SACRAMENTO COUNTY

Department of Health Services
Division of Behavioral Health Services

MHSA INNOVATIVE PROJECT #5: FORENSIC BEHAVIORAL HEALTH

MHSA STEERING COMMITTEE

JANUARY 16, 2020

MHSA Innovation (INN) Component Requirements

MHSA Innovative Projects must contribute to learning

Innovative (INN) Projects must do one of the following:

- Introduce a mental health practice or approach that is new to the system
- Make a change to an existing practice in the field of mental health
- Introduce a new application of a successful non-mental health promising community-driven practice/approach to the mental health system

MHSA INN Component Requirements (cont'd)

- Primary Purpose:
  - Increase access to mental health services
  - Increase access to mental health services to underserved populations
  - Increase the quality of mental health services
  - Promote interagency and community collaboration
- Must align with the MHSA General Standards
- Time-limited
- If successful, County may continue the project but must transition it to another funding component or fund source

MHSA Steering Committee Charge

- October 17, 2019 MHSA SC Meeting:
  - Discussed INN Project #5 focused on adults living with serious mental illness who are justice-involved
  - SC charged Workgroup with developing a recommendation
- Workgroup composition:
  - Consumers
  - Family Member
  - MHSA SC Member
  - Mental Health Board
  - Alcohol Drug Services Board
  - Cultural Competence Committee representative
  - Probation
  - Courts
  - Behavioral Health Services
- Workgroup/Community Meetings: Jan 7, 10, 15, 2020

INN 5 Workgroup/Community Meeting #1

- INN Component requirements
- Forensic Behavioral Health Population
- Panel Discussion
  - Panelists represented consumers, family members, MH Provider, law enforcement, Courts, Probation, Correctional Health
  - Panelists responded to the following questions:
    - Why this population recidivates back to jail
    - What strategies work in terms of reducing the likelihood of recidivism to jail
    - What do individuals need to successfully transition into the community in order to maintain success

INN 5 Workgroup/Community Meeting #1 Input

- Immediate and ongoing coordination, communication between system partners
- Discharge planning pre-release
- Immediate access to services and resources
- Integrated care plan developed by client and all involved system partners and service providers
- One Stop Shop

INN 5 Workgroup/Community Meeting #2 & #3

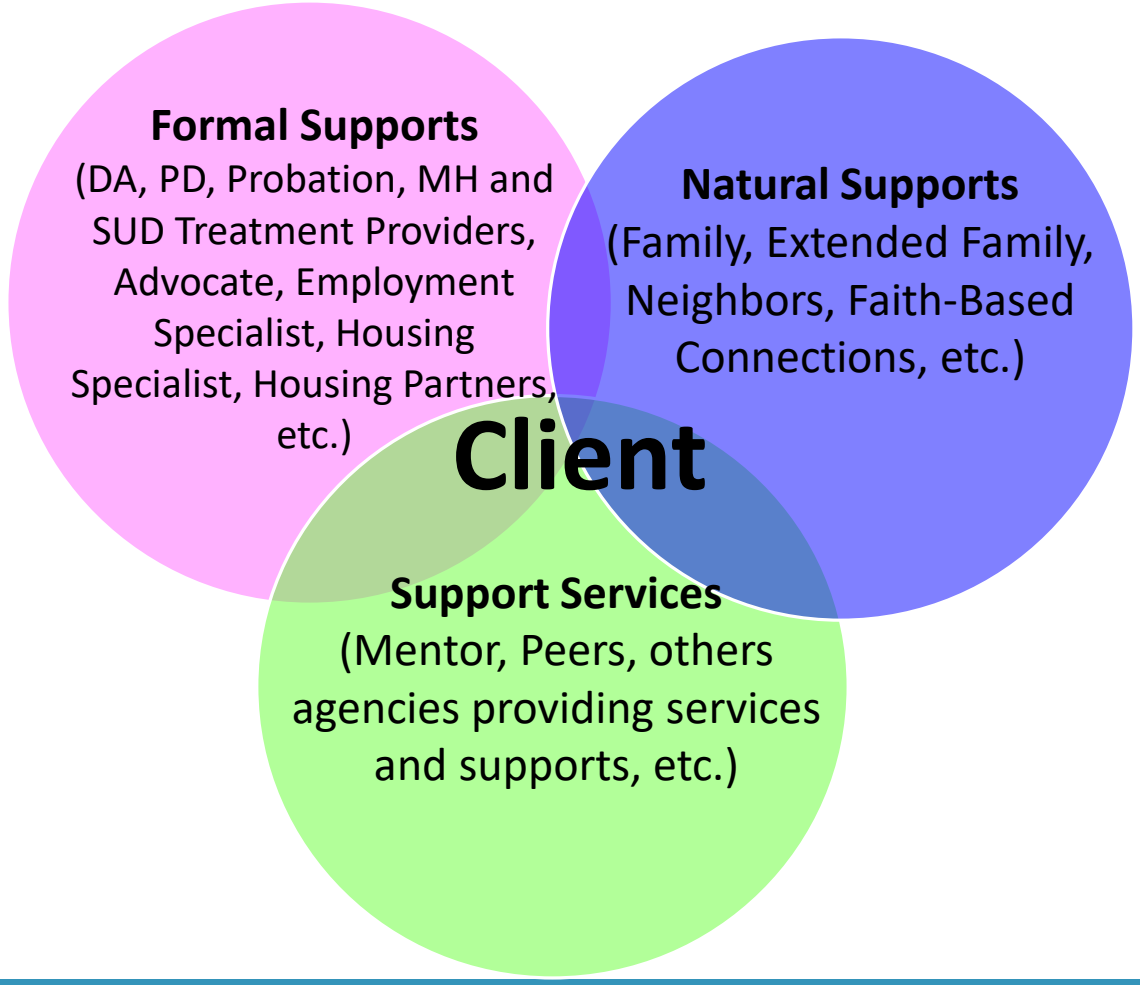
- INN Project Learning Objective:
  - If we provide ideas generated from meeting #1, will we reduce recidivism to jail?
  - What about any of these ideas are new or are currently not in place?

INN 5 Workgroup/Community Meeting #2 & #3

- Adaptation of multi-system teaming model
  - Child and Family Team (CFT) is comprised of client, family, and natural supports, system partners, and other service providers involved in the individual's life
  - Promotes ongoing coordination, communication, shared decision making between system partners
  - Services are delivered within the context of an integrated care plan developed by client and all involved system partners, natural supports and service providers

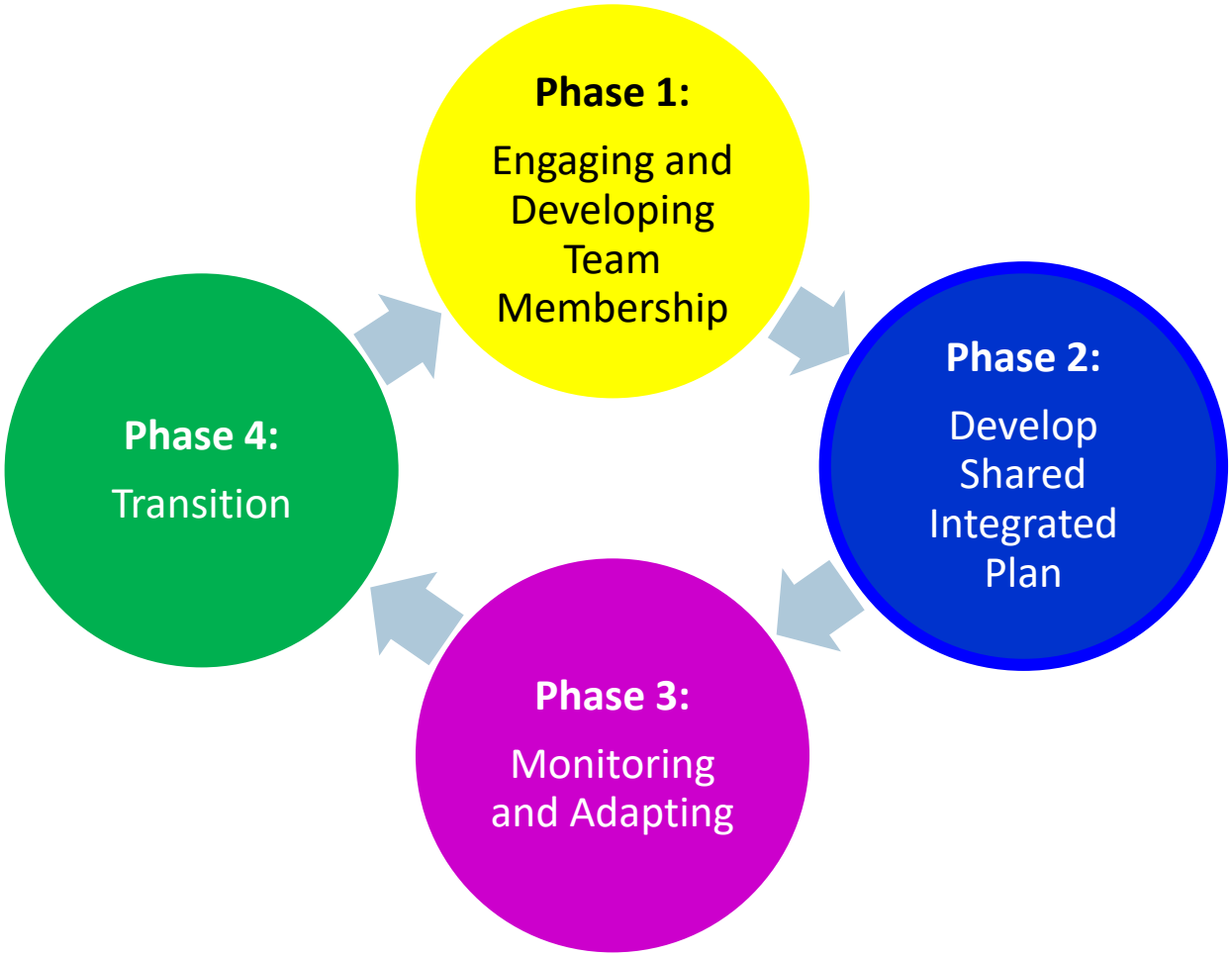
INN 5 Workgroup/Community Meetings #2, #3 Input

Multi-System Team Composition



INN 5 Workgroup/Community Meetings #2, #3 Input (cont'd)

Multi-System Team Process



INN 5 Workgroup/Community Meetings #2, #3 Input (cont'd)

- Phase 1: Engagement
  - Start early
  - Brief and broad screening tool to determine readiness and identify needs
  - Provides education and orientation to the multi-system team process
  - Identify team facilitator, members, roles, responsibilities
  - Community mentors/peers/court alums provides mentoring and peer support at engagement and ongoing
  - Initiates integrated assessment and plan immediately
- Phase 2: Planning
  - Assistance accessing immediate needs
  - Review and/or develop integrated plan
  - Agree on meeting frequency and location

INN 5 Workgroup/Community Meetings #2, #3 Input (cont'd)

- Phase 3: Monitoring
  - Re-clarifying team members role and responsibilities, meeting frequency
  - Revisit and update client goals, milestones, crisis plan
  - Celebrate successes
- Phase 4: Transition
  - Client takes more active role in plan and services
  - Initiate client driven post assessment to determine readiness for transition to the community:
    - Review progress, plans met
    - Ensure that needed services and supports are in place
    - Identify services and supports not in place and develop plan to access them

INN 5 Workgroup/Community Recommendation