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"They Just Helped Save My Life:" Client Perspectives on the Los Angeles County Full Service Partnership (FSP) Program for Serious Mental Illness

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Abstract

The purpose of this qualitative study was to elicit client perspectives on the Los Angeles County Full Service Partnership (FSP) program - an adaptation of Assertive Community Treatment (ACT). Semi-structured interviews were conducted with 20 FSP clients. Qualitative data were analyzed using thematic analysis. Two major themes were identified from the interview data: (1) Clients' acknowledgement of the material benefits of the FSP program; and (2) FSP's impact on restoring and stabilizing clients' social and treatment relationships. Interviewees greatly valued the material (i.e., basic needs, housing assistance) and relational (i.e., relationships with providers, restored personal relationships) aspects of the program, but did not ascribe the same degree of value to mental health treatment. Interviewees' emphases on material and relational aspects reflect the status of assertive mental health treatment as an intervention on intermediary determinants of health in the lives of persons diagnosed with serious mental illness.

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Keywords

Full Service Partnership (FSP); Patient-Centered Treatment; Assertive Mental Health Treatment; Social Determinants of Health

Introduction

Serious mental illnesses (SMI) (e.g., schizophrenia, bipolar disorder) affect 5.6% of adults in the United States and can be associated with significant functional impairment (Substance Abuse and Mental Health Services Administration, 2021). Evidence suggests that individuals with SMI frequently experience co-occurring substance use disorders, housing instability or homelessness, violence victimization, relational instability, criminal justice involvement, and physical illness (Elbogen et al., 2021; Hunt et al., 2018). On average, there is a 10- to 20-year mortality gap between those who do and do not have SMI. This gap is driven by factors such as greater rates of untreated chronic medical illness, higher rates of suicide, and inadequate basic needs support (Parks et al., 2006).

An evidence-supported approach to addressing whole-person needs for individuals with SMI in community settings is Assertive Community Treatment (ACT) (Bond et al., 2012; Spivak et al., 2019). ACT emerged in the 1970s as a comunity-based program for individuals exiting long-stay psychiatric hospitals. ACT sought to bring mental health treatment into community settings, to meet basic needs (i.e. food, clothing, shelter, transportation), and to prevent crises and re-hospitalizations. The model grew to include multidisciplinary staffing (i.e. psychiatrist, nurse, therapist, case manager, substance abuse counselor, and employment coach), an integration of services through team-based approaches, low client-staff ratios that ensure the intensity of service delivery, assertive outreach and proactive medication management, and rapid and flexible responses to clients' concerns and crises (Bond et al., 2012; Test & Stein, 1976). ACT has been tested in 25 randomized controlled trials, which show positive client outcomes in terms of psychiatric hospitalization rates, housing stability, psychiatric symptomatology, treatment engagement, and quality of life (Bond et al., 2012; Nelson et al., 2007). Qualitative interviews with ACT clients indicate that the establishment of trusting relationships with service providers is one of the most beneficial aspects of the program. This relational foundation motivates client treatment engagement and contributes to stability in other areas of life (Davidson, 2003; Leiphart & Barnes, 2005).

While the ACT model proved effective in sustaining clients in the community, practical and financial difficulties (Odden et al., 2019) in adhering to high-fidelity (Rosen et al., 2007; Stanhope & Matejkowski, 2010; Teague et al., 1998; Winter & Calsyn, 2000) ACT programming standards often led state and local governments to implement ACT-like programs, which did not aim to meet these fidelity marks. Such ACT adaptations are now more prevalent in the United States than high-fidelity ACT programs (Moser & Monroe-DeVita, 2019; Spivak et al., 2019). An example of an ACT adaptation is the Full Service Partnership (FSP) program in California. Passed in 2004, Proposition 63, or the California Mental Health Services Act (MHSA), enacts a 1% yearly tax on personal incomes greater than $1 million and generates approximately $1 billion per year for public mental

health treatment in the state of California (California Mental Health Services Oversight & Accountability Commission, 2022). 60% of yearly MHSA funds are allocated toward FSP (Los Angeles County Department of Mental Health, 2022). FSP serves a racially diverse and financially disadvantaged adult population. In Los Angeles County, 24.3% of adult FSP clients identity as Hispanic, 33.0% as Black, 30.4% as non-Hispanic white, and 5.5% as Asian/Pacific Islander (Ashwood et al., 2018). FSP programs share many features of ACT, including enrollment of individuals living with SMI diagnoses and who experience homelessness, criminal justice system involvement, or frequent psychiatric hospitalization; high staff-to-client ratios; multidisciplinary treatment teams; and services delivered in the field rather than in the clinic. FSP programs provide medication management, linkages to substance abuse services, housing supports, and supports for daily living (ex. transportation, education, healthcare), with the underlying mission of sustaining clients in community living (Gilmer et al., 2010, 2013; Starks et al., 2017). In Los Angeles County, FSP programs differ from the ACT model in that visit frequency may be less than recommended in ACT and team staffing may not match ACT recommendations. The philosophical approach of FSP places a strong emphasis on client choice and client-driven recovery (Starks et al., 2017). In general, client-driven service models are defined by their prioritization of clients' treatment goals (ex. quality of life) in addition to providers' goals (ex. psychiatric medication adherence) (Comiskey et al., 2021; Fentress et al., 2021; Mancini, 2008).

There have been several evaluations of FSP program components, including peer support and housing assistance (Gilmer et al., 2013; Siantz et al., 2017). However, little is known about how FSP clients themselves experience the FSP program. The 1 mixed-methods evaluation (Starks et al., 2017) of the initial implementation of FSP made a sub-stantial effort to gather client experiences through surveys and interviews. However, a summary publication (Starks et al., 2017) from this evaluation focused largely on quantitative indicators of program outcomes and included limited in-depth exploration of qualitative client experiences. This lack of client-centered evaluation of FSP in the literature is a significant gap for a client-driven program. To better understand client-centeredness in FSP programs, the present qualitative studyaimed to explore client perspectives and experiences with FSP in four major outcome domains: (1) relationships with family and friends; (2) employment, education, and volunteering; (3) basic needs, including housing, obtaining food, and receiving medical care; and (4) mental health treatment.

Methods

Design and Data

Data gathering for this qualitative and descriptive study took place in Los Angeles from November 2017 to January 2018 as part of a mixed-methods evaluation of FSP programs run by the Los Angeles County Department of Mental Health (Ashwood et al., 2018).

Sample

The FSP program in Los Angeles County serves approximately 7,000 adults (Los Angeles County Department of Mental Health, 2022). Convenience sampling was used to recruit clients who had participated in the FSP program for at least 6 months. Flyers were emailed

to 16 of 183 FSP clinic sites across Los Angeles County. These sites were selected in collaboration with Los Angeles County Department of Mental Health leadership as the sites serve large numbers of FSP clients and were willing to participate in qualitative evaluation activities. Forty-eight interested clients left a voice-mail at a dedicated study phone number. The research team attempted to contact each client who left a voice-mail. In 28 cases, the contact number was disconnected or the client did not answer after multiple attempts. The final study sample was 20 clients from 7 FSP sites.

Procedures

Informed consent was obtained from all interview participants or their legal guardians, if applicable, prior to the interview. Three authors (BE, FM, KC) conducted semi-structured phone interviews with participants, which lasted from 20 minutes to 2 hours. Interviews began with an open-ended ‘grand tour’ question to encourage interviewee sharing of lived experiences with the FSP program. Participants were asked questions about the impact of FSP enrollment on 4 major domains of life function: (1) relationships with family and friends; (2) employment, education, and volunteering; (3) basic needs, including housing, obtaining food, and receiving medical care; and (4) mental health treatment. Participants were encouraged to elaborate on their own understandings of each area of impact and were also asked how their FSP programs could improve in meeting their needs in these areas. Interviewers used a topic grid to ensure that all relevant areas were covered in the order preferred by interviewees. Each interview was audio-recorded and professionally transcribed prior to analysis.

Data Analysis

Thematic analysis was used to derive themes from interview data (Braun & Clarke, 2006, 2012). One author (BE) read each interview and organized participant responses into each of the 4 major domains of impact explored in the interviews (relationships with family and friends; employment, education, and volunteering; basic needs; mental health treatment) using ATLAS.ti software. Then, 2 authors (BE, BB) used inductive thematic analysis to identify underlying themes within and across each of the 4 major domains (Braun & Clarke, 2006). Coders first reviewed interview transcripts for data familiarization. Then, each interview was systematically coded for meaningful segments of data. Authors BE and BB met to compile groups of codes and construct themes from meaningful code clusters. Candidate themes were then reviewed with the full authorship team to develop final themes with central organizing concepts.

Conflict of Interest, Institutional Review Board, Author Certifications

The authors report no financial relationships with commercial interests or other conflicts of interest in the completion of this study. This work was supported by the California Mental Health Services Authority, with funds provided by the Los Angeles County Department of Mental Health, who had no involvement in study design; in the collection, analysis, and interpretation of data; or in the decision to submit the article for publication.

The study was approved by the RAND Institutional Review Board.

All authors certify their responsibility for this manuscript.

Results

Sample Description

Twenty clients from 7 sites enrolled in the study. All but 2 clients had been in their FSP program for over a year. Across enrolled clients, average time in program was 5.5 years (SD 7.7 years; range 7 months to 10 years). Average client age was 48.7 years (S.D. 13; range 21 to 72 years). Twelve participants self-identified as female and 8 as male.

Interview Themes

Two major themes were identified from interview data: (1) Clients' acknowledgement of the material benefits of the FSP program; and (2) FSP's impact on restoring and stabilizing clients' relationships. At the beginning of each interview, interviewees were asked to respond to an open-ended question regarding the single most salient aspect of FSP to their lives. 40% of interviewees (n = 8) emphasized material aspects of the program, including basic needs care and housing. 35% (n = 7) emphasized relational aspects of the program, including improving or creating new relationships with providers, other staff, family, and friends.

A minority of the sample (25%, n = 5) emphasized mental health-specific benefits such as diagnosis and treatment. Most interviewees discussed the relational and material benefits of FSP even when asked about mental health treatment. Interviewees provided only passing commentary, and little to no detail, on the impacts of psychiatric medications and other mental health-specific treatments. They incorporated comments on medication management and therapy into discussions of the benefits and drawbacks of relationships with psychiatrists, psychologists, nurses, case managers, and other FSP staff members. Below, we further summarize, as well as provide illustrative quotes for, the interviewee-elicited themes of material and relational benefits.

Theme: Clients' Acknowledgement of the Material Benefits of the FSP Program—All interviewees commented on the significance of material assistance provided by their FSP programs. Interviewees reported receiving a spectrum of basic needs support including clothing, furniture and appliances, laundry, food, cleaning, cooking, showers, medical care, legal services, transportation, and banking assistance. Interviewees spoke of the necessity of having basic needs met prior to realizing other goals such as repairing relationships, obtaining employment, and enrolling in school. From the perspective of participants, the FSP programs built a foundation to realize these goals.

Most interviewees were or had recently been homeless for periods of months to years. In reflecting on the role of FSP in meeting basic needs, many participants emphasized that receiving housing assistance from their FSP programs was the most meaningful material benefit. Some reported receiving assistance managing money to pay rent, applying for and obtaining social security disability insurance, and obtaining loans to make housing payments. One interviewee shared:

> (Client 1) When I came out of jail, I didn't have anywhere to stay and I was out on the streets. So, this really helped save my life […] because I was going through some mental issues and needed my medication. […] [My FSP program] helped me get back on my medication and they helped me find housing. That's how I got on a team and I've been going there for a while. They really helped save my life because I didn't really know anything about what to do at that time, because I was just stranded. I had to go to a DUI [driving under the influence] class. I had a little bit of money. I didn't have a place to stay. I lost my car in impound, so I was living on the streets […] They just helped save my life.

Interviewees also described receiving assistance from their FSPs in registering for classes at local colleges and trade schools as well as applying to jobs. Some worked part-time at their FSP as a form of job training (e.g. secretarial duties, cafeteria work). Several interviewees described these training opportunities as playing central roles in their future material security.

Theme: FSP's Impact on Restoring and Stabilizing Clients' Relationships—All interviewees commented on the salience of relational aspects of their FSP programs. This theme included 2 subthemes: first, highlighting the impact of FSP in assisting in the repair of old relationships and the establishment of new relationships with family and friends; and second, emphasizing the importance of relationships with FSP staff to client wellbeing and recovery, though finding staff turnover to be a major barrier to relational stability.

Sub-theme: Repairing and Rebuilding Personal Relationships: Interviewees commented on the ways in which FSP interventions, such as housing assistance, medication management, and treatment for substance use disorders helped them to revitalize relationships with family and friends. One interviewee described the impact that housing assistance had on his relationships with family members:

> (Client 2) It actually gave me the ability to kind of complete that family unit. […] The first time I got my own apartment […] was very significant. That was my first, first. Like, Oh, I got to go to sleep in peace because my kid's right here next to me.' So [my FSP] gave me that opportunity to actually start my family up. You know, have constant and […] consistent visits with my child, be a part of his life. Have my mother over more, so our dynamic smoothed over. Things became a lot more peaceful between my mother and I. She saw I was doing things that I should be doing.

Several interviewees credited FSP with helping them end abusive relationships. One described her experience working with a FSP psychologist to end a relationship:

> (Client 3) The relationship that I was in, how depressing it was, how unsupportive it was and how it was just a go-nowhere relationship. Like areas that I'm working on for myself is self-esteem and setting boundaries but I couldn't set any boundaries with somebody who was verbally abusing me and psychologically abusing me. I couldn't hardly build any self-esteem with that type of relationship, either […] The psychologist helped me […] She used to tell me different ways of looking at it and

> different things that turn out and just how abusive - those things never get better, they only get worse. And I think, I don't know, it helped me realize how … I don't know. I wanted to move on in my life. I knew that I had to get out of that relationship to move on. So, so far, I've been able to.

Interviewees also sought out and formed relationships with other FSP clients. These relationships provided social support and awareness of others' experiences with mental illness. These connections reassured interviewees that their own mental health and other personal strivings were understood.

Sub-theme: Meaningful Relationships with Service Providers Complicated by Staff Turnover: Interviewees' comments on therapy focused on the relational aspects of FSP. Interviewees described a variety of ways in which therapy (e.g., goal-directed talk therapy, group therapy) provided by FSP programs helped them cope with daily challenges, maintain connections with others, and defuse stressful situations. One interviewee described her weekly talk therapy as an exercise that: (Client 4) Assists me with moving forward and improving the quality of my life. [Therapy provides a] 'toolkit' [of strategies for] personal engagement, trauma, barriers, goals, hopes, dreams, fun, balance.

Interviewees strongly emphasized the importance of attentive, trusting, and respectful relationships with FSP staff (in particular, psychiatrists, psychologists, case managers, and nurses). Some went so far as to describe client-staff relationships as dependable and family-like in nature. One client shared: (Client 5) I feel comfortable. I feel that I can go ahead and let them [program staff] know whatever is on my mind, whatever is bothering me […] I do have a place of support all day if I want, every day.

Interviewees expressed strong opinions about the ways in which relationships with staff could be improved, chiefly through continuity in client-staff relationships. Interviewees indicated that promises made by staff should be kept if and when possible, particularly those related to services such as housing. Interviewees repeatedly raised concerns over the issue of staff turnover. The extent of this problem can be seen in one interviewee's comment that: (Client 6) [My FSP] is very fluid. One week you'll come and you'll know everybody and the next week, you don't recognize a face.

Interviewees requested the opportunity to provide input on the staff make-up of their FSP teams, to be treated respectfully by staff (e.g., not being spoken to firmly; not being talked down to), and to have more face-time with FSP providers, particularly psychiatrists and psychologists. Interviewees asked for more provider hires in order to meet client demand for therapy and medications as well as more group programming.

Discussion

This study explored clients' perspectives of an ACT adaptation, the Los Angeles County FSP program. Interviewees noted material interventions (e.g., safe and long-term housing) and interpersonal programmatic aspects (e.g., relationships between clients and their providers, other staff, peers, and family members) to be the most beneficial elements of the FSP program. Interviewees generally did not emphasize benefits from psychotropic

medication treatment, though some did speak positively about therapy. The FSP program intends to promote community stability for individuals with SMI through intensive psychiatric treatment and wraparound services (Los Angeles County Department of Mental Health, 2022). While providers often prioritize psychotropic medication adherence in maintaining such stability (Pyne et al., 2006), client interviewees in the present study clearly conveyed that social supports – in the way of basic needs resources and relationships - are the most beneficial aspects for them. Of note, this finding of basic needs as a client priority in FSP contrasts with findings of a previous mixed-methods evaluation, which focused its client questioning more narrowly on mental health treatment (Starks et al., 2017).

Interviewees' emphases on these material and relational aspects echo arguments made by the World Health Organization (WHO) about the significance of intermediary determinants of health (World Health Organization, 2010). The WHO describes structural determinants of health as the macroeconomic, social, and public policies, as well as cultural and societal values, that produce health inequities structured around race, gender, class, education, occupation, and income. Structural determinants operate through downstream intermediary determinants, including material (housing and basic needs care) and psychosocial (social support) circumstances, to produce health outcomes (Brooke-Sumner et al., 2015; Menear & Briand, 2014; World Health Organization, 2010). ACT adaptations like FSP could be understood as interventions on such intermediary factors. FSPs impact health by creating a downstream buffer against structural inequalities and deprivations. From the perspectives of FSP clients with SMI in this study, addressing such intermediary factors was essential to ensuring mental well-being and was perceived as possibly more important than direct psychiatric services. In effect, through an income tax on wealthy Californians, the FSP program redistributes societal resources to build community mental health infrastructure (Erickson, 2021); it thus provides thousands of persons with intensive mental health treatment and basic needs care.

Although clients spoke positively about the meaningful relationships they developed with FSP providers and staff, staff turnover was a major source of dissatisfaction and relational instability for clients within the program. Studies suggest that staff turnover in mental care health is high in general estimated at 25–50% per year, and that this turnover contributes to challenges with care continuity and quality (Brabson et al., 2020; Woltmann et al., 2008). Turnover is associated with reduced provider productivity, fractured client-provider relationships, fragmented clinical teams, extra costs to treatment organizations, client non-attendance, and reduced evidence-based practice (Babbar et al., 2018; Brandt et al., 2016). Therapeutic relationships can be important sources of relational stability and mental health staff play key roles in building trust between clients and service organizations (Davidson, 2003). For vulnerable populations such as those affected by SMI, FSP programs could consider making every effort – whether through increased employee pay or improved benefits - to reduce staff turnover and promote consistent therapeutic relationships. In a FSP setting where interviewees describe their programs and providers in home and family-like ways, client-provider relationships could be treated and understood as fundamental to client-centered assertive treatment (Angell, 2003).

Another way that FSPs might embrace a more client-centered approach could be to prioritize material needs, both since mental well-being is difficult, if not impossible, when basic needs go unmet, and also because prior studies have consistently found that client satisfaction with mental health treatment is highest when support for practical needs are fulfilled and client values are honored (Alegría et al., 2018; Gilmer et al., 2013; Leiphart & Barnes, 2005). Findings from interviews in the present study suggest that assertive mental health treatment could reflect clients' values by explicitly framing itself as an intervention on intermediary determinants of health. Material basic needs supports, from housing to furniture to healthcare, could be viewed as core functions, not the penumbra, of such assertive treatment. Material supports could be expected to be robust and adaptable to the point of sheltering and supporting individuals who have nowhere else to turn. Programs that do not provide adequate material supports could be *de facto* viewed as falling short of client-centeredness (Williamson, 2002).

Finally, client-centered assertive treatment could emphasize long-term, wraparound care to meet and sustain basic needs and relational supports. This runs counter to recent arguments that assertive mental health treatment programs like FSP should be time-limited or should prioritize transitioning to less intensive services (Bromley et al., 2017; Donahue et al., 2012). Participants in the present study viewed the FSP program as aimed toward equity and community, rather than focused solely on mental illness treatment. Given the critical impact of basic needs services on clients' mental and physical health, approaches to considering individuals' readiness for transitioning out of such programs could consider not only improvements in mental health symptoms and physical health status, but also individuals' abilities to live as long-term, engaged members of the community outside of the program (Williamson, 2002).

Limitations

This study used a convenience sample of interviewees from 7 FSP sites in a single geographic region. Multiple clients who expressed initial interest in study participation could subsequently not be reached via telephone outreach. As such, the perspectives of individuals in the interview sample may not reflect the full range of client experiences within all FSP programs. Given the geographic and programmatic focus of this evaluation, perspectives on FSP programs may not be transferrable to other ACT adaptations and/or ACT itself in other geographic locations.

Conclusion

Through analysis of client interview data drawn from an evaluation of FSP programs, this paper explores questions of client-centeredness within FSP. Intentional prioritization of 2 FSP programmatic components identified by FSP client interviewees - material and relational supports - could produce more client-centered FSP care. Nationwide emphasis on these priorities could unify FSP and other ACT adaptations as interventions on intermediary determinants of health, or interventions that intentionally redistribute social and material resources and ameliorate the negative impact of structural determinants that undermine the health and wellbeing of many persons living with SMI. Such a paradigm shift has the

potential to impact the ways in which ACT adaptations are envisioned, in particular by moving away from thinking about assertive mental health treatment in terms of therapeutic clinical efficacy and toward a foregrounding of clients' understandings of beneficial care.

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Declarations

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