Section A: Proposer's Qualifications

A.1 Agency Identification We are a research group located in the Semel Institute for Neuroscience and Human Behavior at UCLA. Our focus is in mixed-methods public mental health service evaluation. Our organizational chart is attached (Attachment 2).

A.2 Experience

A.2.1 Qualifications and experience We have extensive experience evaluating LA County public mental health services in DMH and contract clinics, bringing together skills in quantitative and qualitative data collection and analysis, survey instrument selection, follow-up of challenging research subjects, analysis of DMH IS utilization and cost data, qualitative interviews with clients and providers, and clinic ethnography.

From 2007-12, we fielded a mixed-methods evaluation of MHSA implementation and outcomes in LA County. Data included utilization and cost data from the DMH IS; surveys and qualitative interviews with clients and providers; and 6,000+ hours of ethnographic fieldwork in five clinics. We followed 472 clients and 174 providers for 3 years, surveying clients semi-annually (1,700 surveys) and providers annually (311 surveys). Client surveys included measures of mental health, quality of life, service recovery orientation, and client-provider working alliance, and interviews assessing homelessness, incarceration, and employment. Provider surveys included measures of job satisfaction, stress, and recovery orientation. We interviewed 103 clients and 108 providers annually for a total of 484 interviews that were recorded, transcribed, and coded. Analyses have been presented in a presentation to DMH, a cost-effectiveness evaluation of one year of data, a mixed-methods analysis of system transformation and FSP vs. usual care client and provider experiences in LA, and an in-preparation

manuscript with FSP vs. usual care outcomes (survey, utilization, costs) over 3 years.

We contracted with LA County DMH to evaluate the DMH-DHS Medicaid expansion collaboration, collecting qualitative client and provider interview data and utilization data from DMH and DHS (2012-14), and conducted a national AOT phone survey for DMH, collecting information on AOT program implementation from 38 states (2014-15). We have worked with five large LA contract mental health agencies to create a practice-based research network that develops research projects aimed at quality improvement (2012-present). We have developed novel interventions, such as the “Bridge” health navigator intervention, with a focus on implementation, fidelity, and dissemination (2008-present). We consulted on a RAND contract with the state to select measures for evaluating statewide Prevention and Early Intervention programs (2012). We contracted with Society for Neuroscience to write and web-publish a history of their organization, drawing from historical materials as well as conducting interviews (2013-14).

A.2.2 Application of experience to services in Statement of Work Our approach to delivering required services as described in Section B is heavily informed by our past evaluation work in LA County DMH and contract clinics, including our familiarity in managing a large multi-site project, working collaboratively with clinic administration and staff, selecting appropriate measures, developing rigorous study designs within a non-experimental real-world setting, tracking and following up with challenging clients to ensure a valid cohort, and analyzing survey, utilization, and cost data.

A.3 Performance History Attached are three signed letters of reference from contracts/grants with similar scope of services, as well as Exhibits 6 and 7. There have been no terminated contracts and no pending or threatening litigation.

Section B: Proposer's Approach to Providing Required Services

B.1 Planning Component

B.1.1 Meetings with DMH We will meet frequently with DMH in the initial planning phase to finalize measures and design, followed by quarterly status/planning meetings and annual summary meetings. Agendas will be emailed in advance, determined based on prior meetings and project status (information from the Project Management database described in Section D). A record of minutes will be emailed afterwards. Additionally, we will attend the quarterly AOT-LA Oversight and Accountability Committee meetings to further our understanding of the program, give and receive feedback, and form contacts, and will approach attendees for formal stakeholder interviews when it seems valuable to go beyond informal conversations.

B.1.2 Measurement of outcomes domains We have selected a preliminary set of instruments and data sources to assess the five outcome domains (Table B1; Attachment 3), to be modified and finalized in consultation with DMH. We chose measures that jointly meet evaluation, QI, and clinical goals, to reduce staff burden and maximize value. In some sub-domains (mental health status/functioning; client insight) we prefer clinician-rated measures due to our expectation that they would be more likely to capture initial severity or lack of insight and therefore to capture improvement due to treatment. Additionally, there would be clinical value in having clinicians complete these measures, while self-report measures would be of research value only. However, because clinician rating may not be feasible due to training requirements, we selected client self-report alternatives and will make final selections in consultation with DMH.

B.1.3 Data collection Planned data collection time points (surveys) or intervals

(interviews; dataset queries) for each instrument are summarized in Table B1. Analyses of IS data will use a follow-up ending 6 months post-discharge; all other data collection will end at discharge. Table B2 shows which data sources will be available by subgroup, and how this impacts the evaluation of each domain. We will request that the AOT O&E or treatment team collect survey data (provider-rated; client self-report) at the following intervals, entered directly into REDCap HIPAA-compliant survey software through a web browser (online) or iPad app (online or offline): at initial contact (O&E Start); post-court/at treatment initiation; every 6 months during treatment; and at discharge. For clients waitlisted for an extended period we will request follow-up surveys at the times they would otherwise complete treatment initiation and in-treatment follow-up surveys.

Semi-structured interviews will be conducted by UCLA research staff with a sample of key stakeholders: AOT clients (n=15 who agree to voluntary services early on; n=45 undergoing outreach with possibility of court order); mental health providers (n=25 AOT O&E or treatment team; n=5 non-AOT FSP); police and court officials (n=15); and family members (n=20). Clients and family will be interviewed at 6-month intervals from initial outreach until treatment end, with particular emphasis on experiences with the process and perceptions of program effectiveness at addressing their needs. Other stakeholders will be interviewed at 6-month intervals about their impressions of the program, expected impacts on participants and the community, and impacts on their work roles. Interview guides are attached as Attachment 4.

We will conduct annual focus groups with AOT providers at each site, to gain qualitative insights and also to build relationships and learn how best to facilitate survey data collection at each site.

B.2 Data Collection Component

B.2.1 Human subjects review and protection We will comply with all DMH guidelines for ethical conduct of research and have all procedures approved by the DMH Human Subjects Research Committee (HSRC). Our proposed protocol has been approved as exempt by UCLA's Institutional Review Board. We will obtain all required letters of support and approvals from the Data Security and Privacy Officers as a part of our HSRC application. We will comply with requirements for continuing review and submit a report within 3 months of study end. We will apprise the HSRC of any adverse events as required. We will design and conduct the study to ensure the privacy and confidentiality of participants and to provide timely feedback on program operation. We will use only encrypted devices and secure, encrypted data transmission. We will de-identify or destroy any identified data within 6 years of completing analyses.

B.2.2 Translation of measures into threshold languages We will translate client self-report measures and interview guides into the 12 specified non-English threshold languages via WordExpress, which provides translation services for the UCLA Medical Center and provided the budgeted quote for the preliminary self-report measures in Table B1. We anticipate translation within 3 months, once measure selection is final.

B.2.3 Incorporation of data required by legislation and program Our planned measures for evaluating the five outcome domains (Table B1) include data entered into the Outcomes Measures Application (OMA), at FSP admission and 3-month or key events intervals, and data to be collected by the AOT program under requirements in WIC 5345. We will fully comply with HIPAA requirements. We can receive data via DMH's secure file transfer or pick up an encrypted CD from DMH, and can process files

in Microsoft Access or most flat data formats. Data should be de-identified and coded by study ID only. We plan to request quarterly deliveries of OMA, AOT administrative, and DMH IS data, alongside our internal quarterly schedule for downloading survey data from REDCap. This will allow us to generate updated data summaries for presentation at quarterly with DMH meetings, to facilitate QI and obtain feedback on our approach.

B.3 Analysis and Reporting Component

B.3.1 Regular reporting of analyses to DMH We will generate updated quarterly reports to DMH coinciding with quarterly meetings. Each report will include updated data tables dependent on project stage as described in B.3.3. Additionally, reports will update evaluation status, e.g., HSRC application; selection, translation, and programing surveys into REDCap; administrative (IS, OMA, WIC 5345) data requests; number of surveys due and completed; updates on communications with providers about survey completion and efforts to improve completion rates; number of interviews completed, transcribed, and coded; and progress writing/testing code for quantitative analyses.

B.3.2 Analytic and measurement methodology by domain Table B2 specifies analyses by domain within each client subgroup. Analyses of baseline differences between clients who self-select or are selected by the O&E team into the six subgroups will use t-tests (continuous) or chi-square (categorical). Evaluation of change over time within subgroups will use paired t-tests to test for within-person change, e.g., greater use of outpatient services; reduced hospitalization, homelessness, and incarceration; and improved mental health and insight in the follow-up period relative to baseline. For outcomes with comparison groups we will use difference in differences, comparing change over baseline between groups and/or comparing follow-up measures adjusted

for baseline. We will use zero-inflated negative binomial models for hospitalization, homelessness, and incarceration, and two-part models with log transformation for costs.

For qualitative data derived from interviews and focus groups, researchers will employ a grounded theory approach to the analysis: coding the de-identified transcripts, identifying recurrent themes, and comparing them across respondents and across domains to make a meaningful assessment of the experiences of clients, providers, and other stakeholders and to provide input to shape quality improvement efforts.

B.3.3 Approach to compiling and drafting quarterly reports Quarterly reports will be in a standardized format, with updates made to tables based on the most recent data extractions from REDCap, IS, OMA, and WIC 5345 data. Early reports will include descriptive data regarding number of clients screened and their progress through AOT (outreach; voluntary agreement; pursuit of court order; settlement; court order; etc.) and baseline characteristics from surveys, OMA, WIC 5345, and IS. As clients progress through O&E and treatment, we will add tables with follow-up data, stratified by client subcategory. We will include brief interpretation of tables, and implications for program operations. While analytic findings from interviews will not be available quarterly, we will incorporate summaries of anything that has come up during interviews that might inform program operations. Reports will be presented and discussed in quarterly meetings.

B.3.4 Approach to compiling and drafting final report The final report will contain updated tables from the most recent quarterly report, reflecting the final data collection period for the study. Additionally, it will contain adjusted analyses using methods suitable for publication, complete qualitative analysis of stakeholder interview data, and discussion of findings and lessons learned in all five outcome domains.

Table B1. Evaluation domains and data sources.				
Domain	**Data Source**	**Name of Instrument**	**Items**	**Timing**
Quality Improvement				
Implementation Barriers	Provider interview	*Qualitative Interview*	-	Semi-annual
Implementation Barriers	Other SH interview	*Qualitative Interview*	-	Semi-annual
Implementation Barriers	Provider focus group	*Qualitative Focus Group*	-	Annual at each site
Program Statistics	WIC 5345 data	*Administrative Data*	-	Quarterly from DMH
Client Utilization	IS data	*Administrative Data*	-	Quarterly from DMH
Client Engagement	Provider rating	Client Engagement in Services	5	All F/U
Medication Adherence	Client self-report	Morisky Medication Adherence Scale	4	All F/U
Medications Taken	Provider report	Items from DMH Adult Assessment	1	O&E start; All F/U
Effectiveness				
Hospitalization/ER/PMRT	IS data	*Administrative Data*	-	Quarterly from DMH
Physical Health	OMA	*OMA*	-	Quarterly from DMH
Substance Use	OMA	*OMA*	-	Quarterly from DMH
Employment	OMA	*OMA*	-	Quarterly from DMH
Education	OMA	*OMA*	-	Quarterly from DMH
Death	OMA	*OMA*	-	Quarterly from DMH
Client Mental Health**	Provider rating	Brief Psychiatric Rating Scale	18	O&E start; All F/U
Client Functioning**	Provider rating	Multnomah Community Ability Scale	17	O&E start; All F/U
Client Mental Health**	Client self-report	DSM-5 Self-Rated Level 1 Cross-Cutting Symptom	23**	O&E start; All F/U
Client Mental Health**	Client self-report	Behavior and Symptom Identification Scale	32**	O&E start; All F/U
Client Insight**	Provider rating	Scale to Assess Unawareness of Mental Disorder	9	O&E start; All F/U
Client Insight**	Client self-report	Beck Insight Scale	15**	O&E start; All F/U
Victimization	Client self-report	Items from DMH Adult Assessment	7	O&E start; All F/U
Anger	Client self-report	Dimensions of Anger	5	O&E start; All F/U
Suicidal Ideation	Client self-report	Suicidal Ideation	3	O&E start; All F/U
Willingness to Seek Help	Client self-report	Suicide Disclosure	10	O&E start; All F/U
Client Impressions	Client Interview	*Qualitative Interview*	-	Semi-annual
Provider Impressions	Provider interviews	*Qualitative Interview*	-	Semi-annual
Other SH* Impressions	Other SH interviews	*Qualitative Interview*	-	Semi-annual
Community Improvement (measures overlap with Effectiveness; listed here only)				
Justice Involvement	OMA; IS data	*OMA*	-	Quarterly from DMH
Homelessness	OMA	*OMA*	-	Quarterly from DMH
Financial support	OMA	*OMA*	-	Quarterly from DMH
Other County Services	ELP data***	*Administrative Data*	-	Annual from CPPRN
Client Impressions	Client Interview	*Qualitative Interview*	-	Semi-annual
Provider Impressions	Provider interviews	*Qualitative Interview*	-	Semi-annual
Other SH* Impressions	Other SH* interviews	*Qualitative Interview*	-	Semi-annual
Stakeholder Satisfaction				
Perception of Court	Client self-report	Client Perception of the Court	5	After court
Perception of Program	Client self-report	Client Perception of the Program	10	After AOT end
Perceived Coercion	Client self-report	Modified MacArthur Coercion measure	15	O&E start; All F/U
Working Alliance	Client self-report	Working Alliance Inventory, Short (WAI-S)	12	All F/U
Client Experience	Client interview	*Qualitative Interview*	-	Semi-annual
Provider Experience	Provider interview	*Qualitative Interview*	-	Semi-annual
Other SH* Experience	Other SH interview	*Qualitative Interview*	-	Semi-annual
Cost				
Mental Health Svc Cost	IS data	*Administrative Data*	-	Quarterly from DMH
Baseline Covariates Not Also Used as Outcomes				
ACE Score	Client self-report	Adverse Childhood Experiences (ACE)	10	O&E start

* Other SH = other stakeholder (petitioner, family member, police officer, court personnel, etc.)
** Provider rating preferred; client self-report measures are a backup. We will select measures with DMH based on feasibility.
*** Dr. Wells' PCORI-funded Community Partnered Participatory Research Network (CPPRN) is contracting the Enterprise Linkage Project of the LA County CEO's office to obtain a large de-identified multi-agency (DMH, DHS, DPH SAPC, DPSS, Probation, Sheriff) dataset for individuals with behavioral health risk. Starks, Braslow, and Wells are part of the CPPRN Data Working Group, and committed to making the dataset useful to evaluation and QI projects including AOT. We will work with DMH to see if data delivered to ELP for this dataset can include AOT status. If so the dataset can be used to evaluate community improvement, though not linked to other AOT data due to being de-identified.

Table B2. Subgroups of AOT-referred clients: domains to be evaluated; data sources available/used; detailed outcomes, analyses. PAGE 1 OF 3.

Domains	Data sources available/used	Detailed outcomes, analyses planned.
1. Clients who are referred to AOT but do not receive outreach services		
Quality Improvement	WIC 5345 data IS (service history; diagnosis)	How do AOT-ineligible clients differ at baseline from those eligible? (Limited set of variables available for this subgroup.)* *Comparison groups: 2-5 (all clients receiving outreach).*
	WIC 5345 data	Reasons given for not performing outreach to these clients (e.g., why did not meet criteria; why slipped through the cracks). Data on any alternative assistance/action taken for these clients.
	Interviews, focus groups with O&E team members	Insights regarding the initial referral and screening process.
Effectiveness	IS data	Outpatient, emergency, inpatient utilization: change over baseline.
Community Improvement	IS data	Changes since baseline in jail mental health services.
Stakeholder Satisfaction	Other stakeholder interviews	O&E Team, police, family members.
Cost	IS data	Change in mental health services cost relative to baseline.
Outcomes Comparison		*Not contrasting to comparison group, due to non-comparability.*
2. Clients who are referred to AOT, meet AOT eligibility criteria, and voluntarily accept services		
Quality Improvement	WIC 5345 data IS (service history; diagnosis) OMA data (baseline) Provider-rated/client self-report survey measures (O&E start)	How do clients who accept voluntary services differ at baseline from those who refuse?* *Comparison groups: 4 (settlement agreement); 5 (court ordered). Some comparisons to group 3 (court order not sought) possible.*
	Interviews, focus groups with O&E team members, providers, other stakeholders	Insights into process of getting client to voluntarily accept services; expectations and outcomes regarding treatment engagement.
Effectiveness	IS data	Outpatient, emergency, inpatient utilization: change over baseline.
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, employment, education, financial support, substance abuse, physical health; death.
	Provider-rated/client self-report survey measures (follow-up)	Changes since baseline in mental health, functioning, insight, victimization, anger, suicidal ideation, willingness to seek help.
Community Improvement	IS data	Changes since baseline in jail mental health services.
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, financial support.
Stakeholder Satisfaction	Client self-report surveys	Perception of the AOT program (at end of treatment). Perceived Coercion, Client-Provider Working Alliance.
	Client interviews	Client experience.
	Provider interviews, focus groups	Provider experience.
	Other stakeholder interviews	Family member/petitioner experience; court personnel experience.
Cost	IS data	Change in mental health services cost relative to baseline.
Outcomes Comparison		*AOT clients who voluntarily agree to but are wait listed for services – if there is a subset of voluntary clients in group 6.*

***** Compare diagnosis, illness severity, insight, anger, past-year hospitalization, homelessness, justice involvement, adverse childhood events, history of victimization, willingness to seek help, education, demographics, as available. Some available at start of outreach; others, like OMA, may be timed to start of FSP services, and only exist for clients who enroll in services.

Table B2. Subgroups of AOT-referred clients: domains to be evaluated; data sources available/used; detailed outcomes, analyses. PAGE 2 OF 3.

Domains	Data sources available/used	Detailed outcomes, analyses planned.
3. Clients who are referred to AOT, meet AOT eligibility criteria, & refuse voluntary services, but court order not sought		
Quality Improvement	WIC 5345 data IS (service history; diagnosis) Provider-rated/client self-report survey measures (O&E start)	Among clients who refuse voluntary services, what characterizes those for whom a court order is not sought vs. is sought?* *Comparison groups: 4 (settlement agreement); 5 (court ordered).*
	WIC 5345 data	Reasons given for not seeking a court order for these clients (e.g., reasons for decision; reasons slipped through the cracks). Data on any alternative assistance/action taken for these clients.
	Interviews with O&E team members	Insights into the decision process for whether to seek court order; discussion of sub-categories of clients in this subgroup
Effectiveness	IS data	Outpatient, emergency, inpatient utilization: change over baseline
Community Improvement	IS data	Changes since baseline in jail mental health services.
Stakeholder Satisfaction	Client self-report surveys, if able to obtain a follow-up survey.	Perception of the AOT program (at end of outreach, if able to survey once decide not to pursue court order). Perceived Coercion, Client-Provider Working Alliance.
	Client interviews	Client experience.
	Other stakeholder interviews	Family member or other petitioner experience.
Cost	IS data	Change in mental health services cost relative to baseline.
Outcomes Comparison		*Clients in groups 4 (settlement) and 5 (court ordered).* *Not comparable to clients in group 6 (wait listed).*
4. Clients who are referred to AOT, meet AOT eligibility criteria, and sign a Settlement Agreement with the Court		
Quality Improvement	WIC 5345 data IS data (service history; diagnosis) OMA data (baseline) Provider-rated/client self-report survey measures (O&E start)	How do clients who sign a settlement agreement with the Court differ at baseline from those who agree to voluntary treatment and those who are court ordered? * *Comparison groups: 2 (voluntary); 5 (court ordered).* *Some comparisons to group 3 (court order not sought) possible.*
	Interviews, focus groups with O&E team members, providers, other stakeholders	Insights into the process of getting the client to sign the Settlement Agreement, and likely and actual success of that agreement.
Effectiveness	IS data	Outpatient, emergency, inpatient utilization: change over baseline.
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, employment, education, financial support, substance abuse, physical health; death.
	Provider-rated/client self-report survey measures (follow-up)	Changes since baseline in mental health, functioning, insight, victimization, anger, suicidal ideation, willingness to seek help.
Community Improvement	IS data	Changes since baseline in jail mental health services.
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, financial support.
Stakeholder Satisfaction	Client self-report surveys	Perception of the AOT program (at end of treatment). Perception of the Court (at end of court interaction). Perceived Coercion, Client-Provider Working Alliance.
	Client interviews	Client experience.
	Provider interviews, focus groups	Provider experience.
	Other stakeholder interviews	Family member/petitioner experience; court personnel experience.
Cost	IS data	Change in mental health services cost relative to baseline.
Outcomes Comparison		*Clients who refuse treatment and are wait listed (group 6).*

* Compare diagnosis, illness severity, insight, anger, past-year hospitalization, homelessness, justice involvement, adverse childhood events, history of victimization, willingness to seek help, education, demographics, as available. Some available at start of outreach; others, like OMA, may be timed to start of FSP services, and only exist for clients who enroll in services.

Table B2. Subgroups of AOT-referred clients: domains to be evaluated; data sources available/used; detailed outcomes, analyses. PAGE 3 OF 3.

Domains	Data sources available/used	Detailed outcomes, analyses planned.
5. Clients who are referred to AOT, meet AOT eligibility criteria, and are court ordered to receive AOT services		
Quality Improvement	WIC 5345 data IS (service history; diagnosis) OMA data (baseline) Provider-rated; client self-report survey measures (at O&E start)	How do court-ordered clients differ at baseline from those who agree to voluntary treatment and those who sign a settlement agreement with the Court?* *Comparison groups: 2 (voluntary); 4 (settlement agreement). Some comparisons to group 3 (court order not sought) possible.*
	Interviews, focus groups with O&E team members, providers, other stakeholders	Insights into court order process, and likely and actual success of court order. Insights from providers into experience of working with court-ordered clients and the impact of legal status on treatment.
Effectiveness	IS Data	Outpatient, emergency, inpatient utilization: change over baseline..
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, employment, education, financial support, substance abuse, physical health; death
	Provider-rated/client self-report survey measures (follow-up)	Changes since baseline in mental health, functioning, insight, victimization, anger, suicidal ideation, willingness to seek help.
Community Improvement	IS data	Changes since baseline in jail mental health services.
	OMA data (3mo; KET)	Changes since baseline in homelessness, justice system involvement, financial support.
Stakeholder Satisfaction	Client self-report surveys	Perception of the AOT program (at end of treatment). Perception of the Court (at end of court interaction). Perceived Coercion, Client-Provider Working Alliance.
	Client interviews	Client experience.
	Provider interviews, focus groups	Provider experience.
	Other stakeholder interviews	Family member/petitioner experience; court personnel experience.
Cost	IS data	Change in mental health services cost relative to baseline.
Outcomes Comparison		*Clients who refuse treatment and are wait listed (group 6).*
6. WAIT LIST CONDITION: Clients who are referred to AOT, meet AOT eligibility criteria, and are wait listed due to unavailability of FSP or IMD Step-Down slots. If a wait list becomes necessary due to resource constraints, clients in this subsample would be used as a comparison group. NOTE, for comparisons to be valid, Group 2 (voluntary) clients should be compared to voluntary clients from Group 6, and Groups 4-5 (settlement agreement or court order) clients should be compared to involuntary clients in Group 6. If wait list condition lasts long enough, we would continue to survey these clients at intervals corresponding to when treated clients are surveyed. If wait list condition does not last long enough to re-survey clients before they begin treatment, we would still have WIC 5345 data, IS data, and qualitative data on these clients to allow for quality improvement, effectiveness, community improvement, stakeholder satisfaction, and cost outcomes comparisons.		
Quality Improvement	WIC 5345 data IS data (service history; diagnosis) Provider-rated/client self-report survey measures (O&E start)	Available as comparison for groups 2, 4, and 5 as above.
	Interviews, focus groups with O&E team members, other stakeholders	Insights regarding availability of slots and the process of continuing to engage clients while wait listed; information about how they prioritized clients for AOT services as slots became constrained.
Effectiveness	IS data	Available as comparison for groups 2, 4, and 5 as above.
Community Improvement	IS data	Available as comparison for groups 2, 4, and 5 as above.
Stakeholder Satisfaction	Client self-report surveys, if able to obtain a follow-up survey.	Available as comparison for groups 2, 4, and 5 as above.
	Client interviews	Client experience.
	Other stakeholder interviews	Family member or other petitioner experience.
Cost	IS data	Available as comparison for groups 2, 4, and 5 as above.

***** Compare diagnosis, illness severity, insight, anger, past-year hospitalization, homelessness, justice involvement, adverse childhood events, history of victimization, willingness to seek help, education, demographics, as available. Some available at start of outreach; others, like OMA, may be timed to start of FSP services, and only exist for clients who enroll in services.