



MENTAL HEALTH SERVICES ACT

Innovation Project 5 Plan: Forensic Behavioral Health Multi-System Teams

August 11, 2020

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County Name: Sacramento County

Project Title: Forensic Behavioral Health Multi-System Teams

Total amount requested: \$9,536,739

Duration of project: 5 Years

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT: An Innovative Project must be defined by one of the following general criteria. The project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE: An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

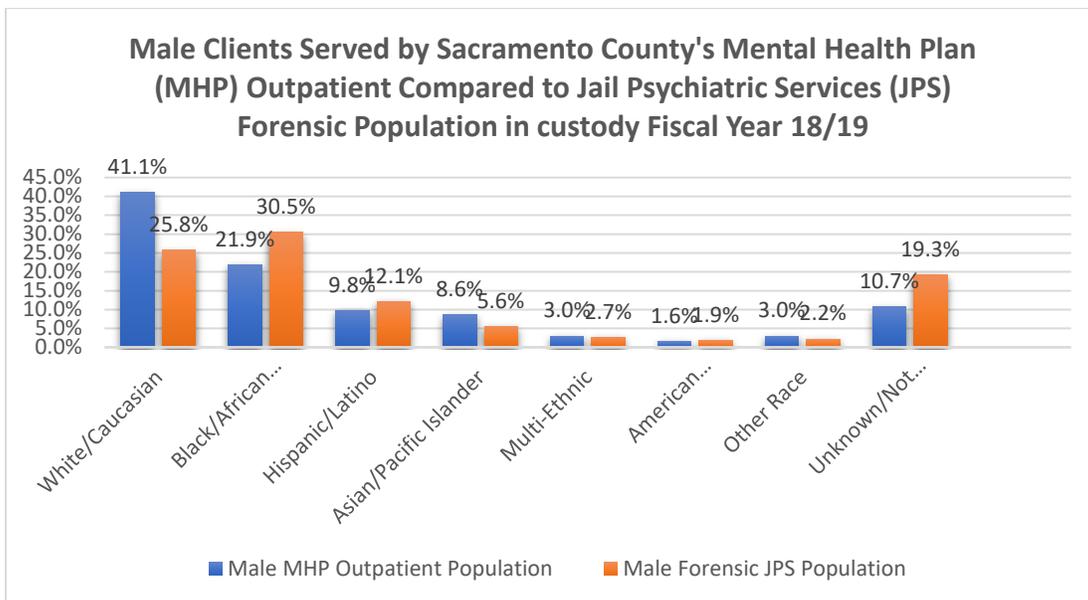
Throughout Sacramento County's Mental Health Services Act (MHSA) Community Planning Processes to date, community members have discussed the unmet complex service needs of individuals living with serious mental illness who are justice involved. Consumers, family members, and stakeholders have voiced concerns about the challenges of the multi-system involvement of the forensic behavioral health population, which are compounded by barriers to immediate access to mental health and other needed resources. The challenges involved in meeting multiple system requirements and overcoming barriers to access needed services and resources increase the likelihood of these individuals returning back to jail. Behavioral Health is invested in reducing jail recidivism for the forensic behavioral health population and community/stakeholder input supports work in this area. When presented with the opportunity to

develop a new innovative project, our community supported focusing the project on the forensic behavioral health population.

The Sacramento County Jail system is comprised of two jail sites. The Main Jail (MJ) is located in downtown Sacramento and is a pre-sentence and intake facility. The MJ has a capacity of 2,400 incarcerated individuals with approximately 50,000 bookings per year. The Rio Consumes Correctional Center (RCCC) is located in a rural area outside the city and is the primary custody facility for incarcerated individuals sentenced to jail by the Sacramento County Courts. RCCC has the capacity to hold approximately 2,400 incarcerated individuals.

Jail Psychiatric Services (JPS) provides mental health services and treatment to individuals experiencing serious mental illness while in custody at both the MJ and RCCC. Since California realigned its prisons in 2011, the number of local incarcerated individuals with mental health issues has increased significantly. Sacramento County Jail Profile reports indicate local incarcerated individuals receiving psychotropic medication has grown from approximately 15% in December 2010 to 25% (about 900) in December 2016. JPS records demonstrate that in the years from 2004 to 2018 there has been a 97% increase in caseloads for psychiatric services delivered to Sacramento County jail facilities (783 in 2004 and 1,543 in 2018) despite a reported decrease in jail bookings during the same time period. Approximately 30% of MJ incarcerated individuals released into the community have had at least one contact with JPS. The number of incarcerated individuals incarcerated at RCCC living with a mental illness has doubled from 17% to 34% since 2011.

In FY 2018/19 the JPS population was 86.1% male, 13.3% female, and 1.5% other or unknown. Men make up the vast majority of this population and some cultural and ethnic groups are overrepresented. As illustrated in the chart below, African American men are over-represented in the JPS population (30.5%) compared to Sacramento County's Mental Health Plan (MHP) outpatient population (21.9%). Hispanic men are also over-represented in the JPS population (12.1%) compared to the MHP outpatient population (9.8%). Conversely, Caucasian men are highly under-represented in jail (25.8%) compared to the MHP consumer population (41.4%).



According to a report compiled by Sacramento Steps Forward “Homelessness in Sacramento County: Results from the 2019 Point-in-Time Count,” approximately 21% of adults experiencing homelessness also live with a serious mental illness. Additionally, the Sacramento County Public Defender anecdotally reports that 50% of misdemeanants who live with a mental illness experienced homelessness. In 2019, more than 4,700 homeless individuals were arrested, a 59% increase from 2012. Individuals with mental illness are also more likely to be homeless at the time of arrest. Frequently, individuals with mental illness are released without identified housing.

Because of the shorter stays at the MJ, re-entry and discharge planning is more difficult to provide at the MJ than at RCCC. Many incarcerated individuals living with a serious mental illness in custody at MJ do not have access to prerelease or discharge planning and are therefore not directly linked to mental health and other needed services and resources at discharge. Additionally, individuals who are cited and deemed safe for immediate release back to the community (the “Quick” population) do not come into contact with JPS. They are not screened by JPS and are not directly linked to needed services and resources. Research demonstrates that discharge planning and directly connecting incarcerated individuals to needed services and resources is an effective tool for reducing jail recidivism for the forensic behavioral health population (La Vigne, Palmer, & Halberstadt, 2008).

Both the “Quick” population and incarcerated individuals living with a severe mental illness typically have immediate and pressing resource needs and are frequently discharged or released without income, housing, benefits, or linkage to medical, mental health, or substance use disorder treatment. Furthermore, individuals are typically discharged or immediately released from MJ outside of business hours or at night, making it impossible for them to immediately access services.

Many of these individuals struggle with the capacity to follow through on referrals given to them and scheduled appointments made for them. The individuals who do attempt to follow through with referrals report that services are difficult to access, intake appointments are frequently scheduled weeks out, and the process of applying for benefits is hard to navigate and complete. These challenges, compounded with the experienced impairment from serious mental illness, contribute to poor treatment compliance, increased homelessness, and a greater chance of re-incarceration. Studies indicate that the first 24 to 72 hours post release from jail is a critical time in terms of linking to needed services and resources (Task Force for Criminal Justice Collaboration on Mental Health Issues, 2011).

Another complicating factor for the forensic behavioral health population is meeting the requirements of court/collaborative courts, probation, and other system partners. Without housing, income, treatment, and community supports, these individuals often report experiencing difficulties in complying with these obligations. Furthermore, many individuals have exhausted family or other natural supports, leaving them alone to navigate complex systems and to manage meeting system requirements.

The literature suggests that recidivism back to jail among individuals living with a serious mental illness may be associated with missing or poor integrated plan coordination, treatment and services upon release back into the community (Cloyes, Wong, Latimer S, et al, 2010). University of California Davis Center for Healthcare Policy and Research February 2020 report, “Integrating Care for People Experiencing Homelessness”, described the primary challenges for the forensic behavioral health population in Sacramento County as: (1) Insufficient capacity in multiple

intervention domains; and (2) Limited communication or coordination between siloed services. The report also stated that communication is poorly coordinated between providers of mental health services, substance use disorder treatments, social services, and medical treatments. It was recommended that individuals living with serious mental illness and with co-occurring substance use disorders who are diverted or released from jail be provided with pre-release planning and immediate warm hand-off to coordinated care and housing services. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation 2013 project, "Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison" emphasizes building and maintaining strong partnerships between criminal justice and behavioral health systems to achieve coordinated and integrated care for clients. Implementing these strategies will improve quality of life, promote successful community integration and reduce recidivism back to jail.

A 2019 Rutgers University Camden study determined that poor physical or mental health increases the likelihood that former offenders will reoffend and return to custody. Former offenders who have access to mental health services and other needed resources and supports have a better chance of maintaining gainful employment and positive relationships with family and friends. This ultimately reduces recidivism back to jail. A longitudinal study of former offenders across 12 states looked at the impact of physical and mental health at the time of release. It was consistently found that physical and mental health limitations decrease the chance of gaining and maintaining employment and that these individuals are more likely to reoffend. Furthermore, former offenders living with mental illness are more likely to report conflict in important relationships. These findings speak to the need to focus on improving physical and mental health among the forensic behavioral health population (Semenza & Link, 2019).

This project was developed through Sacramento County's local community planning process.

PROPOSED PROJECT

A) Overview of the project

This project will serve justice involved, Medi-Cal eligible individuals, 18 years and older, experiencing serious mental illness with significant functional impairment. (See Attachment A: Sacramento County Determination for Medical Necessity and Target Population Policy and Procedure, QM-01-07). Individuals may self-refer into the program or be referred by justice partners and Jail Psych Services.

This innovative project will adapt and expand on the Child and Family Team (CFT) model for the forensic behavioral health population. This teaming model has been successfully used in child welfare systems to address the needs of justice and/or foster system involved youth. The CFT is comprised of client, family, natural supports, system partners, and service providers involved in the individual's life. The purpose of CFT meetings is to assemble team members to create an integrated plan in order to determine how to address the client's needs and goals that promote wellness, resilience and placement stabilization. The CFT process is strength-based, client-centered, individualized, collaborative, culturally responsive, trauma-informed, and outcomes-focused.

Adapting the CFT teaming model for the forensic behavioral health population will increase collaborative efforts between system partners, immediate access to needed services, care

coordination with the goal of improving the client experience in achieving wellness and reducing recidivism back to jail. The increased collaboration among system partners and service providers will allow for immediate MJ in-reach and verification of eligible clients prior to release to ensure that they are provided with immediate support.

The Forensic Behavioral Health Multi-System Teams (MST) INN Project will utilize the following adapted teaming approach in engaging and collaborating with clients, developing and implementing a coordinated and integrated plan with each client that best addresses the client's needs and goals, monitoring and adapting these plans as necessary, and supporting clients in their progress toward successful community transition and wellness and recovery.

The Forensic Behavioral Health Provider will be responsible for assigning staff as MST facilitators, establishing and maintaining the MST process, and delivering the forensic behavioral health services for all eligible clients. The provider will ensure that staff are reflective of the diverse racial, ethnic, and linguistic populations.

Forensic Behavioral Health MST Composition

MST members share the responsibility to assess, plan, intervene, monitor, evaluate and refine plans, and identify needed services over time. The MST will include the following members:



The MST Facilitator will be a Forensic Behavioral Health Provider staff. The facilitator's primary responsibility is to coordinate and facilitate the MST meetings. The facilitator is responsible for the following: establishing the MST composition based on clients' voice and choice, court and probation requirements, and services needs; developing agendas; scheduling and facilitating meetings; ensuring participation of all team members; holding members accountable for tasks and activities between meetings; and, communicating with members in between meetings as required.

The Forensic Behavioral Health Provider will ensure that the client is screened for eligibility into the program and will initiate a thorough biopsychosocial assessment. The provider is responsible for providing clients mental health services, including intensive case management services, and support for completing agreed upon tasks, such as obtaining identification, making and attending a medical appointment, visiting an expungement clinic, and skills building. The provider will ensure that clients are linked to other needed services and resources, such as substance use disorder treatment, housing, etc. The provider attends all MST meetings, updates the MST on progress and linkages made, and apprises the MST on client successes and challenges.

Team members will also include formal supports and system partners, such as the Courts, District Attorney, Public Defender, JPS, Probation, Adult Protective Services, Child Welfare, Division of Behavioral Health Services (BHS), mental health and substance use disorder treatment providers, employment and housing specialists, and Geographic Managed Care (GMCs).

The team will include natural supports identified by the client, such as family, extended family, neighbors, and faith-based representatives. Additionally, the team will include representatives from other support services, such as community mentors, peers, cultural organizations, advocates, educators, coaches, etc. These members will support client throughout the MST process.

The core member of the team is the client. Throughout the MST process, the client will be given priority voice and choice in defining their plan.

In conclusion, MST membership will include the MST facilitator who is assigned by the provider, and representatives from formal supports and system partners, natural supports, and support services who are identified by and involved with the client. MST composition is unique to each client and will be based on their individualized coordinated and integrated plan.

Forensic Behavioral Health Multi-System Team (MST) Structure/Process:

During teaming meetings, MST members will develop an individualized, coordinated, and integrated plan that identifies the client's strengths, needs, interventions, and services that address those needs. This plan is reviewed and reassessed continuously. Team members coordinate and integrate care through consistent and ongoing communication and shared decision making.

MST meetings will result in action plans for members that support the client's goals. At any time, client or MST members may request a meeting should the need arise. For example, if the client is having difficulty with roommates and wants to move, the probation officer may want to work with the client to schedule a MST meeting to problem solve the issue.

Together, the MST will develop a client-centered, culturally responsive, trauma-informed coordinated and integrated plan with a shared vision. The authentic implementation of client voice and choice must be evident in this plan. Prioritizing client voice will ensure power is leveled for all team members and care planning is needs-based, rather than symptoms-based. The coordinated and integrated plan will be developed, reviewed, re-evaluated, and monitored throughout the MST process.

MST services will be client-centered, culturally responsive, and trauma-informed. Clients will be linked to culturally responsive and trauma-informed resources. MST will also offer the client assistance in accessing vocational training, education, and employment opportunities.

Throughout the MST process, the team will also identify and address the client's criminogenic needs. Criminogenic needs are issues, risk factors, characteristics, and/or problems that relate to the likelihood of the individual reoffending. Criminogenic factors include anti-social attitudes, anti-social associates, family dysfunction, poor self-control, poor problem-solving skills, substance abuse, lack of education, and lack of employment/employment skills. For example, if a client's poor impulse control impairs their ability to retain employment, therefore resulting in stealing, the MST members might work with and assist the client to learn to decrease impulsivity.

Forensic Behavioral Health Multi-System Team (MST) Phases:

The Forensic Behavioral Health Provider will utilize a universal, brief, and broad screening tool to determine whether or not incarcerated individuals living with mental illness are eligible for the program and ready for treatment. Once it is determined that clients are eligible and ready for

treatment, they are referred to the program. This could happen while clients are in custody or upon immediate release after being booked.

Phase 1: Engagement: The Engagement Phase starts just before the client is released from jail or immediately thereafter. During this phase, the Forensic Behavioral Health Provider begins building rapport with clients while orienting and educating them to the MST process. The provider will initiate referrals and linkages based on immediate and basic needs identified in the screening tool. For example, the provider might assist a client in locating housing and starting the application process for benefits. The provider will ensure the client is linked to mentors or peers with lived experience for mentoring and peer support.



During the engagement phase, the provider also begins to gather information from clients regarding their other substance use disorder and physical health treatment needs. The provider will ensure the administration of the Adult Needs and Strengths Assessment (ANSA), an assessment tool designed to identify needs to be addressed in each client’s individualized treatment plan.

The provider will assign staff to be the MST facilitator. The facilitator and the client will then identify MST team members. Once MST members have been identified, the facilitator will schedule the initial MST meeting and develop the initial meeting agenda in coordination with other MST members.

Phase 2: Planning: Once the client has reentered the community, Phase 2 begins. In Phase 2, the Forensic Behavioral Health Provider will ensure that a comprehensive biopsychosocial assessment is conducted. This assessment identifies psychological, biological, social factors, criminogenic needs, and needed services and resources beyond what was addressed in the initial screening tool. The information from both the biopsychosocial assessment and the ANSA will assist the MST in remaining focused on a shared vision that reflects the best interest of the client. These assessments, the client, and the MST members will inform the creation of a coordinated and integrated plan.

During this phase, the initial MST meeting is convened. At this initial meeting, the facilitator will orient the client and their support system to the teaming process and integrating planning, introduce MST members, and identify each member’s role and responsibility. The MST may add additional members as identified by the client.

At subsequent meetings, with the client taking the lead, the MST will discuss, develop, identify, and document the following in the coordinated and integrated client plan: (1) MST members, roles,

and responsibilities; (2) client strengths; (3) client goals and objectives; (4) specific service and resource needs; (5) system obligations and requirements (e.g. Court and Probation requirements); (6) peer supports and other support services; (7) challenges and barriers to accessing treatment and resources; and (8) solutions for overcoming challenges and barriers will also be identified in the plan. The MST will prioritize needs and develop the actionable steps for each MST member that will be included in the client plan. For example, the service coordinator may be responsible for making contact with a housing specialist for housing resources for the client. Finally, the MST will agree on meeting frequency and location. Once the coordinated and integrated client plan and MST meeting structure and schedule has been developed, the MST will move to Phase 3, Monitoring and Adapting.

Phase 3: Monitoring and Adapting: The MST will monitor progress on the integrated client plan and make individualized adaptations or revisions as needed. During this phase, the ANSA will be completed at least every six months to monitor needs and progress. Additionally, the client plan will be evaluated and reassessed as needed. The MST members will review actionable items and document whether or not they have been completed. The MST will acknowledge milestones and celebrate successes, problem solve challenges, and hold client and members accountable for task completion. Once the client's primary treatment and resource needs are in place, the MST may explore and support client's additional recovery goals. For example, the MST may explore whether or not the client is ready to explore supportive employment, vocational training, or education or volunteer opportunities. Another example, the client may be rearrested and taken into custody. The MST will continue to provide support by planning for release, problem solving what may have lead to recidivism back to jail, and plan/prepare for release. Successes, new challenges and solutions, and new actionable tasks will be documented in the client plan. Updates to the client plan may also include, but are not limited to, changes to the MST membership or to the frequency or location of the MST meetings.

Phase 4: Transition: During this phase, the client takes a more active role in their coordinated and integrated plan. For example, instead of the service coordinator, the client may independently request a repair to their residence or communicate with their payee service. During MST meetings in this phase, the MST reviews the client's coordinated and integrated plan to ensure that needed services and supports are in place and that progress has been made on the goals and objectives. The MST has the opportunity to review skills learned by the client and that s/he is engaged in services and resources. Should the client need additional services and resources, the MST will identify those services and resources and define the steps that will be taken to access them. These updates will be documented in the coordinated and integrated client plan. The service coordinator will ensure, for example, that the client continues to engage in mental health treatment, has a plan for maintaining housing stability, or has appointments scheduled for needed services and resources.

In Phase 4, the MST will initiate a client-driven post assessment to determine readiness for transition to the community. The ANSA will be conducted to identify client needs that have been addressed and skills that have been learned and strengthened. The MST and client will review and discuss progress made towards goals and objectives and whether or not all actionable items have been completed. The MST and client will determine if services and resources identified in the coordinated and integrated plan are in place and if the client is able to utilize them independently. Ultimately, the decision to transition into the community will be client-driven and supported by the MST. As the client transitions from the project services into the community, the

MST will support client in transferring to the appropriate level of care should ongoing outpatient treatment be needed. As the client prepares to graduate from the program, the client will be invited to return as an alumnus to provide peer support to other program clients. Additionally, the client will be assured by the MST that they can return any time they feel they need the support of the MST and project services. For example, should the client experience a crisis or new difficulty, such as a job loss, increase in symptoms, interpersonal conflict, they are welcome to return.

Additional Project Services and Elements:

The project will include services and key elements that support the MST process in collaborating, coordinating and integrating the client plan, providing mental health services and supports from engagement to transition to the community. Provider staff will be reflective of the diverse racial, ethnic and linguistic populations that they are serving. Clients will have access to a drop-in center designed as a one-stop shop that will be administered by the Forensic Behavioral Health Provider. The provider will deliver mental health services at the drop-in center. System partners and other service and resource providers, such as probation officers or substance use disorder treatment staff, can co-locate and serve clients here as well. Culturally responsive peer mentoring, peer support, and peer run groups will also be offered at this drop-in center.

Clients will receive a warm hand off from jail to project services at discharge or release any time, including after hours and weekends. The provider will assist client with immediate access to housing and Property Related Tenant Services; access to other needed treatment, such as substance use disorder treatment and medication support; and support with benefits application. After initial engagement, the provider will initiate immediate comprehensive assessment to identify needs (including criminogenic needs), services, and resources to start the integrated planning process.

The provider will deliver other service elements that include 24/7 support from start to graduation from project services. Transportation is another important service element to this project. The provider will offer transportation support to clients at the time of discharge or release from jail and for ongoing needs.

Program alumni will be encouraged to remain involved to provide peer support to other clients. Readmission to project services will be welcomed and client-driven. Finally, the provider will partner or subcontract with organizations with experience in providing culturally responsive peer mentoring and support services that are culturally responsive to this client population.

B) General requirement the project will implement.

This innovation project makes a change to an existing practice in the mental health field with an application to a different population.

C) How you have determined that your selected approach is appropriate.

This innovative plan is predicated on long standing community concerns about the complex service needs for the forensic behavioral health population. Further, it is based on stakeholder input and the Innovation Forensic Behavioral Health Project Workgroup's recommendation, supported by the MHSA Steering Committee, to adapt a teaming model for the forensic behavioral health population to: (1) improve collaboration and coordination amongst system partners, service providers, and other involved supporters of the client; (2) develop and implement a coordinated and integrated client plan; and (3) assist in providing immediate access to needed treatment,

services, and resources. The project incorporates the Workgroup's idea of engaging the forensic behavioral health population into project services before discharge or immediately after release from jail. Ensuring that these individuals have immediate access to needed services and resources before or immediately after discharge or release is critical as individuals transition into the community. The ideas generated and discussed throughout the Innovation Forensic Behavioral Health Workgroup meetings mirrored the design of the Child Family Team, a teaming and coordinated and integrated planning process.

Child Family Teams (CFT) have historically been used in the social services field to address the needs of justice or foster system involved youth. In California since 2017, CFTs are required for all children and youth involved with juvenile probation and or child welfare who are in foster care placement. The California Department of Social Services (CDSS) reports that CFTs promote collaboration and communication among system partners and other team members and improve outcomes for children and their families. CDSS also reports that services are most effective when delivered in the context of a single coordinated and integrated plan.

The Virginia Department of Social Services (VDSS) examined the growing body of evidence about the CFT process. Critical elements to the success of CFTs include ensuring that clients and families understand their role as decision makers, promoting client and family leadership, creating a climate of safety, and ensuring that all team members understand their roles. Additionally, developing CFT policies and procedures related to defining how, when, and where CFT meetings are convened is an important element, ensuring that all team members have clear and consistent understanding of the CFT's vision, purpose, and implementation methods.

VDSS' examination of research and outcomes found that the use of CFTs increased child safety, reduced rates of re-abuse in participating families, decreased moves, and contributed to stable placements. They also found that coordinated and integrated service delivery was associated with improved client and family well-being. Clients and families engaged in the CFT process reported that they felt heard and respected, that they had a decision-making role, and that the shared decision-making process was fair. Additionally social workers and service providers reported feeling satisfied with the CFT process. They reported observing less conflict with families and greater service coordination, resulting in an increase in team members' and system partners' engagement and satisfaction.

The California Taskforce for Criminal Justice Collaboration on Mental Health Issues was established to assist state judicial leaders and policymakers in their efforts to improve system-wide responses to mentally ill offender. They recommend that justice involved individuals living with serious mental illness receive the following services while still in custody: discharge planning that includes a plan for obtaining stable housing upon release; in-person contact with mental health provider; peer support to ensure successful community reentry; and initializing other needed services and resources early to bridge the transition from jail to the community. The Taskforce also recognized the need to link these individuals to benefits as soon as possible. They recommend that individuals receive assistance preparing and submitting the necessary forms and documentation to obtain benefits immediately upon reentry into the community (Judicial Council of California, 2011).

As developed and recommended through Sacramento County's community planning process, the adapted teaming model will incorporate the client's voice and choice, cultural responsiveness, and trauma-informed care when developing and monitoring the coordinated and integrated plan

while implementing the described recommendations of the Taskforce for Criminal Justice Collaboration on Mental Health. This adaptation will improve and increase meaningful collaboration and coordination amongst system partners, service providers, and other involved client supporters.

D) Estimate the number of individuals expected to be served

The Forensic Behavioral Health Multi-System Teams (MST) INN Project aims to engage and serve justice-involved individuals age 18 years and older living with a serious mental illness. The program will have the capacity to serve 150 clients at any given time. This estimate is based on the average caseload of local Full Service Partnerships.

E) Describe the population to be served

The Forensic Behavioral Health MST INN Project will serve the forensic behavioral health population who are individuals 18 and older living with a serious mental illness, justice-involved, and experience complex behavioral health needs. This population includes individuals who cycle through multiple systems without lasting improvements to their recovery or wellbeing; reoffend and have frequent contact with Sacramento County Jails; and pre-and post-adjudicated. Many of these individuals experience difficulties in accessing treatment and other needed services and resources. Some are fearful of the behavioral health service delivery system. Many are not linked to treatment or to needed services and supports upon discharge or release from jail.

A JPS September 2019 point-in-time count indicated that of the 3,898 individuals in jail custody, 22% (856) received services from the MHP either currently or within the past year. This count did not include individuals who were referred for MHP services. Of the individuals who received MHP services, 86.1% identified as male, 13.3% as female, and 0.6% as other/not reported. Furthermore, of these individuals, 36% were between 26 and 35 years old; 24% were between 18 and 25 years old; and 19.4% were between 26 and 45 years old. Furthermore, of those incarcerated individuals in custody with MHP service history, a majority (30.3%) were African American, 26.3% were Caucasian, 11.9% were Hispanic, 5.1% were Asian/Pacific Islander, 1.8% were American Native, 3.2% were multi-ethnic, and 2.2% were of another race, while the remaining were unknown or unreported.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The INN Forensic Behavioral Health MST Project is designed to address the multi-faceted needs of justice-involved adults living with a serious mental illness, experiencing complex behavioral health needs. Elements of the project build upon successes of the CFT teaming model. The teaming process will begin before or immediately after the individuals is discharged or released from jail. The MST will engage the client into the project by establishing rapport, identifying needed services and supports, and assisting them in immediate access to those services, resources and peer support. Furthermore, the development and implementation of a coordinated and integrated client plan will begin before the client discharges or is released from jail.

Website research about and informal conversations with other counties regarding their forensic behavioral health programs revealed that no other county is implementing a formalized teaming model for their forensic behavioral health population.

Fresno County's Full Service Partnership (FSP), First Street Center, administered by Turning Point of Central California, serves the forensic behavioral health population. Three probation officers are dedicated to their program participants. Santa Barbara County's forensic FSP's objective is to restore competency for their partners. San Joaquin County's Intensive Justice Response Full Service Partnership partners with local housing programs to provide rent and security deposits for housing until clients get benefits. These programs are not utilizing coordinated and integrated service planning and do not use formalized teaming approaches.

Mariposa County's Team Decision Making (TDM) INN Project utilizes a teaming model for their general adult mental health population, specifically clients who are experiencing crisis or housing instability/homelessness. They have recently expanded the utilization of TDM to their mental health court program as a diversion strategy. Although, there are similarities between both Mariposa County's INN project and Sacramento County's project, there are distinct differences. Unlike Mariposa County, Sacramento County's project is not a diversion strategy or alternative to incarceration. Rather, this project addresses:

1. The need for prerelease/discharge planning for the adult forensic behavioral health population;
2. Assisting clients with immediate access to needed services and resources; and
3. Developing and implementing an individualized coordinated and integrated client plan.

The primary purpose of Sacramento County's project is two fold: increasing access to services for the adult forensic behavioral health population and promoting collaboration amongst system partners, providers, natural supports, community mentors/peers, and the client, through a formalized teaming approach. The learning objectives are specific to measuring timely access to services, degree and effectiveness of a collaborative team, and reducing recidivism back to jail.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing.

Given the multi-faceted needs of the forensic behavioral health population, through Sacramento County's community planning processes, community members and stakeholders have consistently identified unmet needs in services for this population. There are several reasons that may contribute to the likelihood that individuals living with mental illness recidivate back to jail. When individuals lack understanding of complex systems, services, and resources, they become confused and frustrated leading to the inability to follow up on linking to services and resources. Individuals are frequently discharged or released without housing or resources, leaving them alone to scramble to meet their basic needs. Individuals who struggle with symptoms associated with mental illness and lack transportation, therefore, getting to service sites that are geographically spread out can be impossible. Furthermore, there is frequently a lack of coordination with resources the client may have in place. For example, the lack of communication between JPS and client's prescribing psychiatrist due to afterhours release can result in the client with not enough medication or difficulty following up. This leaves the client vulnerable to crisis and/or relying on already learned criminogenic behaviors.

Research, as mentioned above, consistently demonstrates that untreated mental illness is associated with increased recidivism. As mentioned, there are numerous challenges and obstacles to engaging in treatment successfully post release. To prevent this, before discharge/release, individuals should be provided with assistance in navigating systems of care

and accessing services, benefits and other needed resources would connect them to meeting needed care immediately after discharge/release.

Justice-involved individuals living with serious mental illness have higher rates of recidivism than those that do not live with a serious mental illness. The literature suggests that recidivism among individuals living with a serious mental illness may be associated with poor or lack of coordination of services and treatment upon release back into the community (Cloyes, Wong, Latimer, et al., 2010).

Furthermore, advocacy groups point out that many these individuals eligible for public benefits upon release but difficulties and length of time in obtaining benefit contribute to inconsistencies in treatment compliance and recidivism. Individuals frequently lack the necessary personal identification, have difficulty obtaining the necessary records, and are intimidated and confused by the paperwork. Advocacy groups also report that individuals are unable to focus on treatment when they are concerned about obtaining basic needs such as food and shelter

Another compounding factor is that jail culture contributes to maladaptive behaviors and coping that can undermine treatment and or increase trauma for individuals. A 2014 Boston Reentry Study found that incarcerated individuals living with serious mental illness and/or co-occurring substance use disorder issues were significantly less likely than other incarcerated individuals to find stable housing, employment, education, financial stability, and significant support critical for community reentry (Western, et al, 2015).

Former offenders experiencing mental illness are over represented among the homeless population also. In Sacramento County, homeless outreach workers and emergency shelter providers report observing a disproportionate number of individuals experiencing homelessness struggling with serious mental illness. Many of these outreach workers state that at least half of the individuals they encounter appear to live with a serious mental illness. They also report that many of these individuals are more likely to be arrested for offenses related to living outdoors like illegal campfires or trespassing. Homeless service providers and the diverse system partners working with this population report that the intersection between forensic involvement, mental illness and homelessness create numerous challenges. These challenges, which include high stress, unhealthy and dangerous environments, and an inability to control food intake and basic hygiene, often result in psychiatric and or medical hospitalizations, worsening overall health for this population. Communities are struggling with an increase in homelessness and gaps between the criminal justice system and community mental health treatment agencies due to limited resources (Yuan & Capriotti, 2017). The Council on Criminal Justice and Behavioral Health (2019) recommends that the criminal justice system and other system partners collaborate to address and coordinate services and resource needs of the client, including housing and treatment.

Research suggests that the following program characteristics lead to increasing recidivism or ineffective treatment outcomes include: increasing self-esteem without concurrently working on reducing criminogenic needs (needs seen as causing criminal behavior), increasing conventional motivation without assistance in pursuing goals, and merely trying to make the client a “better person”. However program components that have resulted in positive outcomes include identifying and treating changeable risk factors, linked to criminal behavior (needs), such as poor impulse control or family dysfunction, and providing intensive and structured treatment (Gendreau, 1996; Lipsey & Cullen, 2007).

Factors that lead to the increasing number of individuals living with serious mental illness processed in the criminal justice system have been examined. A major factor in the increased presence of individuals experiencing severe mental illness in the criminal justice system is the compartmentalized nature of the mental health, other treatment systems, probation, courts, public assistance, etc. When individuals living with serious mental illness are released/discharged from jail, their experienced impairment complicates and disrupts reentry into the community. Laberge and Morin (1995) recommend a strategy that begins with a comprehensive discharge plan that specifies the individual's needs for community-based treatment, employment, housing, and financial and social support. They also recommend utilizing a team approach to manage clients under supervision. Team composition that includes system representatives, service coordinators, and treatment providers should collaborate in decisions regarding the, probation supervision, treatment, and continuity of care for the supervised client after discharge. Each team member should be familiar with the functions and responsibilities of the others. A team approach underscores the importance of coordinating and integrating care, shared decision-making and providing case management (Laberge & Morin, 1995).

Finally, the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (2013), recommends that assisting individuals with application processes for medical insurance and benefits before or immediately after discharge or release contributes to likelihood that individuals will access and engage in services in the first 90 days post release/discharge. Additionally, they recommend that discharge planning include an assessment of clinical and social needs and identification and coordination with community providers. Additional strategies that support successful transitions into the community that were identified as helpful for this population included intensive strengths-based case management, family psychoeducation and psychopharmacology.

LEARNING GOALS/PROJECT AIMS

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Given the multi-faceted needs of the forensic behavioral health population, the Workgroup and Community identified several reasons that contribute to the likelihood that they recidivate back to jail. They concluded that the forensic behavioral health population lack the following: immediate access to services and resources (i.e. housing, transportation, benefits); service and resource coordination; collaboration between system partners and service providers; discharge planning prior to release from incarceration; access to incarcerated individuals by service providers; peer support; and awareness and understanding of complex systems, resources, and benefits by consumers, community and system partners. These unmet needs leave individuals without treatment and basic resources. Often times this results in individuals experiencing crises, and to cope, they rely on learned criminogenic behaviors potentially resulting in recidivating back to jail.

The project will test whether or not adapting a teaming model as well as developing and implementing a coordinated and integrated client plan for the forensic behavioral health population will lead to the following outcomes:

- Improve care coordination and integration across multiple systems (JPS, BHS, Probation, Courts, GMC, APS/CPS, etc.).
- Reduce jail recidivism, reduce time in custody, and reduce overall justice involvement
- Improve the client experience in achieving and maintaining wellness

- Improve access to services such as but not limited to housing support, medication support services, mental health and substance use disorder treatment services.

There are three (3) primary learning objectives for this innovative project:

1. Will adapting the Child and Family Team (CFT) model for the forensic behavioral health population increase collaboration among system partners, service providers, peers, clients and family members?
2. Will implementation of the teaming model increase immediate access to needed services and resources for the forensic behavioral health population?
3. Will the development and implementation of coordinated and integrated client plans through the MST process reduce jail recidivism, reduce time in custody, jail exposure, and overall justice involvement?

This adapted approach and strategies will be tested to learn whether and how they are effective in improving care coordination and collaboration across multiple systems, reduce jail recidivism, improve the client experience and improve access to services.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The key element of this project is the adaptation of a teaming approach to increase collaboration among system partners, service providers, natural supports and the client and to improve access to services and resources. The learning goal for this project is to determine whether the Forensic Behavioral Health Multi-System Teams Project is effective in engaging the client before discharge/release from jail, developing and monitoring a coordinated and integrated client plan, assisting the client in immediately accessing needed services and resources. Furthermore, we will learn whether this approach reduces recidivism back to jail for clients that engage in the project services.

EVALUATION OR LEARNING PLAN

Collection of Descriptive Data

Data describing the characteristics of populations of the Forensic Behavioral Health Project and the populations served will be collected.

Population Characteristics	Program Characteristics
Age, gender, race, ethnicity, primary language, referral source, payer, legal status, housing status, diagnosis, including co-occurring substance use disorders, trauma history, chronic medical disease	Volume: # of encounters, age range served, system partners referral rate (% of visits), Mode 60 funds utilized, frequency of services (assessment, treatment, case management, etc.), length of stay

Data for the Measurement of Learning Objectives

Data that measure the extent to which the innovation project met its learning objectives will be collected.

Learning Objective 1: Will adapting the Child and Family Team (CFT) model, a non-mental health approach, for the forensic behavioral health population increase collaboration among system partners, service providers, peers, clients and family members?

Measuring Effective Collaborations and Partnerships (MECAP) tool will be utilized to define existing partnerships and key components of the partnerships. Identifying these components will assist partners in structuring conversations regarding their successful collaboration. By observing the characteristics and the behaviors, MECAP users can assess specific and/or overall effectiveness measures and determine what improvements can or should be targeted.

Goals	Objectives	Outcomes
Increase Collaboration	Assess the effectiveness of a multi-system approach utilizing the MECAP	Improve multi-system collaboration
	Utilize an integrated plan	Improve multi-system involvement in the MSTs
	System partner perceptions	Improve overall satisfaction with the MST process and collaboration with multiple systems
	Utilize peer services to support the client	Increase the utilization of peer services Improve client linkages to community resources

Learning Objective 2: Will implementation of the teaming model increase immediate access to needed services and resources for the forensic behavioral health population?

The County Electronic Health Record, Avatar, will be utilized to track outcomes related to access to services and resources including housing status, income and benefits, primary care physician linkage, time between outreach and program engagement, time between engagement and completion of full biopsychosocial assessment, and client no-shows.

Data will be collected at the time of assessment to determine the basic needs of the individuals served, including, but not limited to, housing, entitlements and physical health care. Data (i.e. housing status, linkages to a primary care physician, benefits) will be extracted on a quarterly basis to determine whether individuals are receiving and maintaining housing and entitlements as well as staying engaged with other identified services outside the mental health plan.

Timely access to behavioral health services as well as no show rates will be analyzed on a quarterly basis to ensure clients are receiving services in a timely manner and remain engaged. Timeliness standards will be based on Health Effectiveness Data and Information Set (HEDIS) measures, which require a behavioral health assessment within 10 business days from request for services. The data will be compared to the general behavioral health population to determine whether having a case manager and an MST improves timeliness to services as well as decrease the no show rate.

Goals	Objectives	Outcomes
Remove Barriers to Immediate Access to Mental Health Services, other support services and resources	Meet the clients basic needs	<p>Increase the number of clients stably housed</p> <p>Increase the number of clients receiving income/entitlements</p> <p>Increase the number of clients linked to a primary physician</p>
	Timely access to needed services	<p>Decrease the time between release and engagement</p> <p>Decrease the time between engagement and behavioral health assessment</p> <p>Decrease the number of client no shows to required MSTs</p> <p>Decrease the number of system partner no shows to required MSTs</p>

Learning Objective 3: Will the development and implementation of coordinated and integrated client plans through the MST process reduce jail recidivism, reduce time in custody, jail exposure, and overall justice involvement?

The Adult Needs and Strengths Assessment (ANSA) will be used to measure the clients experience and treatment outcomes and justice involvement. The ANSA is the adult counterpart to the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS is widely used to determine the success and outcomes of the CFT integrated plan and process. The ANSA is a

multi-purpose tool developed for adult’s behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Goal	Objective	Outcomes
Reduce Recidivism and Justice Involvement	Assess and address risk factors that lead to criminogenic behaviors	Decrease the number of arrests Decrease the number of incarcerations Decrease the number of incarceration days
	Utilize the ANSA to assess and address client functioning, needs and strengths that affect the clients overall wellness	Increase client functioning Decrease client risk behaviors Increase clients strengths
	Address client perceptions of services utilizing a multi-system approach	Improve client satisfaction

Section 3: Additional Information for Regulatory Requirements

CONTRACTING / WORK PLAN MANAGEMENT

Sacramento County has a long history of contracting for specialty mental health services, substance use disorder services, and integrated health services. Sacramento County Department of Health Services (DHS), Division of Behavioral Health Services (BHS) provides ongoing management and oversight of all behavioral health contracts. BHS will develop and facilitate a competitive selection process to award a contract to an organization to implement project services. The contract will be negotiated, developed, and monitored by BHS Mental Health Program Contract Monitor. The evaluation plan for the project will be conducted by BHS' Research, Evaluation and Performance Outcomes (REPO) team. Monitoring and evaluation activities include site visits, documenting monthly monitoring visit, reviewing the provider's quarterly outcome reports, gathering client level data and outcomes, tracking MST meetings and attendance, etc. These activities will be utilized to provide ongoing feedback on quality of project and service deliverables, and compliance with project criteria and regulatory requirements.

COMMUNITY PROGRAM PLANNING

The Sacramento County Division of Behavioral Health Services (BHS) Community Planning Process (CPP) for the fifth Innovation Project began at the June 6, 2019 MHSA Steering Committee meeting. At this meeting, the opportunity to develop an Innovation Project focused on the forensic behavioral health population was presented. At the July 18 and August 15, 2019 MHSA Steering Committee meetings, discussions continued regarding innovations for serving this population and regarding the formation of a workgroup to develop an INN project recommendation. During the October 17, 2019 MHSA Steering Committee meeting, the concept of developing an innovative project addressing service needs for justice involved adults living with a serious mental illness was discussed and the Innovation component was explained. The Steering Committee voted in full support of BHS moving this Innovation Project forward.

Consistent with BHS practice and as supported by the MHSA Steering Committee, the Division designed and conducted a CPP to inform the development of this Innovation Project #5. This process included the formation of the Innovation Project #5 Workgroup.

A sixteen (16) member Workgroup was established. Given the disproportionality of the forensic behavioral health population, BHS was intentional about recruiting workgroup members who represented diverse communities, specifically the African American/Black community. Workgroup members represented diverse perspectives of the following stakeholder groups: consumers with lived reentry experience, family members, Sacramento County's Public Defender's Office, Sacramento County's District Attorney's Office, Sacramento County Sheriff's Department, Sacramento County Probation Department, Mental Health Board, MHSA Steering Committee, Alcohol and Drug Services Advisory Board, Cultural Competence Committee, and BHS. Community members were also invited to participate. On average, 28 community members attended each Input Session.

The first Workgroup/Community Input Session was held on January 7, 2020. At this meeting, workgroup and community members reviewed the Innovation component guidelines and discussed the complex needs and multi-system involvement of the forensic behavioral health population. Workgroup and community members listened to panelists, representing consumer,

family member, mental health provider, psychiatry, law enforcement, Courts, and Probation, who responded to the following questions: (1) why members of the forensic behavioral health population recidivate back to jail; (2) what strategies work best in terms of reducing the likelihood of recidivism; and (3) what these individuals need to successfully transition to the community. In small groups, workgroup and community members discussed and responded to the same questions. The workgroup and community members discussed the need for immediate and ongoing collaboration, coordination, and communication between system partners and service and support providers; discharge planning pre-release; assisting with immediate access to needed services and resources; development and implementation of a coordinated and integrate client plan by system partners, service providers, natural support and other involved with the client.

The workgroup and community members met on January 10 and 15, 2020 for their second and third meetings and focused their discussions on the learning objective and recommendation for the project. They discussed utilizing a teaming approach to implement the ideas discussed in the first meeting. Child Welfare's Child Family Team was introduced as a model that could be adapted for the forensic behavioral health population. The workgroup and community members discussed the team composition, process/structure, and phased approach that the team would utilize. Following robust discussions in these meetings, the workgroup and community developed a recommendation to present to the MHSA Steering Committee.

On January 16, 2020, the MHSA Steering Committee reviewed and discussed the draft Innovation Project #5 recommendation (see Attachment B). The Steering Committee fully supported moving this project forward with finalizing the Plan for submission to the Sacramento County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

This Innovation Project was approved by the MHSOAC on June 25, 2020, and by the Sacramento County Board of Supervisors on August 11, 2020.

MHSA GENERAL STANDARDS

The Forensic Behavioral Health Multi-System Teams (MST) INN Project services will reflect and align with the MHSA General Standards. Enhanced meaningful **collaboration** across system partners, community-based providers, and community members is one of the primary strategies of this project. Collaboration is essential to coordinated and integrated planning. All strategies utilized and services provided through this project will be **culturally and linguistically responsive**. During the CPP for this project, workgroup and community members were invested in ensuring that staff who deliver project services are reflective of Sacramento County's culturally and ethnically diverse communities, specifically staff representing the African American and Latino communities. The workgroup and community members also prioritized including peers with lived experience in the MST to support clients in meeting their recovery goals and in successfully transitioning to the community. Strategies and services delivered through this project will be **client and family-driven**, and will embrace the principles of **recovery, wellness, and resilience**. The clients' voice and choice will be at the core of development and implementation of their coordinated and integrated plans. The principles of recovery incorporate hope, empowerment, and accountability, and can assist the client in identifying a meaningful purpose in life. Services delivered through this project will be recovery-oriented, promote choice and self-determination, and maximize community integration to support wellness and recovery. The development and

implementation of a coordinated and integrated client plan will promote the provision of an ***integrated service experience for clients.***

STAKEHOLDER INVOLVEMENT

Stakeholders and community members have been and will continue to be involved in the INN Forensic Behavioral Health Multi-System Teams (MST) Project. Prior to the development of the project, stakeholders have voiced their concerns about the needs of the forensic behavioral health population. The MHSA Steering Committee tasked a workgroup representing system partners, community-based providers, consumers, family members, and community members from diverse cultural and ethnic communities with developing a recommendation for the project. The recommendation was supported by the Steering Committee.

Once the project has begun and throughout the span project implementation, project progress, and evaluation plan including data and outcomes will be presented to the MHSA Steering Committee. The MHSA Steering Committee and community members will have opportunities to provide feedback about the project design, strategies and evaluation activities.

BHS strives to circulate MHSA Component Plans, Three Year Plans, and Annual Updates as broadly as possible. At the beginning of the posting period, a public notice was published in The Sacramento Bee announcing the posting of this INN Plan and the date and time of the public hearing. This notice also provided instructions on how to request a hard copy of the Plan by mail. Fliers announcing the posting and public hearing were posted in public libraries throughout Sacramento. The information was also circulated through multiple email distributions, ethnic, cultural and language-specific media outlets, and hard copies were available for pick up at the Division administrative office.

The Draft Forensic Behavioral Health Multi-System Teams INN Project Plan was posted for a 30-day public comment period from May 18, 2020 through June 17, 2020. The Sacramento County Mental Health Board conducted a Public Hearing to receive public comment at the close of the posting period on Wednesday, June 17, 2020. Due to COVID-19, the Public Hearing was held virtually/teleconferenced for the safety of members and participants.

On June 25, 2020, the Plan was presented to and approved by the MHSOAC. On August 11, 2020, the Plan was presented to and approved by the Sacramento County Board of Supervisors.

Public Comment

During the 30-day public review and comment period, several comments were received related to the Draft Innovation Project 5 Plan: Forensic Behavioral Health Multi-System Teams. Comments are summarized and grouped below for purposes of organization and response.

There were many comments in support of the Forensic Behavioral Health Multi-System Teams Innovation Project. There was support for the client centered approach and MST adaptation for this population. The MHSA Steering Committee, Cultural Competency Committee, and community expressed support of moving this plan forward to the MHSOAC and Sacramento County Board of Supervisors for approval.

There were comments valuing the proposed services which include assisting clients with obtaining basic needs (e.g. food, clothing, shelter), substance use disorder treatment, employment support, and housing options. There were comments in support of identifying and

partnering with existing treatment, support services and resources. There were comments expressed related to increasing the number of clients served. There were comments emphasizing the importance of ensuring that project services are trauma-informed and also support family members.

There were comments made emphasizing that project/program staff should be culturally competent and reflective of the diverse community. Comments made also suggested including cultural brokers as program staff and increasing the number of peer staff with lived re-entry experience. There were also comments recommending that the selected provider be community based and highly experienced in serving the racially and ethnically diverse forensic behavioral health population.

There were comments requesting consideration of implementation of Laura's Law/Assisted Outpatient Treatment and involuntary mental health programs in Sacramento County. There were comments encouraging exploration of diversion programs, programs that prevent individuals from being incarcerated, and programs that reduce the need for first responder support.

There were comments requesting clarification on the proposed referral sources and client eligibility, as well as identifying when and where services begin. There were comments expressed requesting additional demographics in the area of age and race of the jail population. There was a comment suggesting incorporating other tools to measure project services satisfaction.

Division Response

The Division values and appreciates the input provided by community stakeholders, including the MHSA Steering Committee, Cultural Competence Committee, and Mental Health Board. This continues to be a core value of the local community planning process.

The Division will ensure that the provider of the project services will prioritize assisting clients in accessing needed treatment, services and resources. Strong emphasis will be placed on selecting a provider that is community based and experienced in serving the racially and ethnically diverse forensic behavioral health population. Additionally, the provider will be expected to recruit project staff that are reflective of the diverse community and peer staff with lived reentry experience.

The Division acknowledges the complexities surrounding the requests for consideration of Laura's Law implementation in Sacramento County. Recent expansions across the behavioral health system reflect a significantly expanded outpatient treatment capacity for individuals with intractable serious mental health needs who are not responsive to traditional mental health programming. This expanded outpatient treatment capacity with robust outreach and engagement strategies is necessary as a precondition to any consideration of Laura's Law in Sacramento County. Additionally, expanded inpatient as well as a variety of crisis response programming would be a critical component. This discussion, which includes commitment of non-MHSA resources and implications across multiple systems for implementation of Laura's Law consideration in Sacramento County is broader than this MHSA Innovation Project scope or authority and will require separate deliberation regarding the pros and cons for this County. The idea of intensive, criminal justice focused programming will be explored further in the future. The Division recognizes the need for diversion programs, programs that prevent individuals from being incarcerated, and programs that reduce the need for first responder support. With support from the MHSA Steering Committee, Board of Supervisor, and community, the following MHSA Prevention and Early Intervention component funded programs were made possible and work

toward a positive impact in the above noted areas: Community Support Team, Triage Navigators, and Mobile Crisis Support Teams.

The Division will encourage the forensic behavioral health provider to be creative and responsive to client needs. Peer staff have been increased in response to community/stakeholder input and consideration of cultural brokers will be strongly encouraged.

The Division has clarified the project referral sources, client eligibility, as well as identifying when and where these trauma informed services begin in this project plan. The peer staff have been increased in response the comments received. The Division is committed to providing updates/presentations about current available forensic behavioral health population data and project outcomes.

The Division appreciates the support for the Forensic Behavioral Health Multi-System Teams Innovation Project. The Division will continue to explore opportunities to expand programming in the future in partnership with community stakeholders.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Should the INN Forensic Behavioral Health/Multi-System Teams (MST) Project demonstrate success in developing and implementing integrated client plans, providing immediate access to needed services and resources, improving the client experience, and reducing jail recidivism through a teaming model, Sacramento County will return to the MHSA Steering Committee for their input and support for sustaining the project through CSS component funding, if available. If CSS component funding is not available, the County will explore the use of other fund sources to sustain the project. Should the project end for any reason, BHS and the project provider will ensure that clients transition to another service provider(s) that will provide the necessary level of care.

COMMUNICATION AND DISSEMINATION PLAN

The information gathered through the evaluation plan will be reviewed and discussed with the project provider and system partners that serve the forensic behavioral health population. Additionally, the MHSA Steering Committee and the Mental Health Board will receive periodic presentations and reports about the project and will have opportunities to provide input on ensuring continued program quality. The project findings will be available to counties interested learning about Sacramento County's success or efforts in effectively serving the forensic behavioral health population through a teaming approach. The project reports will be incorporated into Sacramento County's MHSA Annual Updates and Three Year Plans, including reporting annually to the MHSOAC.

TIMELINE

The Forensic Behavioral Health Multi-System Teams (MST) INN Project will span up to five (5) years. The following timeline outlines milestones that will occur each year of project implementation:

Year 1:

1. BHS will develop and facilitate a competitive selection process to award a contract to an organization to implement project services.
2. BHS will negotiate and enter into a contract/agreement with selected organization (contractor) to implement project services.
3. BHS and contractor will develop an evaluation core and framework.
4. Contractor will propose service site, develop procedures and hire and train staff.
5. BHS will provide technical support and direction during program start-up/initial implementation to contractor related to project start-up tasks, developing procedures, data collection and evaluation framework.
6. BHS and contractor will outreach to the criminal justice system partners to establish framework for collaborating and coordinating on project services, specifically the MST.
7. Contractor will prepare for service delivery.
8. BHS and contractor will outreach to the community, system partners, community-based providers, consumers, and family members, to provide information about project and program access.

Years 2, 3 and 4:

1. Project services will be fully implemented, including implementation of evaluation framework.
2. BHS will provide ongoing technical support and direction during to contractor related to service delivery, data collection and evaluation activities.
3. Routine meetings will be convened to report out on the evaluation framework and process.

Year 5:

1. Sustainability options will be explored and discussed. Throughout Project implementation, significant efforts will be directed toward sustainability options should the project be successful.
2. Evaluation framework and process will be in its final stages and a final report will be developed.

Section 4: INN Project Budget and Narrative

New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
PERSONNEL COSTs (salaries, wages, benefits)	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
1 Salaries		1,344,580	1,344,580	1,344,580	1,344,580	5,378,320
2 Direct Costs		396,895	396,895	396,895	396,895	1,587,580
3 Indirect Costs		146,210	146,210	146,210	146,210	584,840
4 Total Personnel Costs	0	1,887,685	1,887,685	1,887,685	1,887,685	7,550,740
OPERATING COSTs						
OPERATING COSTs	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
5 Direct Costs		816,315	816,315	816,315	816,315	3,265,260
6 Indirect Costs		296,000	296,000	296,000	296,000	1,184,000
7 Total Operating Costs	0	1,112,315	1,112,315	1,112,315	1,112,315	4,449,260
NON RECURRING COSTS (equipment, technology)						
NON RECURRING COSTS (equipment, technology)	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
8 Not applicable						0
9 Furnishings and Equipment	400,000					400,000
10 Total Non-recurring costs	400,000	0	0	0	0	400,000
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
11 Direct Costs						0
12 Indirect Costs						0
13 Total Consultant Costs	0	0	0	0	0	0
OTHER EXPENDITURES (please explain in budget narrative)						
OTHER EXPENDITURES (please explain in budget narrative)	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
14 Work Plan Management		116,344	119,834	123,429	127,132	486,739
15						0
16 Total Other expenditures	0	116,344	119,834	123,429	127,132	486,739
BUDGET TOTALS						
BUDGET TOTALS	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	Total
Personnel (line 1)	0	1,344,580	1,344,580	1,344,580	1,344,580	5,378,320
Direct Costs (add lines 2, 5 and 11 from above)	0	1,213,210	1,213,210	1,213,210	1,213,210	4,852,840
Indirect Costs (add lines 3, 6 and 12 from above)	0	442,210	442,210	442,210	442,210	1,768,840
Non-recurring costs (line 10)	400,000	0	0	0	0	400,000
Other Expenditures (line 16)	0	116,344	119,834	123,429	127,132	486,739
TOTAL PROJECT BUDGET	400,000	3,116,344	3,119,834	3,123,429	3,127,132	12,886,739
Less Projected Federal Financial Participation	0	(650,000)	(900,000)	(900,000)	(900,000)	(3,350,000)
TOTAL MHSA INNOVATION FUNDING	400,000	2,466,344	2,219,834	2,223,429	2,227,132	9,536,739

New Innovative Project Budget Narrative		
EXPENDITURES		
PERSONNEL COSTs (salaries, wages, benefits)		
1.	Salaries	Contracted salaries include the following staff: 1.00 FTE Program Director, 1.0 FTE Psychiatric Nurse, 1.00 FTE Clinical Director, 0.5 FTE Psychiatrist, 1.00 FTE Housing and Resource Specialist, 5.0 FTE Forensic Behavioral Health Facilitator, 10.0 FTE Forensic Service Coordinator, 3.0 FTE Peer Staff and 1.0 FTE Peer Staff Team Leader.
2.	Direct Costs	Direct costs include staff health benefits, payroll taxes and retirement.
3.	Indirect Costs	Indirect costs include overhead and allocated personnel costs.
4.	Not applicable	
OPERATING COSTs		
5.	Direct Costs	Includes staff training, computer lab and IT support, staff travel and transportation, client housing and flexible supports, etc.
6.	Indirect Costs	Not applicable.
7.	Not applicable	
NON RECURRING COSTS (equipment, technology)		
8.	Not applicable	Not applicable
9.	Furnishings and Equipment	Includes computers, interior and outside patio furnishings, and other features to ensure a warm, family-friendly environment.
10.	Not applicable	
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		
11.	Direct Costs	Not applicable.
12.	Indirect Costs	Indirect costs include overhead and allocated costs.
13.	Not applicable	
OTHER EXPENDITURES (please explain in budget narrative)		
14.	Work Plan Management	County support staff including Research, Evaluation, and Performance Outcomes Program Planner, as well as Contract Administration support services. Includes salaries, health benefits, SSI, retirement and insurance.
15.	Not applicable	
16.	Not applicable	

 <p style="text-align: center;">County of Sacramento Department of Health and Human Services Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	QM
	Policy Number	QM-01-07
	Effective Date	07-01-2005
	Revision Date	03-28-2017
Title: Determination for Medical Necessity and Target Population	Functional Area: Access	
Approved By: (Signature on File) Signed version available upon request		
Alexandra Rechs Program Manager, Quality Management		
Uma Zykofsky Mental Health Director, Deputy Director Behavioral Health Services		

BACKGROUND/CONTEXT:

Sacramento County Mental Health Plan (MHP) is dedicated to serving people with psychiatric disabilities from various target populations, ages, cultural and ethnic communities. The goal is to promote recovery and wellness for adult and older adults with severe mental illness, and resiliency for children with serious emotional disorders and their families.

DEFINITIONS:

Medical Necessity: The criteria that identify service need based on inclusion of specific signs, symptoms, and conditions and proposed treatment associated with mental illness. Determination of medical necessity requires inclusion of a covered diagnosis; an established level of impairment; an expectation that specialty mental health treatment is necessary to address the condition; and the condition would not be responsive to physical health care based treatment. Medical necessity is defined by the California Code of Regulations and is contained in a variety of State Department of Mental Health (SDMH) notices and letters delineating requirements for county mental health services.

Target Population: For the purposes of county mental health services, target population refers to individuals with severe disabling conditions that require mental health treatment giving them access to available services based on these conditions. Public mental health systems are obligated to serve those identified individuals across the age spectrum and acuity of need. Services for each target population are based on acuity of need and impairment as well as varying eligibility criteria. Uninsured individuals are served to the extent resources are available. (W&I 5600.2, W&I 5600.3).

The following target population groups are served in Sacramento County.

Adults:

- (a) Individuals insured by MediCal
- (b) Uninsured individuals (indigent status served as resources permit through realignment or other identified funding)

Youth:

- (a) Youth insured by MediCal
- (c) Uninsured youth (indigent status served as resources permit through realignment or other identified funding).

The following attached documents guide this policy:

1. Adult Target Population: Adult Target Population will be in accordance to the Mental Health Plan definition (see Attachment A)
2. Children's Target Population: Child Target Population will be in accordance to the Mental Health Plan definition (see Attachment C)

Serious and Persistent Mental Illness – W&I Code Section 5600.3(2): An adult is considered to have a serious mental disorder if he/she has an identified mental disorder that is severe in degree, persistent in duration, which cause behavioral functioning that interferes substantially with the primary activities of daily living, and result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Seriously Emotionally Disturbed - W&I Code Section 5600.3(a)(2): A child or adolescent is considered to have a serious emotional disturbance if they have he/she has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria as a result of the mental disorder:

- Has substantial impairment in at least 2 areas (self-care, school functioning, family relationships, ability to function in the community);
- Is either at risk of removal from home or has already been removed OR the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;
- Displays psychotic features, risk of suicide or risk of violence due to mental disorder.

PURPOSE:

This policy and procedure establishes Sacramento County medical necessity parameters for the following populations:

1. Medical Necessity for Adults ages 21 and older, determination will be made in accordance to Title 9, Section 1830.205. (See Attachment B)
2. Medical Necessity for Child/Youth ages 0 – 21 determination will be made in accordance to Title 9, Section 1830.210. (See Attachment D)

This document provides operational guidance for access to services for different target populations and the conditions that determine medical necessity.

DETAILS:

Determination of Medical Necessity Criteria: All Staff conducting the initial assessment meet the qualifications for Licensed Professional of Healing Arts (LPHA) and function as part of the MHP Access Team or specifically designated entry points of services.

1. Adult Outpatient Service Authorization
 - a. The Access Team will make an initial determination of Medical Necessity criteria for outpatient service authorization. The Access Team will document their determination and refer to the appropriate level of care based on said determination.
 - b. The Access Team designates additional specified points of entry for vulnerable population in order to provide presumptive determination of eligibility to prevent barriers to care.
 - c. Service providers receiving referrals from the Access Team are required to confirm medical necessity and to complete the appropriate assessment upon contact with referred individuals.

d. Service providers will continue to review and confirm medical necessity annually at minimum.

2. Child & Family Outpatient Service Authorization

a. The Access Team will make an initial determination of Medical Necessity criteria for outpatient service authorization except as delineated in #2(b) below. The Access Team will document their determination and refer to the appropriate level of care based on said determination.

b. If a client has full scope MediCal, an authorization and referral can be made for a face-to-face assessment to determine if medical necessity is met. This referral and authorization may be made even if, based on initial Access Team screening, medical necessity is not met.

c. Service providers receiving referrals from the Access Team are required to confirm medical necessity and to complete the appropriate assessment upon contact with referred individuals.

d. Service providers will continue to review and confirm medical necessity annually at minimum.

REFERENCE(S)/ATTACHMENTS:

- California Code of Regulations, Title 9
- DMH Notices and Letters

RELATED POLICIES:

- All MHP P&P's
- All MHTC P&P's

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Alcohol and Drug Services		
	Specific grant/specialty resource		

CONTACT INFORMATION:

- Quality Management Program
QMInformation@saccounty.net

**ATTACHMENT A
ADULT TARGET POPULATION**

For services in the adult specialty mental health system, individuals must meet Criteria A, B, C and D to meet service requirements for operational definition or core target population irrespective of funding.

Criteria A: At least one of the following diagnoses as defined in the current edition of the Diagnostic and Statistical manual of Mental Disorders Fifth Edition (DSM 5):

<u>ICD-10</u> (Codes for Included Diagnosis for Adult Target Population)	<u>DSM 5 Classification</u>
	1. Schizophrenia Spectrum Disorder and Other Psychotic Disorders
F20.9 F28 F29* F20.81*	Schizophrenia Other Specified Schizophrenia Spectrum and Other Psychotic Disorder Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (previously Psychotic Disorder NOS) Schizophreniform * Re-evaluation and resolution of diagnosis must be done within 6 months of initial diagnosis
	2. Schizoaffective Disorder
F25.0 F25.1	Schizoaffective Disorder Bipolar Type Schizoaffective Disorder Depressive Type
	3. Bipolar Disorders
F31.11 F31.12 F31.13 F31.2 F31.73 F31.74 F31.9	Bipolar I Disorder current or most recent episode manic, mild Bipolar I Disorder current or most recent episode manic, moderate Bipolar I Disorder current or most recent episode manic, severe Bipolar I Disorder current or most recent episode manic, with psychotic features Bipolar I Disorder current or most recent episode manic, in partial remission Bipolar I Disorder current or most recent episode manic, in full remission Bipolar I Disorder current or most recent episode manic, unspecified
F31.31 F31.32 F31.4 F31.5	Bipolar I Disorder current or most recent episode depressed, mild Bipolar I Disorder current or most recent episode depressed, moderate Bipolar I Disorder current or most recent episode depressed, severe Bipolar I Disorder current or most recent episode depressed, with psychotic features
F31.75 F31.76 F31.9	Bipolar I Disorder current or most recent episode depressed, in partial remission Bipolar I Disorder current or most recent episode depressed, in full remission Bipolar I Disorder current or most recent episode depressed, unspecified
F31.9	Bipolar Disorder current or most recent episode unspecified
F31.9	Unspecified Bipolar and Related Disorder (previously Bipolar NOS)
F31.81	Bipolar II Disorder

F33.9 F33.0 F33.1 F33.2 F33.3 F33.41 F33.42	<p style="text-align: center;">4. Major Depressive Disorder Recurrent Episode</p> Major Depressive Disorder, recurrent episode, unspecified Major Depressive Disorder, recurrent episode, mild Major Depressive Disorder, recurrent episode, moderate Major Depressive Disorder, recurrent episode, severe Major Depressive Disorder, recurrent episode, with psychotic features Major Depressive Disorder, recurrent episode, in partial remission Major Depressive Disorder, recurrent episode, in full remission
F43.10	<p style="text-align: center;">5. Posttraumatic Stress Disorder</p> Posttraumatic Stress Disorder
F60.3	<p style="text-align: center;">6. Borderline Personality Disorder</p> Borderline Personality Disorder

Exclusions: Individuals with a primary diagnosis of substance abuse and those with a sole diagnosis of developmental disability. The criteria exclude those with organic brain syndromes such as dementia or delirium.

Criteria B: Severe impairment in community functioning that includes consideration of sociocultural issues in one or more areas as a result of covered above-listed covered diagnosis. Specific functional impairment must be clearly documented. Functional areas include:

Functional Area	Criteria
Basic self-care, independent living skills, consistent behaviors of endangerment of self or others	Consistent failure to maintain basic activities of independent living; inability to obtain food, clothing, and/or shelter without supports; serious disturbances in physical health such as weight change, disrupted sleep or fatigue that threatens health, separate from physical symptoms due to general medical conditions.
Productive Activities: Includes employment, education, volunteer, parent/caregiver, or other meaningful activities.	Inability to maintain participation in client specific meaningful activities and/or obligations to job, school, self, or others.
Interpersonal Relationships	Marked impairment of interpersonal interactions with consistently contentious or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
Co-morbidity – Substance Use	Inability to maintain roles in the following (see above parameters): self-care, productive activities, or interpersonal relationships due to a co-occurring substance use disorder.
Co-morbidity – Medical	Inability to attend to crucial medical needs as directed by a physician.

Criteria C: Focus of the proposed intervention will be to significantly diminish impairment or prevent significant deterioration in an identified important area of functioning.

Criteria D: Impairments and conditions require specialty mental health services and would not be responsive to physical health care based treatment.

Criteria A, B, C and D will be documented in the client medical record and will be the conditions that support medical necessity for continued services.

**ATTACHMENT B
ADULT MEDICAL NECESSITY CRITERIA**

Must have all, (A, B, and C) as per Title 9, CCR, Chapter 11, Section 1830.205

A. Covered Psychiatric Diagnosis

Must have one of the following DSM-5 diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSIS:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- Attention Deficit and Disruptive Behavior Disorders
- Elimination Disorders
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality disorder
- Medication-Induced Movement Disorders

EXCLUDED DIAGNOSIS

- Mental Retardation
- Learning Disorders
- Communication Disorders
- Autistic Disorders
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of clinical attention, except Medication Induced Movement Disorders, which are included

A client may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Functional Impairment Criteria

Must have one of the following as a result of the mental health disorder(s) identified in the diagnostic "A" criteria:

1. A significant impairment in an important area of life functioning

OR

2. A probability of significant deterioration in an important area of life functioning

C. Intervention Related Criteria

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above,

AND

2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning

AND

3. Not responsive to physical health care based treatment.

**CHILDREN'S/YOUTH MENTAL HEALTH SERVICES
ATTACHMENT C
TARGET POPULATION - CHILD & YOUTH**

**Children and youth to be served in a System of Care
are found eligible in one of two main categories:**

1. MEDI-CAL ELIGIBLE:

Full-SCOPE Medi-Cal eligible children and youth ages 0-21 are entitled by federal mandate to services to "treat or ameliorate any mental health condition" through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). County Mental Health is required by law to ensure access to appropriate service to these individuals in a timely manner.

2. REALIGNMENT:

Children and youth up to age 18 who have a serious emotional disturbance may be the responsibility of the county under Realignment. Realignment resources are not utilized for children or youth with other eligibility or forms of insurance. Realignment Legislation (Welfare and Institutions Code Section 5600.3) secures services for eligible children and youth to the **extent that resources allow**. Children and youth who qualify for services using realignment funding meet the following criteria:

Must have a current included DSM 5 diagnosis. Clients with a primary included DSM 5 diagnosis may have a co-occurring substance abuse or developmental disorder as a secondary focus of treatment. Organic mental disorders are included only if the child currently manifests behaviors that are a danger to self or others and is amenable to treatment interventions which will ameliorate the presenting condition.

Child and youth shall meet one or both of the following criteria:

- A.** As a result of the mental disorder, the child has substantial impairment in at least two of the following areas:
1. Self-care,
 2. School functioning,
 3. Family relationships,
 4. Ability to function in the community;

AND either of the following occurs:

- a. The child is at risk of removal from home or has already been removed from the home.
 - b. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- B.** The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

**ATTACHMENT D
CHILDREN'S MEDICAL NECESSITY CRITERIA**

Must have all, (A, B, and C) as per Title 9, CCR, Chapter 11, Section 1830.205

A. Covered Psychiatric Diagnosis

Must have one of the following DSM-5 diagnoses, which will be the focus of the intervention being provided:

INCLUDED DIAGNOSIS:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality disorder
- Medication-Induced Movement Disorders

EXCLUDED DIAGNOSIS

**Mental Retardation
Learning Disorders
Communication Disorders
Autistic Disorders
Tic Disorders
Delirium, Dementia, and Amnesic and Other Cognitive Disorders
Mental Disorders due to a General Medical Condition
Substance-Related Disorders
Sexual Dysfunctions
Sleep Disorders
Antisocial Personality Disorder
Other conditions that may be a focus of clinical attention, except
Medication Induced Movement Disorders, which are included**

A client may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Functional Impairment Criteria

Must have one of the following as a result of the mental health disorder(s) identified in the diagnostic "A" criteria:

1. A significant impairment in an important area of life functioning;
OR
2. A probability of significant deterioration in an important area of life functioning;
OR
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriated. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated.

C. Intervention Related Criteria

Must have all (1, 2, and 3 listed below):

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above;
AND
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning;
AND
3. The condition would not be responsive to physical healthcare based treatment.

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INN Project #5: Forensic Behavioral Health Workgroup/Community Recommendation (1/15/2020)

The Innovation Project #5 Workgroup recommends to the MHSAs Steering Committee allocating up to \$9m INN Component funds over three to five years to implement an INN Project for the forensic behavioral health population.

This project will focus on adults who:

- Are justice-involved,
- Live with a serious mental illness,
- Experience complex behavioral health needs,
- Have frequent contact with County Jail, pre and post adjudicated, and
- Have multi-system involvement.

The project's primary purpose is to:

- Promote interagency and community collaboration
- Increase access to mental health services to underserved populations

This project will test adapting an existing teaming model, a non-mental health approach that has shown efficacy (Child and Family Team), for the forensic behavioral health population. The multi-system team will include:

- Forensic Multidisciplinary Team Facilitator who will coordinate teaming and planning meetings
- Team members, including the client, system partners (i.e., Public Defender, Probation, Behavioral Health providers, etc.), natural supports (i.e., family, extended family, neighbors, faith-based connections, landlord, etc.)
- Development of an Integrated Plan
- Implementation of Engagement, Planning, Monitoring, Transition Phases
 - Acknowledges milestones toward meeting plan goals and celebration of successes

The project will test by measuring whether this adapted multi-system teaming approach will lead to the following outcomes:

- Reduce jail recidivism, time in custody, and overall justice involvement by creating alternatives to incarceration
- Improve the client experience in achieving and maintaining wellness
- Improve care coordination across multiple systems (JPS, BHS, Probation, Courts, GMC, APS/CPS, etc.).
- Improve access to services such as but not limited to housing support, medication support services, mental health and substance use disorder treatment services.

Project services/elements will include:

- One Stop Shop Campus Model (Drop-in center or Club House model)
- 24/7 Support
 - Warm handoff and support as clients are released from jail after hours
 - Response at the front end and ongoing
- Brief needs screening tool for eligibility
- Discharge planning pre-release
- Peer support during engagement phase and throughout
- Initiates immediate comprehensive assessment to identify needed services and resources to start integrated planning process
- Assists clients with immediate access to the following:
 - Housing and PRTS/property related tenant services
 - Mental Health and Substance Use Disorder Treatment
 - Medication Support
 - Benefits
 - Comprehensive case management
 - Supportive employment and vocational services
 - Transportation upon release and for ongoing needs
 - Peer support and peer facilitated support groups
- Encouraging and increasing program alumni involvement to provide aftercare peer support
- Welcome program readmission
- Project provider will partner/subcontract with organizations that have experience with providing peer mentoring and support services that are culturally responsive to this population