Sequential Intercept Model Mapping Report for Pinellas County, Florida

Prepared by: Policy Research Associates, Inc.

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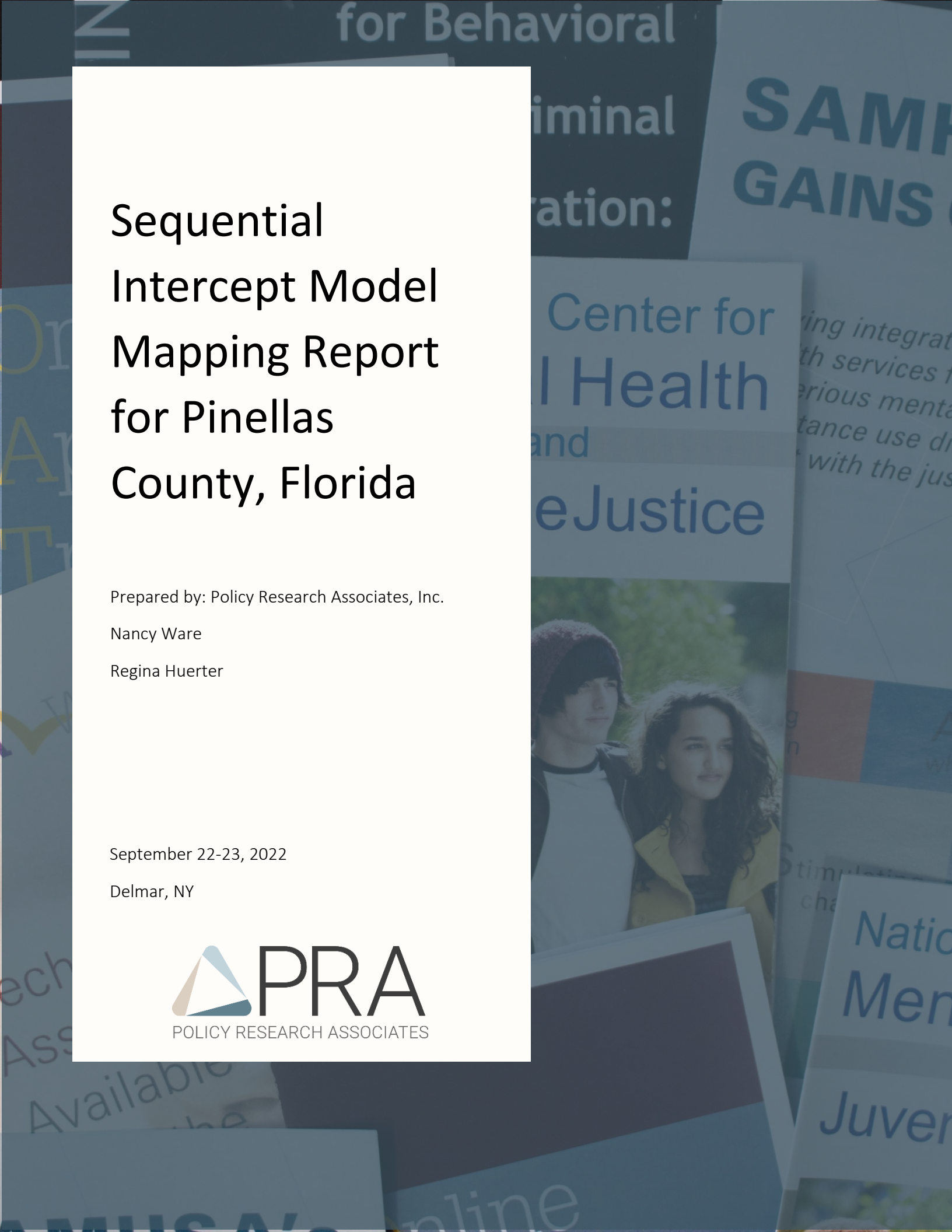
September 22-23, 2022

Delmar, NY



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POLICY RESEARCH ASSOCIATES

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Final Report
January 2023

(Updated – February 2023)

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ACKNOWLEDGEMENTS

This report was prepared by Nancy Ware and Regina Huerter of Policy Research Associates, Inc. Policy Research Associates wishes to thank the Pinellas County Human Services - Justice Coordination Division, Pinellas County Board of County Commissioners, Office of Management and Budget for supporting and hosting this event. Special thanks to Gabriela Piloseno, Section Manager of Pinellas Justice Coordination, for opening the workshop on September 22, 2022, and contributing to this report along with Justice Program Analysts Yashira Gonzalez and Jackie Santos.

RECOMMENDED CITATION

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CONTENTS

BACKGROUND

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available opportunities, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

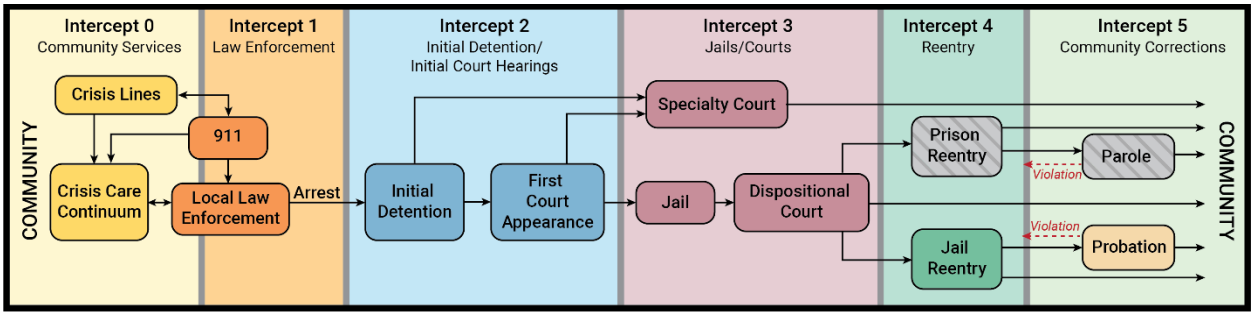
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

2. Identification of gaps, opportunities, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

INTRODUCTION

Policy Research Associates, Inc. (PRA) convened a cross-system group of criminal justice, behavioral health, and community stakeholders from Pinellas County, Florida for a Sequential Intercept Model (SIM) Mapping Workshop. The SIM Mapping Workshop was held September 22-23, 2022. The workshop was hosted and supported by the Pinellas County Board of County Commissioners. Approximately 50 representatives from Pinellas County participated in the 1½-day event.

Opening remarks were provided by Gabriela Piloseno, Section Manager Pinellas Justice Coordination. She welcomed and thanked all community partners/agencies participating in this impactful work.

On the first day, PRA delivered a presentation on the SIM and facilitated discussions across the intercepts. The participants discussed existing resources for responding to the needs of adults with mental and substance use disorders who are involved or at risk for involvement in the criminal justice system, as well as gaps in services. All intercepts were discussed. Following the initial meeting, PRA coordinated a voting process to determine which identified gaps in services were priorities for the group. On the second day, PRA reconvened the same group of stakeholders to review the voting results and discuss the group's priorities in more detail. PRA then facilitated the development of strategic action plans.

Please note that the following report is a working document based on information obtained through collaborative discussions and data collection specific to the SIM Workshop. As a result, the report includes information that is subject to change and may not reflect all services and resources available in the community.

AGENDA

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Sequential Intercept Model Mapping Workshop

Pinellas County, Florida

September 22, 2022

AGENDA

8:30 **Registration and Networking**

9:00 **Welcome and Opening Remarks**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review

4:30 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

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Sequential Intercept Model Mapping Workshop

Pinellas County, Florida

September 23, 2022

AGENDA

8:30 **Registration and Networking**

9:00 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Strategic Action Planning

Finalizing the Action Plans

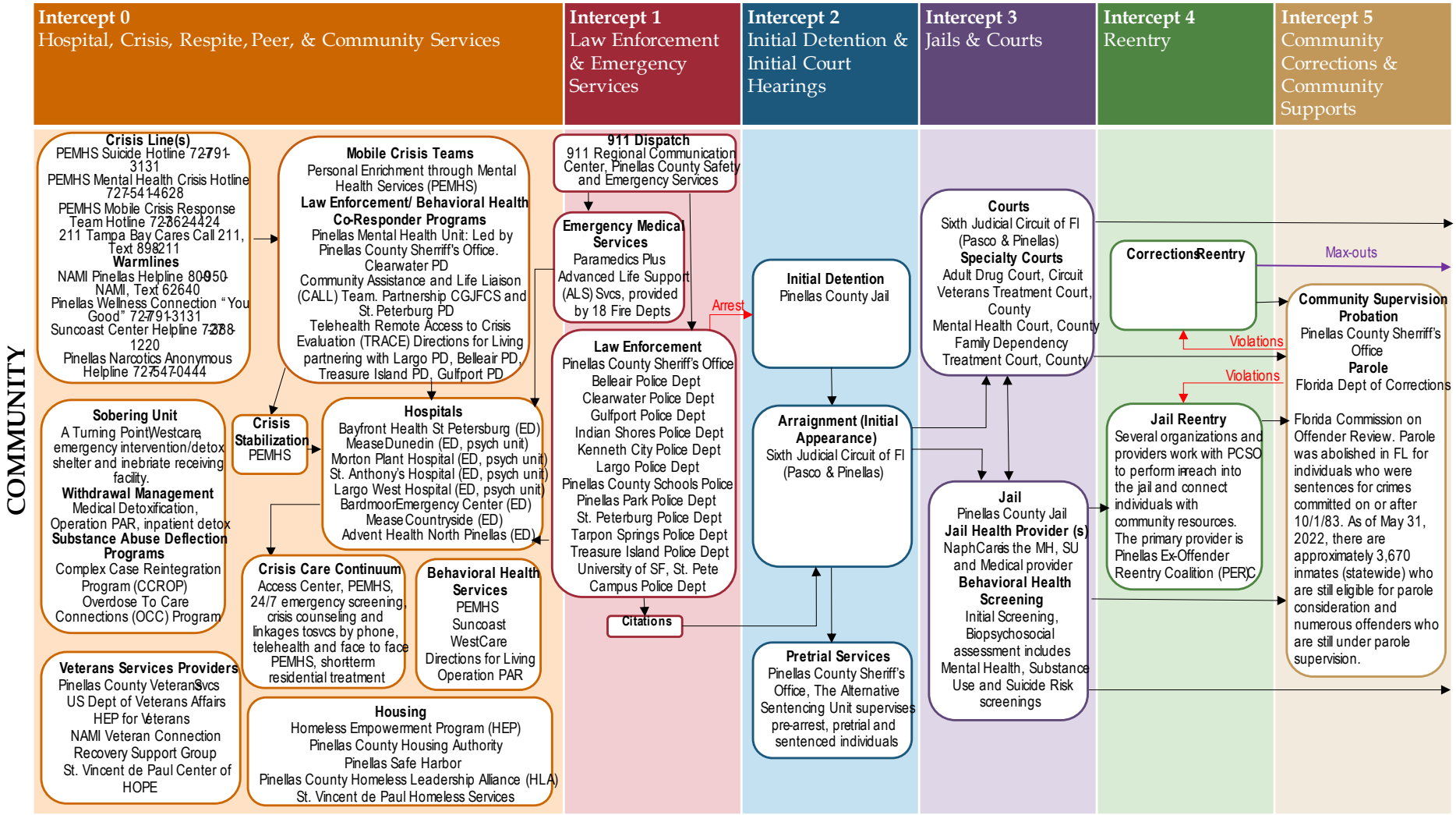
Next Steps

Summary and Closing

12:30 **Adjourn**

There will be a 15 minute break mid-morning.

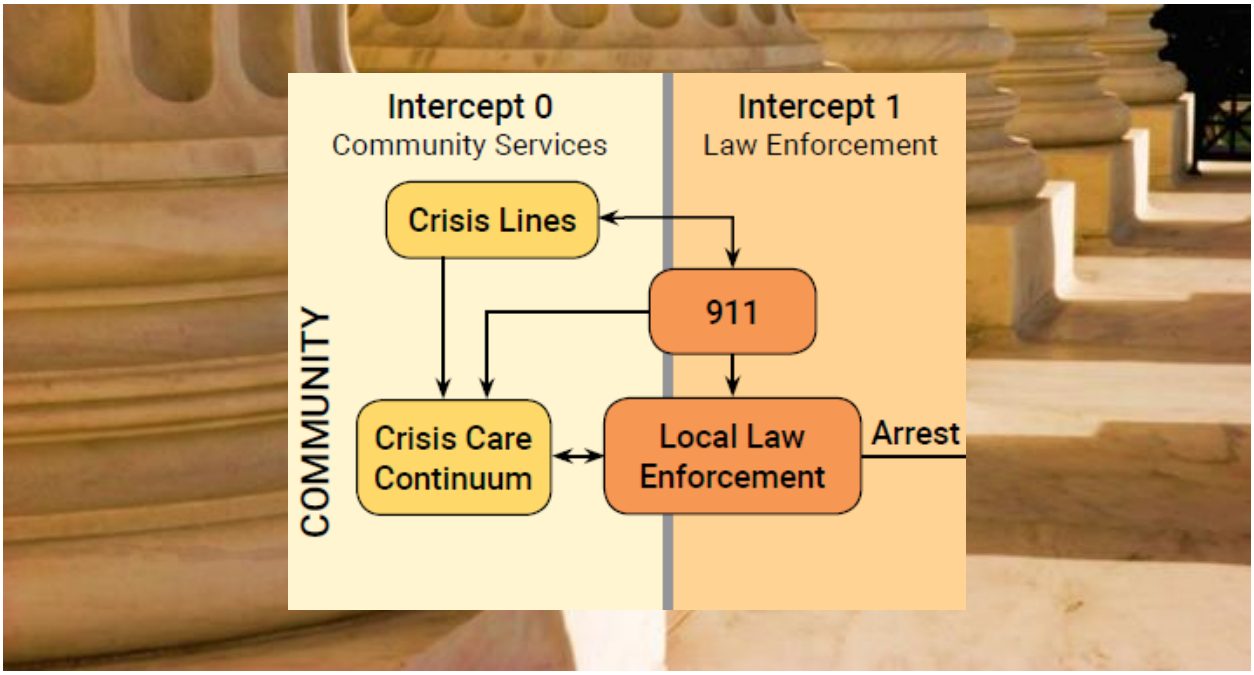
SEQUENTIAL INTERCEPT MODEL MAP FOR PINELLAS COUNTY, FL



NOTE: The components in the SIM Map above are based on information obtained through collaborative discussions and data collection specific to the SIM Workshop. As a result, this information that is subject to change and may not reflect all services and resources available in the community. Continuous review is critical to ensuring successful navigation.

Opportunities and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the workshop participants to identify opportunities and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the opportunities and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing opportunities.



INTERCEPT 0 AND INTERCEPT 1

INTERCEPTS 0 & 1: OPPORTUNITIES

Crisis Call Lines

Pinellas County has several crisis, warm, and resource lines in the community. These include, but are not limited to those provided by:

- Personal Enrichment Through Mental Health Services (PEMHS): PEMHS is a non-profit behavioral health care organization that provides a full-time suicide hotline, emergency screening and crisis intervention, and inpatient services.
    - PEMHS Suicide Hotline, 727-791-3131
    - PEMHS Mental Health Crisis Hotline, 727-541-4628
    - PEMHS Mobile Crisis Response Team Hotline, 727-362-4424
- 2-1-1 Tampa Bay Cares: 2-1-1 Tampa Bay Cares provides information on local services, service referrals, suicide prevention, care coordination, and screening services 24 hours a day, 7 days a week.
    - Resource Line: Call 211, Text 898-211
    - Suicide & Crisis Lifeline provider: Call 988
- NAMI Pinellas: NAMI Pinellas provides advocacy, education, support, and public awareness regarding mental health issues affecting the community.
    - Helpline, 800-950-NAMI (6264), Text 62640

- Pinellas Wellness Connection: The Wellness Connection is a community collaborative to improve access to behavioral health services.
    - "You Good" mental health crisis line: 727-791-3131
- Suncoast Center: Suncoast Center provides a comprehensive range of evidence-based services that address emotional wellness, trauma services, and child advocacy to individuals and families throughout Pinellas County
    - Helpline, 727-388-1220
- Pinellas Narcotics Anonymous Helpline, 727-547-0444

9-1-1/Dispatch

The 911 Regional Communication Center is operated by Pinellas County Safety and Emergency Services. 911 dispatches fire, police and EMS as well as connects to Pinellas County Emergency Rooms (medical information and evaluation is based on the 911 system).

Healthcare

- The Pinellas County Health Program (PCHP) provides quality health care services for uninsured residents ages 18 to 64 who are not eligible for Medicaid, Medicare or other health programs and have an income at or below 100 percent of the Federal Poverty Level. Participants are served in a medical home at one of five participating Florida Health Department of Pinellas County locations, or The Turley Family Health Center. The program covers:
    - Doctor Visits at Your Medical Home
    - Referrals When Necessary – Only to Approved Providers
    - Mental Health and Substance Abuse Services
    - Wellness and Prevention Services such as:
        - Annual Physicals
        - Nutrition Education and Counseling
        - Cancer Screening
        - Physical Therapy
        - Pharmacy Services
        - Referral for Dental Services
    - Laboratory and Medical Services such as:
        - Pap Smears
        - PSA Blood Levels
        - Urinalysis Including Pregnancy Test
        - General X-Rays
        - Ultrasounds
        - MRIs
        - CT Scans
        - Mammograms

    - Case management services may be offered to help residents dealing with challenges such as:
        - Physical illness
        - Disability
        - Psychological concerns
        - Addictive behaviors
- Pinellas County's Health Care for the Homeless (HCH) Program is a Federally Qualified Health Center (FQHC) that provides homeless residents with primary, preventative, and specialty care; healthcare education; prescription coverage; lab work referrals; dental services; and mental health/substance abuse treatment including MAT services, through both mobile and fixed service locations. FQHCs are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. The program is funded by Pinellas County Human Services, the Bureau of Primary Health Care, and the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).
    - The staff includes a medical director, examiner, nurses, and Department of Health (DOH) staff.
    - Pinellas County homeless residents can receive basic health care through the HCH program in two primary locations: Bayside Health Clinic and the Mobile Medical Unit.
    - MAT services through HCH and PCHP are provided by external vendors, with Operation PAR serving as the primary vendor.
- The Pinellas Integrated Care Alliance (PICA) is a collaborative initiative between Central Florida Behavioral Health Network, Pinellas County Human Services, the Pinellas County Health Department, Pinellas County Sheriff's Office, and community-based providers. The primary goal of PICA is to improve coordination and collaboration among Pinellas County behavioral health providers in order to increase access to behavioral health services, address system gaps and inequities, improve follow-up care and long-term outcomes, and decrease utilization of auxiliary services for mental health needs such as jails and crisis stabilization units (CSUs).
- Bayside Clinic, a Federally Qualified Health Center FQHC, provides some primary care services on the jail campus.
- St. Pete Free Clinic (SPFC) Health Center provides primary and some specialty health care services for adults aged 18 and older without private or government insurance. To become a patient, you must be 18 or older, uninsured, and income must be at, or less than, 200% of the federal poverty level.
- Clearwater Free Clinic provides problem-oriented health care to low-income uninsured residents of upper Pinellas County through office visits, medications, lab work, x-rays, and specialty referrals. The Clearwater Free Clinic does not provide office visits for those involved in litigation.

- Three federally qualified healthcare centers have Mobile Medical and Street Medicine outreach vans: the Pinellas Healthcare for the Homeless Program, Evara Health, and Metro Inclusive Health.
-

Hospitals

- Bayfront Health St Petersburg has an emergency department (ED)
- Mease Dunedin has an emergency department (ED) and psychiatric unit
    - BayCare Alliant Hospital is also on campus and provides long term acute care. Itis the only HIH long term acute care hospital in Pasco, Pinellas, and Hillsborough.
    - BayCare Behavioral Health has established a specialized inpatient behavioral health center at Mease Dunedin Hospital.
- Morton Plant Hospital has an emergency department (ED) and psychiatric unit
- St. Anthony's Hospital has an emergency department (ED) and psychiatric unit
- Largo West Hospital has an emergency department (ED) and psychiatric unit
- Bardmoor Emergency Center has an emergency department (ED)
- Mease Countryside has an emergency department (ED)
- Advent Health North Pinellas has an emergency department (ED)

Behavioral Health

- Pinellas County is currently developing the Coordinated Access Model which will provide publicly-, privately-, and non-insured Pinellas County residents of all ages a centralized point of access to behavioral healthcare. Individual or agency callers will be connected to a live professional who will assess, triage, refer and/or schedule appointments for clients in order to facilitate efficient access into the right level of care, including mobile crisis response if necessary.
- Personal Enrichment Through Mental Health Services (PEMHS) offers a range of crisis and emergency behavioral health services, including:
    - The Behavioral Health Network (BNet): a comprehensive behavioral health care plan for children & Young Adults (18 & 19) actively enrolled in Florida KidCare, Inc., a statewide health care plan for children. BNet Mental Health Services are customized to the needs of each individual and include:
        - In-home and outpatient individual and family counseling
        - In-home and outpatient targeted case management
        - Psychiatry services and medication management, including direct access to PEMHS' pharmacy with no co-pays
        - Advocacy and provision for wrap-around services to meet each child's social, educational, nutritional, and physical activity needs.
        - Specialty services, including Behavioral Analysis, Trauma Therapy, and Dialectical Behavior Therapy (DBT)

- The IMPACT Team is dedicated to crisis intervention and diversion. The team addresses the overall well-being of children and adults suffering from co-occurring disorders through assessment, safety planning, individualized service planning, and linkage with resources designed to improve their quality of life. Services are divided into two categories (below). The Impact Team intends to reduce the number of Inpatient Crisis Stabilization Treatment admissions, provide supportive mental health services in the least restricted setting, provide rapid solution-focused services to reduce and prevent crises and connect individuals with long-term services that promote a pathway to sustainable, stable life and self-sufficiency.
    - (1) Engagement services for adults discharged from a Crisis Stabilization Unit within the last 30 days with ongoing concerns of recidivism, including adults who utilize high levels of care to meet their basic needs.
    - (2) Adults and children enduring a crisis could be safely contracted to a less restricted service with the immediate intake of crisis intervention counseling.
  - The Crisis Stabilization Unit (CSU) provides brief, intensive services for adults in crisis, including diagnoses, medication, health education, individual and group therapy, discharge, and aftercare planning
  - PEMHS' Emergency Services (ES) / Access Center operates an emergency screening area known as the Access Center. Emergency screenings are available by phone, telemedicine, and face-to-face for community members. Crisis hospitalization is available for those in need of inpatient services. The Access Center and all crisis units are open seven days a week, 24 hours a day. The Access Center also provides suicide and crisis telephone response, emergency walk-in and Baker Act screenings, outreach and follow-up services, lethality assessment and rescue services, community education, and arranges for medical clearance on consumers from medical hospitals, contact case managers /representatives /guardians /parents /families/ significant others. All crisis units accept admissions seven days a week, twenty-four hours a day.
  - Mobile Crisis Response Team (MCRT) is an On-Demand Crisis Intervention Services for Children and Adults. MCRT will go to the individual wherever they are. Services are available 24/7 on demand and consist of licensed behavioral health therapists and psychiatrists.
- Suncoast provides a broad range of psychiatric and individual, family, and group therapy services designed to develop supports and resolve emotional and behavioral problems. These treatment services include those focusing on emotional wellness, trauma, sexual assault, and child advocacy.
- WestCare has a residential 200-bed program as well as provides outpatient treatment, employment assistance, and other support services. In addition to general substance use and co-occurring treatment services and programs offered include:

- Outpatient and residential treatment, including individual and group counseling and drug screening for individuals referred by the Pinellas County Drug Court.
- Medication Assisted Treatment for individuals receiving treatment for substance use disorders.
- A Turning Point, which serves as an emergency intervention shelter and the only chronic inebriate receiving facility in the County. A Turning Point provides emergency intervention shelter services for homeless adults with substance abuse issues.
- Emerge, which is a six-month residential treatment program for men; Focus and WEMERGE are 12-18-month residential programs for men and women who are generally court-ordered to participate in substance treatment. They can be referred by the courts, any legal system, self-referred, or by family members or friend

- Directions for Living offers a wide range of Outpatient behavioral health services, which include:
  - Adult Therapy, psychiatry, and behavioral health case management
  - An Assisted Outpatient Treatment (AOT) Program– which provides behavioral health case management and court-ordered comprehensive outpatient mental health treatment to Pinellas County residents who have been Baker Acted and need added support to engage in and maintain needed services on their own.
  - Department of Health Adult Counseling & Case Management – In partnership with Pinellas County, DFL provides individual counseling services and linkage to case management and psychiatric services as needed at selected Pinellas County Department of Health locations. DFL is currently at the following Health Departments: Clearwater, Tarpon Spring, Mid County, St. Petersburg, Pinellas Park, and Bayside/MMU Locations.
  - Psychological Testing – In partnership with the Central Florida Behavioral Health Network and the Juvenile Welfare Board, this is a service provided to children or adults seeking testing for various psychological, cognitive, and/or behavioral disorders, from IQ to emotional functioning to autism spectrum tests and more.
  - Group Therapy – Facilitated by Recovery Peer Specialists or Counselors, groups for teens and adults allow clients to share and relate to each other while learning new coping skills, life skills training, addiction supports, and more.
  - Certified Recovery Peer Specialists – DFL employs staff with their own lived experience of having a severe mental illness (peers), who assist clients through mentoring, advocacy, and other supports.
  - CABHI (Cooperative Agreements to Benefit Homeless Individuals) – provides individual, family, and couples counseling services to homeless individuals. DFL provides linkage to care coordination and psychiatric services as needed.
  - Mental Health Court Treatment Services Program – provides comprehensive outpatient mental health treatment to Pinellas County Residents. The program

intends to reduce the number of persons with mental illness who repeatedly enter the criminal justice system by diverting them to appropriate, effective mental health and supportive services.
    - Pharmacy Services – DFL partners with Genoa, a QoL Healthcare Company, to host a full-service in-house pharmacy to allow clients to fill any or all of their medications.
- Operation PAR offers a continuum of care in the county and MAT clinics. Operation PAR works with local social service organizations as well as government agencies, schools, and non-profit and private companies to provide comprehensive prevention, outpatient, and residential treatment services. Their locations and services provided include:
    - Clearwater Highpoint Campus – This location offers multiple services, including Medication Assisted Patient Services (MAPS), the Inpatient and Outpatient Detoxification Program, Case Management, and Co-occurring Recovery and Empowerment (CORE) Program.
    - Largo Campus – This is the main treatment location where clients can receive a variety of programs and services, including outpatient and residential treatment, Motivating New Moms (a program designed to assist mothers who have delivered an infant diagnosed with Neonatal Abstinence Syndrome (NAS), PAR Village for women with children, co-occurring services, and transitional housing.
- Operation PAR also partners with Pinellas County Human Services (PCHS) on the Pinellas MATTERS initiative, which leverages local hospital-based programs to identify and engage individuals in substance use treatment services at the point of care in the emergency department. They are also piloting options for improved efficiencies.
- Gulf Coast Jewish Family and Community Services (GCJFCS): Provides a number of behavioral health and other supportive services in Pinellas County, including:
    - The Quick Response Team (QRT): In partnership with Pinellas County Human Services Department and Pinellas County Safety and Emergency Services, the GCJFCS Quick Response Team comprises both case managers and peer specialists who respond to referred individuals who were recently treated with naloxone or who are at risk of overdose. Services include risk assessment, safety planning, peer support, community stabilization, and a Naloxone Education and leave behind.
- Center for Rational Living: Provides group and individual substance abuse treatment and therapy for clients in a community-based outpatient environment. CRL also provides aftercare treatment for clients who have completed a primary treatment program and would like to continue receiving support.

<u>Sobering Unit</u>

- WestCare's A Turning Point program is an emergency intervention/detox shelter and inebriate receiving facility. It provides emergency intervention shelter services for

homeless adults with substance abuse issues. The shelter is the only facility in the area that accepts inebriated adults directly from the street. Turning Point has extended hours to three days a week. Many individuals served through A Turning Point are transitioned into WestCare's residential or outpatient treatment services.

Withdrawal Management

- WestCare's A Turning Point serves as a withdrawal management provider. A Turning Point is an American Society of Addiction Medicine (ASAM) level 3.5 program, which assists patients whose addiction requires a 24-hour supportive treatment environment to initiate or continue the recovery process.
- Operation PAR's Medical Detoxification offers inpatient detoxification where patients stay at facilities until the process is complete. Along with a physical health screening, Operation PAR's inpatient detoxification program includes a psychosocial assessment, medically monitored detoxification, and stabilization for individuals dependent on drugs and alcohol who meet the admission criteria

Substance Abuse Deflection Programs

- The Overdose To Care Connections (OCC) Program includes Pinellas County (PC) Human Services, PC Emergency Services, and GCJFCS. This program enhances the current first responder's Naloxone program throughout Pinellas County by creating additional training opportunities, increasing community access to a drug or device for opioid reversal, and by increasing connections and engagement in community substance use treatment services. Grant-funded outreach staff will work to connect individuals revived by EMS on scheduled intervals and to seek connection and engagement in community treatment. Outreach efforts will employ motivational interviewing techniques and occur at 7-day internals to allow for rapport development. Efforts will occur for up to 90 days post-overdose.

Law Enforcement and First Responders

Pinellas County has thirteen law enforcement agencies, comprised of a County Sheriff's office, a County schools police department, a university-based police department, and ten municipal police departments:

- Pinellas County Sheriff's Office
- Pinellas County Schools Police
- Belleair Police Dept
- Clearwater Police Dept
- Gulfport Police Dept
- Indian Shores Police Dept
- Kenneth City Police Dept
- Largo Police Dept
- Pinellas Park Police Dept

- St. Peterburg Police Dept
- Tarpon Springs Police Dept
- Treasure Island Police Dept
- University of South Florida, St. Petersburg Campus Police Department

These law enforcement agencies have several behavioral health-focused trainings available for their officers, including a general orientation on Mental Health for new hires as well as a formal Crisis-Intervention Training (CIT). The County's three largest law enforcement agencies; PCSO, Clearwater PD, and St. Petersburg PD, also have behavioral co-response models (discussed in the next section) and approximately half of their officers are CIT trained. These agencies serve approximately 80% of the County's population.

Mental Health & Law Enforcement Co-Responder Programs

Co-responder programs pair law enforcement officers with mental health professionals to respond to calls for service involving individuals experiencing behavioral health crises. Through the combined expertise of the officer and mental health professional, a co-responder team is able to link individuals with mental illness to the services and supports that will help them stabilize.

- The newly expanded Pinellas County Sheriff's Office (PCSO) Mental Health Unit Co-Response Model teams deputies with in-house mental health professionals who work together to address mental health crisis calls. Calls for service are screened and, if determined to be mental health-related, members of the unit respond to the call to provide an initial assessment to address the issue and determine whether a Baker Act is required and what type of services are needed. The case is then referred for follow-up case management. Clearwater PD is now participating as well.
- The Community Assistance and Life Liaison (CALL) Team is a partnership between GCJFCS (provider) and St. Peterburg PD. A team of clinical staff and community navigators are dispatched to non-violent, non-criminal calls including those for: public intoxication, drug overdose, mental health crisis, suicide intervention, truancy, homeless complaints, and neighborhood disputes. This team serves City of St. Petersburg.
- The Telehealth Remote Access to Crisis Evaluation (TRACE) program is a partnership between Directions for Living and several municipal law enforcement agencies, including Largo PD, Belleair PD, Treasure Island PD, Gulfport PD. Through the TRACE program, DFL provides real-time mental health expertise, assessment, and guidance to officers and individuals in crisis via a tablet using a virtual Tele-behavioral Health platform.
- The Threat Management Unit (TMU) is operated by PCSO. Data analysis, individualized case reviews and sheriff/clinician co-response are part of the program and process. The focus is individuals exhibiting peculiar behavior or making threats. Most individuals under review have touched the civil but not criminal process. The process is used to identify and determine next steps including invoking the BAKER ACT. The PSCO has eight mental health

clinicians who ride with deputies and provide interventions. Referrals are made to the PIC team for ongoing services.

Fire and Emergency Medical Services

Pinellas County Safety & Emergency Services is responsible for managing the daily operations of the emergency medical services (EMS) System on behalf of the EMS Authority Special District.

- Pinellas County partners with Paramedics Plus as part of a contractual agreement to operate an ambulance service under the County's trade name, Sunstar Paramedics. It provides all emergency and non-emergency ambulance transportation, including transportation between hospitals and other medical facilities. Sunstar has 70 vehicles in the fleet, including advanced life support ambulances, critical care transportation and mental health van services.
- Emergency response is provided by 18 fire departments housing 62 Advanced Life Support first responder units (fire engines and rescue vehicles) located throughout the county. The closest responder is dispatched to each emergency, regardless of city or district affiliation.

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Crisis Care Continuum

Many individuals seeking psychiatric care are fully cognizant of the decision and its consequences and are able to fully exercise their rights for themselves. When this is not possible due to the severity of the person's condition, the Florida Mental Health act (a.k.a. Baker Act) allows for the involuntary evaluation and potentially commitment of these individuals for up to 72 hours while ensuring they are extended due process rights assured by law.

- Florida Statute 394.462 states that a person may be transported to an approved receiving facility for involuntary examination under the Baker Act if they meet all the following criteria:
    - They are mentally or emotionally impaired to the extent they cannot control their own actions or understand reality. This does not include substance abuse impairment or developmental disability.
    - They have refused voluntary examination, or, because of a mental illness, they cannot understand that an examination is necessary.
    - Without treatment, they may suffer personal neglect or may cause harm to themselves or others.
- According to Florida Statute 394.463, an involuntary examination under the Baker Act may be initiated by any one of the following means:
    - A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed. The order of the court shall be made a part of the patient's clinical record.
    - Law enforcement must take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to 394.462 for examination. A law enforcement officer transporting a person pursuant to this subparagraph shall restrain the person in the least restrictive manner available and appropriate under the circumstances. The officer shall execute a written report detailing the circumstances under which the

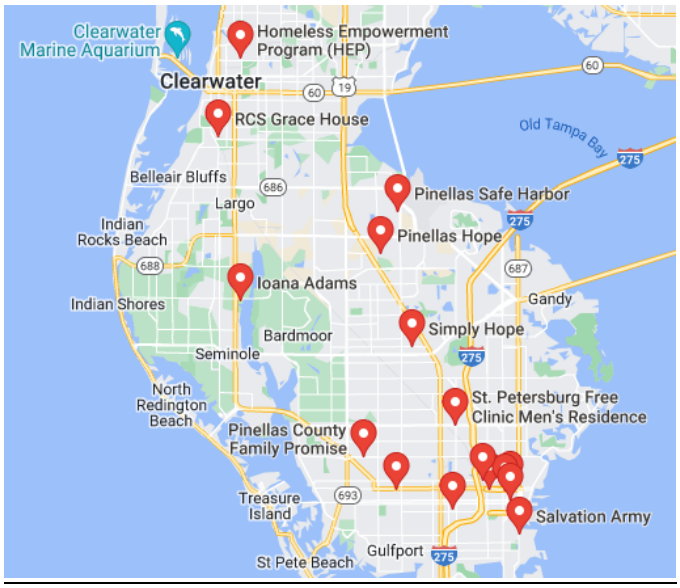
person was taken into custody, which must be made a part of the patient's clinical record.
    - A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under F.S. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. The report and certificate shall be made a part of the patient's clinical record.
- In accordance with F.S. 394.463, the following forms are required in order to initiate an involuntary examination under the Baker Act in Florida:
    - Report of Law Enforcement Officers Initiating Involuntary Examination (Form CF-MH 3052a).
    - Certificate of Professional Initiating Involuntary Examination (Form CF-MH 3052b)
    - Ex-parte Order for Involuntary Examination (Form CF-MH 3001)
- Once an involuntary examination is initiated, law enforcement is contacted for transportation to the appropriate facility within the designated receiving system. Procedures for facilitating this process are outlined in the Pinellas County Behavioral Health Transportation Plan, as required by F.S. 394.462.
- Florida Baker act Designated Receiving Facilities (DRFs) in Pinellas County:
    - Largo Medical Center- Indian Rocks (Hospital)
    - Mease Dunedin Hospital (Hospital)
    - Morton Plant Hospital (Hospital)
    - Saint Anthony's Hospital (Hospital)
    - Windmoor Health Care Hospital of Clearwater. (Hospital)
    - Personal Enrichment Though Mental Health Services (Local Crisis Stabilization Unit).
- The University of South Florida (USF): USF is the Baker Act Reporting Center for Florida. As the Reporting Center, USF receives completed forms used to initiate involuntary (Baker Act) examinations from designated receiving facilities across the state. USF also receives petitions and orders for involuntary inpatient and outpatient services from Clerks of Court. Data collected from these forms are used to produce reports that add insight into Florida's mental health systems.
- The Pinellas Integrated Care (PIC) Team, formed under the Pinellas Integrated Care alliance includes multi agency partners and ten treatment units with the capacity for 120 patients.
- Crisis Stabilization Units (CSUs) hold a no-wrong-door policy. There are ten Baker act teams fully staffed 7 days a week and individuals may be placed under a legal hold for up to 72 hours for evaluation. CSUs typically see adult patients within 24 hours. The standard length of stay is four to five days, though there are individuals who may stay up to a year. There

are 45 adult beds. PEMHS triages individuals and they are admitted at local hospitals including the VA hospital.

- The CSU through Personal Enrichment through Mental Health Services (PEMHS) offers brief, intensive services for adults in crisis including diagnosis, medication, health education, individual and group therapy, discharge, and aftercare planning
- PEMHS operates an emergency screening area known as the Access Center where emergency screenings are available via phone, telemedicine, and face to face. The Access Center is open 24/7. Services offered include assessment, crisis counseling and linkages/referrals to community-based services
- PEMHS offers short-term residential treatment for individuals who need continued support and can assist individuals for one day in what is known as the "recovery room." The Recovery Room can provide after-hours recovery including services for those living with intellectual/developmental disabilities. The Recovery Room is also used by discharge planners as a place for transition support.
- Community Mental Health providers can Baker Act clients for mental health evaluations. Sunstar (paramedic provider) may transport individuals or contact law enforcement which creates some challenges. If the patient is a Baker Act case, then Law Enforcement transports them, otherwise, they are not involved.

Shelter and Housing

Pinellas utilizes the VI-SPDAT (Vulnerable Index – Service Prioritization Decision Assistance Tool) which classifies individuals by level of need for permanent housing. There are several entry points for administering the VI-SPDAT. Most of the shelters are low barrier, but not all providers are equipped to provide detoxification services. Listed below are some of the housing providers in Pinellas County:



- Homeless Empowerment Program (HEP): HEP offers shelter care and supportive services for the entire homeless population, including individuals with mental illness, physical disabilities, or non-violent criminal histories. In addition to several homes and an apartment complex off-site, the HEP campus itself provides clients with access to a number of immediate housing resources, including veterans' apartments, emergency housing for families, emergency shelter, and permanent supportive housing for individuals and families.
- Pinellas County Housing Authority (PCHA): As the largest housing authority in Pinellas County, PCHA provides housing and rental assistance to approximately 8,500 residents through agency-owned affordable housing, public housing, assisted living, and administration of the federal Housing Choice Voucher Program, formerly known as "Section 8". PCHA's area of operation includes all areas of Pinellas County, with the exception of the cities of Clearwater, Dunedin, St. Petersburg, and Tarpon Springs, which have their own local housing authorities.
- Pinellas Safe Harbor (PSH): PSH was created as a means to divert homeless individuals from jail, serving as a shelter and service headquarters for homeless individuals who are involved in the justice system in Pinellas County . It also serves as a portal for homeless individuals who are re-entering the community from the Pinellas County Jail. PSH is operated by the Pinellas County Sheriff's Office and serves an estimated 45% of the Pinellas County homeless population.
    - PSH serves individuals 18 and older
    - PSH has a capacity of 470 and there is no reported wait list
    - The following agencies are examples of services at PSH:
        - Pinellas County Sheriff's Office (PCSO) – Case managers perform needs assessments, coordinate services and placements, and provide mental health and substance abuse referrals.
        - Public Defenders Office – Case managers provide assessments for homeless ordinance violators, and other homeless individuals assigned to a public defender.
        - WestCare – Provides substance use evaluations, substance use counseling, and additional recovery and supportive services.
        - Homeless Leadership Alliance – Provides assessments for shelter diversion, housing and financial assistance, and traveler's assistance.
        - BayCare provides crisis evaluation, post-crisis engagement, mental health navigation,
        - Pinellas County Health and Human Services – Case managers provide assessments for enrollment in County health plans as well as referrals for financial assistance programs and disability advocacy.
- Pinellas County Homeless Leadership Alliance (HLA): The HLA serves as the Pinellas Continuum of Care Lead Agency, Collaborative Applicant, Homeless Management

Information System (HMIS) Lead Agency, and entry point for the Coordinated Entry System (CES). The HLA provides supplemental services, coordination and funding management to carry out the policy goals of the Continuum of Care. HLA's mission is to provide leadership in the planning, development and alignment of community advocacy, resources and strategies to prevent, divert and end homelessness in Pinellas County.

  - All referrals for the County Family Housing Assistance Program (FHAP) must be submitted to HLA's Coordinated Entry System. The Family Housing Assistance Program (FHAP) helps families experiencing homelessness who have been referred by the Pinellas County Coordinated Entry System (CES) which is managed by HLA. A nationwide standardized process, CES ensures that everyone who experiences a housing crisis is quickly identified, assessed, referred, and connected to fair and equal assistance. FHAP offers homeless residents a variety of services, including:
    - Payment of a percentage of security deposits, utility deposits, and rent.
    - Case management and referrals to outside agencies.
    - Workforce development services

- St. Vincent de Paul's (SVdP) Homeless Services are available 24/7 with space for 60 individuals, seven to eight families, and veterans. Their facilities include:
  - SVdP CARES Center - the entry point for homeless services, open 365 days a year. With a "housing first" approach, those enrolled in the CARE Center are assessed and placed with counselors who work together on specialized housing plans with the goal of permanent and stable housing.
  - SVdP Center of Hope - This emergency living facility supports US veterans transitioning to permanent and stable housing. Non-Veteran Families are linked to Bridging Families Collaborative through SVdP
- Pinellas HOPE is a program provided by Catholic Charities to provide temporary emergency shelter. Intake to Pinellas Hope services is facilitated by three Community Outreach teams. Residents are assisted with food, transportation, employment assistance and numerous "wrap-around" social services, including medical and dental services, eye exams, adult education classes, mental health services and many more. Pinellas County provides funding for a portion of their emergency shelter operations and case management positions. There are currently five housing/shelter facilities:
  - Pinellas Hope I: This is an emergency shelter facility comprised of free tents and low cost ($50/week) "Hope Cottages" facilities. Pinellas Hope I shelter options are for adults 18 & older, non-sex offenders. Client length of stay is typically 90 days but may be extended on a case-by-case basis. Intake is one day a week, currently on Tuesday, but changes from time to time.
  - Pinellas Hope II: This is a permanent supportive housing option consisting of 80 efficiency-style apartments, a community center with offices, a kitchen, meeting

rooms, a covered dining area, restrooms with showers, and a laundry room. The clients served are pulled from Pinellas HOPE's internal list.
    - Pinellas Hope III, IV, V: These facilities, built in 2017, expanded Pinellas HOPE's permanent supportive housing capacity by an additional 76 subsidized efficiency apartment units including 40 that are dedicated for military veterans. This option is available to clients for 12 months or longer.
- Hope Villages Grace House is an apartment-style emergency shelter for homeless families with children, available to eligible clients for two to three months. Grace House has capacity for up to 80 people in 14 fully furnished apartments. The program works one-on-one with families through case management, education, job readiness training, and helping families save money in order to secure stable housing. Residents must be able and willing to secure employment and participate in weekly services. Upon successful completion of the program, families are eligible to shop at their local partnering thrift stores for furniture and household goods at no charge.
    - 90% of families who complete the program move to stable housing.
    - Food, clothing, and household goods are available to residents at no cost.
- Boley Centers: Boley Centers provides permanent housing in 54 locations throughout Pinellas County for individuals who are recovering from mental illness, are homeless, or who have re-occurring substance abuse problems, as well as those who are low income, Veterans, and/or living with HIV/AIDS. Housing types provided by Boley include group housing, HUD subsidized Apartments, and Boley-owned rental units. Housing specifically for people and households who are homeless and/or have a disability include safe havens, HUD subsidized supported housing, and tenant-based rental vouchers.
- Pinellas County Adult Emergency Financial Assistance Program (AEFAP): AEFAP helps individuals and married couples without minor children by providing financial assistance to help prevent evictions, foreclosures, and unhealthy living conditions as well as resources to help keep people employed. Eligible individuals and married couples need to be Pinellas County residents, over the age of 18 or legally emancipated youth, under 200% of the Federal Poverty Level, and have been screened by 2-1-1 Tampa Bay Cares.

<u>Veteran Service Providers</u>

- Pinellas County Veterans Services: Pinellas County Veterans Services, a division of Human Services, assists veterans and their families in accessing benefits provided by Pinellas County, the State of Florida, and the United States Department of Veterans Affairs, as well as assists with referrals to other services.
- U.S. Dept of Veterans Affairs (VA): Offers access to federal veteran services, clinics, and hospitals. The VA has several offices and facilities in Pinellas, including the St. Petersburg Regional office, where residents can receive assistance with veteran compensation, veteran readiness and employment, veteran decision reviews, and homeless veteran outreach.

    - Pinellas County is also home to one of the largest VA health care systems in the nation: the Bay Pines VA Health Care System. Veterans can go to Bay Pines for primary care, mental health care, specialty care, and other social programs and services.
- HEP for Veterans (see above in shelter/housing section)
- NAMI Veteran Connection Recovery Support Group: The NAMI Veteran Connection Recovery Support Group is a free, peer-led veterans support group for veterans living with mental illness. The groups are led by trained facilitators who are Veterans with lived experience and are now living in recovery. The groups meet the 3rd Thursday of each month and are open to the community, regardless of diagnosis.
- St. Vincent de Paul Center of HOPE: The Center of Hope is a 24-room facility that provides temporary housing for families and Veterans as they transition on their path to permanent and stable housing. All those within the Center of Hope have a focused plan to address their immediate housing crisis in the Rapid Rehousing program while being connected to external resources that may include mental health, medical, legal, or education services.
- WestCare Mustard Seed Inn: The Mustard Seed Inn provides transitional housing to homeless adults and Veterans who have begun their recovery from alcohol, drug abuse and/or mental illness. The Mustard Seed Inn offers 73 beds for 24/7 transitional living, substance use and co-occurring substance use and mental health disorders treatment, and recovery support services.
- Boley Centers Veterans Housing (see above in shelter/housing section)

<u>Peer Support</u>

- NAMI (National Alliance on Mental Illness) Pinellas has 16 signature programs led by peer and subject matter experts with lived experience. NAMI is currently working on finalizing the "Forensic Peer Specialist" certification curriculum for the county. NAMI offers MOAs for placement of peer specialist and works with crisis intervention team (CIT) to train law enforcement on lived experience
- Several providers in the community offer Wellness Recovery Action Plans (WRAP). WRAP is a self-directed wellness and recovery approach that helps people to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and achieve their own life goals. Clients learn to use WRAP through a peer-led and peer-engaged group process. They develop their own WRAP but may choose to have supporters, including health care professionals, help them create their WRAP.

<u>Collection and Sharing of Data</u>

Pinellas County and its partners have developed and/or actively participate in a number of data strategies to help better identify, collaborate on, and respond to the needs of adults with mental

and substance use disorders who have contact with the criminal justice system. In addition to the grant programs and partnerships listed in earlier sections; these strategies are important to identify because they can provide the underlying infrastructure of support to the SIM efforts of Pinellas County. Identifying them also helps to reveal potential gaps that can be addressed by SIM efforts.

- Pinellas County Data Collaborative: Starting in 1999, the County established a robust, cross-system data collaborative with data stored at the University of South Florida, Florida Mental Health Institute (FMHI). This program provides regular support for data driven decision-making and informing program development. More recently, the County has initiated expanded data sharing for opioid abatement and service access. Working with EMS, Human Services is providing coordination for cross-over clients to help effectively connect individuals to preventative care and substance abuse treatment.
- KPMG Behavioral Health System Analysis: At the request of the Pinellas County Board of County Commissioners, consulting agency KPMG performed a review of publicly funded behavioral health services within Pinellas County. The results of the study demonstrated the need to establish a systemic performance monitoring system that collectively measures behavioral health providers and services as well as a need for increased care coordination. These findings are being used to inform a number of projects, including the Behavioral Health Optimal Data Set (ODS). The ODS will ensure that data regarding access, quality, capacity, productivity, and outcomes are reported from all behavioral health providers to allow for benchmark comparisons and trend analyses, beginning with services funded by the Pinellas Integrated Care Alliance (PICA). The first of multiple ODS's was recently developed for case management (CM) services in partnership with seven service providers as an initial step to toward data-driven transparency and accountability for an improved understanding of the behavioral health service system in Pinellas County
- Building upon The Pinellas County Empowerment Team (PCET), PCET 2.0 is preparing to roll out as an updated model incorporating critical lessons learned from the previous iteration of the project. The program begins in Spring 2023 and will focus on "high need/high use" individuals based on their frequency of involvement in and across behavioral health and other program-identified community systems and resources.

INTERCEPTS 0 & 1: GAPS

9-1-1/Dispatch

- Streamlining a communication process to share information from 911 to dispatch to law enforcement
    - Available information regarding existing programs is provided to the law enforcement officer (LEO) even though the dispatcher does not know where beds or service capacity are available

Healthcare and Crisis Care Continuum

- Currently, programs are operating for people who fit the program model versus providing programs to fit the needs of individuals. Change resistance and funding barriers contribute to this issue
    - While there are some efforts to provide peer services, much of the focus is on individual agency case management, while individuals are part of that program. An individual could have multiple case managers, and multiple care plans while in the community, and post-release from jail. For the most part, clients lose care/case management when they leave a program only to start over if they return to services or the criminal legal system.
- Different areas receive different funding, which interferes with the responses by law enforcement and EMS.
- More options are needed for treatment and diversion, but immediate solutions are not available
    - There are different levels of co-responders who are not available 24/7
    - WestCare does not offer Methadone treatment
    - PAR's outpatient services are now residential and there is no more outpatient, (the interventions for the middle are missing)
    - Fentanyl test strips are currently illegal in the state. There have been legislative efforts to address this.
    - Consider the policy on NarCan used by St Petersburg
- There is a need to review voluntary versus involuntary transport policies and legal requirements that are in place now. These policies need to be updated
    - Florida Statute 394.462 is the guidance for the Baker Act transport.
    - Community Mental Health centers can Baker Act individuals with serious mental health symptoms. Sunstar calls the police which may be a problem if the responding officer is not CIT
    - The field transport is different from the mental health centers
    - The Behavioral Health Transportation Plan is regularly reviewed for updates by the Acute Care Committee. Review and updates are currently progress.

- The quality of services and staffing at DRFs and Reporting Centers is not currently measured.

Housing

- Law enforcement needs more mental health housing available to them for the individuals they come into contact with. There is also a need for more shelter and supportive housing at different levels. Transient populations have nowhere to go, especially if they have a criminal history. Elderly, those with disabilities, and families with children and animals do not have anywhere to go. Families cannot stay together. There are limited options. Shelters other than Safe Harbor often have long waiting lists.
- Homeless shelters and jail diversion shelters require a coordinated shelter list.
- Salvation Army, Turning Point, WestCare, all but Safe Harbor are full. Homeless shelter entry is once a week and some clients burn their bridges with the shelters, some are not admitted, or admission is restricted for them.
    - Safe Harbor provides important services and supports; however, it seems to be underutilized or restricted in its scope
- Transitional Housing programs have seen reduced support by HUD.
- There has been an increase in evictions and homelessness. The collateral consequence is that this policy will also prevent rentals and result in evictions from motels after 30 days.
- It is not known how many shelters can provide MAT medications.
- There is a need to provide mid-level services for the working poor. This is vital to keep them from becoming chronically homeless
- There is a need to innovate services that address pre-crisis -to –short-term stabilization low-barrier (room, board, co-occurring treatment services, life skill training (daily work and pay), employment, cognitive skill training, respite); and longer-term stabilization-into recovery transitional supports and services as previously identified. And long-term recovery supports and services

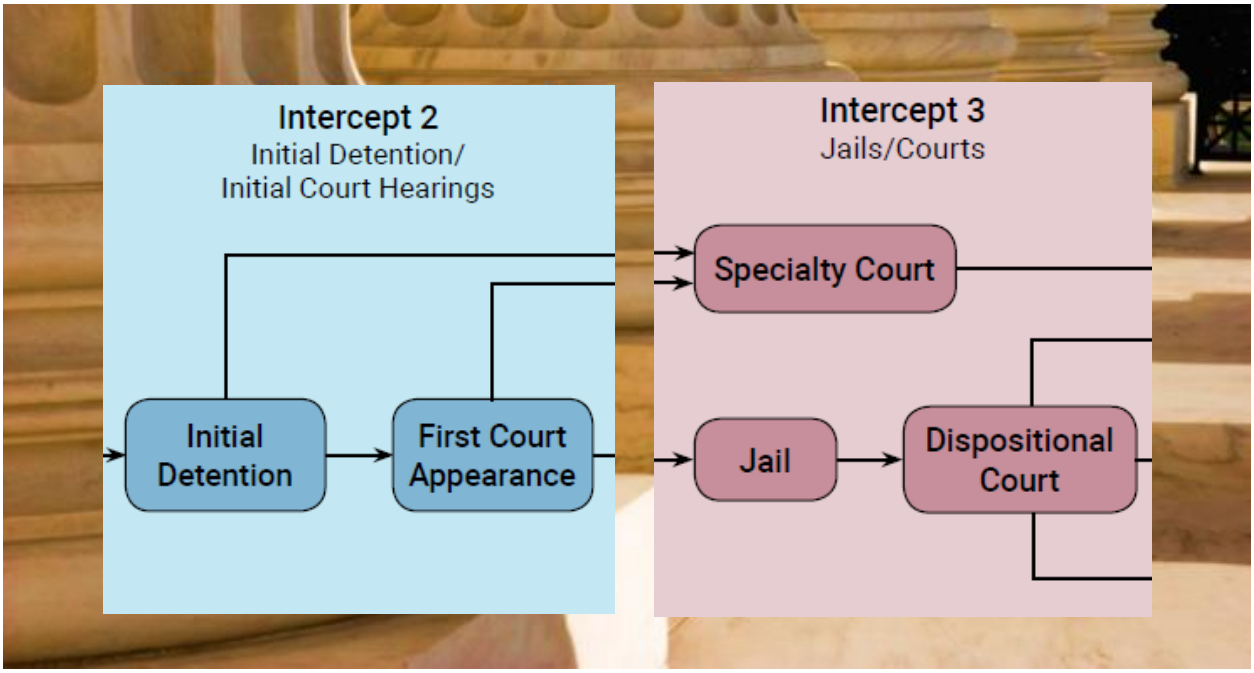
Peer Support

- There are no coordinated peer responses to calls for EMS

Collection and Sharing of Data

- There is no formal standardized intake form/assessment across the board
    - Sharing/syncing data in one place is complex (what information, who will do intervention, etc.).
    - If it is possible to consolidate forms for the intake process, or if there is a better way to streamline throughout the agencies it would substantially help with data sharing.
    - Providers are not able to track by the individual.
- There is a lack of understanding of funding, policies, legislative changes

    - Lack of understanding how efforts at the local and city level work together
    - There is a need for a “community pot of money”
    - Need to break down the hubs of information
- EMS is now focused on population growth management for high utilizers and locations that are frequented.
- Grant for COSSAP (overdose response) and the grant for Law Enforcement must be evaluated for effectiveness.
- There is limited use of the data that is available particularly on the high need clients. This requires better coordination with EMS and 911.



INTERCEPT 2 AND INTERCEPT 3

INTERCEPTS 2 & 3: OPPORTUNITIES

Booking/Initial Detention Process

Notice to Appear cases are resolved without requiring individuals to go back to court and Veteran cases can be resolved through Stand Down, an event that offers an opportunity for court personnel and ancillary agencies to reconcile warrants and low-level cases, while offering support to individuals who need help. The standard court process includes a hearing and bond review within 24 hours of arrest. Arraignment takes place in the Sixth Judicial Circuit Court of Florida, which serves both Pasco and Pinellas counties.

Jail Structure and Personnel

The Pinellas County Jail is located at 14400 49th Street North, Clearwater, Florida. Pinellas County Jail medical services include dental, nursing, physical health and treatment. Jail data are compiled and tracked within the Jail Information Management System (JIMS). At the time of the workshop, the reported census was estimated at 2,900, with an estimated 2,100 on pretrial detention. Males make up approximately 70% of the jail population and there are an estimated 87 bookings and 85 releases daily. The average length of stay is 30 days; however, a significant number of inmates are released within a few days resulting in less time for treatment of chronic diseases and behavioral health issues.

Jail Services

- PCSO has internal and contracted staff for medical and behavioral health services at the jail. Health services are primarily provided by NaphCare, the contracted medical provider in the jail. PCSO offers an initial screening and biopsychosocial assessment of jail intakes for Mental Health, Substance Use, and Suicide Risk needs.
    - Nursing staff are employees of the PCSO. There is an ongoing effort to hire nursing staff. Nursing staff are available 24/7.
    - NaphCare provides a full-time psychiatrist, two psychiatric APRNs, and 5 LMHCs or LCSWs.
    - There are 150 total jail-based medical staff
    - Social workers are available at the jail
    - The jail has a "Kiosk system" which allows individuals to request services they are interested in getting linked with and the social workers make the connections.
- There is a specialized healthcare unit for individuals diagnosed with a severe MH or SUD. There are three levels of care with the goal to work toward crisis stabilization:
    - Special Observation for Suicide Risk level 1 status Inmates on the lowest level are regularly checked on, similar to those with a general mental health need.
    -
    - Suicide Risk level 2 statuses are the most prevalent in the jail. This level indicates a prior attempt or a plan; individuals on this level receive increased observation.
    - Suicide Risk level 3 is reserved for high-risk inmates who have had an active suicide attempt, suicide rehearsal, or persistent suicidal ideation with strong intent. These inmates are housed in specialized single cells with 24-hour observation, including documented physical checks by officers and/or medical staff at intervals not exceeding 15 minutes.
- Within 14 days, individuals are screened/assessed and if the individual discloses they are on medication, medical staff has access to the Tech Care Electronic Medical Record (EMR) Sure Script Pharmacy database to confirm.
    - 18% of the jail population is living with a serious mental illness
    - 60% of jail population is receiving psychotropic medications
    - Persons may deny they need medications
    - Staff do not automatically look up everyone in the prescription system.
- The jail offers medical detox services. Pregnant women are provided methadone by the Drug Abuse Comprehensive Coordinating Office (DACCO); all others go through detox.
- Veteran screening is conducted by jail correctional staff during the Classification process. The jail maintains a special pod for veterans. The Veterans pod was inactive at the time of the workshop due to COVID-19 restrictions but was anticipated to resume shortly.
    - Practice is to have social workers reach out to the VA service providers on behalf of the inmate to set up an appointment within 60-days otherwise veteran benefits can drop to 10%.
    - The VA can pay certain benefits to Veterans who are incarcerated; however, the amount depends on the type of benefit and reason for incarceration. In certain or

part of the compensation not paid to an incarcerated Veteran may also be apportioned to the Veteran's spouse, child or children, and dependent parents on the basis of individual need.

- Central Florida Behavioral Health Network has a pilot project where it receives daily arrest data from the jail and sends it to Suncoast Center, Inc. to notify case managers about clients arrested and released.

Competency

Court Policies include the ability to conduct psychological screenings for competence to stand trial. In addition to general court processes. Pinellas County provides funding to the Public Defender's Mitigation, Advocacy, and Treatment Team (MATT) to support diversion as well as incompetent to proceed initiatives/services provided through their office. Please see later sections for additional detail.

Pre-trial Services

- The Alternative Sentencing Unit through the Pinellas County Sheriff's Office supervises pre-arrest, pre-trial and sentenced individuals who must abide by certain court ordered restrictions while released in the community.
- There is no formal open-eligibility pre-trial program; however, voluntary mental health and substance abuse services are available for those who request them.
- Pretrial Intervention (PTI) Diversion is available for first-time, non-violent, 3rd degree felons. They can apply for Pretrial Intervention (PTI) if they complete the program, they can have their record sealed. They agree to a contract. This is a possible component within Drug Court, which also includes veterans' treatment. About 350-400 individuals are part of this opportunity.

Recidivism Prevention Program

- Pinellas County, PERC, and WestCare partnered on the Complex Case Reintegration Program (CCRP) a recidivism prevention program that seeks to enhance resources, bridge gaps in services, and improve stabilization outcomes for justice involved adults with complex substance use or co-occurring mental health needs, with an emphasis on serving individuals with histories of opioid use.

Courts

Pinellas County is the Sixth Judicial Circuit, which also encompasses Pasco County.

- The Courts data system is called ETO. CRT can see all data in ETO to assist with planning purposes.
- Optional trainings in motivational interviewing and Mental Health First Aid (MHFA) have been made available to Judges, prosecutors and public defenders through a federal grant implementing the Pinellas Mental Health Court.

There appears to be good collaboration and coordination between the prosecution and defense. The State Attorney's Office and Public Defender's Office for the Sixth Judicial Circuit work cooperatively on a number of court initiatives, including drug court, Veterans' Treatment Court, and mental health court. Additional resources include:

- The Office of the Public Defender receives approximately $1.6 million in county funds to provide coordination, staff, and support for jail diversion and incompetent to proceed services. Staffing includes mental health counselors, and case managers. Minor, non-felony offenders are the target population for jail diversion; for those accepted, charges are dismissed, job/employment programs and substance use disorder services are available and offered.
- The Public Defender's Office attorneys support Baker Act, Intellectual disability, Outpatient, Drug Court, Mental Health (MH) Court, and the Mitigation Advocacy Team
    - Public Defender Treatment Case Manager services include picking up individuals from the jail upon release and taking them to community-based treatment appointments across counties
    - Public defender therapists
- The State Attorney's Office provides clients access to victim services as well as works with the Courts on the projects mentioned above as well as several additional diversion programs such as the pre-trial intervention program (PTI) and DUI Rehabilitation of Offenders program (DROP).

<u>Diversion Programs and Problem-Solving Courts</u>

There are several diversion programs and treatment courts:

- The Court provides General Magistrates to hear Baker Act and Marchman Act civil commitment proceedings, including involuntary outpatient placements through Assisted Outpatient Treatment (AOT):
    - At the time of the workshop, the Assisted Outpatient Treatment (AOT) grant was scheduled to end in June of 2023, with work underway for an extension. Efforts are made to not use the jail for this population at any time.
    - Very few jurisdictions in Florida have an AOT court.
    - The Florida Mental Health Authority (FMHA) is actively working to secure ongoing funding. AOT is legislatively directed but funding is not provided in the state budget.
    - Dependency actions support children under the Baker Act. The primary focus is the children's parents.
- Adult Drug court serves a combination of pre-plea (pretrial intervention), post-plea, post adjudication, and probation violators. The Drug Court served 589 individuals in 2021, with 228 of them being new clients. These numbers include Veteran Treatment Court participants.

- There is a specialty docket within Drug Court for court-involved women with histories of sexual abuse/trafficking. This trauma-informed court, referred to as "Aurora" is funded by a federal grant (see first section). In 2021, 56 new clients entered the court and 183 were served.
- Division Z is a post-adjudicatory expansion of the Adult Drug Court program that launched in 2009. It diverts prison-bound offenders (those whose sentencing assessments scored high enough for prison but were lower than 60) into drug treatment and mentoring instead of confinement. It is now funded by state dollars. In 2021, 18 new defendants entered the court, and 58 individuals were served.
    - $599,928/year is provided by the State to support Division Z
    - Division Z provides Outpatient levels II and III, residential treatment, transitional housing, and aftercare counseling
- Division N is a pre-trial/post-plea expansion of the Drug Court that diverts non-violent, first-time felony offenders into treatment and supportive services.
    - $655,000/year (adult drug court); $60,000/year (juvenile drug court) is provided by the County to support Division N.
    - Participation is voluntary and successful completion/graduation results in dismissal of the charge or withholding of adjudication and reduced probation.
    - Division N provides Outpatient levels II and III, residential treatment, transitional housing, and aftercare counseling
- The Family Dependency Treatment Court (DDC) serves parents involved with the courts for substance use/related offenses who also have a dependency adjudication where the primary cause for dependency adjudication is the parental substance use disorder. Parents and children receive support, treatment and services. About 35 families are served annually. In 2021, 32 new participants were accepted and 54 served throughout the year.
    - Early Childhood Court serves parents in Dependency Treatment Court who have children under the age of 5.
- Veterans Treatment Court is a County Court (administered by the Circuit) within Drug Court. It is a court-supervised, comprehensive treatment court for non-violent misdemeanor or felony defendants, who are serving or have served in the armed services. This is a voluntary program that involves frequent appearances before the VTC judge, substance abuse and/or mental health treatment, and frequent random drug testing. It is a treatment-based approach with various treatment options and a strong focus on veteran-specific trauma.

- The Mental Health Court (MHC) was initiated with grant funds in 2021. A year-long planning process incorporating judicial, prosecutorial, defense, provider, County, and stakeholder input was utilized to develop the court. The MHC is the most recent treatment court to open and was a concerted cooperative effort to implement.

- The Public Defender (PD) completes a form and submits names for the State Attorney's Office (SA) to review. SA reviews for legal-risk and approves or denies the application. Once approved the PD provides information to Directions for Living who receive grant funds to provide a biopsychosocial assessment and determine if the primary underlying issue is mental illness; they review competency history, and mental health nexus or circumstances around the offense.
- Directions for Living (DFL) provides community-based counseling services, care coordination and peer navigators.
- NAMI will provide Peer-to-Peer curriculum to participants. The goal is to have peers on the court staffing team. Time in court can count towards peer certification.
- MHC is a phased program. There are routine staffing and hearings, as well as coordination meetings. It is estimated the court will serve 30 -40 individuals at a time. The target population are high-risk, high-need individuals.
- There are therapists who provide counseling services and Suncoast Center provides case management. These positions/services are provided but are not funded by the grant. There is one therapist and one case manager at DFL that are funded. Suncoast provides services through their contract with the court but is not funded under the award. These services may include:
  - Clients see therapists weekly
  - Anticipated length of stay in the program is 6 months
  - The program functions like a triage unit by sending individuals to local facilities.

- The Recovery Project is a jail diversion program run by the Public Defender's office for 30-40 clients that has a written agreement with one judge.
- The Family Dependency Treatment Court is a County Court (administered by Circuit) within Unified Family Court (UFC). The UFC oversees all cases that involve juvenile/family issues such as dependency and delinquency.
- Domestic Violence Courts order substance abuse or mental health assessments of respondents, as deemed appropriate. The County is currently finishing a Domestic Violence grant called the "Batterer's Intervention Program" that provides training for detained persons
- The State Attorney's DUI Rehabilitation of Offenders Program (D.R.O.P.) is a supervised, comprehensive program for first time, misdemeanor DUI offenders. This is a voluntary program that involves the statutory DUI sanctions, including any recommended substance abuse treatment and frequent, random testing for substance abuse.
  - Upon successful completion of the program, participants will receive reduced charges of "reckless driving". For defendants with BAC levels ≤ 0.120 or drug DUIs, the state will recommend that adjudication be withheld. For defendants with BAC levels >0.120 and ≤ 0.150 or who refused a breath test, the state will recommend that they be adjudicated guilty.

- The Pre-Trial Intervention program (PTI) may be available for defendants with no or minimal prior records charged with certain misdemeanors and non-violent felonies. Accepted applicants are diverted from regular court divisions. PTI includes specific probationary sanctions and requires repayment of any restitution. Upon successful completion of all sanctions, the charges will be dismissed. In those instances where sanctions are not completed timely, the case will be sent back to the regular court division.

Data Collection and Sharing

- There are standardized releases of information and a jail population review process. Pinellas County Sheriff's Office (PCSO) has dedicated personnel to maintain jail population data as well as social work staff to facilitate connections to external services upon release. PCSO provides monthly reports to relevant stakeholders as well as the Public Safety Coordinating Council (PSCC), which serves as Pinellas County's Criminal Justice Coordinating Council and includes representatives from the Courts, the State Attorney, and the Public Defender. Reviews of jail data are performed on a regular basis to examine jail trends and identify opportunities to reduce the jail population.
- The Criminal Justice Data Transparency Project: In 2018, the Florida Legislature created Florida Statutes 900.05 and 943.6871 which established the Criminal Justice Data Transparency (CJDT) initiative. The initiative began with a pilot in the Sixth Judicial Circuit, encompassing Pinellas and Pasco counties, and eventually expanded to all of Florida's 67 counties. The goal of the CJDT initiative is to standardize and improve transparency regarding criminal justice data statewide. Dashboards with CJDT data are maintained by the Florida Department of Law Enforcement and can be viewed on their website. Contributors to CJDT data include:
    - The Clerks of Court
    - County Detention Facilities (jails)
    - Florida Department of Corrections
    - Justice Administrative Commission
    - Public Defender Offices
    - Regional Conflict Counsel
    - State Attorney Offices

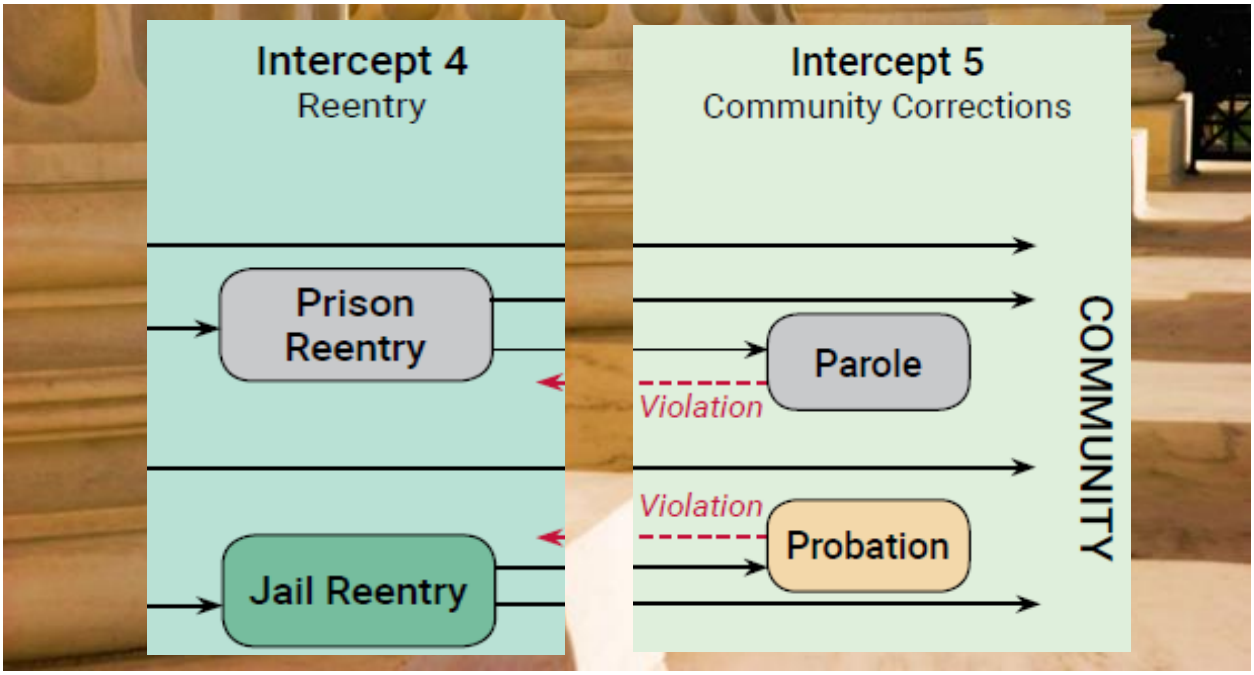
INTERCEPTS 2 & 3: GAPS

Jail Services

- Mindset change – from "they need to ask for help" to "let us offer them help."
- There is a need for pre-release and post-release services, including peer-led and cross-agency care and case management coordination.
- Need a way to identify and be in contact with those individuals coming in and going out to provide service or have a plan when they return
    - There is a brief jail screening, but no connections to services, especially for those held less than 24 hours.
    - There is limited in-reach within jails.
    - There are limited questions at intake about whether individuals are receiving services in the community.
    - It is difficult to plan for/coordinate around when someone is leaving.
- There are no common case management functions or standardized approaches that can translate across programs. As a result, there are multiple release of information forms, and there can be many case managers.
- Programs are not person-focused and not coordinated across systems

Treatment Courts

- Many of the court initiatives are grant funded, with funds ending soon. Fortunately, state and county funds provide ongoing support to several of the treatment courts.
- Trauma is recognized as a prevalent issue across justice involved populations, especially those in treatment courts. Training, generally from providers on trauma and Adverse Childhood Experiences (ACE) is taking place, however, there is no formal and universal screening of trauma being used
- There are multiple diversion opportunities where the Offices of the Public Defender (PD), and State Attorney identify individuals for diversion, however, it is unclear if there is a streamlined process to identify individual defendant needs and match to justice involvement. With the exception of the Mental Health Court, screening is charge-based rather than individual criminal risk, charge, and need.
    - Other identification of individuals in need of services is at the individuals request, family request, and referrals from providers or others, particularly from the jail nursing staff.



INTERCEPT 4 AND INTERCEPT 5

INTERCEPTS 4 & 5: OPPORTUNITIES

Jail In-Reach Services

Several organizations and providers work with Pinellas County Sheriff's Office (PCSO) to perform in-reach into the jail and connect individuals with community resources.

- The Pinellas Ex-Offender Reentry Coalition, also known as People Empowering and Restoring Communities (PERC) has existed for over 30 years. The website describes the mission statement: to help the offender become and remain an ex-offender, reunited with family through advocacy, education, programming, and comprehensive service delivery and referral. There are 10 caseworkers who provide services in coordination with jail diversion staff. PERC is a community-based reentry services provider who does in-reach in the jail.
    - PERC has two houses in collaboration with One Unique Transition totaling 21 beds (soon to be near 30) and the Continental Inn Housing Program, which can have up to 120 beds.
    - In the Second Chance Tiny Homes Program participants can receive Carpentry and OSHA Certification at Pinellas Technical College and get paid part-time for hands on training in the construction trades.
    - Career Pathways from PERC provides employment services for those with justice-related background challenges who are making changes in their lives and seeking employment.

    - Individuals may request services and those who have been past PERC clients are welcome to return for services. PERC clients with a release plan receive post-sentence follow-up services.
    - Individuals leaving prison receive 3-month pre-release planning and coordination which has proven to be effective.
- The Program Services Supervisor through the Sheriff's office staffs a social Worker at the jail and Safe Harbor. They offer interventions to individuals preparing to reenter the community.
- The jail shut down for COVID which made it difficult to have any form of service in-reach into the jail, get assessments completed, or hold classes for batterers intervention, sexual assault training, etc. As of ten days prior to the workshop, providers were allowed back into the jail to initiate and provide services:
    - Social Workers facilitate groups to the inmate population; however, the jail recently granted access to practitioners/volunteers to provide services.
    - Providers teach Batterer's Intervention, drug prevention, GED, and EAS.
    - Volunteers at the jail facilitate 12-step AA and NA groups.
    - RED Tent provides a program for women providing life skills training, re-entry support, and art therapy through sewing/crafting instruction.
    - Safe Harbor is starting a new program for women.
- Incarcerated persons that would benefit from SOAR services are referred to Directions for Living (DFL). However, due to the lack of a standardized transition form, it is likely that some individuals are not being referred to DFL

<u>Community Reentry</u>

Many of the providers and services discussed in the preceding sections offer services that are available to clients not only at the prevention and diversion stages, but also the reentry stage. In addition to the services previously mentioned, the following services are available to help individuals get back on their feet as they reenter the community from jail or prison:

- The Jail to Jobs program through Pinellas County Utilities provides resume review assistance, CDL training and entry level positions for applicants with prior justice system involvement.
    - Created a "trainee" position to create more opportunities for those with no experience to get formal training on the job.
    - Individuals can send an email for help with resume completion and applications. Many jobs are entry level positions. There are two hiring managers.
    - The program has identified a need for more night-time and weekend jobs. Currently, most are Monday – Friday, 8am to 5:00pm. They are changing intake process to ask more questions about what hours individuals are willing to work and type of jobs.
- Communications have been initiated with the Florida Health Department about medications and transitioning pharmaceutical needs for clients reentering the community.

- DayStar Life Center is a non-profit food pantry that provides clothing, hygiene supplies, financial services, assistance with requesting/obtaining birth certificates and forms of ID
- The Public Defender's Office provides access to housing for eligible clients through a partnership the Housing Authority. There are 10 apartments in total for sober housing. Eligible clients must have SSI or another form of income according to HUD guidelines, and they can self-pay once employed.
- Public Defender client Transportation needs are currently met through Uber and bus passes; however, the court is seeking more affordable/consistent alternatives
- The SOAR (SSI/SSDI Outreach, Access and Recovery) model is utilized to access/increase social security benefits such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Pinellas County funds the Directions for Living (DFL) SOAR program to provide outreach services to people at risk of or experiencing homelessness to assist and provide Case management to clients applying for SSI/SSDI benefits. As part of Pinellas County's continuum of care, DFL is contracted to enhance service delivery, address issues, and bridge the necessary gaps. Additionally, the DFL SOAR program can receive and accept referrals from any agency.
    - All network service providers under DCF are also required to implement SOAR processes through their contracts with the managing entity, Central Florida Behavioral Health Network (CFBHN).
    - There are also SOAR staff (funded by CFBHN) that work at the Public Defender's Office to connect those clients to benefits – those staff are also employed by Directions but not affiliated with the County funded program.
- Pinellas County Human Services (PCHS) also works with community partners to help County residents meet essential needs and increase their self-sufficiency through a range of community programs. PCHS partners include non-profit and community organizations; local, state, and federal social service agencies; state and federal governments; veterans; consumers; and residents in need. PCHS collaborative efforts and initiatives include, but are not limited to, projects related to justice services, physical and behavioral health services, housing assistance, age-friendly resources, and other supports.
    - These projects are funded by a combination of General Fund dollars as well as State and Federal Grants administered by the Human Services Department.

<u>Probation</u>

- By County Ordinance, Pinellas County Sheriff's Office runs misdemeanor probation and Day Reporting
    - County Court Probation does an initial assessment and the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) Risk and Needs (RnR) Assessment for higher risk individuals

- A specific mental health or substance use screen is not used unless ordered by court, and then it is usually a DUI Alcohol evaluation; there are standards for first time DUI offender intervention.
- There are an estimated 2800 individuals on misdemeanor probation in Pinellas County. There are 13 probation officers within PCSO with an average caseload of approximately 200 individuals each.
- Individuals on probation are under supervision for 6-12 months; early termination is possible for those who have completed their probation requirements.
- Probation Officers may refer clients to services and, in some cases, individuals on probation will have completed conditions before they come to court and receive credit for their completion.
- Staff includes a Probation Clinical Social Worker.

- Individuals on state Probation/Parole are supervised by the Florida Department of Corrections and The Florida Commission on Offender Review serves as the parole decision making authority.
  - The Florida Legislature abolished parole in Florida for individuals who were sentenced for crimes committed on or after 10/1/83. As of May 31, 2022, there were approximately 3,670 inmates (statewide) who are still eligible for parole consideration and numerous offenders who are still under parole supervision
- District Probation (Felony) uses the LS-CMI Risk and Need Assessment tool. Probation personnel from the Florida Department of Corrections were not available to talk with during the SIM process.

<u>Data Collection and Sharing</u>

- Established by Florida statutes 394.657 and 951.26. The Public Safety Coordinating Council (PSCC) has 21 members. The Public Safety Coordinating Council's primary goal is to assess the trends, population status, and programs affecting the county jail and make recommendations to ensure against jail overcrowding and reduce recidivism. As the designated planning council, the PSCC may also make recommendations to the Board of County Commissioners regarding the selection of applicants for criminal justice, mental health, and substance abuse reinvestment funding/grants. The PSCC's mission is to create and execute an effective public safety strategy to ensure availability and accountability of programs, sound and efficient justice system operations, and necessary jail facilities.
- The County's Justice Coordination Section, housed within the Human Services Department, provides subject matter expertise regarding services for justice-involved residents and works collaboratively with other Human Services subject matter experts (SMEs) in the areas of behavioral health and homelessness to develop approaches that address the needs of the community. Justice Coordination also analyzes justice system data and works with other divisions within the Human Services Department to develop grants and contracts and inform decision-making regarding justice services.

INTERCEPTS 4 & 5: GAPS

Jail Discharge Planning and Process

- Need intensive case management and discharge planning to develop community reintegration plans with warm hand offs.
    - Forensic peer managers to include faith-based partners
    - Transition case-management
- Need immediate access to individuals in the jail/prisons
    - A standardized and universal transition plan is not being used. Ideally release planning occurs as soon as someone enters the facility.
    - Lack of pre-planning and service coordination for individuals who are frequently in jail (three to four or more times in a year).
    - Lack of funding and dedicated reentry staff were identified as needed for comprehensive reentry services.
    - Release coordination is hampered by providers not knowing release date.
- Correctional staff and nursing/medical staff may not know what an individual's sentence is and the next steps for the individual.
    - It is a challenge to get individuals to first reentry appointments, especially to secure psychotropic medication.
    - Individuals are provided with either three days of medication when leaving jail (on rare occasions a 10-day supply can be given), or a prescription that needs to be filled which is an issue when released at the end of the week and runs out over the weekend.
- Transitional housing – Boley could be an example of what is working well and see if there is any opportunity to expand and build upon what is available to fill some of the need.
- The peer specialist position with Suncoast has ended and there are no case managers currently for misdemeanor and felony cases.

Community Reentry

It is unclear how detained persons are identified and matched to community-based providers.

- Jail Level
    - COVID restrictions have precluded community providers from jail in-reach, an essential component to building rapport and relationships with individuals within the facility and determining the needs.
    - There are no dedicated funds or funding resources for community-providers to provide services to currently detained individuals.
    - Substance use screening tools, such as the Texas Christian Universal Drug Screen-V (TCUDs) with Opioid or the Substance Use Severity Index (SSI) or GAINS-SV are not being utilized.

- General
    - Screening, referral, and access to services is not done universally even though there are several natural “hubs "across the system where such screening and care coordination could take place. The result is some individuals getting many services, including multiple case managers and “case plans, while others in need of services are receiving none, or access to only limited services.
    - Case management is focused on programs rather than an overall care plan to address the client’s needs.
- Long waiting times for residential beds in jail diversion program
- Many detainees are living with chronic disease or conditions and require targeted collaborative cross-provider coordination including scheduled appointments, medication, transportation and coordinated case-management across services. In the current jail reentry process individuals are either not taking advantage of existing resources, or not engaging in the resources offered.

<u>Probation</u>

- County Probation caseloads are very high
- There are no specialized caseloads or weighted (RnR level) caseloads
- County and District Probation Departments use different Risk-and-Needs (RnR) Assessment tools. County Probation uses the COMPAS and District Probation uses LS/CMI. While both are validated tools, not using a shared tool makes it difficult to use data to understand the overall risk and needs of the justice involved population in Pinellas County.

<u>Data Collection and Sharing</u>

- Data analysis collected through a standardized transition plan is not available. This data can be used to identify community-service needs by sorting populations (age, gender, type of needs, length of stay, etc.) as well as trends in needs.
- Data is not being used to sort and understand population needs by length of stay across settings. Analysis of this population and longer-term stay populations presents an opportunity to identify short-term stay, rapid release, vs longer-term (sentenced, and case-processing) needs
    - Jail inmates had an average length of stay of approximately 32 days in FY2022.
    - Pretrial inmates, who typically have the shortest length of stay, comprise approximately 57.5% of the jail’s daily population on any given day (FY2022 Overall ADP was approximately 2,875, of which 1,995 were pretrial inmates).

CROSS-INTERCEPT GAPS & OPPORTUNITIES

The following three items Housing, Data, and Funding are overarching, cross-intercept issues. Related items may be found in specific intercepts:

Housing

- Lack of availability and access to housing across the continuum of housing needs is a salient issue.
- There are none or very limited designated or prioritized housing for the justice involved population, especially individuals with complex needs, who would likely show as high utilizers of expensive cross-system services.
- There are no transitional "contracted beds" for individuals in transition who are justice-involved. Safe Harbor often has beds but is not utilized for this purpose

Data, Data Analysis as A Guide to Systemic Strategies Rather Than Program Needs

- Data collection and reporting is largely "transactional" for grants. There is little cross-system data collection and analysis.
- Common data points across providers, regardless of funding source, including grants are not being used, reported, and analyzed.
- Data is not being used to guide a systemic response to needs. Due to the reliance on grant funding, cornerstone services and innovation is impacted by what grant is available, and which grants are ending, rather than establishing and addressing foundational system-wide priorities.
- Data analysis at the individual level is not occurring to identify and sort populations, trends and needs.

Funding Across the Intercepts

- Florida is not a Medicaid Expansion State Resulting in Heavy Reliance of Grant Funding
    - Reliance on grant funds and in some respects County funds, results in frequent changing of services. In addition, County-funded programs must go out for re-bid every few years. There is an effort to transition populations to other services.
    - While grant funds are helpful to pilot a program, they are not assured to continue programs unless other grants, or County or State funds are secured. The result is consistent change in service opportunities. There are many competing needs for scarce County and State funds.
    - The Medicaid Inmate Exclusion Policy (MIEP) under Federal Law allows for Medicaid to be turned on for those under hospital care for a minimum of 24 hours. Currently, Pinellas County Sheriff is not taking advantage of this act.

        - State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care | KFF
        - NACo Medicaid and Jails One-Pager_wNSA.pdf (sheriffs.org)
        - How and When Medicaid Covers People Under Correctional Supervision | The Pew Charitable Trusts (pewtrusts.org)
- The process to allocate state and county resources has multiple steps each with different stakeholders, agendas, and priorities making it difficult secure funds that support the original intended goal.
    - Through the Central Funding process State funds go to Pinellas County and the County chooses where to put funds.
    - County Commissioners present legislative packets to legislators. A local representative may also be asked to present to the State Legislative body.
    - Legislative priorities dictate "set asides" as well as funded and non-funded mandates.
        - Access to set asides is not equitable across the State.
        - The allocation of resources for funded mandates across the State is not based on consistent use of data or populations, and population needs per County.
        - Non-funded mandates cause demands and shifts in County priorities and limited funds.
    - The Central Florida Community Alliance has a child welfare focus and has significate input into funding allocations.
- 1115(i) Waiver is used for Medicaid SR services. Serious and Persistent Mental Illness (SPMI) status is not covered under Florida Medicaid, except with Federally Qualified Health Care (FQHC) services. Federal Waivers (myflorida.com)
- Approximately 60% of justice involved individuals have private insurance, however, there are long waits for services and many services are denied for payment.
- Given the high level of tourism in the County, there is not a dedicated tax to fund services.

GRANT-FUNDED PROJECTS

Pinellas County identified a number of existing grant-funded projects and services available for residents. These grants assist with ongoing service improvement and expansion, as well provide an opportunity to pilot new programs and policies. These grant funded programs are a starting point for SIM so that Pinellas County can determine what funded activities are important to sustain and how they can be replicated outside of the grant support.

At the time of the SIM workshop, Pinellas County Human Services received the following grant funding from SAMHSA:

- Assisted Outpatient Treatment (1H79TI081905): This grant funds court-ordered outpatient treatment for justice involved Pinellas County residents with mental illness.
- Thrive - Adult Drug Court Expansion Grant (1H79TI084551): This grant funds the capacity of drug court to address gaps in treatment and reduce recidivism and substance abuse among drug court participants.
- FR-CARA - Pinellas County Overdose to Care Connections Project (H79TI084551): This grant supports a partnership between Emergency Medical Services and Human Services to enhance the current first responder's naloxone program throughout Pinellas County.

Pinellas County also actively seeks out other grant opportunities to create or expand programs that provide diversion, mental health, substance use, and other services that help improve stabilization outcomes for justice-involved residents. Active awards at the time of the SIM workshop included but were not limited to:

- Families on Track! Expansion of the Pinellas Family Drug Treatment Court (DOJ, OJP; 2018-DC-BX-0023): This grant expands the capacity of Family Drug Treatment Court to serve parents with co-occurring substance abuse and mental health disorders who are involved with the justice system for child abuse and/or neglect issues.
- VALOR: Veterans Treatment Court Enhancement (DOJ, OJP; 2019-VC-BX-0067): This project provides services to veterans involved in the justice system for substance use-related crimes who have physical and/or mental health issues as a result of service.
- Quick Response Team (DOJ, OJP; 2020-AR-BX-0055):This grant funds expanded access to supervision, treatment, and recovery support services for non-violent drug offenders in Pinellas County.
- Strategic Information Partnership/Comprehensive Opioid Site-based Program (DOJ, OJP; 2018-AR-BXK019): This grant provides funding to support the Pinellas Opioid Task Force through centralized data collection.
- Aurora Project (DOJ 2020-DC-BX-0152) This project provides treatment to non-violent offenders with histories of sexual abuse and/or who have been victims of human trafficking.

- Justice For Families (DOJ, OVW 2020-FJ-AX-0011): This grant provides funding for personnel and services to improve the response of the Pinellas Domestic Violence Court.
- COSSAP CARE Team Expansion (DOJ, OJP; 2020-AR-BX-0055): The Pinellas County CARE Team Expansion enhances our current overdose response by increasing connections and engagements in community substance use treatment services, providing peer support to overdose survivors and families, conducting overdose fatality reviews to identify trends and gaps in the system of care, and increasing first responder and community access to naloxone.
- Health Center Grants (DOH, HRSA; 5 H80CS00024-20-00 and 6 H80CS00024-20-03): These awards support Pinellas County's Health Care for the Homeless program, which seeks to improve the health of Pinellas County homeless residents through continued access to comprehensive, culturally competent, quality primary medical care, prevention services, and behavioral health treatment
- Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grants: There is a State Criminal Justice Reinvestment effort through the Florida Department of Children and Families. They are focused on broader statewide needs and provide grant opportunities to localities through the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant (Florida Statutes: 394.656). This program provides funding for counties which they may use to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems. Pinellas county had 2 active CJMHSA Reinvestment Grants at the time of the Sequential Intercept Mapping Workshop:
    - The Road to Success Project (DCF, LHZ91): Serving Crossover youth who have dual involvement in the delinquency and dependency systems through case management, counseling, referrals, and supportive services through the Public Defender's office.
    - Complex Case Reintegration Program (DCF, LH834): serving justice-involved adults with complex behavioral health needs. Prioritizes individuals with histories of CSU/Baker Acts, opioid use, and/or homelessness. Provides intensive case management, counseling, supportive services, referrals, and residential or outpatient treatment for eligible participants.

PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place September 23rd, 2022. The top four priorities are highlighted in bold text.

	Priority	Votes
1	Affordable Supportive Housing needed without barriers as part of a continuum that includes temporary hotel space and accommodations for adult family placements with supportive services	17
2	Greater peer support across the continuum and centralized service navigator that follows an individual throughout the system to provide adult wraparound services.	16
3	A Formalized Reentry Process and/or Reentry Center	12
4	Create a person-centered system	9
5	A data platform to identify individuals with behavioral health issues	7
6	A Central receiving facility that is non-hospital	6
7	Short Term residential placement options	5
8	Make felony and misdemeanor probation resources available	3
9	Increase the variety of levels of care	3
10	Formalized discharge planning	3
11	Separating public health and mental health tracks	2
12	Jail population review	1
13	A Centralized system that provides a technology mechanism for sharing legal issues on individuals	1
14	Accommodation support for persons unable to live alone	0

STRATEGIC ACTION PLANS

Goal 1: Improve Access to housing (supportive, temporary, affordable etc.) as part of a continuum.			
Agencies with an (*) indicate they were not present at the mapping workshop			
Priority Area #1: Affordable supportive housing needed without barriers as part of a continuum that includes temporary hotel space and accommodations for adult family placements with supportive services			
Objective	Action Step	Who	Timeline
1.1 Increase awareness and understanding of the housing services continuum in the community	a) Inventory and create a centralized database of all community-based housing providers and eligibility requirements b) Identify existing meetings that focus on community housing services and addressing consumer-specific priorities. c) Research successful regional and national housing models. d) Create CPA central point access with a priority scale for housing.	• HLA • NAMI • Clearwater • St. Pete • Treatment Providers • ES Providers • Transitional Housing Providers • Homeless providers • Pinellas Safe Harbor	a) 6-12 months b) 6-12 months c) 6-12 months d) 18-24 months
1.2: Address key barriers to housing for justice-involved residents.	a) Review existing trends to address potential changes in barriers/priorities. b) Promote access to pretrial Eviction Mediation Protection services to help tenants prevent eviction proceedings before they begin. c) Review tenant bill of rights to promote understanding of the barriers/protections for residents with criminal records.	• Public Defender • HLA • Clearwater • Foundations • St. Pete* • Legal Aid providers*	a) Ongoing b) 12-18 months c) 6-12 months
1.3: Identify opportunities to expand access to housing for justice-involved residents.	a) Promote access to the Florida Housing Waiver program. b) Identify barriers to Treatment Housing and identify opportunities to expand. c) Review diagnostic crossover with housing/mental health as priority for housing. d) Emergency Housing customized consumer specific priorities and protections.	• Pinellas Safe Harbor • CC • PICA • Treatment Providers • HLA • NAMI • AHCA • HMOs* • Boley* • HEP*	a) 6-12 months b) 6-12 months c) 12-18 months d) 18-24 months

Goal 2. Establish a sustainable High-Fidelity Wraparound (HFW) system available within the community through efforts of system navigators/peer navigators.			
Agencies with an (*) indicate they were not present at the mapping workshop			
Priority Area #2: Establishing a sustainable "HPW" system available within the community through efforts of a service/system navigator (one service navigator)			
Objective		Who	Timeline
2.1 Establish Capacity for HFW Team/Services in the Community	a) Inventory community agencies currently providing HFW. b) Identify community training needs to increase capacity. c) Create and conduct inventory of HFW certified trainers within Pinellas County to address training needs.	• HFW certified agencies • Behavioral health providers • Peers • Public Defender • Housing providers • Legal Aid	a) 6-12 months b) 6-12 months c) 6-12 months
2.2 Develop community knowledgebase regarding HFW services and best practices.	a) Engage local agencies providing HFW to mentor agencies who would like to begin practicing this model. b) Create a guide to increase understanding of how an agency can initiate HFW services (staff qualifications, client eligibility criteria, etc.). c) Conduct outreach to learn about how other areas provide HFW services and how they are funded.	• HFW certified agencies • Behavioral health providers • PEMHS • Operation PAR • NAMI • Directions for Living • WestCare	a) 6-12 months b) 12-18 months c) 12-18 months
2.3 Build-out HFW system incorporating system navigator/peer navigator roles.	a) Define roles, qualifications (education and experience), and responsibility of a system navigator (SN) and/or Peer Navigator (PN) position(s). b) Explore training models for system navigator position and create a list of appropriate courses. c) Define referral process and eligibility criteria for HFW services	• HFW certified agencies • Behavioral health providers • PEMHS • PERC • Operation PAR • NAMI • Directions for Living • WestCare	a) 6-12 months b) 6-12 months c) 12-18 months
2.4 Identify funding source and initiate HFW system and navigator services as needed.	a) Identify a pilot funding source if expansion of services is needed and begin sustainability planning b) Take inventory of staff placement accessibility, identify SN/PN home agencies, and begin hiring for SN/PN positions c) Implement HFW system with peer/navigator supports.	• PEMHS • PAR • NAMI • Directions for Living • WestCare • Windmoor* • Hospitals (as needed) • Suncoast* • Boley* • Evara Health*	a) 18-24 months b) 18-24 months c) 24-36 months

Goal 3. **Develop formalized reentry processes to prepare recently incarcerated residents for transition into the community**			
Agencies with an (*) indicate they were not present at the mapping workshop			
Priority Area #3: Prepare sentenced population and returning citizens for system of care			
Objective		Who	Timeline
3.1 Increase incarcerated individuals' engagement in reentry services prior to release.	a) Prepare sentenced population for reentry system of care beginning, at minimum, 60 days prior to release. b) Identify opportunities to incentivize participation in services and programs prior to release. c) Perform focus groups with providers, clients, and other localities regarding what works in Pinellas and what can be improved. d) Create standardized transition plans for individuals reentering the community from incarceration that incorporate all basic needs: food, shelter, employment, transportation, etc.	• PCSO • Public Defender • Jail personnel • Judiciary • PERC	a) 12-18 months b) 12-18 months c) Ongoing d) 18-24 months
3.2 Develop transition processes for former offenders entering Pinellas County from state correctional facilities.	a) Identify state correctional facilities with the highest number of discharged individuals returning to Pinellas County. b) Perform outreach to FDC transition specialists at identified facilities and develop notification processes that ensure information about returning citizens is given to service providers at least 60 days prior to release.	• PCSO • PERC • Community providers • Florida Department of Corrections*	a) 6-12 months b) 12-18 months
3.3 Implement a full-time dedicated Discharge Planner position.	a) Define roles, qualifications, and responsibility of the role. b) Explore training models for the position and create a list of appropriate courses. c) Identify home agency(s) and begin hiring.	• PCSO • PERC • Community providers	a) 6-12 months b) 6-12 months c) 18-24 months

QUICK FIXES

While most priorities identified during a Sequential Intercept Model mapping workshop require significant planning and opportunities to implement, quick fixes are priorities that can be implemented with only minimal investment of time and little, if any, financial investment. Yet quick fixes can have a significant impact on the trajectories of people with mental and substance disorders in the justice system.

- The Attorney General's Office agreed to work with the Department of Health to work out a system of notification when individuals with minor charges are required to produce bail bonds that they cannot afford in order to remain out of jail.

RECOMMENDATIONS

Pinellas County has a number of exemplary programs that address criminal justice/behavioral health collaboration. Still, the mapping exercise identified areas where programs may need expansion or where new opportunities and programming must be developed.

1. Improve housing continuum that addresses client needs, type, and readiness.
    a. Affordable supportive housing without barriers is needed that offers accommodations for adult family placements, and pets.
        - Increase housing first Permanent Supportive Housing. Work with Boley Center to develop more PSH units.
    b. Contracted/designated beds, services, and resources.
        - Contract with local motels to provide short-term immediate housing for returning residents. This should include planning for transitional housing, identifying family members or shelter beds for longer housing/ reentry planning.
        - Purchase hotels/motels, modular home units/park. Rehabilitate vacant and abandoned buildings.
        - Add supportive wrap-around services at new and existing units. Some settings. services and units may be HUD, or Medicaid, state plan or eligible for other funding resources.
        - Crisis beds for behavioral health emergencies requiring evaluation and recommendations for care.
        - Transitional housing with supportive case management services, financial literacy, for individuals with a variety of needs (disability, behavioral health, families, pets, etc.).
    c. Permanent Housing (apartments, rooms, etc.) for people ready to move from transitional housing. (See HUD guidelines and discrimination safeguards).

d. Create access to crisis-to-stabilization housing such as respite, safety-net, transitional and bridge housing including daily employment, and intervention services.
e. Address local zoning barriers to improve housing options.
f. Consider creating consumer protections housing protocols.
g. Implement landlord education and incentives, and landlord liaisons.
h. Create flexible funding assistance for fees, deposits, repairs, furniture, kitchenware, etc. Work with local hotel and tourist industry for furnishing and food; and employment.

2. Greater peer support and infusion across the SIM continuum.
   a. Consider using a peer as the primary service navigator or part of the team that supports an individual throughout the system to coordinate with case managers across agencies involved with the individual.
   b. Increase training for peer navigators and ease policy restrictions for trained and vetted peer navigators to work with justice involved individuals.
   c. Engage the NAMI peer navigator program as a resource and incorporate cross training around working with justice involved individuals.

3. Consider how "reentry" and transitions from various settings are conducted including pre-release jail planning and post-release coordination.
   a. Develop transitional interventions especially for individuals in community-based services who return to symptoms. Safe Harbor is not full and used to its full potential. Consider using some space differently especially given the proximity to the jail and hospital. For example:
      - Alternative space in lieu of jail for individuals who return to symptoms. Explore the Colorado Strategic Individualized Remediation Treatment (STIRT) interrupts return to symptoms Strategic Individualized Remediation Treatment (STIRT) program | Behavioral Health Administration (colorado.gov)
      - Consider developing a formalized reentry and diversion process and/or hub. Consider the Sheriff and other provider roles in the hub.
        - Santa Clara, CA, - Diversion and Reentry Resource Center Resource Center - Diversion and Reentry Services - County of Santa Clara (sccgov.org); Home - Diversion and Reentry Services - County of Santa Clara (sccgov.org), and dashboard, Reentry Resource Center At-a-Glance May - July 2022 (sccgov.org).
        - Harris County reentry and diversion Harris County Mental Health Jail Diversion Program (theharriscenter.org); and Reentry process. The Respite, Rehabilitation, and Re-Entry Center (theharriscenter.org)
        - Hillsborough County Residential Re-entry Center (HREC) Goodwill Suncoast - Hillsborough County Residential Re-entry Center | The Right Service at the Right Time (rightservicefl.org).

b. Create a dedicated reentry position to be the main reentry access point. Focus on high-needs sentenced population, and short, and long-stay repeat populations regardless of sentence.

- Develop a reentry taskforce and services Toledo OH ReEntry Programs
- Implement use of a standardized needs inventory including questions about multiple domains of an Individuals' life including past and current service history, and service needs at release. Charleston, South Carolina is using a similar form that could easily be tailored to Pinellas CO. Encrypt the forms (excel based) and share with appropriate providers to improve care coordination.
- Domains for the inventory include:
  - Physical, and behavioral health, medications, disabilities, supports and accommodations
  - Income and benefits
  - IDs and documents including military discharge documents.
  - Basic needs such as clothing, food, transportation, and housing
  - Employment history, training, supported and placement.
  - Care for children or elders.
- Analyze aggregate data from the forms to identify common needs, trends, and client profiles.

c. Develop reentry processes for quick release, special population, and longer-term stay. Proactively develop plans to for FF individuals who may be quickly released. Continue to use the Health Information Exchange (HIE) to identify individuals who need medical continuity of care upon release from the jail and to connect them to medical providers (making their medical information available to providers electronically) to improve medical outcomes upon release.

4. Develop a "*Familiar Face"* strategy

"Most Vulnerable Persons" (MVP), is a term used to illuminate the complex needs (CN) needs of individuals including untreated or undertreated mental health, substance use disorders, traumatic brain injury, intellectual disabilities, other health conditions and co-occurring conditions. Undesirable behaviors in public spaces and concerns for individual welfare often result in police calls for service, giving new meaning to MVP as *Most Visible Persons.* Over time vulnerable individuals become known to multiple systems as Familiar Faces (FF) or those individuals who frequently cycle through jails, homeless shelters, emergency departments and other crisis services. How individuals become FF is understandable given the nature of frequent public facing behaviors and both acuity and chronic presentation of needs. Reducing the overuse of these costly services can only occur when we address why individuals become Familiar Faces. Addressing "why" is greater than accepting that for the most part our laws and policies support an individual's

right to live with untreated needs. Untangling "why" means addressing structural flaws in how we think, pay for, and deliver care, especially to those living with complex needs.

The national push to create and elevate 9-8-8 response across the country has highlighted the need to distinguish between what is a "crisis" and what is an "emergency". It is this authors belief that efforts to create "crisis" response in communities are really an "emergency" response and therefore are largely short-term, time-limited strategies that address the presenting issue but fail to focus on the greater, ongoing individual needs that, without addressing the circumstances of the presenting issue, will lead back to a person being again in need of intervention. These responses, include outreach strategies such as "rapid response" and clinical outreach teams (police and mental health clinicians, paramedics and clinicians, peer responders, and virtual linkages between first responders and clinical support), and place-based strategies including designated licensed crisis centers or locations providing services under state civil voluntary and involuntary commitment laws. Each set of strategies is likely to result in a short-term response if they are not coupled with stabilization-to- recovery strategies. In short, communities that want to address MVPs or FFs, cannot continue to use an "emergency" framework. Rather, a crisis- to-recovery framework must be used to create a service delivery continuum of care.

When pressed, the certainty was based on who was being referred to certain teams or agencies for services. Pinellas County has a strong focus on data and to a large degree data analysis: community efforts have focused on familiar face populations through a range of data sharing and targeted programming, including the Pinellas Data Collaborative (1999-present); PCET and PCET 2.0; a complex case program with health, EMS, and other system programs; and other coordinated efforts. This recommendation is just one method to consider to why someone is a familiar face within the County and develop strategies to reduce the underlying reasons while addressing the individual needs.

a. Court (need to include lower courts) or jail booking data can be sorted to identify individuals (name and DOB) with the greatest number of bookings or court events 2019, 2021, 2022, or every other month of those years. (Obviously 2020 was impacted by COVID but could still be used.) Sort the data and create tiers of individual for in groups of 100 up to the top 500 or so individuals. Work across behavioral health (community and institutions) providers, withdrawal management, peer providers, housing and homeless providers, existing cross-system coordination, and service entities, HIE, and police to compare each tier with their client base. They need to report only the number of common individuals within each tier, and average costs per tier, and % payor source. Analyze demographic data by tier including race, ethnicity, age, gender/preference. Analyze and add in the number of custodial and non-custodial arrest each year and average length of stay per tier. Work across stakeholders to determine cut-off points.

b. Create information sharing agreements. Based on common client needs identify and innovate initiative-taking and reactive strategies at the individual and tiered level based on data outcomes, and deliver services with the frequency, intensity and duration needed. Track and analyze service utilization, returns to costly services, stabilization factors such as appropriate housing and client outcomes.

c. Consider using the data to inform and obtain get voter approval for a low public tax to be used to implement and innovate services.

5. **Because community supervision can require unique approaches to the complex needs of individuals, there may be benefit in considering some examples from the DC Court Services and Offender Supervision Agency (CSOSA) that Pinellas could replicate.**

Many of the persistent drug users require full substance abuse treatment services to address their issues, which consist of residential detoxification services (7 days) (where applicable), followed by residential treatment (28-90 days), and outpatient treatment (54 sessions) or transitional housing (90 days). Substance abuse treatment needs can be met through contracts with service providers for a range of residential, outpatient, transitional housing, and sex offender treatment services. Contractual treatment can also encompass drug testing and ancillary services, such as mental health screening and assessments, to address the multiple needs of the population.

The Reentry Sanctions Center (RSC) serves as the sole 24/7 residential facility operated by CSOSA to support the highest-risk, highest-need offender and Pretrial defendant supervision population. The RSC program is specifically tailored for offenders with long histories of crime and substance use disorders coupled with long periods of incarceration and little outside support. These individuals are particularly vulnerable to both criminal and drug relapse. It provides intensive assessment and reintegration programming for high-risk offenders/defendants who violate conditions of their release. Many of the offenders and defendants supported in this facility are not eligible for placement into other contract residential programs nor are there services offered by the DC Government to meet their needs in a timely manner. RSC participants receive holistic and multi-disciplinary interventions. Comprehensive assessment (physical/psychological), treatment readiness, aggression reduction, reintegration programming, and motivation are the focus of the interventions offered at the RSC. These interventions are structured to address one or more factors that challenge the residents' successful reentry into the community. The treatment and cognitive behavioral health services provided to residents at the RSC are designed to provide the tools necessary to prevent relapse, succeed in a treatment modality, adhere to supervision requirements, improve familial relationships, initiate productive community reintegration, and reduce recidivism. Prior to COVID-19, approximately 75 staff at the RSC performed 24/7 operation of five (5) separate units supporting: a) Pretrial defendants, b) offender sanctions, c) female-specific programming, and d) two (2) units for offenders with co-occurring disorders (suffering from both mental

health and substance abuse issues). In addition, specialized contractors provide medical, psychiatric and other mental health services. The maximum capacity of the RSC is 83 residents. The program duration is 28-42 concurrent days depending upon the assessed needs of the offender or defendant. In FY 2019, an Extended Stay unit was deployed with a duration of 42 concurrent days to provide more intensive, longer-term support to highest-risk defendants and offenders. Most offenders and defendants are referred to the RSC program through internal Agency assessment and placement mechanisms versus a public order placement. The treatment model calls for participating offenders to remain at the RSC facility for the duration of their program, only leaving the facility for medical appointments or other required departures.

Specialized Supervision Units - To address the unique needs of CSOSA's population based on the risk/needs assessments, the agency allocated direct resources to increase specialized supervision and support programming for female, young adult, mental health, warrant status and sex offenders. Each team was trained to address the needs of their clients. (See CSG, Implementing Specialized Caseloads)

6. Consider standardizing first responder observations

As the co-responder model and effort grows, a standardized observation form completed by law enforcement and first responders can help first responders quickly document their observations of a an individual and share that information with hospitals, crisis stabilization units, or jail. The form can be used as part of developing an understanding. An example of such a tool from the LA County Sheriff Department is illustrated in Appendix 3: Observation Checklist.

RESOURCES

Competence Evaluation and Restoration

- Policy Research Associates. https://www.prainc.com/competence/ .
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- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

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- National Association of State Mental Health Program Directors. Crisis Now: Transforming Services is Within our Reach.
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- Abt Associates. (2020). A Guidebook to Reimagining America's Crisis Response Systems.
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- Vera Institute of Justice. (2020). Behavioral Health Crisis Alternatives: Shifting from Policy to Community Responses.
- National Association of State Mental Health Program Directors. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.
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- Crisis Intervention Team International. (2019). Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises.
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- Bureau of Justice Assistance. (2014). Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.
- International Association of Chiefs of Police. One Mind Campaign: Enhancing Law Enforcement Engagement with People in Crisis, with Mental Health Disorders and/or Developmental Disabilities.
- Bureau of Justice Assistance. Police-Mental Health Collaboration Toolkit.
- Policy Research Associates and the National League of Cities. (2020). Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers.
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- Optum. (2015). In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program (CAMP) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.
- Crisis Assistance Helping out on the Streets (CAHOOTS) in Eugene, Oregon, is a collaborative program to assess and respond to emergency situations. CAHOOTS is comprised of two-person (crisis workers and medics) intervention teams that respond to 911 and non-emergency calls of individuals experiencing a behavioral health crisis. CAHOOTS - White Bird Clinic
- Alternative, non law-enforcement crisis response program. Support Team Assisted Response (STAR) Program - City and County of Denver (denvergov.org)

Brain Injury

- National Association of State Head Injury Administrators (NASHIA). (2020). Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
- National Association of State Head Injury Administrators. Supporting Materials including Screening Tools and Sample Consent Forms.
- Achieving Healing Through Education, Accountability and Determination A.H.E.A.D. - MINDSOURCE Brain Injury Network (mindsourcecolorado.org)

Community Supervision

- The Justice Center, Council of State Governments. (February 2021). Implementing Specialized Caseloads to Reduce Recidivism for People with Co-Occurring Disorders by Risë Haneberg

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Information Sharing/Data Analysis and Matching

- Center for Policing Equity. (2020). Toolkit for Equitable Public Safety.
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- The Council of State Governments Justice Center. (2011). Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.
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- Vera Institute of Justice. (2012). Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.
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- The Cook County, Illinois Jail Data Linkage Project: A Data Matching Initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the Cook County Jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of the enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

Jail Inmate Information/Services

- NAMI California. Arrested Guides and Medication Forms.
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- R Street. (2020). How Technology Can Strengthen Family Connections During Incarceration.

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- Mental Health First Aid. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
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- Policy Research Associates. (2020). Peer Support Roles Across the Sequential Intercept Model.
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- Local Program Examples:
    - People USA. Rose Houses are short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. They are 100% operated by peers.
    - Mental Health Association of Nebraska. Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with Peer Specialists.
    - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
    - MHA NE/Lincoln Police Department REAL Referral Program. The REAL referral program works closely with law enforcement officials, community corrections officers and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained Peer Specialists.

Pretrial/Arraignment Diversion

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- CSG Justice Center. (2015). Improving Responses to People with Mental Illness at the Pretrial Stage: Essential Elements.
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- Laura and John Arnold Foundation. (2013). The Hidden Costs of Pretrial Diversion.
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Racial Equity and Disparities

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- Actionable Intelligence for Social Policy. (2020). A Toolkit for Centering Racial Equity Throughout Data Integration.
- The W. Haywood Burns Institute. Reducing Racial and Ethnic Disparities: A NON-COMPREHENSIVE Checklist.
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SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

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APPENDICES

Appendix 1 Sequential Intercept Mapping Workshop Participant List
Appendix 2 Community Self-Assessment
Appendix 3 LA County Sheriff Department Observation Checklist