary needs would include transporting the client to appointments, seeking housing, negotiating rental contracts, providing help with filling out applications and helping the client navigate through outside agencies/services, such as the court system. These services and the level of support required by this client is far beyond what can be provided by traditional outpatient services. Without the increase in services and more intensive support, it can be expected that Client X would be unable to achieve her goals or make progress in her recovery.

   c. Inappropriately Served – Those who are receiving some mental health services though they are inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical or other needs specific to the client. These are often individuals who are from racial/ethnic

populations that have not had access to mental health services due to barriers such as poor identification of their needs, poor engagement and outreach, limited language access, and lack of culturally-competent service within existing mental health programs. For example, Client Y is from the Clatsop Nehalem Tribe and, while he is proficient in English, he prefers to speak in Tillamook, his primary language. Although he has been receiving clinical/case management services in a traditional outpatient clinic, lack of cultural understanding and competency on the part of his clinicians has resulted in misunderstandings. For example, Client Y looks at the floor during conversations with clinicians, even when he is talking. Clinicians have interpreted this as avoidant pathological behavior. This lack of cultural understanding and competency has led to Client Y's increased dissatisfaction with the services and adversely impacted his progress toward recovery.

GUIDELINES:

1. FSP enrollment is contingent upon potential clients meeting FSP eligibility criteria, including focal population and level-of-service requirements. To avoid supplantation of services, clients already linked to intensive mental health services, such as Assertive Community Treatment (ACT), AB 2034, Children's System of Care (SOC), Wraparound and Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS), are not eligible for the FSP program.

2. Upon determining a client meets both focal population and level-of-service criteria, complete a Full Service Partnership Referral and Authorization Form and submit it to the Impact Unit in the desired Service Area (see III.A. Referral Procedures and the Role of the Impact Unit).

FORMS:

- Full Service Partnership Referral and Authorization Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
ELIGIBILITY CRITERIA – EXCLUSIONARY ISSUES FOR MEDICARE HMO, THIRD PARTY INSURED AND PAROLEES	**II.C.**	**11/1/2006**	**1 of 1**

PURPOSE: To establish guidelines for clients referred to a Full Service Partnership (FSP) program who may be ineligible for FSP enrollment due to benefits criteria for the following categories:

1. HMO Medicare and Third Party-Insured
2. Parolees

DEFINITION:

1. An agency that refers a client of pre-paid health care plan, (e.g., Health Maintenance Organization (HMO), Prepaid Health Plan (PHP), Managed Care Plan (MCP), Primary Care Physician Plan (PCCP), and Primary Care Case Management (PCCM)), must first look to those entities as responsible for the provision of mental health services as defined by their contracts, unless the prepaid health plan or the client, as appropriate, is willing to pay for the full cost of their care.

2. The California Department of Correction and Rehabilitation (CDCR) is responsible for the State's parole system and the provision of specific and intensive levels of service to its parolees to enable them to successfully reintegrate into the community, including, but not limited to, substance abuse treatment, mental health services, case management and supervision.

GUIDELINES:

1. If a private prepaid health plan member or parolee is being referred to a FSP program, the referral agency should be advised that their client's health care plan or parole agency is responsible for managing their care.

2. In the event that a FSP client is found out to be a beneficiary of a prepaid health plan or a parolee, the client must be immediately referred back to the referring agency, health plan, and/or parole agency for disposition and continued services. All FSP services need to be terminated if the benefit source is unwilling to pay full cost of services.

AUTHORITY/ REFERENCE:

- DMH Policy and Procedure 401.8 (9/1/04)
- DMH Revenue Management Bulletin (3/05)
- California Department of Correction and Rehabilitation Parole Service Description (1/06)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
FAMILY SUPPORT SERVICES	**II.D.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish Family Support Services eligibility criteria and service delivery standards based upon the design elements and principles identified through the Department of Mental Health (DMH) Stakeholders planning process for the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan.

DEFINITION: Family Support Services (FSS) are intended to provide parents/caregivers whose children are enrolled in a Full Service Partnership (FSP) program access to mental health services for themselves on a voluntary basis.

GUIDELINES:

1. Eligibility Criteria

    a. Parents/caregivers of children aged 0-15 with serious emotional disturbance (SED) who are enrolled in a FSP.

    b. Parents/caregivers without other funding sources to cover the cost of their own mental health care. (**Note**: Because of this, parents/caregivers with Medi-Cal coverage are <u>not</u> eligible.)

    c. Parents/caregivers who are not eligible for mental health services under the adult system of care.

    d. Parents/caregivers for whom collateral services are insufficient.

2. Range of Services

    a. The FSS program should offer eligible parents and caregivers a full array of clinical services, including individual therapy, couples therapy, group therapy, psychiatry/medication support, crisis intervention, case management/linkage, and parenting education.

    b. Treatment should incorporate services for substance abuse and domestic violence.

    c. The FSS program should complement the FSP's peer support and parent advocacy services.

3. Service Delivery Standards

    a. Parent/caregiver treatment should be integrated with the treatment of their child and family.

    b. Joint planning should be utilized to address the needs of the family, as well as the individuals being served.

    c. The FSS program should have a wellness focus.

    d. Parent/caregiver treatment should focus on symptom reduction or the elimination of symptoms. The goal is to empower parents/caregivers to live, work, learn and participate fully in their families and communities.

4. Claiming and Recordkeeping

    a. The FSP agency should open a record and establish a Client ID# in the Integrated System (I.S.) for the parent/caregiver who is to receive FSS.

    b. FSS are to be claimed via the Integrated System (I.S.) under MHSA – Family Support Services (C-02). Mode 15 Service Function Codes are included in the agency's I.S. Provider File for Targeted Case Management, Mental Health Services (individual, group, collateral), Medication Support and Crisis Intervention.

    c. Services that are not units of service-based should be billed under Client Supportive Services (CSS) via an invoice the agency submits to DMH (see CSS Service Exhibit attached to FSP contract amendment).

    d. The FSP agency should maintain a separate clinical record for the parent/caregiver receiving FSS.

        i. The clinical record must adhere to current rules for direct services reimbursed by County General Funds (CGF), as described in the current *DMH Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services.*

ii. The FSP agency is required to complete and maintain all of the appropriate forms for adult clinical records, such as Consent for Services, Assessment, Client Care/Coordination Plan, Progress Notes, etc. (see attached sample forms).

ATTACHMENTS:

- Adult Initial Assessment
- Annual Assessment Update
- Client Care/Coordination Plan
- Client Care Plan Continuation Page
- Change of Diagnosis

ADULT INITIAL ASSESSMENT

I. Demographic Data:

Age: ____ Gender: _____ Ethnicity: _____ Marital Status: _____ Preferred Language: _____

Referral Source: _____

II. Presenting Problem/Chief Complaint:

Describe precipitating event(s), symptoms and functioning, including intensity and duration, from the perspective of the client as well as any significant others.

III. Psychiatric History:

A. Hospitalizations [date(s) & location(s)]. Outpatient treatment [date(s) & location(s)]. History and onset of current symptoms/manifestations/precipitating events (i.e., aggressive behaviors, suicidal, homicidal). Treated & non-treated history.

B. Describe the impact of treatment and non-treatment history on the client's level of functioning; e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

C. Family history of mental illness.

ADULT INITIAL ASSESSMENT

IV. Medical History

MD Name and Phone:_____ Date of last Physical Exam: _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
___	___	___	seizure/neuro disorder	___	___	___	cardiovascular disease/symp	___	___	___	liver disease	___	___		weight/appetite chg
___	___		head trauma	___	___	___	thyroid disease/symp	___	___	___	renal disease/symp	___	___		diarrhea
___	___		sleep disorder	___	___	___	asthma/lung disease	___	___	___	hypertension	___	___	___	cancer
___	___	___	vision/glaucoma	___	___	___	blood disorder	___	___	___	diabetes	___	___		sexual dys
												___	___		sexually trans dis

Allergies ___ no known ___Yes, specify:_____

pap smear ☐ N ☐ Y_____ (date) mammogram ☐ N ☐ Y _____ (date) HIV test ☐ N ☐ Y_____ (date) pregnant ☐ N ☐ Y_____ (date)

Comments on above medical problems, other medical problems, and any hospitalizations, including dates & reasons.

V. Medications

List "all" past and present medications used, prescribed/non-prescribed, psychotropic, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

Medication	Dosage/Frequency	Period Taken	Effectiveness/Response/Side Effects

ADULT INITIAL ASSESSMENT

VI Substance Use/Abuse A " Yes" answer to any of the questions on the *Adult Substance Use Self Evaluation (MH555)* requires completion of this page.

☐ **Client denies any current or past use/abuse**

Check one of the following "degrees of risk" based on Self Evaluation

☐ None-low: 0-1 Yes ☐ Minimal: 2-3 Yes ☐ Mod-High: 4+ Yes

Substance	Never Used	Date Last Used	Period of Use (From - To)	Frequency (X/daily/ wk./mo.)	Amt. Used Per Occasion	How Used? (inhaled, IV, smoked etc.)	Family History Use (father,mother, grandparents etc.)
Alcohol							
Amphetamines (Meth, crank, ice, etc.)							
Caffeine (Coffee, tea, sodas)							
Cocaine or crack							
Ecstasy (MDMA)							
Hallucinogens (LSD, mushrooms, peyote, etc.)							
Inhalants (Glue, paint, aerosols, etc.)							
Marijuana							
Nicotine (Cigarettes, cigars, smokeless tobacco)							
Opiates (Heroin, codeine, etc.)							
Over the Counter Meds							
PCP							
Prescription Meds (Pain meds, etc.)							
Other							

Has client ever experienced or noticed a change in mood, perception, or behavior when, or after using substances? ☐ Yes ☐ No
specify:

Does client view the use of any of the above as causing social, family, educational, legal, or employment problems for them? ☐ Yes ☐ No
specify:

How does/did client pay for indicated substances?

Has client ever attempted to stop using or cut back use of indicated substances? ☐ Yes ☐ No

Substance Abuse Treatment History:

Program	Type of Setting		Dates of Treatment (From - To)	Reason Entered Treatment (spouse, children, court ordered, etc.)	Results of Treatment	
	IP	OP			Effective	Ineffective

VII. Psychosocial History

A. Family & Relationships: Family constellation, family of origin and current family, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual or sexual abuse, home safety issues (i.e., the presence of firearms.)

B. Dependent Care Issues: #_____ of Adults, #_____dependent children, age(s) of child(ren), school attendance/behavior problems learning problems, special need(s), including physical impairments, discipline issues, juvenile court history, dependent care needs; any unattended needs of children, child support, child custody, and guardianship issues, foster care/group home placement.

C. Current Living Arrangement & Social Support Systems: Type of setting and associated problems, support from community, religious, government agencies, and other sources (i.e., Section 8 Housing, SRO, Board and Care, Semi-independent, family and transitional living, etc.)

D. Education: Highest grade level completed, educational goals. Skill level: literacy level, vocabulary, general knowledge, math skills, school problems, motivation.

E. Employment History/Employment Readiness/Means of Financial Support: Longest period of employment, employment history, military service, work related problems, money management, source of income. Areas of strength.

F. Legal History and Current Legal Status: Parole, probation, arrests, convictions, divorce, child custody, conservatorship.

VIII. Mental Status Evaluation

Length of current treatment: _____ Is this part of a 5150? ☐ Yes ☐ No Medication: ☐ Yes ☐ No Check one: ☐ Stable, ☐ Not Stable

Instructions: Circle all descriptions that apply

General Description

Grooming & Hygiene: Well groomed Average Dirty Odorous Disheveled Bizarre

Comments: _____

Eye Contact: Normal for culture Little Avoids Erratic

Comments: _____

Motor Activity: Calm Restless Agitated Tremors/Tics Posturing Rigid Retarded Akathesis E.P.S.

Comments: _____

Speech: Unimpaired Soft Slowed Mute Pressured Loud Excessive Slurred Incoherent Poverty of Content

Comments: _____

Interactional Style: Culturally congruent Cooperative Sensitive Guarded/Suspicious Overly dramatic Negative Silly

Comments: _____

Orientation: Oriented Disoriented: Time Place Person Situation

Comments: _____

Intellectual Functioning: Unimpaired Impaired

Comments: _____

Memory: Unimpaired Impaired: Immediate Remote Recent Amnesia

Comments: _____

Fund of knowledge: Average Below average Above average

Comments: _____

Mood and Affect

Mood: Euthymic Dysphoric Tearful Irritable Lack of pleasure Irritable Hopeless/Worthless Anxious: Known stressor Unknown stressor Euphoric

Comments: _____

Affect: Appropriate Labile Expansive Constricted Blunted Flat Sad Worried

Comments: _____

Perceptual Disturbance

None Apparent

Hallucinations: Visual Olafactory Tactile Auditory (command/ persecutory/ other)

Comments: _____

Self-Perceptions: Depersonalizations Ideas of reference

Comments: _____

Thought Process Disturbances

None Present

Associations: Unimpaired Loose Tangential Circumstantial Confabulations Flight of Ideas Word Salad

Concentration: Intact Impaired: Rumination Thought blocking Clouding of Consciousness Fragmented

Abstractions: Intact Concrete

Judgements: Intact Impaired: minimum moderate severe

Insight: Adequate Impaired: minimum moderate severe

Comments: _____

Serial 7's: Intact Poor

Comments: _____

Thought Content Disturbance

None Apparent

Delusions: Persecutory/ Paranoid Grandiose Somatic Religious Nihilistic Being controlled

Comments: _____

Ideations: Bizarre Phobic Suspicious Obsessive Blames others Persecutory Assaultive ideas Magical thinking Irrational/Excessive worry Sexual preoccupation Excessive/Inappropriate religiosity Excessive/Inappropriate guilt

Comments: _____

Behavioral Disturbances: None
Aggressive Uncooperative Demanding Demeaning Belligerent Violent/ Destructive Self-destructive Poor impulse control Excessive/Inappropriate display of anger Manipulative Antisocial

Comments: _____

Suicidal/Homicidal: Denies Ideation only Threatening Plan Past attempts

Comments: _____

Passive: Amotivational Apathetic Isolated/ withdrawn Evasive Dependent

Comments: _____

Other: Disorganized/ Bizarre Obsessive/ Compulsive Ritualistic Excessive/ Inappropriate Crying

Comments: _____

ADULT INITIAL ASSESSMENT

IX. Summary and Diagnosis

A. Diagnostic Summary: (Significant: strengths/weaknesses, observations/descriptions, or list of symptoms.)

B. Admission Diagnosis: (check one Prin and one Sec)

Axis I ☐ Prin ☐ Sec Code _____ Nomenclature _____

(Medications cannot be prescribed with a deferred diagnosis.)

☐ Sec Code _____ Nomenclature _____

Code _____ Nomenclature _____

Code _____ Nomenclature _____

Code _____ Nomenclature _____

Axis II ☐ Prin ☐ Sec Code _____ Nomenclature _____

☐ Sec Code _____ Nomenclature _____

Code _____ Nomenclature _____

Axis III _____ Code _____

_____ Code _____

_____ Code _____

Axis IV Psychosocial and Environmental Problems which may affect diagnosis, treatment, or prognosis

Primary Problem ____ **Check as many that apply:** ☐ 1. primary support group ☐ 2. social environment

☐ 3. educational ☐ 4. occupational ☐ 5. housing ☐ 6. economics ☐ 7. access to health care

☐ 8. interaction with legal system ☐ 9. other psychosocial/environmental ☐ 10. inadequate information

Axis V Current GAF ____ **DMH Dual Diagnosis Code** _____

☐ Above Diagnosis from _____ dated _____

C. Disposition/Recommendations/Plan:

X. Signatures

_____ _____ _____ _____

Assessor's Signature & Discipline* Date Co-Signature & Discipline** Date

*LPHA or PHA student with LPHA co-signature

**Medicare requires signature of M.D. or licensed Ph.D.

ANNUAL ASSESSMENT UPDATE

This form is to be completed annually and is to accompany the Client/Coordination Plan. Responses should focus on changes in the respective areas since the last assessment and addressed in Client Plan, if appropriate.

Primary Language: _____ **Interpreter? Yes** ☐ **No** ☐ **Does the client request the family to act as interpreter? Yes** ☐ **No** ☐

1. What progress has the client made toward meeting objectives as identified in the previous Client Plan?

2. Describe the client's current symptoms/problems. **(To be completed by Licensed Mental Health Professional)**

3. Describe any Co-Occurring (substance abuse) issues influencing symptoms, impairments and treatment.

4. Describe any cultural factors influencing symptoms, impairments, and treatment.

5. Does the diagnosis remain the same? Yes ☐ No ☐ If No, a Change of Diagnosis form has been completed by Licensed Mental Health Professional and the diagnosis changed in the IS.

6. Current Status on Below Areas:

LIVING ARRANGEMENTS: Identify Current Status. Check all that apply.

☐	Homeless	☐	Long Term Residential Program	☐	Sober Living/Drug Rehabilitation Center
☐	Shelter	☐	Lives Alone - private home, rental unit	☐	Supportive housing, Section 8, etc.
☐	Board and Care	☐	Lives with Family/Relatives	☐	Satellite Housing (Semi - Independent Living)
☐	Crisis Residential Program	☐	Lives with other (unrelated)	☐	Skilled Nursing Facility
☐	Transitional Residential Program	☐	Lives with spouse/children	☐	At risk from removal from home
☐	Foster Care	☐	Group Home	☐	Other:

Do **mental health** symptoms affect Living Arrangements? If yes, or client wants change, explain:

SOCIAL SUPPORT: Identify Current Status. Check all that apply.

Is the family or significant others involved in treatment? Yes ☐ No ☐ If yes, family/SO provides support in the following areas:
Emotional ☐ Housing ☐ Tx Compliance/Relapse Prevention ☐ Recreation ☐ Education ☐ Transportation ☐ Financial ☐

☐	Socializes with others	☐	Is linked to self-help groups	☐	Requires outreach
☐	Develops and maintains friendships	☐	Is linked to other social or support groups	☐	Requires advocacy
☐	Has support of clergy	☐	Requires protection from abuse	☐	Other:
☐	Has a Power of Attorney; with whom?	☐	Has an Advance Directive	☐	Is Conserved; with whom?
☐	Has a Payee for Finances; with whom?	☐	Has a caretaker relationship; with whom?		

Do **mental health** symptoms affect Social Support? If yes, or client wants change, explain:

FINANCIAL/BENEFITS: Identify Current Status. Check all that apply.

☐	Medi-Cal	☐	GR/GA	☐	SB 90	☐	Indigent	☐	Family Preservation
☐	Medicare	☐	Unemployment benefits	☐	VA Benefits	☐	Family Support		
☐	Health Families	☐	HMO	☐	Private Insurance	☐	Participates in CalWORKs		
☐	SSI/SSDI	☐	SDI	☐	Employed	☐	Other		

Do **mental health** symptoms affect Financial Status/Money Management capability? If yes, or client wants change explain:

DAILY ACTIVITY / VOCATIONAL / EDUCATIONAL: Identify Current Status. Check all that apply.

☐	In School - identify level	☐	Supported Employment	☐	Full Time Work	☐	Is illiterate
☐	Part - Time work	☐	Sheltered Workshop	☐	Retired	☐	Has learning disability
☐	Occupational training	☐	Adult Day Health Care	☐	Isolates	☐	
☐	Attends a socialization program	☐	Senior Center Participation	☐	Has transportation needs	☐	

Do **mental health** symptoms affect Daily Activity/Vocational/Educational functioning? If yes, or client wants change, explain:

PHYSICAL HEALTH: Identify Current Status. Check all that apply.

☐	Describe medical problems: Last Physical:	☐	Needs medication counseling	☐	Needs Visual, Hearing Support:
☐	Describe dental problems: Last Dental Appt.	☐	Needs Medication Management	☐	Needs Ambulatory Support:
☐	Allergies:	☐	Requires Home Health	☐	Other:
☐	Describe nutritional problems:				
☐	Describe any physical/developmental handicaps:				

Do **mental health** symptoms affect Physical Health? If yes, explain: _____

Do **physical health** problems affect Mental Health? If yes, explain: _____

HOSPITALIZATION / CRISIS STABILIZATION / PMRT: Not Applicable ☐

Date(s) of hospitalizations last year:										
Identify reason(s):	☐	Med/Surg	☐	Psych	☐	Substance Abuse				
Identify Status:	☐	Voluntary	☐	Involuntary	☐	Conservatorship				
Was client admitted to an ER or Crisis Stabilization Unit, but not hospitalized within year?					☐	Yes	☐	No	☐	How many times
Was client seen by PMRT within year?					☐	Yes	☐	No	☐	How many times
Did any of the PMRT calls result in hospitalization?					☐	Yes	☐	No	☐	How many times

LEGAL: Not Applicable ☐

Did client have contact with police within year?	☐	Yes	☐	No If yes, identify type:						
Was the contact related to mental health issues?	☐	Yes	☐	No or substance abuse issues?	☐	Yes	☐	No		
Was the client incarcerated within year?	☐	Yes	☐	No	If yes provide dates:					
Identify type of conviction	☐	Misdemeanor	☐	Felony	☐	Probation	☐	Parole		
Was the conviction related to mental health issues?	☐	Yes	☐	No or substance abuse issues?	☐	Yes	☐	No		
Did client become a ward of the court?					☐	Yes	☐	No		
Was the client placed in Juvenile Hall/Camp within year?					☐	Yes	☐	No		
Was treatment court ordered?			☐	Yes	☐	No	Name of Probation/Parole Officer			
Was this placement related to mental health issues?	☐	Yes	☐	No or a substance abuse issues?	☐	Yes	☐	No		

Do **mental health** symptoms affect Legal Status? If yes, explain: _____

_____ _____

Service Provider Signature Date

How does client continue to meet Medical Necessity? (Diagnosis, Impairment, Intervention, EPSDT Criteria) (To be completed by Licensed Mental Health Professional)

_____

_____

_____

Annual Update reviewed and approved by:

_____ _____

Signature and Discipline (Licensed Mental Health Professtional) Date

CHANGE OF DIAGNOSIS

Check either Current or Admission Diagnosis

- ☐ ***Current:** this change reflects the treating diagnosis of the patient based on information currently available on the condition of the patient at any point after admission.
- ☐ ***Admission:** this change reflects a more accurate admission diagnosis based on information currently available regarding the condition of the patient at admission.

PRINCIPLE

From: _____ _____ _____
Nomenclature | Code | Axis

To: _____ _____ _____
Nomenclature | Code | Axis

SECONDARY

From: _____ _____ _____
Nomenclature | Code | Axis

To: _____ _____ _____
Nomenclature | Code | Axis

Justification from current diagnostic manual: _____

_____

_____

_____

_____

Note: The medication monitoring computer program will compare both the Principle and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication MUST appear as either the Principle or Secondary Diagnosis in the current/discharge diagnosis fields of the MIS. If a diagnosis is inconsistent for the usual usage of a medication, the medication MUST be specifically authorized through review and approval procedures.

_____ _____
Therapist's Signature and Discipline | Date

***Data entry note:** The **Admission Diagnosis** information above must be entered into the admission diagnosis fields of the Episode screen of the MIS. If the previous admission diagnosis was deferred, no mental disorder, or no diagnosis, this entry will automatically update the current/discharge diagnosis fields of the Episode screen of the MIS. DO NOT ENTER a date with the current diagnosis unless the patient is being discharged. If subsequent **Current Diagnosis** changes occur, overwrite the information in the current/discharge fields, thus ONLY the most recent treating diagnosis are active in the MIS.

CLIENT CARE/COORDINATION PLAN (To Be Used For MHS, TCM, Med. Supp., Res., Soc., and Voc. Svcs.)

DTI, DR and TBS will use the on-line treatment plan format in lieu of pages one / two. The third page must be completed.

DESIRED OUTCOME/LONG TERM GOALS:

Barriers to Reaching Goals:

Presenting Problems/Symptoms: (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment.)

Do cultural/linguistic, co-occurring, and/or health factors impact on Presenting Problems? If yes, please describe:

Functional Impairment(s) Caused by Problem(s)/Symptom(s) [Work, School, Home, Community, Living Arrangements, etc]: (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment.)

Describe client's strengths: (As related to problems and objective in client plan)

OBJECTIVES: (Must be specific, measurable/quantifiable, attainable, realistic, time bound. Must relate to assessment, presenting problems/symptoms and functional impairment. Include cultural/linguistic, co-occurring factors, if appropriate. Include Med Support and Targeted Case Management, if appropriate)	**CLINICAL INTERVENTIONS:** (Must be related to objective. List clinical interventions for each group/individual service. Includes Med Support and Targeted Case Management, if appropriate.)	**Type/Frequency of Services to meet objectives:** (MHS - Ind and Grp); Med Sup; TCM; Soc; Residential; Voc; etc.	**OUTCOMES/Date/Initials:** To be completed at the end of the Care Plan Review timeframe, 30 days, 3, 6, 12 months or more frequently as appropriate.
Date			

Client agrees to participate by:

Staff Signature/Title:

Family Involvement

Does client consent to family involvement? Y ___ N ___ N/A ___

Does family agree to participate? Y ___ N ___

Planned Family Involvement

- ☐ Input for Initial Assessment/Annual Update
- ☐ Development of Treatment Plan
- ☐ Support for Life Domain Issues
- ☐ Psychoeducational/Support Group
- ☐ Collateral
- ☐ Family Therapy
- ☐ Crisis Management

Outcome Family Involvement

- ☐ Input for Initial Assessment/Annual Update
- ☐ Development of Treatment Plan
- ☐ Support for Life Domain Issues
- ☐ Psychoeducational/Support Group
- ☐ Collateral
- ☐ Family Therapy
- ☐ Crisis Management

Frequency of Care Plan Review	**30 Days** (Crisis Residential / other residential requirements)	**3 Months** (CalWORKs)	**6 Months** (All services except Med Sup and CM)	**12 Months** (All services)

SIGNATURES * Document Reason For Lack Of Signature In Progress Note. Signature Must Be Obtained At Next Face To Face Contact.

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

* Client		Date		Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date		
Family/Conservator/Significant Other		Date		
M.D. Medication, Medicare/Private Insurance		Date		

Revision Date: 01/23/2006

COORDINATION CYCLE DATE: _____ Program/Provider Number Completing Assess/Eval _____

Date of Coordinator Face to Face Contact: _____ Translation: ☐ No ☐ Yes This plan was translated into: _____ for the client and/or responsible adult.

CYCLE PERIODS: ☐ JAN/JULY ☐ FEB/AUG ☐ MAR/SEPT ☐ APRIL/OCT ☐ MAY/NOV ☐ JUN/DEC

CalWORKs & DTI (Identify date every three months) _____ _____ _____ _____

PAYOR: ☐ Medi-Cal ☐ Medicare ☐ Private ☐ HMO ☐ None ☐ Other: (SOC, WRAP, Schiff-Card, PATH, AB3632, CalWORKs) _____

Verification of Medical/Service Necessity was completed on the Initial Assessment/Annual Assessment Update conducted on: _____ Verification of Medical and/or Service Necessity is an annual requirement, please complete for current year.
Date:

COORDINATION: (Exclude Crisis and 24 hour Services - Attach printout of Episode Overview Screen) **AUTHORIZATION** (Excludes Crisis, 24 Hour, DTI, DR, TBS)

Start Date (Mo/Day/Yr)	End Date (Mo/Day/Yr)	Discharge Date	Type of Service (MHS, Meds Support, DTI, DR, TCM, Res, Voc, Soc.etc.)	Provider Name/Number	Contact Person/Team	Coordinator's Authorization Dated Initial *

* Required when services are added after Coordinator's date signature.

ADDITIONAL PLAN PARTICIPANTS/RELATIONSHIP (Reg Ctr, DPSS, Probation, DCFS, Substance Abuse, Health, other brokered non-mental health services)

_____ _____ _____ _____

Single Fixed Point of Responsibility (SFPR) Signature | Date | Licensed Mental Health Professional Signature | Date

Client Care Plan Continuation Page

OBJECTIVES: (Must be specific, measurable/quantifiable, attainable, realistic, time bound. Must relate to assessment, presenting problems/symptoms and functional impairment. Include cultural/linguistic, co-occurring factors, if appropriate. Include Med Support and Targeted Case Management, if appropriate)		**CLINICAL INTERVENTIONS:** (Must be related to objective. List clinical interventions for each group/individual service. Includes Med Support and Targeted Case Management, if appropriate.)	**Type/Frequency of Services to meet objectives:** (MHS - Ind and Grp); Med Sup; TCM; Soc; Residential; Voc; etc.	**OUTCOMES/Date/Initials:** To be completed at the end of the Care Plan Review timeframe, 30 days, 3, 6, 12 months or more frequently as appropriate.
Date				
Client agrees to participate by:			**Staff Signature/Title:**	
Date				
Client agrees to participate by:			**Staff Signature/Title:**	
Date				
Client agrees to participate by:			**Staff Signature/Title:**	
Date				
Client agrees to participate by:			**Staff Signature/Title:**	
Date				
Client agrees to participate by:			**Staff Signature/Title:**	

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
REFERRAL PROCEDURES AND THE ROLE OF THE IMPACT UNIT	**III.A.**	**5/11/2007**	**1 of 6**

PURPOSE: To establish referral procedures for individuals referred to Full Service Partnership (FSP) programs. There are three routes (see Referral Procedures below in Guidelines section) by which clients can be referred to a FSP program:

1. FSP agencies identify through outreach individuals who may qualify and submit Full Service Partnership Referral and Authorization Form to the Impact Unit for pre-authorization to enroll.

2. Individuals may be referred to the Impact Unit by a non-FSP entity, (e.g., mental health services providers, social service agencies, and the community). The Impact Unit will pre-authorize enrollment of the client and will direct these referrals to the appropriate agency for outreach and engagement.

3. Individuals may be referred to the Impact Unit by a non-FSP entity, (e.g., mental health services providers, social service agencies, and the community). The Impact Unit will pre-authorize enrollment of the client and will direct these referrals to the appropriate agency for enrollment.

DEFINITION:

1. Pre-authorization – Referrals are screened by the Impact Unit to ensure they meet criteria for a FSP program. Appropriate referrals are pre-authorized and forwarded to Countywide Programs Administration for final review and authorization.

2. Authorization – Countywide Programs staff makes the final determination as to the appropriateness of the individual for FSP services and indicates approval of authorization.

3. Impact Unit – The Service Area (SA) Impact Unit is comprised of Impact Unit Teams that process referrals, link clients to community resources, and provide consultation and follow-up. Impact Units can refer clients directly to intensive service providers. (For older adults, see III.A.1. Older Adult Centralized Impact Unit.)

4. Impact Unit Teams – Impact Unit Teams are comprised of SA representatives, such as SA Navigators, Parent Advocates, Housing Specialists, Hospital Liaisons, intensive services providers, and hospital/IMD representatives. The team's responsibility is to

discuss and determine the appropriate disposition for clients with intensive service needs, (e.g., FSP, Assertive Community Treatment (ACT), AB 2034 programs, and Wraparound).

5. Service Area Navigator – The SA Navigators were created through the MHSA Community Services and Supports (CSS) Plan to assist individuals and families in accessing mental health and other supportive services and to network with community-based organizations in order to strengthen the array of available services.

6. Impact Unit Coordinator – The Impact Unit Coordinator has the lead responsibility for processing referrals to FSP programs. The coordinator is a representative of either a SA or Countywide program (see X. DMH Contacts) and is part of the Impact Unit Team. The coordinator provides pre-authorization for enrollment into the FSP program, triages referrals to SA Navigators, and ensures all referrals to their SA are screened and linked to appropriate services and supports.

GUIDELINES: (For older adults, see III.A.2. Older Adult FSP Referral Procedure.)

1. DMH authorization must be obtained prior to an agency enrolling an individual into a FSP program, opening a FSP episode on the Integrated System (IS) or the agency's Data Collection System (DCS), or providing any billable services other than outreach. FSP agencies must obtain pre-authorization from the designated Impact Unit Coordinator and authorization from the appropriate Countywide Programs Administration.

2. If a client is currently receiving outpatient mental health services and has an open episode on the IS, but is underserved or inappropriately served, the requesting agency must include written justification on the Full Service Partnership Referral and Authorization Form for a client to be considered for enrollment in a FSP program. Written justification must detail why the individual needs the supportive services of a FSP, including such information as the frequency of hospitalizations, incarcerations or episodes of homelessness.

The following referral procedures outline the three routes by which clients can be referred to a FSP program:

Referral Procedure 1:

1. FSP agency will outreach and engage clients that appear to meet focal population criteria.

2. When client agrees to participate in a FSP program, the FSP agency will complete the Full Service Partnership Referral and Authorization Form and submit it to the Impact Unit Coordinator for pre-authorization for enrollment. Incomplete or altered referral forms will be refused and returned to the referral source with a request to re-submit once the referral form has been completed/corrected.

3. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria will be pre-authorized and forwarded to Countywide Programs Administration. FSP agency will be notified by Impact Unit Coordinator of clients who do not meet FSP eligibility criteria and the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

4. Countywide Programs staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from Countywide Programs Administration within two (2) business days of sending a referral for authorization shall call to follow up. If Countywide Programs Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment.

Referral Procedure 2:

1. For FSP referrals by a non-FSP entity, the Impact Unit Coordinator will obtain contact information and complete the Full Service Partnership Referral and Authorization Form.

2. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria will be pre-authorized and forwarded to an FSP agency with available slots for outreach and engagement.

3. The FSP agency to which the individual was referred will outreach to the prospective client within seventy-two (72) hours of receiving the referral and until such time a determination is made as to the individual's appropriateness for, and interest in, a FSP program. Discussions related to the extent and duration of outreach activities shall be held in Impact Unit meetings based the specific needs of the individual client.

    a. If the referred individual is in an institution, (e.g., county or fee-for-service (FFS) hospital; Institutions for Mental Disease (IMD); Skilled Nursing Facility (SNF); State Hospital (SH); Psychiatric Health Facility (PHF); Community Treatment Facility (CTF); jail; juvenile hall; Probation camp; Level 12-14 group home), outreach and engagement should include communication between the FSP and the institution, regular contact with the client and, for minor clients, the parent/guardian, and participation in the client's discharge plan (see I.A. Outreach and Engagement for Clients in Institutions).

4. Once a determination has been made, the FSP agency will notify the Impact Unit of the outcome of the outreach activities.

    a. If the individual does not agree to or is determined inappropriate for FSP services, the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

    b. If the FSP agency declines to enroll a client who has been pre-authorized for enrollment, then III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer shall be followed.

    c. If the individual agrees to FSP services, the FSP agency will confirm with the Impact Unit Coordinator their intent to enroll the individual. The Impact Unit will forward the completed Full Service Partnership Referral and Authorization Form to Countywide Programs Administration for enrollment authorization.

5. Countywide Programs staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from Countywide Programs Administration within two (2) business days of sending a referral for authorization shall call to follow up. If Countywide Programs Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment.

Referral Procedure 3:

1. For FSP referrals by a non-FSP entity, the Impact Unit Coordinator will obtain contact information and complete the Full Service Partnership Referral and Authorization Form.

2. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria and agree to FSP services will be pre-authorized and forwarded to an FSP agency with available slots for notification of intent to enroll.

3. Upon notification, the Impact Unit will forward the completed Full Service Partnership Referral and Authorization Form to Countywide Programs Administration for enrollment authorization.

4. Countywide Programs staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from Countywide Programs Administration within two (2) business days of sending a referral for authorization shall call to follow up. If Countywide Programs Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment.

5. If the FSP agency declines to enroll a client who has been pre-authorized for enrollment, then III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or

Transfer shall be followed.

Once the FSP agency has obtained the required authorization, it may open the client episode in the IS and DCS (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

FORMS:

- Full Service Partnership Referral and Authorization Form

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OLDER ADULT CENTRALIZED IMPACT UNIT	**III.A.1.**	**11/1/2006**	**1 of 2**

PURPOSE: To clearly define the roles and responsibilities for the Older Adult Centralized Impact Unit (CIU) related to the Older Adult Full Service Partnership (FSP) program.

DEFINITION: The Older Adult CIU is composed of Department of Mental Health (DMH) staff members and Older Adult FSP providers. The CIU is the body responsible for identifying clients who meet eligibility criteria for a FSP program. CIU members engage in regular coordination of care meetings to review referrals, process enrollment, monitor progress, and disenroll clients from FSP programs as appropriate. The CIU serves as an advisory and care coordination body; ultimate responsibility for enrollment and disenrollment rests with DMH.

GUIDELINES: <u>CIU Membership</u>

1. Attendance to the CIU may vary depending on the circumstances of each individual case. Core members who must be present in order to convene a CIU meeting include:

    a. DMH Older Adult Programs Administrator
    b. DMH Older Adult FSP Enrollment Coordinator
    c. Clinical Expert
    d. Representatives from Older Adult FSP Team

2. Participation of additional individuals may be arranged, as needed, according to the specific care coordination requirements of each potential FSP enrollee. Occasional participants may include, but are not limited to, the following:

    a. Representative(s) from referring agencies
    b. Representative(s) of client or family member
    c. Representative(s) of housing providers
    d. Representative(s) from Public Guardian

<u>CIU Membership Roles</u>

1. <u>Enrollment Coordinator</u> – Responsible for the initial screening of a referral. When a referral is received that provides adequate preliminary information, (i.e., referral form is completed correctly; referral meets general criteria for FSP; client has had a clinical evaluation prior to referral), then the Enrollment

Coordinator will contact the referring party to inform them of client disposition. Enrollment Coordinator will convene a meeting of the CIU to review the case. Enrollment Coordinator will ensure the appropriate agency representatives are in attendance.

2. Older Adult Program Administrator – Responsible for facilitation of CIU case conferences. Also has responsibility for providing final approval of client enrollment in FSP program. This approval is necessary for FSP provider to begin billing for services provided to client.

3. DMH Clinical Expert – Has clinical expertise with Older Adults who have a severe mental illness. The function of the Clinical Expert is to provide a clinical opinion and consultation to the CIU.

4. Representatives from FSP Providers – Attend CIU conferences to participate in the authorization and enrollment of clients in an appropriate FSP program that best meets the client's needs.

5. Occasional CIU Participants – Includes representative(s) from referring agency(cies) and/or representative(s) of client or family member. These participants will provide information about the client's needs for coordination of care and treatment planning purposes.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OLDER ADULT FULL SERVICE PARTNERSHIP REFERRAL GUIDELINES	**III.A.2.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish procedures for referrals to Older Adult Full Service Partnership (FSP) programs.

DEFINITION: All clients referred to an Older Adult FSP will be processed following one of two procedures described below:

(A) For clients who have had clinical assessments completed prior to FSP referral, or

(B) For clients who have not had a clinical assessment prior to referral for FSP services.

GUIDELINES: Referral Procedure A:

Referring party is a mental health provider (inpatient or outpatient) and has completed a clinical assessment prior to referral.

1. Referring party submits completed Full Service Partnership Referral and Authorization Form to Impact Unit.

2. Impact Unit Coordinator screens the referral for FSP eligibility criteria.

    a. If eligibility criteria are met, the Impact Unit Coordinator will contact referring party to schedule presentation at the Older Adult Impact Unit in order to arrive at a determination regarding authorization for enrollment.

    b. If referral information is insufficient to determine whether eligibility criteria have been met, Impact Unit Coordinator will contact the referring party and request additional information or discuss return of the referral.

    c. Impact Unit Coordinator will respond to non-emergent referrals within 72 hours of receipt of referral and within 24 hours to referrals from hospitals and IMDs when feasible.

3. Older Adult Impact Unit reviews the FSP referral.

    - If referral is appropriate, Impact Unit will assign client to a specific FSP program and authorize enrollment and billing for FSP services.

    - If referral is not deemed appropriate for FSP enrollment, Impact Unit will return referral to source.

    - The Older Adult Impact Unit will review referrals within ten (10) business days of receipt from Impact Unit Coordinator.

Referral Procedure B:

Referring party is not a mental health provider, (e.g., Adult Protective Services caseworker; senior apartment manager or ombudsman; Code Enforcement; law enforcement; Animal Control, Public Defender or prosecutors; city or county officials; etc.) and a clinical assessment has not been completed prior to referral.

1. Referring party submits completed Full Service Partnership Referral and Authorization Form to Impact Unit Coordinator for review.

2. Impact Unit Coordinator arranges clinical assessment for prospective client by either:

    a. FSP program that is responsible for providing services in the geographic area in which the prospective client resides. The FSP program will provide outreach and engagement to complete the clinical assessment and submit it to the Impact Unit Coordinator, OR

    b. GENESIS Program staff conducts outreach and engagement to complete the clinical assessment and submits it to the Impact Unit Coordinator.

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OLDER ADULT FULL SERVICE PARTNERSHIP REFERRAL GUIDELINES	**III.A.2.**	**11/1/2006**	**3 of 3**

3. Impact Unit Coordinator screens the referral for FSP eligibility criteria.

    a. If eligibility criteria are met, the Impact Unit Coordinator will contact referring party to schedule presentation at the Older Adult Impact Unit in order to arrive at a determination regarding authorization for enrollment.

    b. If referral information is insufficient to determine whether eligibility criteria have been met, Impact Unit Coordinator will contact the referring party and request additional information or discuss return of the referral.

    c. Impact Unit Coordinator will respond to non-emergent referrals within 72 hours of receipt of referral and within 24 hours to referrals from hospitals and IMDs when feasible.

4. Older Adult Impact Unit reviews the FSP referral.

    a. If referral is appropriate, Impact Unit will assign client to a specific FSP program and authorize enrollment and billing for FSP services.

    b. If referral is not deemed appropriate for FSP enrollment, the Impact Unit Coordinator will confer with the referring party, Service Area Navigators and others, as appropriate, to ensure client is linked with appropriate program for needs.

    c. The Older Adult Impact Unit will review referral within ten (10) business days of receipt from Impact Unit Coordinator.

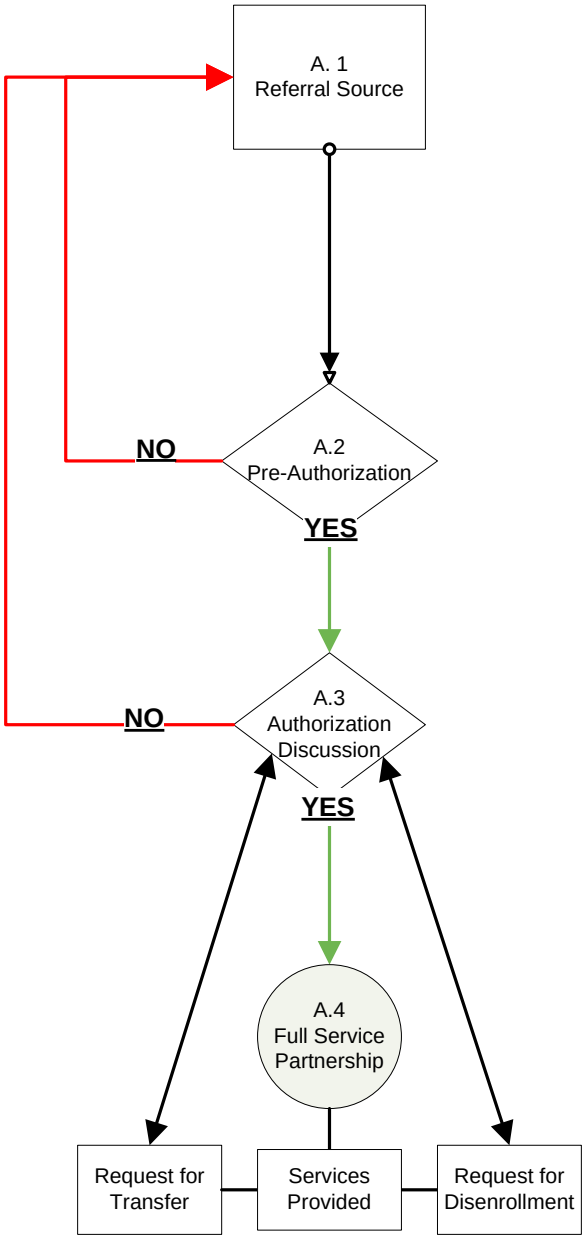
FORMS:

- Full Service Partnership Referral and Authorization Form

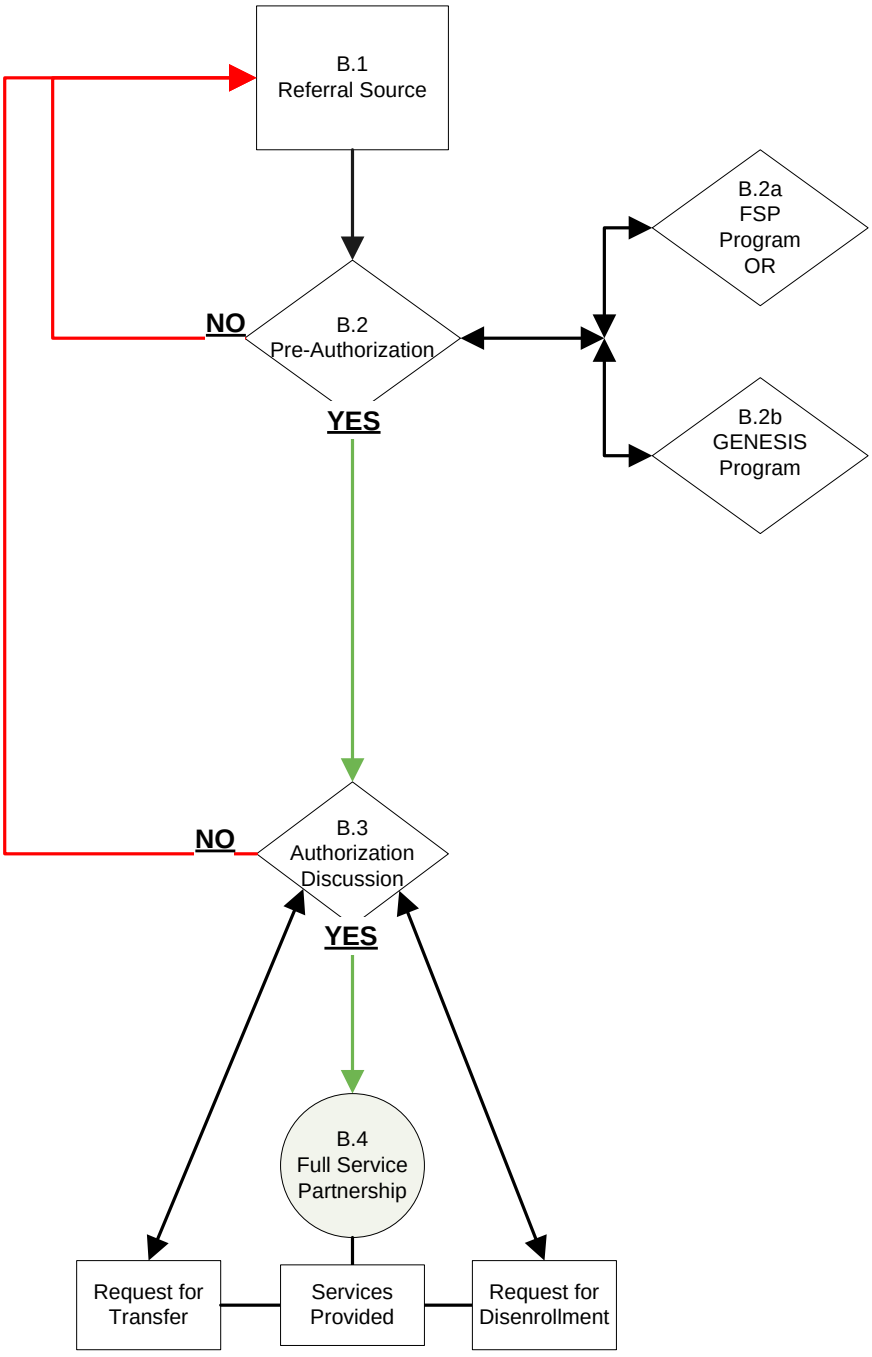
ATTACHMENTS:

- Attachment A – Referral Procedure (A) Flow Diagram
- Attachment B – Referral Procedure (B) Flow Diagram

Referral Source has completed Clinical Assessment



Referral Source has not completed a clinical assessment



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
PROCEDURE FOR FILING APPEALS RELATED TO FSP CLIENT ENROLLMENT, DISENROLLMENT OR TRANSFER	**III.B.**	**11/1/2006**	**1 of 1**

PURPOSE: To establish guidelines for agency appeals in the event Full Service Partnership (FSP) agencies and DMH Impact Unit staff fail to reach agreement regarding client enrollment, disenrollment or transfer.

GUIDELINES:

1. Agencies are expected to adhere to guidelines regarding enrollment, disenrollment and transfer of FSP clients that have been established for this purpose (see III. Referral, Authorization and Enrollment Guidelines). In the event that a disagreement occurs about an enrollment, disenrollment or transfer decision, Impact Unit participants shall attempt to reach consensus regarding the client's disposition through discussion in the Service Area Impact Unit (for Children, Transition-age Youth and Adults) or Centralized Impact Unit (for Older Adults).

2. In the event that an agency elects to appeal an enrollment/ disenrollment/transfer decision, the agency will complete the Full Service Partnership Appeal Form and submit it to the Service Area District Chief (see X. DMH Contacts) overseeing the area in which the agency is delivering FSP services. The Service Area District Chief will confer with the age-appropriate Countywide District Chief to make a joint determination regarding disposition.

Conditions under which an appeal may be filed include the following:

1. DMH Impact Unit refers an eligible client to an FSP agency that declines to enroll the individual.

2. FSP agency requests authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration denies permission to enroll.

3. FSP agency requests authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration denies permission to disenroll.

4. FSP agency requests authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration denies permission to transfer.

FORMS:

- Full Service Partnership Appeal Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
SPECIAL PROGRAM DESIGNATION FOR SINGLE FIXED POINT OF RESPONSIBILITY ON THE INTEGRATED SYSTEM	**IV.**	**3/13/2007**	**1 of 1**

PURPOSE: To establish a procedure for assigning a Single Fixed Point of Responsibility (SFPR) on the Integrated System (IS) for clients enrolled in intensive services programs: Assertive Community Treatment (ACT), AB 2034, Full Service Partnership (FSP) for Children, Transition-age Youth (TAY), Adults and Older Adults, or Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS).

DEFINITION: SFPR refers to the designation of responsibility to an agency or agency representative for completion of the Client Care Coordination Plan (CCCP) and for coordinating/authorizing mental health services.

GUIDELINES: When a client enrolled in an intensive services program is opened on the IS, the agency must indicate that the client is enrolled in a "special program" in the SFPR field on the "Other" tab of the Client Information Screen. The program in which the client is enrolled must be selected from the drop-down menu.

Once this is completed, two separate messages will appear for all enrolled clients alerting providers of their participation in an ACT, AB 2034, FSP or IIHMHS program:

1. When agencies view a client enrolled in an intensive services program, the following alert will appear on the IS Client Information Screen:

   "LAMH400 CALL SFPR WITHIN ONE WORKDAY TO COORDINATE SERVICES"

2. When any other provider attempts to open an episode for a client who is enrolled in an intensive services program, the following alert will appear:

   "This is a <*Special Program Name goes here*> **client. You must contact** <*Special Program Name*> **provider within one workday to coordinate services. For provider SFPR telephone number, see the SFPR icon on the Find Client results screen."**

If the client has an existing SFPR in another program, the intensive services program must request that the SFPR be transferred as per DMH Policy No. 202.31, *Single Fixed Point of Responsibility*.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR HOUSING AND EMPLOYMENT	**V.A.**	**11/1/2006**	**1 of 2**

PURPOSE: To establish procedures to enable intensive services programs, Assertive Community Treatment (ACT), AB 2034, and Full Service Partnership (FSP), to work directly with potential landlords and employers on behalf of a client.

DEFINITION: Protected Health Information (PHI): PHI is defined in the Health Insurance Portability and Accountability Act (HIPAA) as "any health information, either oral or recorded in any form, that was created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse, that details past, present, or future physical, mental health, or the general health condition of an individual."

GUIDELINES: Prior to agency staff discussing/disclosing to any potential landlord and employer the fact that a client receives mental health services, it is necessary for the staff to 1) fully inform the client of the reasons for authorizing such disclosure, and the client's options with respect to this issue, and 2) obtain an Authorization for Use or Disclosure of Protected Health Information signed by the client.

These guidelines pertain to both the direct and indirect, (i.e., by virtue of the staff being employed by a mental health agency), revelation of a client's mental health status.

1. Prior to asking a client to sign the Authorization for Use or Disclosure of PHI, agency staff must:

    a. Inform the client of the way in which PHI would be used to advocate for employment and housing needs on the client's behalf, as well as the limitations of disclosure, (i.e., only relevant information and only to individuals who would assist the client with employment and housing issues).

    b. Inform the client that s/he has the option of withdrawing the authorization at any time.

Once the client has been fully informed and agrees to the disclosure of PHI, agency staff must request that the client sign the Authorization for Use or Disclosure of PHI.

2. Once a client has signed the authorization form, the agency staff may share relevant and necessary PHI with a potential landlord or employer. The case manager must exercise discretion in sharing PHI, sharing only the information necessary to obtain services for the client.

When a client refuses to sign (or once a client revokes an authorization), the case manager may not reveal PHI to prospective landlords or employers and should explain the implications of this restriction to the client.

FORMS:

- Authorization for Use or Disclosure of Protected Health Information "Potential Landlords and Employers" version (MH 602 Rev. 2/04)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
INTERRUPTION OF SERVICE DUE TO INSTITUTIONALIZATION	**V.B.**	**5/11/2007**	**1 of 4**

PURPOSE: To establish guidelines for making decisions about whether a participant in the following intensive services programs, Assertive Community Treatment (ACT), AB 2034, Full Service Partnership (FSP) or Specialized Foster Care Intensive In-Home Mental Health Services (IIHMHS), should continue in the program while living in an institution, and to clarify billing and data issues for different institutional settings.

DEFINITION:

1. Interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact.

2. Discontinuation of service is defined as a long-term situation in which the client is not expected to return to services for more than twelve (12) months from the date of last contact.

3. Institution includes jail; prison; juvenile hall; Probation camp; California Youth Authority (CYA); Institutions for Mental Disease (IMD); State Hospital (SH); Skilled Nursing Facility (SNF); Psychiatric Health Facility (PHF); Community Treatment Facility (CTF); and Level 12-14 group home.

GUIDELINES: During a client's stay in an institution, the agency must make a clinical determination about whether to keep the client actively enrolled in the intensive services program while living in the institution. All mental health treatment must be coordinated with, and permission granted by, institution staff if the intensive services program staff is going to enter the institution to continue providing services. All applicable claiming policies and procedures and data collection requirements must also be followed.

There are five categories of institutions that require special consideration upon entry of an intensive services program participant:

1. Incarceration in jail or prison, or detainment in Probation camp or CYA, that is anticipated to last less than ninety (90) days.

    a. The intensive services program should continue to provide services during the client's incarceration/ detention.

    b. A "residential" Key Event Change (KEC) must be entered for the client in the agency's Data Collection

System (DCS). (See VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com .)

c. For any services provided, the Medi-Cal box in the DMH Integrated System (IS) must be unchecked and Mental Health Services Act (MHSA) funds should be claimed.

2. Incarceration in jail or prison, or detainment in Probation camp or CYA, that is anticipated to last more than ninety (90) days.

   a. The intensive services program may discontinue providing services during the client's incarceration/ detention. If services are discontinued, the client episode in the IS must be closed.

   b. A "discontinuation/interruption of community services" must be entered for the client in the agency's DCS (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   c. If/when the client is released from jail, prison, camp or CYA, the intensive services program is expected to prioritize the client for re-enrollment.

3. Admission to an IMD, State Hospital or Level 12-14 group home that has a contract with DMH for comprehensive mental health services.

   a. Upon admission, the intensive services program should close the client episode in the IS.

   b. A "discontinuation/interruption of community services" must be entered for the client in the agency's DCS (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   c. Any continued services and supports provided during the client's stay in the institution may not be claimed to Medi-Cal.

      i. If the client episode in the IS is closed, Community Outreach Services (COS) can

be claimed using a special Community Outreach Services claim form in the IS (refer to DMH *Community Outreach Services Manual* for service definitions, codes and claiming instructions).

ii. If the client episode in the IS is not closed, the Medi-Cal box in the IS must be unchecked and MHSA funds should be claimed.

iii. Thirty (30) days prior to discharge from the institution, agencies may begin billing Medi-Cal for case management/discharge planning services.

d. If/when the client is released from the IMD, SH or Level 12-14 group home, the intensive services program is expected to prioritize the client for re-enrollment.

4. Admission to a Skilled Nursing Facility.

a. Upon admission to a SNF, a clinical determination must be made about whether to continue to provide services to the intensive services program participant.

b. If the client continues to need mental health services, then he/she should remain enrolled in the intensive services program and the client episode in the IS should remain open. A "residential" KEC must be entered for the client in the agency's DCS (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

Medi-Cal can be billed for eligible services provided in the SNF by the intensive services program staff.

c. If the client does not need ongoing mental health services, then services should be terminated, the client episode in the IS should be closed, and a "discontinuation/interruption of community services" should be entered for the client in the agency's DCS

(see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

5. Admission to a Psychiatric Health Facility.

   a. Upon admission to a PHF, the client should remain enrolled in the intensive services program and the client episode in the IS should remain open.

   b. A "residential" KEC must be entered for the client in the agency's DCS (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   c. For any services provided while the client is in the PHF, the Medi-Cal box in the IS must be unchecked and MHSA funds should be claimed. If this is not done, the PHF will be locked out from billing.

If the client remains enrolled in the intensive services program while in an institution, Service Plans and Coordination Plans continue to be due in accordance with the existing cycle dates. The case manager must note in the chart that the intensive services program is unable to complete the Plan(s) due to the client's current status and enter the following note on the Plan(s): "Client in institution; unable to update."

Upon the client's discharge from the institution*****, the case manager must create Service and Coordination Plans to cover the current period. The cycle dates remain the same and the start date for providing services is the day after the client is discharged from the institution. *Refer to the DMH Medical Director's WebLink below for important prescription guidelines for uninsured clients.

FORMS:

- Community Outreach Services claim form

REFERENCES:

- Community Outreach Services Manual (pending release 1/07)
- http://dmh.lacounty.info/hipaa/r3COS.htm (COS claim tutorial on IS)
- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)
- http://www.rshaner.medem.com →Pharmacy→Fund-One Initiative: Letter and Information (posted 4/20/07)→*Changes in DMH Pharmacy Operation That Affect Prescriptions Involving Potential Polypharmacy With Specific Highly Expensive Antipsychotic Medications.*

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
TRANSFER OF CLIENTS BETWEEN FULL SERVICE PARTNERSHIP PROGRAMS	**V.C.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish a procedure for the transfer of a Full Service Partnership (FSP) client from one FSP program/agency to another FSP program/agency.

DEFINITION: A client may be transferred between FSP programs within the same agency, or between FSP agencies, provided the new FSP program/agency has an available slot and agrees to the transfer. (Hereafter, the term "program" refers to transfers between programs within the same agency or between agencies.) The reasons for transfer are as follows:

1. Client requested a transfer.
2. Client has moved out of Service Area.
3. Client has moved within Service Area but closer to another FSP agency.
4. Client's linguistic/cultural needs.
5. Client aged out of current services.
6. Other (provide explanation)

GUIDELINES: Transferring clients between FSP programs must be coordinated between the current program, the new/receiving program, and the Impact Unit(s). Countywide Programs Administration must authorize all requests for client transfer from the current FSP program prior to an agency officially terminating services.

1. Upon determining that a client meets transfer criteria, current FSP program will complete Full Service Partnership Transfer Request Form and submit to the age-appropriate Impact Unit Coordinator for pre-authorization of transfer.
2. Impact Unit Coordinator will review transfer request within five (5) business days of receipt to determine appropriateness of transfer request and desired transfer location (if known).
    a. If client meets transfer criteria and is transferring within the Service Area, Impact Unit Coordinator will identify

new/receiving FSP program based on client need and slot availability. Impact Unit Coordinator will forward Transfer Request to new/receiving FSP program for screening and acceptance.

b. If client meets transfer criteria and is moving out of the Service Area, current Impact Unit Coordinator will forward transfer request to new/receiving Impact Unit for determination of FSP program options. When new/receiving FSP program has been identified, new/receiving Impact Unit will forward Transfer Request to new/receiving FSP program for screening and acceptance.

c. If client does not meet transfer criteria, Impact Unit Coordinator will complete and send Full Service Partnership Disenrollment/Transfer Request Supplemental Form to FSP program. FSP program must continue services.

4. Once new/receiving FSP program indicates it intends to accept the client, they must initiate the Transfer/Assignment of Coordinator form as per DMH Policy No. 202.31, *Single Fixed Point of Responsibility*.

    a. New/receiving coordinator will complete and sign Transfer/Assignment of Coordinator form and submit it to transferring coordinator for authorization.

    b. Transferring coordinator will complete and sign Transfer/Assignment of Coordinator and indicate on the form that client and significant other(s) agree to the transfer. Transferring coordinator will forward the form to current Impact Unit.

        i. If client is transferring within the Service Area, current Impact Unit will forward the completed and signed Full Service Partnership Transfer Request Form and Transfer/Assignment of Coordinator form to Countywide Programs Administration for authorization.

ii. If client is moving out of the Service Area, current Impact Unit will forward the completed and signed Full Service Partnership Transfer Request Form and Transfer/Assignment of Coordinator form to new/receiving Impact Unit. New/ receiving Impact Unit will pre-authorize client transfer and forward both completed, signed forms to Countywide Programs Administration for authorization.

Current FSP program must continue services to client until Countywide Programs staff has authorized enrollment of client to new/receiving FSP program.

5. Countywide Programs staff will review request for transfer and pre-authorization information and will notify FSP programs and Impact Unit(s) of authorization for transfer within two (2) business days. Once transfer is authorized, current FSP program may close the case in the DMH Integrated System (IS) and relevant Data Collection System (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

6. If Countywide Programs Administration does not authorize client transfer they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to current FSP program and Impact Unit. FSP program must continue services.

7. If FSP agency does not agree with the decision of the Impact Unit or Countywide Programs Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

FORMS:

- Full Service Partnership Transfer Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form
- Transfer/Assignment of Coordinator (MH 530 Rev. 10/25/05)

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
OUTCOMES DATA COLLECTION	**VII.A.**	**11/1/2006**	**1 of 1**

PURPOSE: To establish a procedure to collect Full Service Partnership (FSP) client outcomes data using the DMH Outcome Measures Application.

DEFINITION: Outcome Measures Application (OMA): An electronic application for collecting, tracking and reporting outcomes data for clients enrolled in FSP programs.

GUIDELINES: All FSP agencies must complete a Baseline Assessment, report Key Event Changes as they occur, and complete 3-Month Quarterly Assessments for all FSP clients.

1. A Baseline Assessment must be completed and entered into the OMA or sent electronically to DMH via XML data transmission within thirty (30) days of the Partnership date. A client has only one baseline created for life. The only exception to this is if a client is restarting a Partnership more than twelve (12) months after discontinuation/disenrollment from a FSP program.

2. A Key Event Change (KEC) must be completed each time the agency is reporting a change in status from the Baseline Assessment in certain categories. These categories include residential status, employment, education, crisis/PMRT, and benefits establishment. Complete only the section pertaining to the reported change.

3. If a client is being transferred from one FSP program/agency to another, disenrolled, or the Partnership is being restarted after less than 12 months from an interruption/discontinuation, a full KEC must be completed. In the case of a transfer, a full KEC must be completed by the program/agency transferring the client and the program/agency receiving the client.

4. 3-Month Assessments (3M) should be completed near every 3-month anniversary of the Partnership date. Agencies have from fifteen (15) days prior to thirty (30) days after the anniversary date to complete the assessment. If the 3M assessment cannot be completed within this forty-five (45)-day window, it should be skipped altogether and completed when the next one is due.

FORMS:

- Outcome Measures Application Baseline Assessment, Key Event Change, and 3M Quarterly Assessment for Children, Transition-age Youth (TAY), Adults, and Older Adults (3 forms for each age group)

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
OUTCOMES DATA CERTIFICATION	**VII.B.**	**11/1/2006**	**1 of 1**

PURPOSE: To establish a procedure to certify the accuracy of outcome data for the following intensive services programs: Assertive Community Treatment (ACT), Full Service Partnership (FSP), AB 2034, and Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS).

DEFINITION: Data Certification: The process of reviewing state- and county-mandated outcome data for accuracy and signing the Certification of Accuracy of Data form indicating that the data are accurate.

GUIDELINES: All agencies must certify the accuracy of their outcome data. Outcome data inputted into a Data Collection System (DCS)* and submitted to DMH detailing client Baseline, 3-Month Quarterly (3M) and Key Event Tracking/Change (KET/KEC) data must be certified quarterly.

1. DMH will provide each agency with a dataset entered by their staff for the three (3) previous months for their review.

2. Each agency is required to review the dataset and certify its accuracy on a Certification of Accuracy of Data form. It is recommended that this process be part of the agency's supervisory staff meeting.

3. In the event there are inaccuracies, they must be corrected immediately and resubmitted to DMH, which will submit the corrected data to the state or state-designated recipient. Corrections should be made directly into the DMH OMA or relevant DCS. The agency should make DMH aware of the inaccuracies they have corrected in case they are outside of the window for the 3M or beyond ninety (90) days for the Baseline.

4. Data certification is due within fourteen (14) calendar days of the certification request. The completed Certification of Accuracy of Data form should be faxed and then mailed to the appropriate Countywide Programs Administration.

*Agencies providing FSP and/or IIHMHS have the option of inputting data directly into the DMH Outcomes Measures Application (OMA) or submitting the data electronically to DMH via XML data transmission (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

FORMS:
- Certification of Accuracy of Outcome Data

REFERENCES:
- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VIII.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish a procedure for the disenrollment of a Full Service Partnership (FSP) client from a FSP program.

DEFINITION: Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to services for more than twelve (12) months from the date of last contact. The reasons for disenrollment are as follows:

1. Target population criteria are not met. Client is found not to meet target population; in most cases, clients who are discovered to have no major mental illness or serious emotional disturbance (SED).

2. Client decided to discontinue Full Service Partnership participation after partnership established. Client has either withdrawn consent or refused services.

3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and has discontinued FSP services.

4. After repeated attempts to contact client, client cannot be located. Client is missing, has not made contact with FSP agency. Agency may request disenrollment of a client after multiple documented outreach attempts for at least thirty (30) days but not more than ninety (90) days.

5. Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, an Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital (SH). Client is admitted to an IMD, MHRC or SH.

6. Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/ CYA/jail/prison sentence. Client is anticipated to remain in one of these facilities for over ninety (90) days.

7. Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. Client has successfully met his/her goals, as demonstrated by involvement in meaningful activities, such as, employment, education, volunteerism or other social activities and is living in the least restrictive environment possible, such as an apartment. The client no longer needs intensive services.

8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.

GUIDELINES: Countywide Programs Administration must authorize all requests for client disenrollment from the FSP program prior to an agency officially terminating services.

1. Upon determining that a client meets disenrollment criteria, the FSP agency will complete the Full Service Partnership Disenrollment Request Form and submit it to the age-appropriate Impact Unit Coordinator for pre-authorization of disenrollment.

2. Impact Unit Coordinator will review the disenrollment request within five (5) business days of receipt. Clients that meet FSP disenrollment criteria will be pre-authorized and forwarded to Countywide Programs Administration. For clients that do not meet disenrollment criteria, Impact Unit Coordinator will complete and send Full Service Partnership Disenrollment/ Transfer Request Supplemental Form to FSP program. FSP program must continue services.

3. Countywide Programs staff will review the request for disenrollment and pre-authorization information and will notify the FSP program and Impact Unit of authorization for disenrollment within two (2) business days. Once disenrollment is authorized, the FSP program may close the case in the DMH Integrated System (IS) and relevant Data Collection System (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   If Countywide Programs staff does not authorize client for disenrollment they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to FSP program and Impact Unit. FSP program must continue services.

4. If FSP agency does not agree with the decision of the Impact Unit or Countywide Programs Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

A client transferring from one FSP program to another FSP program is not considered a disenrollment (see V.C. Transfer of Clients Between Full Service Partnership Programs).

FORMS:

- Full Service Partnership Disenrollment Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
GUIDELINES

SUBJECT	GUIDELINE NO.	REVISION DATE	PAGE
24/7 CRISIS COVERAGE	**IX.**	**3/20/2007**	**1 of 1**

PURPOSE: To establish a procedure for crisis coverage for intensive services programs: Assertive Community Treatment (ACT), AB 2034, Full Service Partnership (FSP) and Specialized Foster Care Intensive In-home Mental Health Services (IIHMHS).

DEFINITION: Crisis coverage: An on-call system that includes LPS-designated staff to address clients in crisis 24 hours a day, 7 days a week (during and after regular program hours, and on weekends and holidays).

GUIDELINES: Agencies must provide crisis coverage for all enrolled clients 24 hours a day, 7 days a week. Agencies are to implement a crisis response system for clients in need of these services.

1. The crisis response system must include agency treatment staff to respond to crisis calls. Responses may include a telephone call or field visit.

2. If the agency has LPS-designated staff available, they shall assume responsibility for the 5150/5585 evaluation, writing the hold, transportation and hospital admission. When the Department of Health Services – Psychiatric Emergency Services (PES) is at operating capacity, the Medical Alert Center (MAC) will not provide admission authorization or hospital destination for uninsured individuals in need of involuntary hospitalization. If the client is uninsured, the agency should contact the DMH ACCESS – Continuing Care Unit at (800) 801-7886 for assistance with involuntary inpatient admission of uninsured clients (see attached Psychiatric Outreach Diversion Program Guidelines).

3. If the agency does not have LPS-designated staff available to write the 5150/5585 hold, the agency should call DMH ACCESS at (800) 854-7771 to request a Psychiatric Mobile Response Team (PMRT) for the evaluation. To best serve the client, a staff member from the agency must be present for assistance with the client when a 5150/5585 evaluation is requested.

In the event ACCESS receives a call from a client, ACCESS will link the client to the assigned agency. The agency must take responsibility for the call and ensure that the client's needs are addressed. If ACCESS is unable to reach the assigned agency, PMRT will then handle the crisis call and will inform the PMRT supervisor and the appropriate Countywide Programs Manager for follow-up with the agency.

ATTACHMENT:
- Psychiatric Outreach Diversion Program Guidelines (3/16/07)

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

EMERGENCY OUTREACH BUREAU

PSYCHIATRIC OUTREACH DIVERSION PROGRAM GUIDELINES

PURPOSE: To provide transport guidelines for patients from a non-hospital setting to a designated private hospital under the Psychiatric Outreach Diversion Program (PDP).

PRINCIPLES:

1. A County Psychiatric Emergency Department (PED) may report diversion status to the Medical Alert Center (MAC) when it determines that it has reached capacity.

2. PDP beds may be accessed by Department of Mental Health (DMH) emergency outreach teams and intensive services programs by calling the DMH PDP gatekeeper located at ACCESS, (800) 854-7771, twenty-four hours a day, seven days a week.

3. When all County PEDs have requested diversion, the MAC will assign patients of DMH emergency outreach and intensive services programs who meet PDP criteria to the nearest participating PDP hospital with open capacity.

4. PDP hospitals are required to communicate their PDP capacity status to the MAC/DMH gatekeeping via the ReddiNet system every four hours or whenever a change in status occurs.

DESTINATION PROCEDURE:

I. DMH Emergency Outreach Team and Intensive Services Program Responsibilities.

A. Will determine the client is:

1. Uninsured
2. Is on a 5150/5585 and requires acute psychiatric inpatient services.
3. Appears medically stable for transfer to an acute psychiatric facility.
4. Does not appear to require conservatorship.
5. Ambulatory without assisted device (can take patients in a wheelchair who are able to self-transfer).

6. Does not have a significant emergent medical or other condition as noted below:
    a. Indwelling intravenous device.
    b. Reliance on mechanical airway device.
    c. Renal Dialysis.
    d. Other conditions:
        I. Pregnancy.
        II. Morbid obesity (300 pounds and above).
        III. Presenting as being physically impaired due to substance abuse.

B. Contact gatekeeping unit located at ACCESS to advise of patient meeting PDP criteria requiring a PDP destination.
C. Provide gatekeeping unit with patient's name, sex, age, presenting behavior or diagnosis and provide FSP information, if applicable.
D. Gatekeeper will run MED/APPS to ensure client is uninsured.
E. Gatekeeper will review ReddiNet to determine bed availability and obtain a PDP destination for the patient.
F. Gatekeeper will document patient information on the gatekeeping sheet as indicated.
G. Gatekeeper will arrange transportation and fax completed payment authorization to the PDP hospital and Countywide Resource Management (323) 223-8380.
H. DMH emergency outreach team or intensive services program will contact the receiving PDP hospital to provide the estimated time of arrival.
I. Notify Countywide Resource Management (CRM) within 48 hours of patients who were inappropriately denied.

II. MAC Responsibilities:

A. Provide DMH emergency outreach and intensive services program teams with the nearest receiving PED destination based on patient age, sex, incident location and diversion status.
B. When all County PEDs have reported diversion, assign the patient to nearest PDP facility with open bed capacity.
C. Fax the completed authorization for payment form to the receiving PDP hospital and DMH prior to admission.
D. MAC will notify DMH CRM within 72 hours of patients who were inappropriately denied by PDP hospitals.

III. PDP Hospital Responsibilities:

A. Must notify the MAC of their bed capacity via the ReddiNet system every four hours or more frequently, as indicated.
B. Will accept PDP patients when they have reported open capacity via the ReddiNet system.
C. Will notify DMH CRM of patients who were received that did not meet PDP criteria within 48 hours.
D. Will be reimbursed only for those patients whom they have received written authorization from the PDP gatekeeper prior to admission.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP (FSP) GUIDELINES

DMH CONTACTS

Service Area	Children (0-15)	Transition-age Youth (16-25)	Adults (26-59)	Older Adults (60+)
1	Sheila Carter IU* Coordinator Ph: (661) 575-1800 Fx: (661) 575-9165	Sheila Carter IU Coordinator Ph: (661) 575-1800 Fx: (661) 575-9165	Marge Borjon IU Coordinator Ph: (661) 723-4260 Fx: (661) 723-6975	**See Page 2: Countywide Contacts**
	JoEllen Perkins District Chief Ph: (661) 575-1800 Fx: (661) 575-9165	JoEllen Perkins District Chief Ph: (661) 575-1800 Fx: (661) 575-9165	JoEllen Perkins District Chief Ph: (661) 575-1800 Fx: (661) 575-9165	
2	Ben Aguilar IU Coordinator Ph: (818) 708-4510 Fx: (818) 654-1962	Ben Aguilar IU Coordinator Ph: (818) 708-4510 Fx: (818) 654-1962	Suzanne Holland IU Coordinator Ph: (818) 598-6916 Fx: (818) 598-6971	
	Eva Carrera District Chief Ph: (213) 738-3190 Fx: (213) 736-5802	Eva Carrera District Chief Ph: (213) 738-3190 Fx: (213) 736-5802	Ron Klein District Chief Ph: (818) 598-6920 Fx: (818) 719-9152	
3	Marta Lopez IU Coordinator Ph: (626) 455-4613 Fx: (626) 455-4608	Frances Casas Liese FSP Coordinator Ph: (626) 455-4606 Fx: (626) 455-4608	Eugene Marquez IU Coordinator Ph: (626) 258-1999 Fx: (626) 455-4608	
	Carlotta Childs-Seagle District Chief Ph: (213) 738-3572 Fx: (213) 351-2490	Carlotta Childs-Seagle District Chief Ph: (213) 738-3572 Fx: (213) 351-2490	Carlotta Childs-Seagle District Chief Ph: (213) 738-3572 Fx: (213) 351-2490	
4	Nancy Weiner Navigation Supervisor Ph: (323) 769-6152	Nancy Weiner Navigation Supervisor Ph: (323) 769-6152	Nancy Weiner Navigation Supervisor Ph: (323) 769-6152	
	Ruby Quintana IU Coordinator Ph: (323) 769-6186 Fx: (323) 957-2597	Ruby Quintana IU Coordinator Ph: (323) 769-6186 Fx: (323) 957-2597	Murdis “Latoya” Boston IU Coordinator Ph: (323) 769-6186 Fx: (323) 467-2606	
	Edward Vidaurri District Chief Ph: (213) 738-3765 Fx: (213) 427-6166	Edward Vidaurri District Chief Ph: (213) 738-3765 Fx: (213) 427-6166	Edward Vidaurri District Chief Ph: (213) 738-3765 Fx: (213) 427-6166	
5	Rachel Melvald IU Coordinator Ph: (310) 268-2515 Fx: (310) 235-2263	Rachel Melvald IU Coordinator Ph: (310) 268-2515 Fx: (310) 235-2263	Maureen Cyr IU Coordinator Ph: (310) 268-2511 Fx: (310) 235-2263	
	Karen Williams District Chief Ph: (310) 268-2507 Fx: (310) 235-2263	Karen Williams District Chief Ph: (310) 268-2507 Fx: (310) 235-2263	Karen Williams District Chief Ph: (310) 268-2507 Fx: (310) 235-2263	

*Impact Unit

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP (FSP) GUIDELINES

DMH CONTACTS

Service Area	Children (0-15)	Transition-age Youth (16-25)	Adults (26-59)	Older Adults (60+)
6	Deirdre Sermons Navigation Team Leader Ph: (310) 668-6958 Fx: (310) 898-3473	Deirdre Sermons Navigation Team Leader Ph: (310) 668-6958 Fx: (310) 898-3473	Kimberly Spears IU Coordinator Ph: (323) 298-3675 Fx: (323) 299-8870	
	Jacquelyn Wilcoxen District Chief Ph: (310) 668-6800 Fx: (310) 898-3473	Jacquelyn Wilcoxen District Chief Ph: (310) 668-6800 Fx: (310) 898-3473	Renee Woodruff District Chief Ph: (323) 298-3671 Fx: (323) 299-8870	
7	Jesus Ramirez IU Coordinator Ph: (213) 738-3313 Fx: (213) 351-2490	Jesus Ramirez IU Coordinator Ph: (213) 738-3313 Fx: (213) 351-2490	Tere Antoni IU Coordinator Ph: (213) 738-4068 Fx: (213) 487-9658	
	Ana Suarez District Chief Ph: (213) 738-3499 Fx: (213) 351-2490	Ana Suarez District Chief Ph: (213) 738-3499 Fx: (213) 351-2490	Ana Suarez District Chief Ph: (213) 738-3499 Fx: (213) 351-2490	
8	Kathrine Lundy IU Coordinator Ph: (562) 435-3037 Fx: (562) 435-3128	Lorrie Horst FSP Coordinator Ph: (562) 435-3037 Fx: (562) 435-3128	Neena Paltanwala IU Coordinator Ph: (562) 435-2078 Fx: (562) 435-3128	
	Cathy Warner District Chief Ph: (562) 435-2337 Fx: (562) 435-3128	Cathy Warner District Chief Ph: (562) 435-2337 Fx: (562) 435-3128	Cathy Warner District Chief Ph: (562) 435-2337 Fx: (562) 435-3128	
Countywide	Mary Silvestrini Program Manager Ph: (213) 351-6669 Fx: (213) 639-6310	Adrienne Gee Ph: (213) 639-6730 Michael Lyles Ph: (213) 738-2401 Fx: (213) 351-6571	**TBA**	Matthew Wells IU Coordinator Ph: (213) 351-5344 Fx: (213) 380-4873
	Lisa Wicker District Chief Ph: (213) 738-2217 Fx: (213) 639-6310	Terri Boykins Division Chief Ph: (213) 738-2408 Fx: (213) 351-6571	Maria Funk District Chief Ph: (213) 251-6582 Fx: (213) 351-2762	Kevin Tsang District Chief Ph: (213) 739-7347 Fx: (213) 351-2493

5/2/07

XI. FORMS

A. Community Outreach Services

B. Referral and Authorization
   1. Children (ages 0-15)
   2. Transition-age Youth (ages 16-25)
   3. Adult (ages 26-59)
   4. Older Adult (ages 60+)

C. Appeal (Related to Enrollment, Disenrollment and Transfer)

D. Authorization for Use or Disclosure of Protected Health Information

E. Certification of Accuracy of Data

F. Disenrollment Request

G. Transfer Request

H. Disenrollment/Transfer Request Supplemental

I. Transfer/Assignment of Coordinator

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC.5238

PROVIDER #:	**DATE OF SERVICE:**	**RENDERING PROVIDER:**	
SERVICE RECIPIENT TYPE:		**# OF PERSONS CONTACTED:**	
SERVICE LOCATION INFORMATION ENTER AGENCY SERVICE RECIPIENT AND ACTIVITIY INFORMATION BELOW SERVICE TYPE DESC.			
AGENCY NAME:		AGENCY ADDRESS NUMBER/STREET:	
AGENCY CONTACT:	PHONE #:	CITY / STATE / ZIP:	
PLEASE ENTER CODE TO INDICATE PREDOMINANT ETHNICITY AGE RANGE AND LANGUAGE OF TARGET GROUP			
PRIMARY LANGUAGE:	**ETHNICITY:**	**If Hispanic, indicate Origin:**	**If American Indian/Alaska Native, Indicate Tribe:**
AGE CATEGORY:	**DURATION:** (FMI - Fifteen Min. Increment)	**HANDICAP:**	**PROGRAM AREA:**
FUNDING SOURCE:			
SERVICE CODE:			
ADDITIONAL PARTICIPATING STAFF:			

CERTIFICATION OF CONSULTANT

I CERTIFY THAT THE ABOVE COMMUNITY OUTREACH SERVICES WERE PROVIDED AS DOCUMENTED.

SIGNATURE:_____ DATE: _____

COS Form v1
Rev. 10/23/2006 – nhd

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC.5238

PROGRESS NOTES/FUTURE PLANS/RECOMMENDATIONS

PROGRESS NOTES: (Include presenting problems, goals, content, process and outcome)
FUTURE PLANS/RECOMMENDATIONS: (Include major topics or problem areas to be addressed and any special problems or successful techniques which might be helpful in the future consultation)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHILDREN'S (AGES 0-15) FULL SERVICE PARTNERSHIP REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

DATE: _____ DMH IS#: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F SSN: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE: ( ) _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ HEALTHY FAMILIES ☐ HEALTHY KIDS ☐ PRIVATE ☐ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: ( ) _____

CONSERVATOR ? ☐ YES ☐ NO WHOM?: _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

☐ FSP BROCHURE WAS GIVEN TO THE REFERRED INDIVIDUAL

FOCAL POPULATION

Individual's Name: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL** OF A CHILD WITH SERIOUS EMOTIONAL DISTURBANCE (SED):*

1. Zero to five-year-old (0-5) who:

   ☐ is at high risk of expulsion from pre-school

   ☐ is involved with or at high risk of being detained by Department of Children and Family Services (DCFS)

   ☐ has a parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders

2. Child/youth who:

   ☐ has been removed or is at risk of removal from their home by DCFS

   ☐ is in transition to a less restrictive placement

3. Child/youth who is experiencing the following at school:

   ☐ suspension or expulsion

   ☐ violent behaviors

   ☐ drug possession or use

   ☐ suicidal and/or homicidal ideation

4. Child/youth who:

   ☐ is involved with Probation, is on psychotropic medication, and is transitioning back into a less structured home/community setting

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

*A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely affects his/her functioning:

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;
(4) A general pervasive mood of unhappiness or depression;
(5) A tendency to develop physical symptoms or fears associated with personal or school problems.
[34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

LEVEL OF SERVICE

Individual's Name: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts

Other _____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Sheila Carter	(661) 575-9165	SA 4: Ruby Quintana	(323) 957-2597	SA 7: Jesus Ramirez	(213) 351-2490
SA 2: Ben Aguilar	(818) 654-1962	SA 5: Rachel Melvald	(310) 235-2263	SA 8: Kathrine Lundy	(562) 435-3128
SA 3: Marta Lopez	(626) 455-4608	SA 6: Deirdre Sermons	(310) 898-3473		

DISPOSITION

Individual's Name: _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: ( ) _____

Service Area: _____ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY FSP AGENCY↓↓

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND INDIVIDUAL DOES NOT AGREE TO OR IS DETERMINED INAPPROPRIATE FOR FSP SERVICES** (Explain why and indicate plan for linkage to other services):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND DECLINES ENROLLMENT** (Explain reason for decision and indicate status of client): _____

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND REQUESTS ENROLLMENT***

FSP Agency Representative: _____ **Date:** _____

***IMPACT UNIT:** **Fax** completed Referral and Authorization Form to Children's MHSA **Countywide Programs Administration** at **(213) 639-6310**. If you have any questions, please contact Mary Silvestrini at (213) 351-6669.

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

_____

_____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date Impact Unit Representative

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

TRANSITION AGE YOUTH (TAY) (16-25)
FULL SERVICE PARTNERSHIP
REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

DATE: _____ DMH IS#: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F SSN: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE: _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ HEALTHY FAMILIES ☐ HEALTHY KIDS ☐ PRIVATE ☐ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: _____

CONSERVATOR ? ☐ YES ☐ NO WHOM?: _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Is Individual currently receiving services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

_____

_____

☐ FSP BROCHURE WAS GIVEN TO THE REFERRED INDIVIDUAL

FOCAL POPULATION

Individual's Name: _____

Transition Age Youth must have a Serious Emotional Distubance (SED)* and/or Severe and Persistent Mental Illness (SPMI)**

Indicate TAY FSP Focal Population identified (check all that apply):

1. ☐ Homeless or currently at risk of homelessness
   (Indicate current living situation): _____

2. ☐ Youth aging out of:
   - ☐ Child Mental Health System
   - ☐ Child Welfare System
   - ☐ Juvenile Justice System

3. ☐ Youth leaving Long-term Institutional Care
   - ☐ Level 12-14 Group Homes
   - ☐ Community Treatment Facility (CTF)
   - ☐ Institution of Mental Disease (IMD)
   - ☐ State Hospital
   - ☐ Probation Camps

   Estimated Discharge Date: _____

4. ☐ Youth experiencing their first psychotic break

5. ☐ Co-Occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.

Provide Detail for Any Checked Items: _____

*(**SED**) A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely affects his/her functioning:

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;
(4) A general pervasive mood of unhappiness or depression;
(5) A tendency to develop physical symptoms or fears associated with personal or school problems.
[34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

** (**SPMI**) For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

LEVEL OF SERVICE

Individual's Name: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code)_____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts
- ☐ Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Sheila Carter	(661) 575-9165	SA 4: Ruby Quintana	(323) 957-2597	SA 7: Jesus Ramirez	(213) 351-2490
SA 2: Ben Aguilar	(818) 654-1962	SA 5: Rachel Melvald	(310) 235-2263	SA 8: Lorrie Horst	(562) 435-3128
SA 3: Frances Liese	(626) 455-4608	SA 6: Deirdre Sermons	(310) 898-3473		

DISPOSITION

Individual's Name: _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: _____

Service Area: _____ Supervisorial District: _____ Fax: _____

Impact Unit Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY FSP AGENCY↓↓

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND INDIVIDUAL DOES NOT AGREE TO OR IS DETERMINED INAPPROPRIATE FOR FSP SERVICES** (Explain why and indicate plan for linkage to other services):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND DECLINES ENROLLMENT** (Explain reason for decision and indicate status of client): _____

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND REQUESTS ENROLLMENT***

FSP Agency Representative: _____ **Date:** _____

Fax completed Referral and Authorization Form to TAY MHSA Countywide Programs Administration at (213) 351-6571.
If you have any questions, please contact Adrienne Gee at (213) 639-6730 or Terri Boykins at (213) 738-2408.

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

_____

_____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____
Date Impact Unit Representative

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ADULTS (AGES 26-59) FULL SERVICE PARTNERSHIP REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

DATE: _____ DMH IS#: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F SSN: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE: ( ) _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ V.A ☐ PRIVATE ☐ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: ( ) _____

CONSERVATOR ? ☐ YES ☐ NO WHOM?: _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Parole ☐ Probation ☐ APS ☐ GR/DPSS

If Individual was referred to any other programs, please identify: _____

☐ FSP BROCHURE WAS GIVEN TO THE REFERRED INDIVIDUAL

FOCAL POPULATION

Individual's Name: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL:**

Indicate FSP focal population:	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless	_____	_____
☐ Jail	_____	_____
☐ INSTITUTION TYPE (mark all that apply):		
Acute/Long Term Psychiatric Facilities _____ NAME OF INSTITUTION		
☐ Institution for Mental Disease (IMD)	_____	_____
☐ State Hospital	_____	_____
☐ Psychiatric Emergency Services	_____	_____
☐ Urgent Care Center	_____	_____
☐ County Hospital	_____	_____
☐ Fee For Service Hospital	_____	_____

☐ Living with family members without whose support the individual should be at Imminent Risk of Homelessness, Jail Or institutionalization. Specify _____

_____

_____

_____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

_____

_____

_____

_____

LEVEL OF SERVICE

Individual's Name: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts
- ☐ Other _____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Marge Borjon	(661) 723-6975	SA 4: Murdis Boston	(323) 467-2606	SA 7: Tere Antoni	(213) 487-9658
SA 2: Suzanne Holland	(818) 598-6971	SA 5: Maureen Cyr	(310) 235-2263	SA 8: Neena Paltanwala	(562) 435-3128
SA 3: Eugene Marquez	(626) 455-4608	SA 6: Kimberly Spears	(323) 299-8870		

DISPOSITION

Individual's Name: _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: ( ) _____

Service Area: _____ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY FSP AGENCY↓↓

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND INDIVIDUAL DOES NOT AGREE TO OR IS DETERMINED INAPPROPRIATE FOR FSP SERVICES** (Explain why and indicate plan for linkage to other services):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND DECLINES ENROLLMENT** (Explain reason for decision and indicate status of client):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND REQUESTS ENROLLMENT***

FSP Agency Representative: _____ **Date:** _____

***IMPACT UNIT:** **Fax** completed Referral and Authorization Form to Adults MHSA **Countywide Programs Administration** at **(213) 351-2762**. If you have any questions, please contact Jaime Nahman, Ph.D. at (213) 251-6504.

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision):

_____

_____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date — Impact Unit Representative

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OLDER ADULT (AGES 60+) FULL SERVICE PARTNERSHIP REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

DATE: _____ DMH IS#: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F SSN: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE ( ) _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ VA ☐ PRIVATE ☐ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: ( ) _____

CONSERVATOR ? ☐ YES ☐ NO WHOM?: _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ APS ☐ Probation ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

☐ FSP BROCHURE WAS GIVEN TO THE REFERRED INDIVIDUAL

FOCAL POPULATION

Individual's Name: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL** OF AN OLDER ADULT WITH SERIOUS MENTAL ILLNESS:

1. ☐ Homelessness (# Number of Days Homeless over last 12 months _____)
2. ☐ Incarceration (# of Incarcerated days over last 12 Months _____)
3. ☐ Hospitalization (# of acute psychiatric inpatient days _____)
4. ☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)
5. ☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months or more)
6. ☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home
7. ☐ Being released from SNF/ Nursing Home (What facility _____)
8. ☐ Presence of a Co-occurring disorder:
   - ☐ Substance Abuse
   - ☐ Developmental Disorder
   - ☐ Medical Disorder
   - ☐ Cognitive Disorder
9. ☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS- referred clients)
10. ☐ Serious risk of suicide (not imminent)
11. ☐ Current enrollment in an ACT/AB2034 program and is aging up in the system (ACT/AB2034 program _____)

Provide Detail for Any Checked Items: _____

LEVEL OF SERVICE

Individual's Name: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts

Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit Coordinator**:

Matthew Wells **(213) 380-4873**

DISPOSITION

Individual's Name: _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: ( ) _____

Service Area: _____ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY FSP AGENCY↓↓

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND INDIVIDUAL DOES NOT AGREE TO OR IS DETERMINED INAPPROPRIATE FOR FSP SERVICES** (Explain why and indicate plan for linkage to other services):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND DECLINES ENROLLMENT** (Explain reason for decision and indicate status of client): _____

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND REQUESTS ENROLLMENT***

FSP Agency Representative: _____ **Date:** _____

***IMPACT UNIT:** **Fax** completed Referral and Authorization Form to Older Adult's MHSA **Countywide Programs Administration** at **(213) 380-4873**. If you have any questions, please contact Matthew Wells at (213) 351-5344.

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

_____

_____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date Impact Unit Representative

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP APPEAL FORM

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

Reason for Appeal (Check ONE Only):

☐ DMH Impact Unit has referred an eligible client to our agency that we decline to enroll.

☐ Our agency has requested authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to enroll.

☐ Our agency has requested authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to disenroll.

☐ Our agency has requested authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to transfer.

Explain Reason for Appeal: _____

Fax completed Appeal Form and copy of denied request to appropriate **Service Area District Chief.**

↓↓TO BE COMPLETED BY SERVICE AREA DISTRICT CHIEF↓↓

District Chief Name: _____ Service Area: _____

Phone: ( ) _____ Fax: ( ) _____

DISPOSITION: ☐ APPEAL APPROVED ☐ APPEAL DENIED

Explain Reason for Decision: _____

Service Area District Chief Signature: _____ Date

Countywide District Chief Signature: _____ Date

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names	Birth Date	MIS Number
Street Address	City, State, Zip	

AUTHORIZES:	**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**
	Potential landlords and employers participating in the DMH Housing and Employment Programs
Name of Agency	Name of Health Care Provider/Plan/Other
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation ___ Results of Psychological Tests ___ Diagnosis
___ Laboratory Results ___ Medication History/ ___ Treatment
___ Entire Record (Justify) Current Medications
_X_ Other (Specify): The fact that you are receiving mental health services.

PURPOSE OF DISCLOSURE: (Check applicable categories)

___ Client's Request
_X_ Other (Specify):

This program assists clients in finding and maintaining jobs and housing. In order to successfully do this we have developed relationships with potential employers and landlords that know that we work with clients who are receiving mental health services. If you refuse to sign this authorization DMH will not be able to contact potential employers and landlords on your behalf to assist you with finding and maintaining jobs and housing.

Will the agency receive any benefits for the disclosure of this information? ___ Yes _X_ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/_____/_____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____ _____

Contact person Agency Name

_____ _____

Street Address City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____

Month Day Year

CERTIFICATION OF ACCURACY OF OUTCOME DATA

By signing below, I certify that this data set has been reviewed and accurately reflects the status changes occurring in my program for the period

between _____/_____/_____ and _____/_____/_____

_____

Print Name of Program Manager

_____ _____

Signature of Program Manager **Date**

_____ _____

Agency Name **Program Name**

Data certification is due within 14 calendar days of the certification request. The completed Certification of Accuracy of Outcome Data form should be faxed and then mailed to the appropriate Countywide Programs Administration:

For Child MHSA Programs: County of Los Angeles – Department of Mental Health 550 S. Vermont Ave, 4th Floor Los Angeles, CA 90020 Fax: (213) 639-6310 ATTN: Children's MHSA Program Manager	For Adult MHSA Programs: County of Los Angeles – Department of Mental Health 695 S. Vermont Ave., 8th Floor Los Angeles, CA 90005 Fax: (213) 351-2762 ATTN: Adult Systems of Care Countywide Programs Manager
For TAY MHSA Programs: County of Los Angeles – Department of Mental Health 550 S. Vermont Ave, 4th Floor Los Angeles, CA 90020 Fax: (213) 639-1804 ATTN: TAY MHSA Program Manager	For Older Adult MHSA Programs: County of Los Angeles – Department of Mental Health 550 S. Vermont Avenue, 6th Floor Los Angeles, CA 90020 Fax: (213) 351-2493 ATTN: Older Adult System of Care Program Manager

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT REQUEST FORM

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

ENROLLMENT DATE: _____ **REQUESTED DISENROLLMENT DATE:** _____

Reason for Disenrollment (Check ONE Only)

☐ Target population criteria are not met. Briefly explain: _____

☐ Client decided to discontinue Full Service Partnership participation after Partnership established.

☐ Client moved to another county/service area. **Aftercare Arrangements:** Briefly describe any referrals made or any linkages to ongoing care. Include date of referral, facility name, contact name and phone numbe

☐ After repeated attempts to contact Client, Client cannot be located
►Date of last face-to-face contact: _____
►Date of last check of DMH IS: _____
►Date of last check of jail/juvenile justice system: _____

Outreach Efforts: Briefly describe your attempts to locate client. Make reference to progress notes that document your efforts: _____

☐ Community services/program interrupted – Client's circumstances reflect a need for residential/institution mental health services at this time (such as, IMD, MHRC, State Hospital

☐ Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/CYA/jail/prison sentence.

☐ Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropria (Please include a copy of the Client Care & Coordination Plan and summary of how the goals were me

☐ Client deceased Date of death: _____

Impact Unit Decision

IU Signature _____ Date _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Countywide Programs Decision

CW Programs Signature _____ Date _____ ☐ AUTHORIZED ☐ NOT AUTHORIZED*

*Requires completion of Supplemental Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP TRANSFER REQUEST FORM

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

ENROLLMENT DATE: _____ **REQUESTED TRANSFER DATE:** _____

NEW/RECEIVING PROGRAM/AGENCY (if known): _____

Reason for Transfer (Check ONE Only):

- ☐ Client requested a transfer.
- ☐ Client has moved out of Service Area.
- ☐ Client has moved within Service Area but closer to another FSP agency.
- ☐ Client's Linguistic/cultural needs.
- ☐ Client aged out of current services.
- ☐ Other: _____

Briefly explain checked reason for transfer _____

_____

_____

Impact Unit Decision

Current IU Signature _____ Date _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Receiving IU Signature _____ Date _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Countywide Programs Decision

CW Programs Signature _____ Date _____ ☐ AUTHORIZED ☐ NOT AUTHORIZED*

*Requires completion of Supplemental Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT/TRANSFER REQUEST SUPPLEMENTAL FORM

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

↓↓TO BE COMPLETED BY IMPACT UNIT↓↓

☐ **NOT PRE-AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

_____

_____

_____

_____

_____

_____

Impact Unit Representative: _____ Date: _____

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

_____

_____

_____

_____

_____

_____

Countywide Programs Representative: _____ Date: _____

MH 530
Revised 10/25/05

TRANSFER/ASSIGNMENT OF COORDINATOR

CLIENT AND SIGNIFICANT OTHERS

I agree to the transfer of the coordination of my services to _____
Reporting Unit #

_____ to be effective _____.
Reporting Unit Name — Date (NOT the Coord. Cycle)

_____ _____ _____ _____
Client or Statement below* — Date — Significant Other — Date

☐ Client is aware of assignment/transfer but unable/unwilling to sign because _____

Translation ☐ No ☐ Yes This section was translated into _____ for the client and/or responsible adult.

TRANSFERRING COORDINATOR

Copies of the Assessment, Coordination Plan, Service Plan(s), Discharge Summary, and any other relevant coordination documents were sent by me to the new Coordinator on _____.
Date

I was deleted as the SFPR on the MIS Client ID Screen on _____ by _____.
Date — Initials

☐ Individual Coordinator _____ ☐ Team Coordination _____
Staff ID# — Team Name/& ID#

_____
Staff authorizing transfer: Sign & Print Name*

_____ _____ _____ _____
Phone — Rep. Unit # — Reporting Unit Name — Date

NEW/RECEIVING COORDINATOR

Data entry completed on _____ by _____.
Date — Initials

Our agency has been in contact with the client and transferring Provider and accepts Coordinator responsibilities (as stated in the Los Angeles County/State Manual) on the above effective date. I will ensure the MIS Client ID Screen is updated.

☐ Individual Coordinator _____ ☐ Team Coordination _____
Staff ID#** — Team Name/& ID#**

_____
Staff agreeing to transfer: Sign & Print Name*

_____ _____ _____ _____
Phone** — Rep. Unit #** — Rep. Unit Name — Date

☐ Level of care unchanged ☐ I have assigned this new level of care** _____.

*Required **data entry items

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Name: **MIS#:**

Agency: **Prov. #:**

Los Angeles County - Department of Mental Health

TRANSFER/ASSIGNMENT OF COORDINATOR

Purpose: This form, which most often will document the transfer of coordinator, is to ensure all necessary communication and activities occur when a client is transferred from one coordinator to another. It may also be used to document the assignment of a Coordinator, when the Client's Face Sheet cannot be used.

It must be used for interagency transfers by all Providers, county-operated and contract. County-operated Providers must also use this form when Coordinators are changed within the Provider. Contract Providers may use this form for internal transfers or may use one of their own design.

Recording Procedure: If this form is used to record the assignment of a Coordinator, only the section "New/Receiving Coordinator" needs to be completed. All sections must be completed when transferring Coordination. The single asterisks (*) are required signatures.

If the transferring Coordinator (the Single Fixed Point of Responsibility or SFPR) is not available, someone in the transferring Coordinator's Provider must be designated by the clinic manager to complete the responsibilities identified on this form. If coordination is done by a team, the team leader is responsible for ensuring this form and all transfer activities are completed.

Client and Significant Other Section: Either the transferring or receiving Coordinator should assist the client in completing this section of the form. Please note the effective date is NOT the Coordination Cycle Date. The Coordination Cycle Date does not necessarily change when the Coordination is transferred; the Coordination Cycle Date changes only when a person/client has NO open episodes.

Transferring Coordinator Section: The signature of the transferring Coordinator in this section means all the activities identified in the section regarding the forwarding of client information and deletion of data have been completed. It is NOT necessary for the transferring Coordinator to obtain the client's approval for release of information nor should the transferring agency request reimbursement for the copying of any information.

Receiving Coordinator Section: The five items marked with double asterisks (**) are essential for updating the Department data system. If the transferring Coordinator of his/her agency does not complete their responsibilities in a timely manner, the receiving Coordinator can complete this section and, with the client, complete the Client section and then request assistance from central office for updating the SFPR in the data system. The receiving Coordinator's signature in this section means that all activities identified in the section have been completed.

Filing Procedure: If the information on this form is needed for data entry, a copy should go there before the form is filed. The original of this form is to be filed with the Client's Face Sheet in the Administrative Section of the Clinical Record for county-operated programs.

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

SUSAN KERR
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.info

Reply To: Program Support Bureau, Standards & Quality Assurance
Telephone: (213) 738-2289 Fax: (213) 381-8386

Date: _____

TO: Norma A. Fritsche, RN, CNS, MPA
Program Support Bureau
Standards And Quality Assurance

FROM: _____

_____

_____

SUBJECT: TRANSFER OF COORDINATOR (MH-530)

Attached is a *Transfer of Coordinator* form for your processing. On these dates:

_____ I requested _____
Date Name

_____ I requested _____
Date Name

of _____ to delete the SFPR from the MIS Client ID Screen.
Agency Name

Since this has not yet happened, I am requesting you assist us by making these data changes.

Attachment: Transfer of Coordinator, MH-530

c: Deputy Directors
Transferring Agency
Clinic Manager

To Dance With Grace: Outreach & Engagement To Persons On The Street

by
Sally Erickson, M.S.W.
Jaimie Page, M.S.W., L.S.W.

Abstract

Outreach and engagement strategies are critical in helping homeless persons transition from the streets into housing and services. A literature review was conducted and commonalities across populations were found (although the preponderance of literature describes homeless persons with mental illnesses). Definitions, exemplary practice models, values/principles, worker stances, measurable outcomes, and multi-level factors relating to outreach and engagement are presented as well as issues related to research and funding.

Lessons for Practitioners, Policy Makers, and Researchers

- Outreach work is based on a foundation of strong values, principles and unique worker stances
- Engagement is the key in Outreach
- The homeless persons outreach is designed for are those who unserved or underserved by existing agencies and who aren't able or willing to seek services from those agencies
- The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and to help people get connected to mainstream services and ultimately into the community through a series of phased strategies
- Effective outreach has been demonstrated, with positive outcomes
- Peer based outreach and the use of the expertise of homeless and formerly homeless persons and consumers are valued and should be actively sought out
- Discrimination and marginalization are part of the experience of both outreach clients and workers; as a result, advocacy must take place at all levels
- Outreach services cannot exist in isolation from larger systems: both homeless systems and mainstream systems at community, state, and federal levels
- Outreach services must be included, required, valued, and funded as part of a national and local continuum of care
- More research, including controlled and longitudinal studies, are needed particularly in answering the question of what factors promote success in helping people access mainstream services and resources across homeless outreach populations

The process of outreach and engagement is an art, best described as a dance. Outreach workers take one step toward a potential client, not knowing what their response will

be—will the client join in or walk away? Do they like to lead or follow? Every outreach worker has a different style and is better at some steps than others. To dance with grace, when the stakes are high, is the challenge for all of us.

In the U.S., we now have the benefit of more than ten years of McKinney funding which has made possible scores of outreach programs across the country. Rural and urban, small and large, comprehensive or finite, they reach out to people who are homeless and challenged by poverty, violence, marginalization, poor health, mental illness, substance abuse, and other issues.

This paper will provide definitions; exemplary practice models, including worker stances, values/principles, outreach functions and services, outreach across populations; measurable outcomes; and an extensive bibliography for further inquiry. The preponderance of available literature was published in the late 1980s and early 1990s, and focuses on mental health-related outreach programs. The few outreach-related articles published in recent years perhaps reflect the greater use, acceptance, and integration of existing outreach programs as part of a community's effort to provide a "continuum of care" to persons in need. This paper will present both a review of the literature and experiential information relating to best practices.

Priority Home! (1994) describes the federal plan to break the cycle of homelessness by "public and private mental health, medical, and substance abuse service-providers to initiate street outreach efforts, the utilization of safe havens ... and implementation of a continuum of care..." This federal validation of outreach as an accepted and expected part of a community solution to homelessness, which includes access to housing and services, recognizes the unique efforts of outreach workers across the country.

Definitions

Outreach is the initial and most critical step in connecting, or reconnecting a homeless individual to needed health, mental health, recovery, social welfare, and housing services. Outreach is primarily directed toward finding homeless people who might not use services due to lack of awareness or active avoidance (ICH, 1991; McMurray-Avila, 1997), and who would otherwise be ignored or underserved (Morse, 1987). Outreach is viewed as a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept (ICH, 1991; McMurray-Avila, 1997). Outreach is first and foremost a process of relationship-building (Rosnow, 1988) and that is where the dance begins.

Engagement is a crucial process for successful outreach. It is described as the process by which a trusting relationship between worker and client is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering these services (Barrow, 1988, 1991; ICH, 1991; Winarski, 1994). Some clients require slower and more cautious service approaches (Morse, 1987). The engagement period can be lengthy-and the time from initial contact to engagement can range from a few hours to

two years (ICH, 1991) or longer. Effective workers can "establish a personal connection that provides a spark for the journey back to a vital and dignified life" (Winarski, 1998).

Assumptions Of Exemplary Programs

Based on a review of the literature and best practices found in the field, the following are important elements to address in a good outreach program: characteristics of the population served, values and principles, worker stances/characteristics, and goals of outreach.

Programs cannot assume is that all communities have the same percentages of "types" of homeless people. There is a range in the population that may differ from one region to the next. Rather than basing interventions on formulaic assumptions such as "1/3 mentally ill, 1/3 veterans, 1/4 families," each community needs to assess the characteristics of it's homeless persons, identify service gaps, and develop effective responses. For example, in one city 80 percent of the homeless were single men, while in another, 65 percent were families with children (U.S. News & World Report, 1988).

Characteristics Of Homeless Persons Needing Outreach

Outreach programs attempt to engage individuals who are unserved or underserved by existing agencies (Axelroad, 1987). This distinction is significant because the outreach model was developed to meet the large service gap found among this unique population. An outreach model is unnecessary and even counter-productive with other populations.

Outreach programs serve persons who may have psychiatric disorders and/or substance abuse issues. They may be highly vulnerable and considered "difficult to serve" (Rog, D.J., 1988). They usually cannot negotiate the requirements of or trust traditional service-providers. These persons may have poor health, lack insurance, and are unable to make or keep medical appointments and follow through with complex medical regimes. Homeless youth may be those who are estranged from family and fearful of adult service-providers. Homeless youth are perhaps the most vulnerable group of youths, and are in need of creative and early interventions, in order to prevent an acclimation to street life which includes prostitution, substance abuse, and crime. Further, homeless teems with children are viewed as perhaps the most vulnerable of homeless families (Bronstein, 1996).

Two factors commonly associated with homelessness among women include pregnancy and the recent birth of a baby. Homeless pregnant women experience a range of problems including poverty, isolation, substance abuse, and histories or past and present victimization. A lack of prenatal care and poor nutrition may also exacerbate health problems (Weinreb, et al., 1995).

Other groups include the elderly, women escaping domestic violence, families, and marginalized persons such as those who are transgendered and those in the sex industry.

Many of the people outreach programs attempt to serve are isolated, have minimal resources, minimal access to social services (Sullivan-Mintz, 1995; ICH, 1991), have had negative experiences with service-providers (McMurray-Avila, 1997), and have been victims of violence (Goodman, et al., 1995; Weinreb, et al., 1995). Workers give priority to those who are most at-risk who are least likely to seek out and successfully access available services, for whatever reason: fear, mental status, lack of insight and motivation, or low self-esteem. Rog (1988) describes the need to reduce barriers to service-utilization and facilitate the engagement process. Workers may also encounter persons who are able to access services and can help by providing one-time information and direction, but the focus is on the former group.

Values & Principles Of Outreach

Successful outreach programs must be based on a core set of values and principles which drive interventions. Values and principles also serve to set the stage for developing realistic goals in an arena of limited resources and potentially slow progress.

- A person orientation: Exemplary programs possess a philosophy which aims to restore the dignity of homeless persons, dealing with clients as people (Axelroad, 1987; Wobido, 1990).
- Recognizing clients' strengths, uniqueness, and survival skills.
- Empowerment & self-determination: (Sullivan-Mintz, 1995) Workers can facilitate this by presenting options and potential consequences, rather than solutions (Rosnow, 1988), by listening to homeless persons rather than "doing" for them, and by ensuring a balance of power between homeless individuals and outreach workers (Rosnow, 1988).
- Respect for the recovery process (Winarski, 1994): Behavior change is on a continuum. Small successes are recognized. Any move toward safer/healthier activities is viewed as a success. Clients need to recognize for themselves how change may be beneficial, in relation to their own goals.
- Client-driven goals (Winarski, 1994): Services and strategies are tailored to meet the individuals' unique needs and characteristics (Morse, 1987). Workers start with clients' perceived needs and go from there.
- Respect (Cohen and Marcos, 1992): Workers are respectful of people, including their territory and culture. Outreach workers view themselves as a guest and make sure they are invited, welcome, or at least tolerated. Workers must take care not to interrupt the lifestyle of the people they are trying to help. Lopez (1996) makes the point that clients don't lose the right to be left alone in the privacy of their home even when that client calls the streets home. Clients are viewed as the experts in their life and on the streets. The worker takes the role of consultant into that lifestyle.
- Hope: Workers instill a sense of hope for clients while helping them maintain positive, realistic expectations. Unrealistic expectations may bring on clients' cycles of frustration, despair, and hopelessness, as well as anger at the outreach worker. The worker restores hope in clients who have faced years of disappointment as well as reframes raised expectations. The worker needs to

communicate to the client that changes may take considerable time, effort, and patience (Morse, 1991).
- Kindness: People are always treated with warmth, empathy and positive regard, regardless of their behavior or presentation.
- Advocacy: Workers advocate for social justice on many levels.

Outreach Worker Stances/Characteristics

There are common worker stances/characteristics found among successful outreach workers and programs. These characteristics are critical because successful engagement will largely be determined by the relationship between clients and workers. Effective worker stances/characteristics include:

- Good judgment, intuition and street sense: this includes safety for themselves and the client-being observant and vigilant, as well as using good common sense. Strategies include going out with a partner, avoiding closed, remote or dangerous areas, developing a relationship with local police (Winarski, 1998), carrying a cellular phone, dressing appropriately, and assessing situations before acting.
- Non-judgmental attitude (ICH, 1991): Regardless of the worker's personal beliefs, no behavior on the part of the client is morally judged.
- Team player: Workers must know when to ask for help, from getting backup on the streets to a second opinion in clinical assessments. Outreach staff must have a strong commitment to the "team" approach to service delivery (Axelroad, 1987; Wobido, 1990).
- Flexibility (Rosnow, 1988;ICH, 1991): Outreach workers are flexible in reassessing daily work priorities, in setting work schedules, and in the treatment planning process (Morse, 1987), and content.
- Realistic expectations: Workers have an "expectation of non-results." They understand that they will not be able to "cure" or "save" clients (Axelroad, 1987; ICH, 1991), and at the same time continue to persevere.
- Commitment: Outreach workers are both consistent and persistent in their dealings with clients (Axelroad, 1987; Wobido, 1990). They do what they say they are going to do and only make promises they can keep (Sullivan-Mintz, 1995). They are in it "for the long haul" and continue to persevere.
- Less is more. At the outset of intervention, there is less application of intensive and costly treatment, less professional distancing, less rigidity, less intrusiveness, and less directiveness (Rosnow, 1988). Services offered are purely voluntary (Cohen, 1989).
- Altruism: Staff find rewards in doing outreach work, such as a spiritual commitment to helping others, furthering an academic interest, or simply enjoying the process of working with individuals (Axelroad, 1987).
- Sense of humor: the ability to use humor at appropriate times, as well as maintaining as sense of humor during difficult times is essential.
- Creativity & resourcefulness are strengths that outreach workers tap into daily.
- Cultural competency: Workers demonstrate competence across ethnicity, gender, transgender, lifestyle, and age spectrums.

- Resilience: Workers are resilient and patient in a work environment marked by high turnover, difficulty tracking clients (McQuistion, et al., 1996), high stress, lack of resources, and lack of immediate improvement in the clients they serve. Effective workers are able to continue working despite the difficulties endured by their clients, without personalizing them.

Outreach programs vary in relation to considering credentials, ethnicity, or gender when hiring outreach workers. People with a variety of backgrounds may function as mental health outreach workers: physicians, social workers, nurses, nurse-practitioners, and para-professionals. Some programs employ formerly homeless persons with mental illnesses (Axelroad, 1987; Morse, 1987). A survey of ACCESS programs reported that 75 percent of programs do not require a bachelor's degree for an outreach worker. More important were characteristics such as a personal commitment to the work, flexibility, and a willingness to adjust schedules to the needs of the clients (Wasmer, 1998).

Some programs state that it is not necessary to have workers of the same ethnicity, cultural background or gender as the clients, nor who have a lot of street experience. They further state that the only essential characteristic is a common language (Axelroad, 1987; Nasper, 1992). However, an outreach team of two males in Milwaukee found that they had served 80-90 percent men and had difficulty establishing trust with homeless women. As a result, they now have mixed gender teams (Rosnow, 1988). Agencies promote an equal opportunity atmosphere, and the staff composition mirrors that of the general population.

Many outreach programs successfully use mental health consumers as outreach workers (Tosh, 1990 and 1993, and Lieberman, et al., 1991) and/or formerly homeless persons (Mullins, 1994). The benefits of such peer models allow for effective outreach, sharing of their personal expertise, fostering of partnerships between consumers and non-consumers, increased self-esteem of the working peers, and the evolution of consumers becoming active in changing services throughout the country.
Consumers/peers/formerly homeless persons can contribute significantly in the development of program design, implementation, and evaluation. Their expertise should be actively sought out by outreach programs. To be sure, homeless persons and formerly homeless persons have expertise, skills, and insight that professionals who have never experienced homelessness lack. Programs recognize that peers working in homeless and mental health fields often endure the pressures of maintaining their own housing and overcoming stigma (Tosh, 1993), allow for reasonable accommodations to assist them, and offer training and on-going meetings (Leiberman, et al., 1991).

Goals of Outreach

There are four main goals of outreach found across different areas of outreach client populations. The first is to care for immediate needs (Plescia, 1997), including to ensure safety, provide crisis intervention, refer to immediate medical care, and help clients with immediate clothes, food, and shelter needs. Workers must develop a trusting relationship

(Plescia, 1997; Cohen and Marcos, 1992; Sullivan-Mintz, 1995) in order to achieve the additional goals of providing services and resources, whenever and for as long as needed (Winarski, 1998). Lastly, workers aid in connecting clients to mainstream services (Plescia, 1997).

An inherent factor related to these goals is the notion of phasing. Objectives are developed and reached over a period of time with small steps that are directed to a more structured, service-oriented goal. Persons often phase from accepting food from the outreach worker, to developing trust, to discussing a goal that in part can be achieved through services provided in the community and to accepting those services. Case management goals are gradually developed by both the client and worker. Outreach and engagement principles carry over into case management and are viewed as an ongoing process. As trust develops, clients take a more active role in setting and achieving case management goals. Ultimately, the goal is to successfully phase or integrate persons into the community and/or into a social service agency (ies) which would assume the task of promoting community integration. Just as clients are phased into outreach services from the streets, they are phased into the community from outreach.

Outreach Service Structure

There are at least three ways of classifying outreach models found in the literature. One set looks at a linkage model versus a continuous relationship model. A second set looks at a mobile versus fixed model. A third set describes models based on a service continuum.

Linkage vs. Continuous Relationship Model

Some outreach programs serve as linkages, referring clients to mainstream mental health or other service-providers. Examples of "find and link" programs are New York's Project HELP, which conducts in-vivo assessments and delivers people to the psychiatric hospital by voluntary and involuntary means, and Chicago's Mobile Assessment Unit (MAU), that visits shelters and streets to identify mentally ill persons and link them to resources (Wasmer, 1998). Other examples may include linking temporarily displaced families with housing.

Linkage-only programs that do not provide follow-up tracking have been determined to be ineffective for some disabled populations. A 1986-87 study of 13 federally funded homeless mental health demonstration programs reported that most outreach programs were running ineffective models. Many spent the majority of their time in screening and identifying individuals and providing verbal referrals, but little follow-up assistance. One project contacted 430 eligible persons, yet only 22 received follow-up mental health treatment. Five found housing and three received entitlements (Hopper, et al., 1990 in Morse, 1996).

Providing linkage-only services to certain homeless populations can lead to barriers and service gaps, resulting in lost clients. Morse (1991, 1996) suggests strategies to increase the effectiveness of this model: incorporate the expectation of an eventual service-

provider transition early in the engagement and service-planning with a client; remain involved and actively involve the client in the referral process, including scheduling appointments, arranging transportation, and providing emotional support; work with the linkage site staff, informing them about client needs and characteristics; provide follow-up support as needed to both client and new staff; and provide advocacy on behalf of the client if needed.

In a continuous relationship model, workers perform outreach and continue on as the person's case manager. Outreach has been shown to be a necessary component of ongoing case management for mentally ill clients. Axelroad and Toff (1987), point out the difficulty in distinguishing outreach from case management for homeless mentally ill persons for two reasons. First, the fragility of the population requires trust and continuity of care when helping clients move from an outreach phase to a treatment phase. Second, outreach workers must often provide case management services because of the frequent shortage of appropriate and relevant case management services for which to refer clients.

The drawbacks to the continuous relationship model are small recommended caseloads, 10:1, which may be unrealistic for many agencies, and little capacity to outreach with new clients (Morse, 1991, 1996). However, the approach has been shown to be effective at maintaining contact with clients and housing retention (Morse, 1996). In addition, outreach workers may prefer the excitement, lack of structure, and immediacy of outreach. For this and other reasons related to individual personality traits, some outreach workers may not be as effective as case managers.

At Safe Haven in Honolulu, outreach workers opted for the continuous relationship model out of necessity when they were unable to transition "graduated" residents to case managers at the community mental health centers. Historically, the engagement strategies used in interaction between clients and outreach workers have been substantially different from strategies used at traditional service settings, leaving clients with little incentive to transition to a less user-friendly service-provider. Outreach roles expanded to encompass case management and advocacy, and they remained connected with clients through follow-up. Perhaps as a result, a majority of Safe Haven clients have successfully transitioned into the community. In Safe Haven's first 28 months, 43 residents transitioned from the program—63 percent into permanent independent housing, with 98 percent of these retaining their housing.

Mobile vs. Fixed

Outreach may be mobile or fixed depending on the needs of the target population (Sullivan-Mintz, 1995). Outreach may take place on the streets, as well as in shelters, drop-in centers, emergency rooms, hospitals, and jails (Axelroad, 1987; Morse, 1987). The mobile model requires that the projects be "equipment heavy," including agency vehicles/vans, employee cars, and communication systems such as pagers, cellular phones, and walkie-talkies (Wasmer, 1998).

Fixed-site outreach programs such as drop-in centers or day programs for the mentally ill, within high-density homeless areas, can be more easily accessed by greater numbers of clients, increase staff efficiency, and can provide additional incentive services. Many outreach programs have both a mobile and fixed-site component (Morse, 1987). In a survey of eight ACCESS programs, 77 percent of clients were engaged by mobile methods and the balance at drop-in centers. (Wasmer, 1998)

For certain clients with primary substance abuse issues, mobile outreach is more successful for several reasons. There is less stigma and community opposition when outreach workers meet clients individually on the streets rather than having clients come to a centralized location. Another reason is that clients who are high or intoxicated are often asked to leave fixed service sites.

Outreach Continuum

Wasmer (1998) describes a link/serve continuum, with outreach programs that "find and link" or "find and serve." The latter include case management programs, assertive community treatment and intensive case management programs, drop-in centers, shelter-based programs, and low demand residences/safe havens. Of eight ACCESS outreach programs Wasmer surveyed, all were the "find and serve" type.

The Team Approach

Different types of team approaches are described in the literature, depending on the mission of the team. They may focus on emergency psychiatric intervention, case management, health care, HIV education/prevention, harm reduction for sex industry workers, substance users, and others.

With mentally ill persons, using a team approach after engagement has been established assures that a client will learn to develop trusting relationships with several staff people. It also increases the likelihood of being able to attain assistance when necessary. Teams can include or have access to social workers, nurses, nurse-practitioners, substance abuse staff, medical and psychiatric consultants, and other outreach specialists. The team approach can also aid in combating burn-out and expanding caseloads (Axelroad & Toff, 1987) **and the inherent sense of isolation individual outreach workers can feel**. A study of five New York outreach programs showed that 98 percent of homeless mentally ill clients had a significant relationship with more than one staff member, indicating that involvement with the programs did not consist only of the client's relationship with a single worker (Barrow, 1988).

One survey of eight ACCESS-funded outreach programs reported that all sites used a team approach, with majority of first contacts made by two mental health professionals, one taking the lead and one observing (Wasmer, 1998).

Exemplary Outreach Functions/Services

Based on a review of the literature (Winarski, 1994, 1998; ICH 1991; Morse, 1996) and review of best practices in the field, several outreach functions/services are common among exemplary outreach programs.

Determine the Target Population

Outreach programs cannot serve all potential clients. Exemplary programs have clearly defined program goals and objectives. Some programs target a subset of the population, such as persons with mental illnesses, and others limit outreach to a particular geographic or "catchment" area (ICH, 1991).

If geographic limits or catchment areas are a defining factor in determining the target population, then the size of the area allows for repetitive contact. Knowing fewer clients better is the goal. Workers have the flexibility to leave this zone and follow their potential clients elsewhere (McQuistion, 1996). If a client is determined to be out of the mission of the outreach program, provisions can be made for referring non-target clients to the appropriate programs. (ICH, 1991).

Locate Street Dwellers

Once workers identify the target population, the next task is to locate them. Individuals can be found under bridges and freeway overpasses, alleys, parks, and vacant lots. In rural areas or on the fringes of urban areas, outreach workers may go to the beaches, riverbanks, foothills, wooded areas or desert. They may be in public facilities such as libraries, airports, and bus stations. They may be in places where people live on the edge of homelessness, such as welfare hotels, cheap motels, and SROs. Some teams have special arrangements with jails, detox/treatment programs or other institutions, to enter and make contact with ongoing clients or potential clients regarding available services on their release (McMurray-Avila, 1997).

Sometimes homeless persons will serve as voluntary scouts for outreach workers, alerting them to homeless persons who appear to be in need of intervention. Volunteer homeless persons can also help outreach workers locate clients who have been missing for some time. Outreach coalitions, comprised of outreach workers from different agencies, can meet periodically and help each other locate missing clients, as well as help each other stay on top of recent trends in geographic concentrations of homeless persons.

Outreach conducted by peers, such as youth, substance users, or sex industry workers, can be effective in locating, engaging, and completing assessments of the clients perceived needs. When going out in teams with non-peer professionals, they are able to introduce professionals to participants on the streets. **Youth who serve as peers/mentors for other homeless youth, for example, help convey a sense of understanding of the factors that may have led them to becomes homeless such as abuse and share resource information, teach safety, and help make a bridge between street life and the world of "professional" adults whom they generally don’t initially trust.** Hiring program participants encourages increased feelings of self-esteem and empowerment on

the part of participants and generates empathetic, effective outreach staff (Mullins, nd). **An effective outreach program for at-risk HIV youth in the sex industry in New York provides training to peer youth outreach workers, a support group, an active and real voice in program development, and a stipend for their work. These youth outreach workers have been successful in saving lives and reducing risk associated with their lifestyle and that of their peers in a way that adults could not have.**

Engagement

Engagement is a crucial, on-going, long-term process necessary for successful outreach (Morse, 1991, 1997). In a study of five New York outreach programs, homeless mentally ill clients first contacted by outreach workers were engaged an average of 3.9 months before intensive services began (Barrow, 1988).

Engagement reduces fear, builds trust, and sets the stage for "the real work" to begin (Cohen, 1987). Morse (1991) classifies engagement in terms of four "stages": 1) setting the stage, 2) initial engagement tactics, 3) ongoing engagement tactics, and 4) proceeding with the outreach/maintaining the relationship.

Setting the stage: Workers become a familiar face and begin to establish credibility in places where homeless persons frequent (Morse, 1991). They use a non-threatening stance/approach (Cohen and Marcos, 1992), and get some kind of permission from the client, either verbal or non-verbal, before approaching. In these early stages, workers gently cease interactions that appear too overwhelming to clients and try again later.

Initial engagement tactics: Workers attempt to engage the potential client in conversation, beginning with non-threatening small talk (Morse, 1991). This allows workers to assess for signs of problems and also the impact of the interaction. Is the client feeling intruded upon (Morse, 1991)? Workers provide incentive items (Cohen, 1989; Cohen and Marcos, 1992) such as food, drinks, condoms, cigarettes, vitamins, toiletries, etc., with real and perceived benefits that promote trust.

Ongoing engagement tactics: Workers begin to "hang out" and "share space" with clients (Morse, 1987). As clients become more comfortable, workers begin to provide or help the client to meet some important needs that can be easily solved or obtained. This might include providing transportation to get clothes, linking the client with medical care, and providing incentive services that are based on clients' perceived needs (Cohen, 1989). Engagement strategies used in the initial phase continue.

Proceeding with outreach/maintaining the relationship: As trust is established, workers help clients define service goals and activities, which may include the pursuit of housing, income, and medication (Morse, 1991). Staff accompany clients to appointments, help them prepare for upcoming tasks, and assist in the negotiation of service settings.

At Honolulu's Health Care for the Homeless Project, staff use six simple engagement strategies in their interactions with diverse groups.

- Treating people with positive regard, by demonstrating that workers are glad to see them and care about them. Workers remember details of past encounters and discussions. Workers are honest, humble, and share information about themselves when appropriate, to equalize power and respect.
- Working with their perceived needs
- Providing incentive items and services, as listed above.
- Letting clients set the pace whenever possible
- Communicating effectively, both verbally and non-verbally. For example, workers get to the client's level. If the client is sitting on the curb, the worker sits on the curb. Workers gauge the expression of language so that it fits with that of the client's in terms of vocabulary, speed, eye contact, and culturally relevant responses.
- Being creative. For example, an outreach dog is used by one worker. A pet is a great ice-breaker and has been effective in connecting with some paranoid and very isolated mentally ill persons. One woman who would previously never speak to workers, will now talk to the dog (but still not to the worker), providing opportunities for ongoing assessments, and topics for future discussions. Staff use art as an engagement tool, and incorporate client interests, like hobbies, books, and collections, in incentive items and discussions. When possible, outreach workers transfer engagement strategies on the streets to the clinics, where clients can receive further care. For example, a drawing by a client on the streets might be displayed in the clinic where pertinent services are offered. **Other effective programs use creativity as an outreach foundation and reach out and engage homeless persons through such non-traditional approaches as the use of theater, the arts, and creative grass-roots community organizing.**

Assessment

Workers need to conduct an assessment of an individual's comprehensive, holistic needs before providing services and linkages to meet these needs (Morse, 1987). The assessment process is informal and usually takes place over time. Outreach workers, rather than asking direct questions, may make inferences (Cohen and Marcos, 1992) about an individuals' mental and physical state. As the relationship builds, workers may be able to ask more direct questions as they try to get more history.

The crises faced by many homeless persons are usually related to basic survival, such as lack of food and water, lack of clothing, exposure, poor health, and deteriorated mental status. Outreach workers must initially provide basic triage assessment to help identify and respond to potential life-threatening problems.

When clients are experiencing potentially life-threatening problems such as dangerousness to self or others, serious medical problems, or exposure to extreme cold or heat, outreach workers must be prepared to intervene. Whenever possible, workers should encourage clients to voluntarily accept treatment, and present this treatment within the context of the client's perceived needs. When the situation is life-threatening, workers should be prepared to initiate involuntary treatment or interventions that will reduce

harm. Clinical supervision in this situation is highly recommended so as to not infringe upon clients' rights and self-determination.

Provide Basic Support

In response to a lack of homeless persons being able to get their basic needs met, workers help them to access food, clothing, shelter (Axelroad, 1987), showers, laundry, and basic medical care. **In some cases, homeless persons may not perceive these as basic needs, particularly in the case of those with severe mental illness who have decompensated and/or those with chronic substance use problems. They may perceive other needs as more important. In these cases, workers can educate people about the resources available when they're ready for them, encourage them to use them when needed, accompany them to the service sites, and suggest what may be a marriage of the worker's perception of what the homeless person may need, and what the person him/herself feels they need.**

Linkage

Outreach programs should attempt to engage individuals who are unserved or underserved by existing agencies, and link them to resources. Many persons who are homeless are unaware of what is available (McMurray-Avila, 1997). Effective workers learn about available resources and establish working relationships with the people who provide these resources. Workers also tap into the knowledge of other homeless persons, who are often more aware of details and subtleties of changing resources**. Effective workers are able to make durable linkages across systems: homeless/non-homeless systems, youth to adult systems, and across private and public systems. When these systems aren't user friendly to homeless persons, workers advocate for change.**

Advocacy

Clients who are disenfranchised and discriminated against, often need outreach workers to assume an advocacy role on their behalf. **This occurs on many levels such as when helping clients access benefits and services to which they are entitled, within the outreach worker's own agency, and within the criminal justice system. Indeed, in many communities, political views about homelessness are resulting in what may be perceived as meaner streets where persons are criminalized because of their homelessness. This can be seen in arrests for trespassing, criminal littering, and loitering. Legislation is increasingly pursued as a vehicle to continue criminalization of homeless persons, the effects of which are devestating to the homeless person and counterproductive to the outreach process.**

Follow-up

Effective workers provide short-term follow up with respect to immediate tasks at hand and long-term follow-up with clients to ensure that they remain in a stable situation.

Outreach Across Populations

Primary health, mental health, and substance abuse treatment approaches similarities in outreach approaches are found in different treatment areas and client populations including families, veterans, mentally ill and transgendered persons, sex industry workers, substance users, HIV+ persons, and youth.

Health

A significant characteristic of homeless persons is poor health. A one-year study of 300 mentally ill homeless persons in New York City, revealed that 73 percent suffered from at least one medical condition in addition to a psychiatric diagnosis. The most common medical conditions were peripheral vascular diseases, anemia, infestations, and respiratory diseases, particularly tuberculosis. 35 percent had a secondary diagnosis of substance abuse (Marcos, 1988).

A two-year study of 1,751 homeless clients in Honolulu showed exceptionally high rates of mortality, with an average life expectancy of 48 years. Death rates have long been used as a measure of deprivation and as a guideline for public health resource allocation. With that in mind, homeless populations are in urgent need of increased attention and health care spending (Martell, 1992). A Philadelphia study of mortality rates for homeless people was 3.5 times that of the general population (Hibbs, 1994). Another study showed that causes of death varied by age group: (1) homicide: men ages 18-24; (2) HIV/AIDS: persons 25-44; and (3) heart disease and cancer: persons 45-64 (Hwang, 1997). In a study of hospitalizations of homeless persons, admissions to acute care hospitals were five times greater than the general population. They were admitted nearly one hundred times more often to the state psychiatric hospital (Martell, 1992).

Health care delivery to homeless persons can be challenging due to: lack of insurance, distrust of service-providers, bad experiences with health care in the past, difficulty making and keeping appointments, difficulty with complex medical and follow up care routines, and lack of understanding or interest in health problems in relation to seemingly more important issues at hand.

As with mental health and substance abuse, health care approaches for homeless persons are based on a process of engagement, assessment, planning, advocacy, education/motivation, and follow up. There are different models of health care approaches to serving persons who are homeless. Health care services may be provided at either permanent or mobile clinics and at rotating sites, some of which may be near homeless shelters. Health care providers may include salaried or voluntary physicians, physician assistants, nurses, and/or nurse practitioners who comprise a medical team. They reach out to homeless persons at sites where they have agreements with the host agencies. The goal is to provide care and help clients access a more mainstream medical system that will continue to be available to them. Staff make referrals and arrange transportation and an escort if needed (Plescia, et al 1997).

Escorting clients to appointments can be critical if a person is unable to go on his/her own. Staff can help clients by making medical appointments, preparing them for the appointment (getting insurance card/paperwork in order, educating them about what might be expected), advocating for them if needed, translating medical jargon, and helping them follow through with aftercare instructions and appointments. Further, outreach workers can be the "eyes" and "ears" on the streets for health care providers who are monitoring clients from afar. When clients reach a dangerous state of health, outreach workers can elicit assistance from mobile medical outreach staff, or stationary medical staff who are willing to leave a clinic and provide in-vivo services.

Often, homeless persons are more willing to address health problems because of decreased stigma, compared to willingness to address mental health or substance abuse issues. As outreach workers continue to engage clients during the health care process, they can begin to slowly and gently address other issues. For example, they may work toward obtaining clinical history and the client's thoughts and perspectives regarding their experiences with mental illness, substance abuse, and other areas.

Outreach workers play a key role in illness prevention, from providing blankets and socks, helping clients access insurance and free medication/medical care, and educating them about topics like safe sex, hepatitis, TB, harm reduction, and nutrition. They can help clients get food and vitamins, and help them obtain past medical records and reconnect with previous service providers who may be familiar with their medical case(s). Outreach workers can also help by being aware of other organizations' involvement in medical care so that there can be nd ears" for psychiatrists and clinicians making decisions about the direction of mental health care.

Effective outreach workers are able to demonstrate flexibility in their treatment responses. For example, with some clients, the connection can be so tenuous that the engagement phase can take months or even years of gentle, slow, and careful interactions. Other clients' mental status may indicate the need to set limits. For clients who lack insight into their mental illness, workers take an education and normalizing approach, emphasizing the stressful nature of homelessness (Morse, 1991). Workers can help clients make connections between homelessness and their perception of the bad things that happen to them, hoping to spark some motivation to consider housing and other related social services. Workers can also help clients make connections between negative symptoms and the potential relief that medications or other interventions might offer. However, discussion about medication can only occur after sufficient trust has been established. For many people, the only mental health involvement they recall has been involuntary and coercive, usually resulting in unwanted medication and treatment.

Some clients may persist in denying the existence of a mental illness, but become successful in housing (Barrow, 1991). Workers can help clients translate street skills into independent living skills while treatment and referrals progress. Engagement strategies can help with linkage to services. For example, one client on the streets liked jewelry, and a lot of it. The outreach worker invited her to the clinic where health and mental health services are provided, stating that they had "a lot of jewelry there." The outreach worker

alerted staff, who the next day brought in jewelry from home and from thrift stores. The client enjoyed picking out one piece of jewelry every time she came to the clinic. This allowed linkage to services in a clinic where she learned to trust service-providers. Similar creative linkages are required to ensure success.

Outreach workers can help prepare clients as they begin to access services, at the same time informing staff at those agencies about the client's unique needs, strengths, and interests to help ensure successful transition.

Substance Abuse

Outreach to substance users crosses many sub-groups, such as those with dual diagnoses, sex industry workers, and persons with HIV/AIDS. One major gap in services to persons with substance abuse problems is the lack of an entry point into services for those who don't want formal treatment (Bonham, et al., 1990). A sub-group of this population are the "public inebriates" (Willenberg, et al., 1990). Three errors in treatment modalities have contributed to failures with this population. One is that the population is severely and chronically disabled. Second, programs often have unrealistic and high goals. Third, treatment models used are those that are more successful with middle-class, non-alienated alcoholics (Willenberg, et al., 1990). Moreover, treatment programs often fail to take into consideration cultural factors and fail to address the serious marginalization of disenfranchised groups. Engagement strategies are much the same as with health or mental health outreach—a non-judgmental stance, listening, educating, and linking. Project Connect's service model is based on principles that services fit client needs, focus on their strength rather than weaknesses, and that the worker/client relationship is primary and essential (Bonham, et al., 1990). Worker activities can include education about safe sex and safer drug use and newsletters, and connecting clients to support groups and sobering up stations (Bonham, et al. 1990). Incentive items may include vitamins, condoms, bleach kits, and clean needles. Alcoholics and drug users who are homeless frequently lack the motivation or skill to seek out currently available services. They often distrust service-providers because of real or imagined poor treatment in the past, or difficulty negotiating the system (McCarty, et al., 1990).

Since many street users do not have insight into the harmfulness of their drug use, outreach workers may implement the use of a "Motivational Interviewing" (Miller and Rollnick, 1991) or "Stages of Change" (Prochaska, et al., 1994) approach. Programs may want to consider training in these models for all staff, rather than having one designated substance abuse counselor. Homeless persons with co-occurring substance abuse issues will be better served by outreach workers with a working familiarity with these models. Workers are familiar with and provide linkage to community resources or support groups, when the person begins to express interest. A Harm Reduction approach is generally the best engagement strategy.

The main tenets of Harm Reduction are:

- a non-judgmental and respectful approach

- helping residents to identify harmful effects of drug and alcohol use and the benefits of decreasing and/or ceasing use
- exploring alternate, safer routes and patterns of use
- praising small successes
- developing flexible plans that address substance abuse issues.

Common strategies successfully used to help addicted homeless persons include:

- Stabilization services like detox centers (McCarty, et al., 1990), inebriate reception centers (Bennett, 1990), and sobering-up stations (Bonham, et al., 1990) help to address immediate needs, provide respite, and an entry to substance abuse services.
- Case management services (McCarty, et al., 1990, Bonham, et al., 1990, and Willenberg, et al., 1990) help link persons to services, provide support, and help clients reach decisions regarding their own recovery. Persons can move back and forth between basic and intensive case management based on their needs (Bonham, et al., 1990).
- Jail liaisons (Bonham, et al., 1990) help explain services and link clients to them, identify those in need of case management, track clients, and advocate for mandated treatment rather than incarceration for revolving "public inebriates."
- Vocational training (Bonham, et al., 1990 and Ridlen, et al., 1990) in a variety of areas is offered to homeless men and women who are ready for such services.
- Housing in conjunction with supportive services (Willenberg, et al., 1990 and Ridlen, et al., 1990) are offered along with education in areas of housing management like tenant rights, budgeting, and problem-solving. Families are further assisted in areas of childcare and linkage to schools (Ridlen, et al., 1990).
- Drop-in centers (Bennett, et al., 1990) which offer showers, meals, information and referral services, on-site substance abuse services, benefits counseling, telephone, transportation, a warm, homelike environment, and friendly faces.
- Access to treatment (Bennett, et al., 1990). Successful programs reduce barriers for homeless persons needing substance abuse treatment. This may include reserving a percentage of beds for homeless persons, reducing waitlists, and improving inter-agency relationships.

Measurable Outcomes

Successful Outreach and Engagement Strategies

Studies have shown that outreach and engagement strategies, while initially time-consuming and slow-moving, are successful because they reach more severely impaired persons who are less motivated to seek out services (Lam and Rosenheck, 1998). Three month outcome data compiled via the ACCESS study (Lam and Rosenheck, 1998), showed that clients reached in outreach on the streets experienced improvement on nearly all outcome measures equivalent to clients who were contacted in other services agencies and shelters. Outreach clients did equally well in areas of housing outcomes, quality of housing, improved mental health and decrease of psychiatric admissions, substance

abuse, employment, social support, reduced victimization, and quality of life. This suggests that this hard-to-reach population has the same capacity for improvement as groups more connected to services and who may be more high-functioning.

The ACCESS program has demonstrated that people will use services if they are accessible and relevent and that effective outreach will lead to an increase in access to other services. Although helping homeless persons access mainstream services is difficult nationwide, ACCESS has shown that programs with sufficient resources can help people to be successfully treated in a community setting and that the bridge from homeless services to mainstream services is possible.

Positive housing outcomes, a major focus of homeless services, was also found by Bybee, et al., to be linked to outreach services (1994 and 1995). The likelihood of success in independent living was impacted by the amount of services, and a wide range of interventions and the intensity of those interventions and services. Recruitment sources also impacted housing success, in that those recruited from inpatient psychiatric settings were more likely to experience housing success than long-term Community Mental Health clients, suggesting that greater stabilization possibilities follow acute psychiatric episodes across populations. Anyone may have the opportunity for successful housing placement following a crisis. Those recruited from shelters also had greater likelihood of successful independent living, but also may continue to live in temporary settings, suggesting the variance of the degree to which persons from shelters can be easily housed. There was a smaller, yet significant predictability between housing status and client functioning, symptomatology, and substance abuse problems.

Quantitative Measures

Improvement is often so subtle that it doesn't register on typical functional improvement scales. One program measures number of days per month spent in housing, number of times victimized, level of hygiene, number of contacts with other service providers, and so on (Axelroad, 1987).

In some cases, quantitative measures can be deceptive, as evidenced in Barrow's 1988 survey. After a six month survey of completed referrals, only a small minority were successful, such as only 24 percent of entitlement referrals, 42 percent of housing referrals, and 13 percent of psychiatric referrals. While this appeared to be a reflection of ineffective services, it also reflected a short study period, discrepancies between client and program perceived needs, and lack of resources.

One outreach program measures success by four criteria: present living arrangement, receipt of financial aid or other income, enrollment in a program for the treatment of alcohol abuse of mental illness when appropriate, and receipt of treatment for other medical conditions. The first year's data suggest that about four out of five persons have made at least one significant change (Rosnow, 1988).

Project Connect uses quantitative methods including face to face pre- and post-interview data with clients, monthly program data on clients, self-administered pre- and post-questionnaire data for community agency staff, and selected administrative record data from Project Connect agencies (Bonham, et al., 1990).

As part of the continuum of care delivery, workers can implement successful strategies described in Critical Time Intervention (CTI) to prevent recurrent homelessness and promote successful transitions to housing. One component of CTI is to strengthen the relationship between the individual and family, friends, and services, and secondly to provide emotional and practical support during the critical time after discharge from a shelter. Outcomes of CTI included significant reduction in homelessness and a preliminary indication that CTI is cost-effective (Jones et al., 1994, Susser, et al., 1997). Interventions are short in duration, simple, can be implemented by nonprofessional staff, and can be implemented in marginal settings (Susser et al., 1997).

A series of studies of homeless veterans by Rosenheck et al. (1989, 1993, 1995) evaluated the impact of outreach programs for homeless veterans with mental illness and found that outreach services are successful. The 1993 study found that outreach services increased access to outpatient and domiciliary services and reduced inpatient services. The 1989 study found outreach to be successful in that a significant number of homeless vets eventually wanted services and that outreach and advocacy efforts enhanced access to health care services. Outreach services have been found to be costly although there was a slight reduction in inpatient costs. Rosenheck, et al. (1995) caution that one cannot conclude, on the basis of cost alone, that less expensive treatments should replace more expensive ones. Many outreach programs have found that the initial cost of outreach and engagement pays off in the end.

Studies evaluating substance abuse programs found that offering an array of stabilization services along with case management services, contributed to recovery and utilization of services (McCarty, et al., 1990, Willenberg, et al., 1990, and Ridlen, et al., 1990).

Qualitative Measures

Qualitative measures are useful for service providers in evaluating program functioning (Axelroad, 1987). One helpful technique is questioning formerly homeless individuals who have been outreach clients to find out which elements in the outreach team's approach were appealing or useful and which were perceived as negative. Project Connect uses ethnographic observations, interviews, and journals maintained by immediate program personnel (Bonham, et al., 1990). Qualitative evaluations can also be helpful in demonstrating to potential funders the complex nature of clients, outreach efforts, linkages, and length of engagement periods (Axelroad, 1987).

Challenges and Limitations In Determining Effectiveness

The very factors which contribute to a successful outreach effort—flexibility, ability to alter service systems—may impede evaluations which strive to concretely measure their

effectiveness (Axelroad, 1987). There is a lack of controlled studies that demonstrate effectiveness and a lack of longitudinal studies. These are critical evaluation designs, yet are often difficult to implement with outreach clients who may be difficult to track.

Evaluations aimed at measuring the overall effectiveness of an outreach program must focus on the extent to which services and resources are available to outreach clients. In addition to evaluating effectiveness of services provided by the program, programs must also determine who is not being served by the program (Axelroad, 1987), why they are not being served, and how they might be served in the future.

Successful outcomes are not necessarily related to program services and should be considered in evaluating those programs. In one study, for example, success in obtaining housing and remaining housed were found to be related to socioeconomic background, defined by education and past employment, and level of functioning. Program services that were related to positive housing outcomes included an early focus on entitlements and housing-related services and participation on the part of the homeless person in defining housing goals were critical to their long-term success (Barrow, 1991).

While it is difficult to generalize outcome parameters across populations, regions, culture, and other factors across the country, a standard set of street outreach outcome measures is desirable at the national level. These standard outcomes should be different from standard outcomes used for other homeless populations which may be unrealistic for outreach populations. Outcome standards should also be set by individual programs. HUD requires Supportive Housing applicants to provide goals and objectives and later the extent to which goals were attained.

Future research and programmatic goals might include: identifying what national homeless outreach measureable outcomes might be; identifying specific factors that allow for successful transition from homeless to mainstream systems for the general outreach homeless population and for specific populations; the extent to which outreach teams are successfully used; the extent to which peer based outreach models and consumer involvement in program planning, implementation, and evaluation are successful; the development of more controlled and longitudinal studies; how the use of data-tracking within information systems might be implemented ethically and effectively; incorporating outreach outcomes within the managed care system; and the cost-effectiveness of providing outreach services and answering whether or not exemplary practices should be equated with effectiveness.

To Dance In A Bigger Ballroom—Toward Exemplary Practice At All Levels

There are effective strategies for influencing the adoption of exemplary practices and policies on each major administrative level—agency, local community, state and federal. There are also many questions still open for discussion. Outreach workers rarely can be successful unless exemplary practices exist at other levels.

Agency

Effective administrators or program directors must educate the agency board about outreach activities and philosophy and advocate on behalf of outreach staff at the board level. Directors must also support the outreach team and advocate for their efforts with other service providers in the community; (Axelroad, 1987; Wobido, 1990).

Outreach staff must be given flexibility in work schedules so they can seek out and find persons in the evening and on weekends. Funds must be available for incentive and basic need items, as well as equipment. Providing outreach workers with on-call medical and psychiatric consultants is critical as is promoting a sense of teamwork—preferably a multi-disciplinary one. This helps workers feel supported and provides them with tools with which they can provide better services. Exemplary agencies, with outreach as a component, make provisions in service delivery for outreach clients, like allowing clients to receive medical/ psychiatric/substance abuse services when needed rather than by appointment. They allow bypassing of unnecessary forms and paperwork, and adopt the engagement stance.

Orientation and training of new outreach staff is critical particularly in the area of street safety. Training should include: street safety, characteristics of the target population, substance abuse/dual diagnosis, the criminal justice system, benefits and entitlements, community resources, involuntary hospitalization, client rights, harm reduction, confidentiality, de-escalation, boundaries, CPR, basic first aid, regional laws regarding child and elder abuse, engagement strategies, cultural competency, and infection control. Safety training should require that new staff sign a document indicating that they understand safety guidelines. This makes worker risks clear prior to hiring, while protecting the worker from injury and the agency from future liability.

Outreach workers often feel a sense of isolation in the field, from other homeless and non-homeless service providers and are likely to be viewed as marginalized themselves. As a result, agencies need to ensure a system of support, advocacy, and inclusion for their outreach staff.

Exemplary agencies provide opportunity for ongoing discussion around ethical issues. Clinical supervision and/or peer supervision is recommended for outreach staff who need to get second opinions on implementation of their ideas to creatively engage persons. The question must always be asked, to what extent are the engagement strategies used by workers non-coercive and non-deceptive (Lopez, 1996)? Supervision can also address issues like engagement versus enabling, boundaries, legal issues, and service-provision.

Outreach workers sometimes get harassed and are discriminated against along with their clients. If outreach workers function as service and/or rights advocates, their agency needs to determine which parameters of advocacy efforts are allowed and encouraged. They should also develop positive relationships with police and security personnel. Finally, outreach workers should attempt to develop positive relationships with intake workers and staff at other agencies where they might refer clients.

Community

In addition to direct services, outreach workers and administrators can enhance the knowledge base of effective outreach practices on a community-wide level, by providing consultation, education, training and referrals (Morse, 1991; Slagg, et al., 1994). Outreach workers can start an "outreach coalition," sharing resources, ideas, information, client tracking efforts, and mutual support. This process is essential in providing linkages to resources. In many communities, there are a dearth of resources, and outreach workers end up providing intensive case management, in a continuous relationship model.

Outreach workers can share success stories—they encourage other workers, combat the community's "compassion fatigue," and give hope to those clients still in crisis. Success stories are an essential part of informing funders, politicians, and policy-makers that services work.

Outreach programs cannot be designed in isolation from other service programs (Axelroad, 1987; Morse, 1987; Barrow, 1988). Survival depends upon community networking: providing referrals, sharing resources, pooling knowledge, and participating in community-wide groups (Nasper, 1992). In discussing outreach, it is essential to discuss the gaps and barriers in these systems (Axelroad, 1987). The most flexible, well-staffed and funded outreach program will have little impact if the mental health, health, housing and social service systems in a community are not capable of serving people linked through outreach efforts.

One urban outreach program made efforts to minimize coordination problems by expanding the makeup of a coalition with representatives of human service organizations in both the public and private sector; getting active participation with various planning and coordination bodies concerned with homelessness; and structuring the outreach program so that the workers could become familiar enough with their counterparts in other service-provider agencies (Rosnow, 1988).

Public-private partnerships can lead to effective service-provision. One example is the Times Square Consortium (TSC). This is a partnering of the Times Square Business Improvement District and social service agencies to provide outreach and a drop-in center for homeless persons in the Times Square area. Rather than a business-community attempting to simply arrest and move along persons who are homeless, they provided the impetus for social services. Together the TSC has applied for and received funds from state and HUD (Porter, 1997).

Project Respond in Portland, Oregon, won the 1997 Gold Achievement Award by the American Psychiatric Association for its exemplary outreach program. Exemplary community practices cited include successful and collaborative relationships with "community partners" like police, housing managers, service-providers, and businesses. Also cited was the reduction of stigma, seeking of missing persons, consultation, community education, including police education, and diversion (Talbot, 1997).

These approaches are heartening in an apparent climate toward the criminalization of homeless people. There has been an increase in anti-vagrancy laws which prohibit sitting, panhandling, or being in an airport during certain hours. Outreach is one of the few formal contacts where service professionals connect with homeless people who may be breaking laws. Outreach workers and their agencies could be held legally accountable because of their association with these homeless persons.

State/Federal

One outstanding issues that still needs to be addressed at the state/federal level is funding. Who should pay for outreach? Through the Continuum of Care process, communities are encouraged to include outreach as part of the continuum. On a national level, service-providers must advocate that managed care plans make point-of-access exceptions for homeless persons, and the homeless Medicaid population must be carved out of Medicaid managed care and financed separately (Plescia, 1997).

The cost-effectiveness of outreach programs often comes into question. One reason is related to the comparison of numbers of people served on outreach versus the number of people served in homeless shelters. If funders think of effectiveness in terms of the numbers of people served, then homeless shelters will be viewed as more effective. The people outreach programs tries to serve are those who don't readily come to and accept services and who need a period, sometimes a lengthy one, of engagement. The positive outcomes of outreach services may not be readily seen. Yet, the cost of providing outreach services may divert costs from other systems such as emergency rooms, hospitals, psychiatric units, jails, and other crisis systems of care. This issue also reflects a structural obstacle to demonstrating cost savings between systems. For example, at the federal level, HUD funds many outreach programs, but the cost savings are realized in other systems such as Medicaid, the mental health system and substance abuse system. The same obstacles to demonstrating cost savings exists at state and community levels as well.

Agencies and communities need to ask what more could be done on a federal level to support outreach programs. One possibility could be a requirement of outreach services in states' Medicaid plans. HUD does not fund emergency services or prevention of homelessness, and perhaps they should. Another possibility, could be a mandate that all Continuum of Care proposals include a strong outreach component, with penalties if outreach is not included.

More publications and guidelines for outreach are needed. Federal departments charged with addressing homelessness could provide "how to" information for service providers, and present options for service delivery based on research findings. Exploration of the range of services could be done nationally to determine specific trends related to successful outreach. Inquiry into what is optimal and what should be expected of outreach programs can take place federally. For example, the authors are familiar with outreach programs with a range of hours—from weekdays only to 7 days/week 16 hours/day. What have we learned about optimal services delivery? Several cities combine

outreach with police escorts. Does this implied concern for worker safety in fact drive away potential clients and eliminate a Harm Reduction approach? Expertise is needed in this area if outreach programs decide to try and build collaborative relationships with police and security.

Homelessness among severely mentally ill persons, and chronic substance abusers represents a failure of state and federal policy to adequately address or sustain long-term community support systems. Rather than stimulating new funding mechanisms and service delivery systems, they should be preventing homelessness by bolstering basic community resources for the long-term care of disabled persons (Rosnow, 1988). In the long run, prevention efforts should be incorporated in structural measures to prevent homelessness and provide appropriate services to those with chronic disabilities.

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Return to the Table of Contents, ASPE Home Page, or HHS Home Page.