Duval County
Criminal Justice, Mental Health, & Substance Abuse Diversion
Strategic Plan

June 2009

Submitted by the
Institute for Health, Policy, and Evaluation Research
Duval County Health Department

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I. EXECUTIVE SUMMARY

This report summarizes results from a 10-month criminal justice, mental health and substance abuse (CJMHSA) diversion planning process funded by Department of Children and Families and led by the Duval County Health Department, Institute for Health, Policy, and Evaluation Research and members of the Jacksonville Mental Health Coalition, Criminal Justice Subcommittee. Planning was conducted through a group process that included treatment providers, representatives from the Jacksonville Sheriff's Office (JSO), Florida Department of Children and Families (DCF), City of Jacksonville (COJ) Behavioral and Human Services Division, the criminal justice system, peers (persons who identify themselves as having a mental illness or substance abuse issue), and families. The Planning Group was required by state statute to, "…have a strategic plan to initiate systemic change to identify and treat individuals who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders who are in, or at risk of entering, the criminal or juvenile justice systems" (State of Florida Statutes, 394.651 1.a).

The results of the 10 month planning process, conducted by an agency outside the regular scope of providers, funders, and other key stakeholders revealed a host of systemic problems that not only obstructed the planning process, but cripple any potential for real systems change, including diversion planning, despite an often extraordinarily dedicated workforce. Systemic problems include:

1. A lack of transparency
2. Limited data, which when they exist, are difficult to obtain and are primarily restricted to some cost and service data
3. Nonexistent outcome data
4. Contracts based on historic relationships, rather than performance
5. Strong provider competition for scarce resources
6. Absence of a coordinated system for seeking outside funding or advocating for Duval County interests
7. An absence of funded, coordinated local leadership across systems (mental health v substance abuse, adult v juvenile, civil v forensic)
8. No effective means of communication across systems of care
9. Affected community and stakeholder disenfranchisement

Consequently, decision-making, including treatment and funding decisions, is not driven by data. Collaboration, including data- and resource-sharing, as well as collaboration around grant opportunities is minimal. Local interests are lost in an inefficient and costly bureaucracy and ultimately, the consumer and the community suffer.

STRATEGIC PLAN RECOMMENDATION

For these reasons **our foremost recommendation for fundamental system change** is the development of a **Local Mental Health and Substance Abuse Authority**, hereafter referred to as "the Authority." Such an Authority would require no additional funding, instead existing funds that currently support DCF administration would be requested to

support the Authority. In addition, such an Authority may free up jail space and/or reduce expenses for the JSO and make better use of county dollars for criminal justice and behavioral healthcare needs, because they will be used in a planned and coordinated system. We envision that the Authority would have the following characteristics:

1. Locally constituted – with high constituent involvement, particularly by consumers and their families
2. Comprehensive – across child and adult, as well as civil and forensic systems
3. Decision-making power regarding funding based on:
    a. Local needs assessment
    b. Locally-defined priorities
    c. Service and outcome data
    d. Program evaluation
    e. Provider use of evidence-based practices
4. Other characteristics to be defined by a workgroup convened for this purpose

A similar recommendation was made by the COJ Adult Mental Health Task Force in January 2006 (Burns, 2006). That task force recommended the establishment of a Mental Health Coalition and a Mental Health Authority and further recommended that:

"The Mental Health Authority be an independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, recommend statutory changes and act as legislative liaison" (2006, 54).

There is local precedence in the Jacksonville Municipal Codes to establish such an Authority, with the primary example being the Jacksonville Children's Commission (City of Jacksonville, Municipal Codes, 2009). Additionally, several good models for local Authorities have been implemented in other states including California (City of San Francisco, 2009), which has a decentralized mental health service delivery program, with most direct services provided through the county mental health system and Ohio (State of Ohio, 2009).

The Florida Department of Children and Families is currently promoting a Managing Entity, which is defined as, "…a corporation that is organized in this state, is designated or filed as a nonprofit organization under s. 501(c)(3) of the Internal Revenue Service, and is under contract to the Department to manage the day-to-day operational delivery of behavioral health services through an organized system of care (State of Florida, 2009). It is unclear if the operating costs of a managing entity will be financed through funds received from the department and hypothesized savings and efficiencies achieved by the Managing Entity and/or financed with a percentage of services dollars (currently anticipated at 4% – 8% of the total budget).

It is the consensus of this planning group that a Managing Entity, as proposed by DCF, is not the best solution for Jacksonville. Instead, our strategic planning process

has directed us to lobby for the local Authority, which would allow maximum local control over local needs, priorities, and resources.
As a first step towards achieving *this goal, we urge that DCF provide funding for staff and consultants to develop a best model local Mental Health Authority for Duval County. We further propose that these positions and this process be conducted through the Duval County Adult and Children's Mental Health Coalitions.*

The local Authority is overdue:

- Mental Health and Substance Abuse funding is not distributed equitably throughout Florida. Duval County, along with the remaining 19 counties that comprise DCF's Northeast Region receives among the least amount of funding per capita in the State ($28.16 *versus* a high of $53.41). Yet no one in Tallahassee can explain the funding formula or advocates for equitable funding on our behalf.
- District 4 (which includes the counties of Duval, Baker, Clay, St. Johns, and Nassau) receives the least amount of funding for the Severe & Persistently Mentally Ill in the state ($677.44 per consumer *versus* the state average of $802.80). Florida's Substance Abuse and Mental Health Corporation has recommended to the Governor that the per-client average should be increased to $1,165 for all districts.
- Uninsured mentally ill individuals are routinely released from Crisis Stabilization Units (Baker Act facilities), where they have been placed as a result of the risk they pose to themselves or others after an average stay of approximately 3 days with 21 days of medication and referrals to programs that are at capacity.

The local context impacts diversion planning. In a focus group with parents of adult children with mental health and/or substance abuse issues, one parent report that she had to leave her adult son in jail in order to get him treatment:

"...he was in and out of the hospital two or three times a year. …he came out of one hospital and had a new medication. He stopped on his way home for a beer and ran into a stop sign and was arrested for reckless driving - so he spent time in jail. I used that opportunity to keep him on his medication because he was just coming in and out of the hospital …and there wasn't the support …even though the judge kept lowering the bail, lowering the bail …I kept him in there for six weeks so that he would be on his medication and be able to understand what's happening."

Jail is not the appropriate place for many offenders with mental health and/or substance abuse issues, who are off their medications and have committed simple or petty crimes such as trespassing, petty theft, public nuisance, etc. The Duval County Pre-trial Detention Facility (PTDF, or jail) estimates spending over $4 million dollars per year to house offenders in mental health wards. Not included in this figure are the dollars the Jacksonville Sheriff's Office spends on calls related to mental illness - diffusing the situation, making an arrest, and bringing the individual to jail or the costs associated with the booking process. As individuals with mental illness/substance abuse issues become caught up in the criminal justice system they initiate a process that draws them deeper into the system and their underlying illness and away from appropriate, community-based care.

- Mental health screening at the PTDF identifies only acutely mentally ill offenders – it is not known how many opportunities to identify and treat the mental health needs of less severely mentally ill offenders are missed

- While the recent attention and funding directed towards the Jacksonville Reentry Center, particularly as a result of the Jacksonville Journey, is highly commendable, these services target individuals released from prisons and third degree felons released from the PTDF. Locally, there are no early intervention programs that might divert individuals from penetrating deeper into the criminal justice system or reentry services that target misdemeanants with mental health issues released from the PTDF. This is shortsighted. Individuals with mental illness, whose underlying mental health issues may draw them further into the criminal justice system, receive few, if any interventions locally. Instead, the current system is designed only to provide deep end services upon release from prison.

SECONDARY RECOMMENDATIONS

Much of the problem of incarcerating individuals with mental illness is related to their inability to pay for services and a lack of early intervention programs. These problems together lock the City into a crisis-driven system.

Jail diversion programs can be thought of as occurring either *pre*-booking or *post*-booking. Pre-booking programs divert the individual prior to arrest, while post-booking programs divert the individual from prosecution and incarceration after arrest. They may also simply be preventative in nature. The remaining recommendations are grouped into four areas: global (recommendations that can be implemented throughout the system); crisis; recovery; and prevention.

GLOBAL

- SSI/SSDI Outreach, Access, and Recovery (SOAR) Training and Central Referring Agency (multiple intercepts)
- Peer Educators/Support (multiple intercepts)
- Health Care Surrogate (multiple intercepts)
- Electronic Health Record system (multiple intercepts)

CRISIS

- Respite Crisis Center (pre-booking)
    - Research shows patients could do as well or better in a less restrictive environment for about a third the cost of a CSU.
- Triage Center / Low Demand Shelter (pre-booking)

RECOVERY

- Baker Act Recovery and Support Services (BARS) (preventive)
- Mental Health Court (post-booking)
- Intensive Case Management after release from the PTDF

PREVENTION

- Expand Mental Health/Substance Abuse Screening at the JSO/DOC PTDF to identify individuals with serious mental illness (in addition to those already identified with severe and persistent mental illness-SPMI) (post-booking)
- Create a Non-Specialty First Appearance Program for Early Intervention (post-booking)
- Peer-run Living Room (preventive)
- Club House (preventive)

The impact of a failed mental health system overflows into the criminal justice system with local dollars used without local controls. Large scale systems such as DCF do not address the unique cultural needs of Duval County. Stakeholder input competes with statewide needs. County dollars used for behavioral healthcare needs would be more productive in a coordinated system rather than as a band aid on a failed system. An effective mental health system is one which partners and coordinates with local agencies for housing, criminal justice, homelessness and transportation unlike the current system.

II. INTRODUCTION

In January 2008, Duval County (Jacksonville), was awarded one of 12 Criminal Justice Mental Health and Substance Abuse (CJMHSA) diversion planning grants awarded by DCF and administered by the Florida Substance Abuse and Mental Health Corporation. Funds were received in June 2008. The CJMHSA funding represents an effort to establish mental health and substance abuse as one of the top five priorities for the Florida state government. The first round of funding -- administered a $2.8 million grant program established in the Criminal Justice, Substance Abuse and Mental Health Reinvestment Act and requested expansion of the program for fiscal year, 2009-2010**.** Duval County received $91,200., with an additional $93,000. in matched funds, primarily in the form of in-kind salaries provided by partnering agencies. The City of Jacksonville, Behavioral and Human Services Division, was the grant recipient and the Institute for Health, Policy, and Evaluation Research, a Division of the Duval County Health Department, subcontracted to provide grant activities.

The term "jail diversion" refers to programs that divert individuals with mental illness and/or substance abuse issues involved with the criminal justice system for low-level offenses to community services and treatment. In these cases, there is strong agreement that individual and community health, as well as public safety, are better served by community treatment, rather than incarceration (http://cjmh-Infonet.org/ about/ continuum#). A decision was made early on in the process to principally limit the scope of the planning process to adults and in actuality the process primarily addressed jail diversion strategies, rather than diversion from prison or state forensic hospitals, and the publicly funded system. The process was conducted by the Planning Group in two overlapping phases. Phase I consisted of information gathering activities. Phase II consisted of the analysis and identification of system gaps and proposed interventions, followed by group discussion of the strengths and weaknesses of proposed solutions. The original intent of the planning process was to develop a strategic plan that would be eligible for implementation funding during the second round of State funding. However, for most of the funding period, the Planning Group operated under the belief that implementation funding would not be forthcoming, due to budgetary constraints the State of Florida anticipated during the 2010 fiscal year. For this reason, the planning process resulted in one primary recommendation. The remaining recommendations were not prioritized, but simply described in order to target other funding mechanisms as they might become available. It now appears that implementation funding will be forthcoming in the 2010 budget year. Nonetheless, the Planning Group is committed to the primary recommendation, regardless of the availability of funding.

Organizational Structure

The organizational structure is presented in Appendix I. In accordance with the funding requirements, the Duval County Planning Council approved the grant application. Members of the Council, at the time of the grant submission appear in Appendix II. The planning process addressed systems change at the interface between the criminal justice system and institutional and community mental health. The explicit goals were to: 1)

develop and enhance collaborations among multiple stakeholders at the criminal justice – mental health interface, in order to; 2) create a strategic plan which will initiate system change to identify and treat individuals 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 criminal and/or juvenile justice systems.

Partnering agencies that pledged matched time included: the Duval County Health Department; Jacksonville Sheriff's Office, Renaissance Behavioral Health Systems, Inc, COJ Behavioral and Human Services Division; I.M. Sulzbacher Center for the Homeless; State Attorney's Office, 4th Circuit; Gateway Community Services; Law Offices of Jenna Lopes; Department of Children and Families; Fourth Judicial Circuit of Florida. Many other individuals, including peers and family members, and agencies participated in the process without a formal commitment of matched time.

In what follows, we summarize results from the 10-month planning process. Following a Mission Statement, Background and Methods are described. Next, results from a Gap Analysis are presented. The Gap Analysis was structured around the Sequential Intercept Model (described below, Background) and includes a description of existing services, identification of gaps, and suggested strategies to implement at each intercept. Following the Gap Analysis, a Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis is presented for each suggested strategy. Finally, results are summarized and recommendations are presented.

III. CJMHSA Diversion Planning Group: Mission, Vision, Values

The CJMHSA Partnership voted unanimously in favor of the following Vision, Mission, and Values Statement on October 8, 2008.

CJMHSA Partnership Mission

The mission of the CJMHSA Partnership is to develop and sustain an economically feasible strategic plan that is supportive of our vision.

CJMHSA Partnership Vision

The CJMHSA Partnership envisions a collaboration of multiple community partners including criminal justice, public health, mental health and substance abuse treatment and other service providers and family members and peers. The partners will work together to seek external funding to reduce the number of Duval County residents incarcerated or at risk for incarceration with a mental illness, substance dependency or co-occurring disorder. The CJMHSA Partnership will work together to redirect them into evidence-based, integrated systems of care.

CJMHSA Partnership Values

- Transparent, collaborative partnerships which integrate systems of care and support resource and data-sharing, are central to criminal justice diversion programs.
- Active participation of family members and peers is essential to planning effective service system change.
- Incarcerating people with a mental illness or substance dependency or co-occurring disorder only treats the symptoms of the disorder and not the disorder itself.
- Treatment and education of offenders with a mental illness or substance dependency or co-occurring disorder will reduce recidivism and reduce costs unnecessarily placed on the judicial system.
- Treatment of offenders with a mental illness or substance dependency or co-occurring disorder through evidence-based treatment programs, rather than incarceration, will promote wellness and enhance community health.
- Treatment of offenders with a mental illness or substance dependency or co-occurring disorder through evidence-based treatment programs is a basic human right and a morally-just responsibility.

IV. BACKGROUND

Prevalence

Mental illness results in over 15% of the global cost of all diseases and is particularly prominent among incarcerated individuals, ex-offenders and homeless people. Using data extrapolated from federal epidemiologic studies and the U.S. Census, the Jacksonville Adult Mental Health Task Force estimated that over 171,000 individuals in Jacksonville have a diagnosable mental illness and over 62,000 persons have a severe mental illness or a severe and persistent mental illness (Burns, 2006).

Further information on the prevalence of mental illness locally comes from the Agency for Health Care Administration (AHCA), which collects data on in-patient hospitalizations and more recently emergency room visits. These data are presented in Tables 1 and 2, respectively, for Duval County. Cases were identified as mental health, substance abuse or behavioral health based on ICD-9 codes. In the past five years (2002-06) over 22% of inpatient hospitalizations had at least one mental health, substance abuse or behavioral health code listed on any of twenty diagnosis variables. Hospital visits among males were somewhat higher (25.6%) than females (20.4%). In the Emergency Department, 10.5% of the visits had at least one mental health, substance abuse, or behavioral health code. As with the inpatient hospitalization, males had a higher percentage of conditions than females (11.6% vs. 9.7%).

Table 1

Mental Health, Substance Abuse and/or Behavioral Issues
Inpatient Hospitalization Visits by Gender
Duval County Residents 2002-06

	Yes	No	Total	Percent
Male	54677	158671	213348	25.6%
Female	65206	254269	319475	20.4%
Unknown	0	1	1	0.0%
Total	119883	412941	532824	22.5%

Source: AHCA, 2002-06 Hospitalization Data
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, January 2009

Table 2

Mental Health, Substance Abuse and/or Behavioral Issues
Emergency Department Visits by Gender
Duval County Residents 2005-06

	Yes	No	Total	Percent
Male	30533	233718	264251	11.6%
Female	34191	317904	352095	9.7%
Unknown	0	2	2	0.0%
Total	64724	551624	616348	10.5%

Source: AHCA, 2005-06 Hospitalization Data
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, January 2009

Mental Health and Criminal Justice

In the U.S., state mental hospital closures have caused increased rates of arrest among former patients, up to three times that of the general population. Consequently, mental health problems are highly prevalent in correctional institutions. The Bureau of Justice Statistics recently described the mental health problems of inmates (James & Glaze, 2006). Mental health problems (a recent history or symptoms based on DSM-IV criteria) were most prevalent in local jails (64% of all inmates), followed by state (56%), and federal prisons (45%). In this study, approximately 15% of state prisoners and 24% of jail inmates met the diagnostic criteria for a psychotic disorder, while 43% of state prisoners and 54% of jail inmates met diagnostic criteria for mania. Recent diagnostic results from jail inmates using the Structured Clinical Interview for DSM-IV (SCID) of the prevalence of current serious mental illness revealed rates for males and females of 14.5% and 31.0%, respectively (Steadman, et al. 2009).

Inmates with mental health problems are more likely to have been homeless in the year before arrest, victims of past physical or sexual abuse, and have had parents who abused alcohol or drugs, in comparison with like inmates without mental health problems. Few inmates with mental health problems (1 in 6) receive treatment while in jail and most are charged with misdemeanors (Naples & Steadman, 2003).

About three-quarters of individuals diagnosed with mental health problems also meet criteria for substance dependence or abuse in both state prisons and jails (James & Glaze, 2006; Teplin et al., 1996). More than two-thirds of inmates in local jails are dependent on or abuse alcohol or other drugs and half are under the influence of drugs or alcohol when they commit their offense (McCampbell, 2005; Wilson, 2000). Co-occurring disorders are especially concerning, given recent data supporting an association between violent behavior and co-occurring disorders, rather than violence and mental health issues alone.

Individuals diagnosed with mental health problems and/or substance abuse/dependence place an undue burden on the criminal justice system. Mental health treatment in correctional settings in comparison with community-based settings is not cost effective (Clark et al., 1999; Solnit, 2000). A 2006 report by the US Bureau of Justice Statistics found that nearly one quarter of state prisoners and jail inmates who had a mental health problem had served 3 or more incarcerations; only one fifth of those with no mental health problem had a similar rate of incarceration (James and Glaze, 2006). The Consensus Project provides a variety of other examples: In Orange County, Florida, the average length of stay in jail for individuals with mental illness is 51 days, compared to an average of 26 days for all other inmates, while in Lucas County, Ohio, 72 percent of people with mental illnesses were rearrested within 36 months of release from jail.

Treatment for both substance abuse/dependence and/or mental health problems has been demonstrated to reduce correctional and other crime-related costs. In a 1999 report, Koenig et al. evaluated the crime-related costs of substance abusers before and after treatment. The authors found significant reductions in crime-related costs (up to 79%) following treatment. (NEDS). In other research, the 1997 National Treatment Improvement Evaluation Study (NTIES) examined the overall cost of substance abuse treatment and concluded, "Treatment appears to be cost effective, particularly when compared to incarceration, which is often the alternative. Treatment costs ranged from a low of about $1,800 per client to a high of approximately $6,800 per client." In contrast, the average cost of incarceration

in 1993 (the most recent year available) was $23,406, per inmate, per year (http://www.ncjrs.gov/nties97/costs.htm).

A recent, widely cited report describes the situation in Florida (Florida Supreme Court, 2007):

- As many as 125,000 people with mental illnesses requiring immediate treatment are arrested and booked into Florida jails annually
- The vast majority of these individuals are charged with minor misdemeanors and low level felony offenses that are a direct result of their psychiatric illnesses
- The State of Florida currently spends roughly approximately $250 million yearly to treat approximately 1700 individuals under forensic commitment
- The treatment provided in Florida's forensic hospitals is entirely funded by state general revenue
- The State of Florida ranks 48th nationally in overall per capita public mental health funding

Locally, JSO Dispatch Call Data reveal a total of 992,368 calls for police services in 2008. Of these, 7631 were calls for service for mentally ill persons, representing 4163 distinct individuals (Table 3); 7080 of these calls were placed by citizens, 5707 were verified mental health service calls.

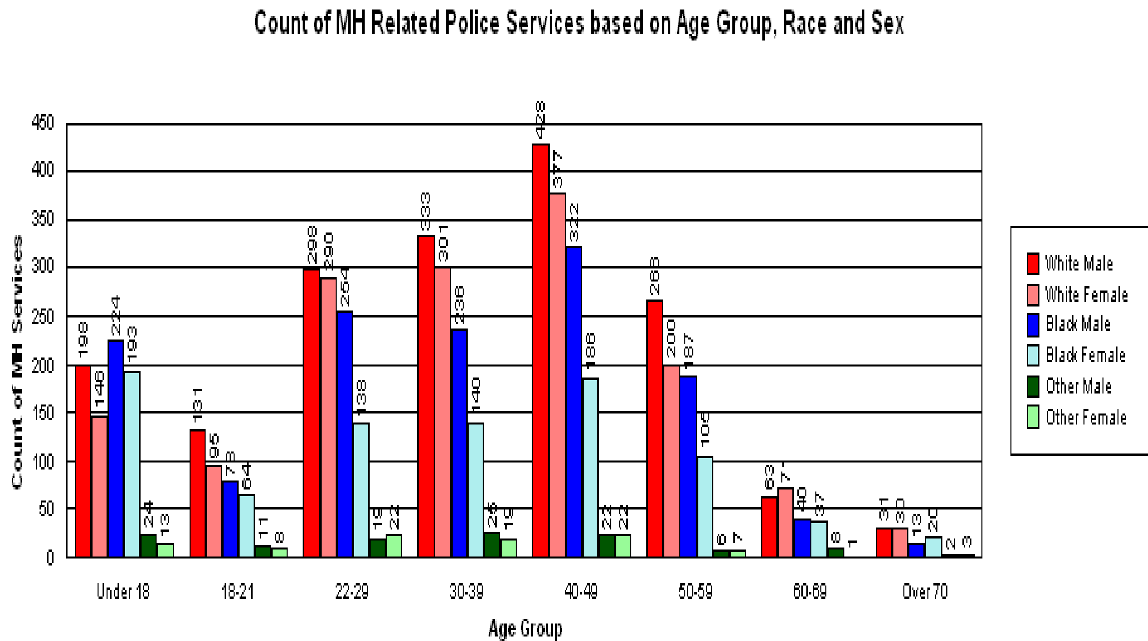
Table 3. Calls for Service (Mental Illness), 2008

Total Calls for Service for Mentally Ill Persons (Signal 27)	7,631
Citizen Calls for Service	7,080
Verified MH Related Police Services	5,707
Total distinct people involved in the verified MH related police Services	4,163

Source: Jacksonville Sheriff's Office
Prepared by: Duval County Health Department, Institute for Health, Policy and Evaluation Research

The distribution of mental health-related police service calls by age, race and sex is presented in Figure 1 for the year 2007.

Figure 1. Mental Health Related Police Services, 2007



In absolute numbers, white males predominate in all age categories, followed by white females; black males predominate in the youngest age category (under 18).

The Jacksonville Mental Health Coalition (MHC), Criminal Justice System (CJS) Work Group recently conducted an analysis of mental health-related police services and concluded that between October 1, 2005 and Sep 30, 2006, 4,058 distinct individuals received some mental health-related police services. Only 10% were transported to the Jacksonville Pre-trial Detention Facility (PTDF); the remainder was transported to area treatment centers and hospitals. This same analysis revealed that a core group of individuals received a disproportionate number of services; 150 individuals with 4 or more mental health-related police services received 914 services (MHC CJS Work Group, 2007, unpublished data).

An informal records review conducted in 2007 by the Jacksonville Sheriff's Office indicated that 37 individuals with a history of mental illness and contact with our local criminal justice system had an average of 18 arrests prior to their forensic commitment. Their offenses included an average of five felonies, 12 misdemeanors, and at least one municipal ordinance violation.

Additional information regarding the situation locally for publicly funded mental health and substance abuse services is provided by the University of South Florida, Louis de la Parte, Florida Mental Health Institute, Criminal Justice, Mental Health & Substance Abuse Technical Assistance Center (Appendix III). These data reveal a number of points that hold particular salience for Duval County. First, the large majority (> 65 %) of Baker Act initiations within the county occur among arrestees and 44 percent of these are diagnosed

as having a Severe Mental Illness. Second, the percent of uninsured Duval County residents is almost three times the state percentage (13.7 and 4.7, respectively), despite almost equivalent percentages of Medicaid Enrolled individuals among arrestees (33.3 Duval County vs 31.3 Florida). These data suggest that our mental health system misses a significant opportunity to enroll arrestees in Medicaid and thereby expand the services available to this population. Medicaid is a major source of funding for mental health and related support services. Individuals who are not Medicaid eligible, but are unable to pay for health care insurance often fall between the cracks of the existing system. Very little funding is available from the Department of Children and Families (DCF) to cover indigent costs. Untreated individuals, without access to care, are often unable to manage their illness and thus pose a risk to themselves and the community.

Funding

Access to mental health services in Jacksonville is determined by a client's ability to pay. Uninsured people are often shut out of treatment. Without access to disability payments people with mental illnesses who come in contact with the criminal justice system can become trapped in cycles of arrest, release, destitution, deterioration and re-arrest. Consequently, assisting these individuals to qualify for Medicaid is critical. Although indigent programs (such as the Indigent Drug Program, IDP) are available, the funding level is not sufficient to meet the need.

Mental Health and Substance Abuse funding is not distributed equitably throughout Florida. Based on City of Jacksonville, Behavioral and Human Services Division estimates, Duval County, along with the remaining 19 counties that comprise DCF's Northeast Region receives among the least amount of funding per capita in the State ($28.16 *versus* a high of $53.41 in fiscal year 2008-2009).

DCF reports that funding for adult and children's mental health and substance abuse services in Duval County totaled over $ 25.6 million dollars in 2008-2009 (Appendix IV). The City of Jacksonville additionally contributed another $2.5 million to mental health and over $3.3 million dollars to substance abuse services (Appendix V). It is noteworthy that very little of this money is committed to prevention, while a substantial amount is committed to deep end services, such as emergency (crisis) stabilization.

Sequential Intercept Model

The Sequential Intercept Model (SIM) (Munetz and Griffin, 2006)) was used as a framework for understanding the interface between the criminal justice, mental health and substance abuse systems (see also Appendix VI for Consensus Project Flow Chart of Select Events for a Person with Mental Illness in the Criminal Justice System). The model is conceptualized as a funnel, with a series of intercept points, at which mentally ill and/or substance dependent individuals encounter the criminal justice system (Figure 2). Each point of interception presents an opportunity for intervention. Ideally, most people are intercepted at earlier intercept points, with increasingly fewer individuals penetrating deeper into the criminal justice system. The ultimate intercept is decidedly an efficient local mental health system, followed by law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations and forensic commitments;

reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The objectives vary with each intercept including: preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent in the criminal justice system, improving continuity of care and linking individuals to community treatment upon release from incarceration and decreasing recidivism.

While the SIM includes five intercepts within the criminal justice system, it is important to emphasize that the local mental health system is the ultimate intercept. The concept of decreasing the "criminalization" of mental health is essentially preventing those individuals affected by mental disorders, from encountering the criminal justice system. The ultimate diversion is a comprehensive, accessible and effective mental health treatment system. While that is the ideal option, most communities do not possess such a system and even in the best systems some individuals will inevitably come to the attention of law enforcement, therefore, the next intercept, and first encounter with criminal justice, is **law enforcement and emergency services**. Since this is generally the first response to a mental health emergency, law enforcement plays a pivotal role in diversion, as they have considerable discretion at the scene. The most effective outcome from this intercept would be to divert the individual from arrest to treatment in the community. When either the officer is not knowledgeable and properly trained in dealing with this population, or the alternatives are not sufficient, this outcome is not likely, resulting in unnecessary arrests, rather than diversion. Examples of strategies used at this intercept include mobile crisis teams of police officers and mental health professionals and Crisis Intervention Team training, which is a program that trains police officers to properly handle individuals with a mental health crisis.

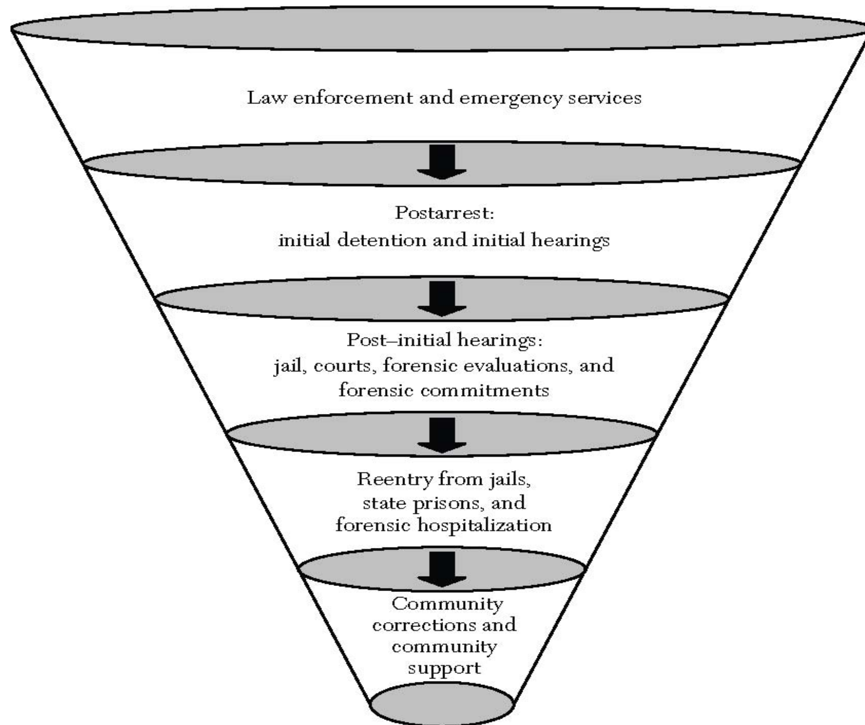
The second intercept occurs at **initial detention and initial hearings**. This intercept presents a post-arrest point when the individual could be diverted from prosecution or enroll in treatment in lieu of incarceration. The ideal outcome is to engage the individual in treatment rather than release or continued incarceration without treatment. Strategies employed at this point include assessment at intake and courts may intervene to recommend and provide oversight for community treatment. The third intercept is at **jails and courts**. There are two primary outcomes at this point - including limiting punishment and providing or promoting prompt, high-quality treatment to the offender. To this end, one strategy is to establish a specialized court program to address the specific needs of the individual. Mental health courts have earned notoriety for their efficacy in facilitating stabilization and decreasing recidivism

Intercept 4 is at **reentry from jails, prisons, and hospitals**. The primary objectives at this junction are two-fold. First to ensure continuity of care from the correctional facility or hospital to the community and to reduce recidivism. Communication and collaboration between the criminal justice and mental health systems are crucial for success at this intercept. One strategy used is the APIC model for reentry from incarceration, focusing on assessing, planning, identifying, and coordinating transitional care. Finally, the last intercept is **community corrections and community support**. Individuals under continuing community supervision are often required to comply with mental health treatment as a condition of probation. Several communities designate specialized caseloads to trained community corrections officers.

The Sequential Intercept Model provides a systematic framework to identify points at which individuals with substance abuse and/or mental health issues come to the attention of the criminal justice system.

Figure 2

The Sequential Intercept Model viewed as a series of filters
Best clinical practices: the ultimate intercept



Source: Munetz, M. and Griffin, P. Psychiatric Services April 2006 Vol. 57 No. 4

V. METHODS

The Institute for Health, Policy and Evaluation Research, a Division of the Duval County Health Department provided leadership and staff support for the strategic planning process. For clarity of explanation, the planning process is described as occurring in two phases, an information gathering phase (Phase 1) and a planning phase (Phase 2). In actuality, the process was participatory, iterative and mutually informing. **Phase 1** consisted of a variety of information gathering techniques, which were conducted from July 2008 through April 2009 to describe current services available generally in the local mental health system and at each intercept. A total of six focus groups (Krueger 1994) (n = 34 participants) were conducted: 2 groups with consumers (n = 14 participants), 1 group with family members (n = 4 participants), 1 group each with CIT patrol officers (n = 6 participants) and CIT correctional officers (n = 5 participants) and 1 group with Forensic Assertive Community Treatment (FACT) team members (n = 9 participants). Sampling was by convenience and recruitment for the groups was conducted by our community partners. All focus groups were conducted by a moderator/note taker team in a confidential setting and audio-recorded. Focus group discussions were professionally transcribed. The two focus groups with CIT officers and the FACT team focus group were considered primarily informational and were used to broaden our understanding of MHSACJ services and processes. The three remaining focus groups (two consumers, 1 family member) were of interest both for the information they contained, as well as the perceptions of participants regarding mental health and substance abuse services in the context of criminal justice system involvement. Consequently, these transcripts were analyzed using grounded theory techniques. In these analyses, there was an emphasis on representing the participant's point of view and the meanings they attached to events and situations discussed. Consequently, these three transcripts were independently coded and analyzed for themes by two qualitative data analysts. Any differences in themes was discussed together by the two analysts and the Project Director (Dr. Winterbauer) and resolved. This team approach to qualitative data collection and analysis enhanced the validity of results (Patton, 2002).

We also conducted 30 key stakeholder interviews with a variety of community stakeholders, including those representing the criminal justice system, mental health and substance abuse treatment providers, consumers, family members, DCF staff, and others. Sampling was purposive and recruitment was conducted by DCHD staff. Interviews were conducted in a confidential setting, in-person or by phone. The majority of interviews were audio-recorded and professionally transcribed, although some were recorded only in the interviewer's notes. Personal and place names were removed and replaced by codes. These interviews were considered primarily informational and were used to broaden our understanding of MHSACJ services and processes, identify gaps in service in the current system and identify strengths and weaknesses of current and potential programs and services.

Additionally, a member of the DCHD research team went on a "ride along" with police officers in an area known for a significant share of Duval County's mental health calls for service. The team member rode with two officers and spoke with others about issues pertinent to the project. She also witnessed the day-to-day activities of a Duval County police officer.

We also conducted a literature review and search for interventions and best practices which informed the strategic planning process. The bibliography is included here as an appendix (Appendices VII and VIII). We expended a great deal of staff time attempting to locate and acquire pertinent data to inform the decision-making process and create a foundation for sharing data among providers and JSO. With rare exceptions (primarily JSO), service and cost data were not forthcoming and when they did exist, occurred primarily at the aggregate level.

Phase 2 consisted of the participatory planning process. 11 large group meetings and 18 small group meetings were conducted (attendance at large group meetings generally ranged from 20 - 25). The agencies and individuals, other than DCHD, with the most consistent attendance included COJ, JSO, Renaissance Behavioral Health, DCF, consumers and other advocates. Other provider attendance was less regular. Data for the planning process consisted of information gathered through literature review and web searches, existing state and local reports, key stakeholder interviews, focus group analyses, and service and cost data as was made available by providers and funding agencies. As information became available it was reviewed in both the large group meeting and smaller workgroup. A gap analysis was conducted to identify system limitations and potential interventions, which were subsequently evaluated through a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats). Recommendations and priorities were discussed in both the small and large group settings and decisions were made by the large group. A consensus decision-making process was used to arrive at our final recommendations.

It should be noted that significant barriers to data collection were encountered and limited our ability to devise an *evidence-based* strategic plan. Although some data were shared by community partners, several barriers to data access were encountered. These included:

- Non-responsive or slow to respond data contacts at provider agencies
- Inability of some agency data contacts to explain the meaning of the data elements collected and/or data discrepancies
- Variable data consistency and quality

Most importantly, there was very little outcome data available. Data consisted primarily of program descriptions with some cost and service utilization data. Ideally, the type of data needed to develop a comprehensive strategic plan is outcome data. Outcome data show the effectiveness of a program. Outcome data answer the question: *Does the program work?* Other types of data that would be helpful are service and cost data. Service data show the number of clients that received services and the total number of services provided. It also includes demographics data such as age, gender and race. Financial data shows the total cost of the program and includes cost per service(s). This type of data is helpful in comparing different programs (i.e. cost benefit or cost savings). Program description data provides information on what the program does and who it serves.

VI. RESULTS: GAP ANALYSIS

1. Intercept 1: Law Enforcement and Emergency Services

Intercept 1 is the pre-arrest intercept. It is the first encounter between the mentally ill and/or substance abuse population and the criminal justice system. When a crisis occurs, law enforcement and emergency services are the first responders. In lieu of the movement toward deinstitutionalization, the unstable mentally ill population has become a burden to first responders, such as law enforcement.

Existing programs include:

a. Patrol and Corrections Crisis Intervention Team (CIT) Training
b. Crisis Stabilization Unit (CSU; Baker Act; Florida's Mental Health Act)
c. Gateway Detoxification
d. Marchman Act
e. Indigent Drug Program

a. Patrol and Corrections Crisis Intervention Team (CIT) Training is modeled after programs in Memphis and Montgomery County, Maryland (Hill, Quill, Ellis 2004) and includes 40 hours of training for all police and corrections officers. Diversion from incarceration is the central component of the curriculum, which also includes communication skill-building and 8 hours of site visits and shadowing case managers. Approximately 800 officers have been through the training, which is delivered by community treatment providers and JSO staff and retirees. Almost all officers now go through CIT training, but after the training the officers are given the opportunity to be designated as a CIT Officer, which means they will be called first to respond to a crisis situation, if feasible.

b. Crisis Stabilization Unit (CSU; Baker Act; Florida's Mental Health Act). Baker Act receiving facilities accept voluntary and non-voluntary admissions. Jacksonville's public receiving facilities are the Mental Health Center of Jacksonville and the Mental Health Resource Center. Private receiving facilities include Shands Hospital, Baptist Hospital, Ten Broeck Hospital (now River Point Behavioral), and Orange Park Medical Center. Private facilities are obligated to conduct an evaluation of anyone brought to the facility, but they are not obligated to admit them. If they do not admit them, they must refer them to a public facility, unless the public facility is at capacity, in which case, they must be admitted. The following summarizes Baker Act criteria:

- An involuntary examination under the Baker Act can be initiated by a circuit court judge, an authorized mental health professional or by a certified law enforcement officer. Criteria:
  - The person has either refused a voluntary examination **or** is unable to determine for himself or herself whether an examination is necessary; **and**
  - Either:

- The person is likely to suffer from neglect which poses a real and present threat of substantial harm to his or her well-being that can't be avoided through the help of willing family members or friends or the provision of other services; **or**
- There is substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

The data below are from the two public CSU facilities: the Mental Health Center of Jacksonville (MHCJ, Figure 3) and the Mental Health Resource Center (MHRC, Figure 4) (under management of Renaissance Behavioral Health Systems). These two facilities together have **59 adult and 28 child CSU beds**. The first graph illustrates utilization of CSU beds at MHCJ. The values range from 73% to over 100%. (Over 100% utilization occurs when the facility opens extra beds, if available.) The second graph shows utilization of CSU beds at MHRC. The values range from 78% to 99%. In short, the two public CSUs are at or near capacity year round.

Figure 3.

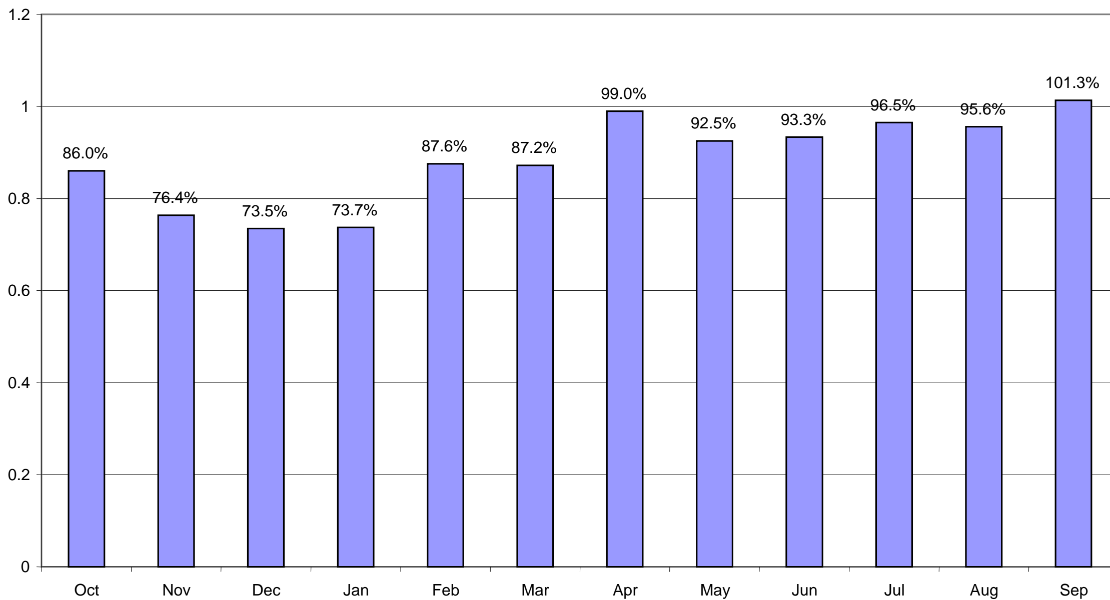
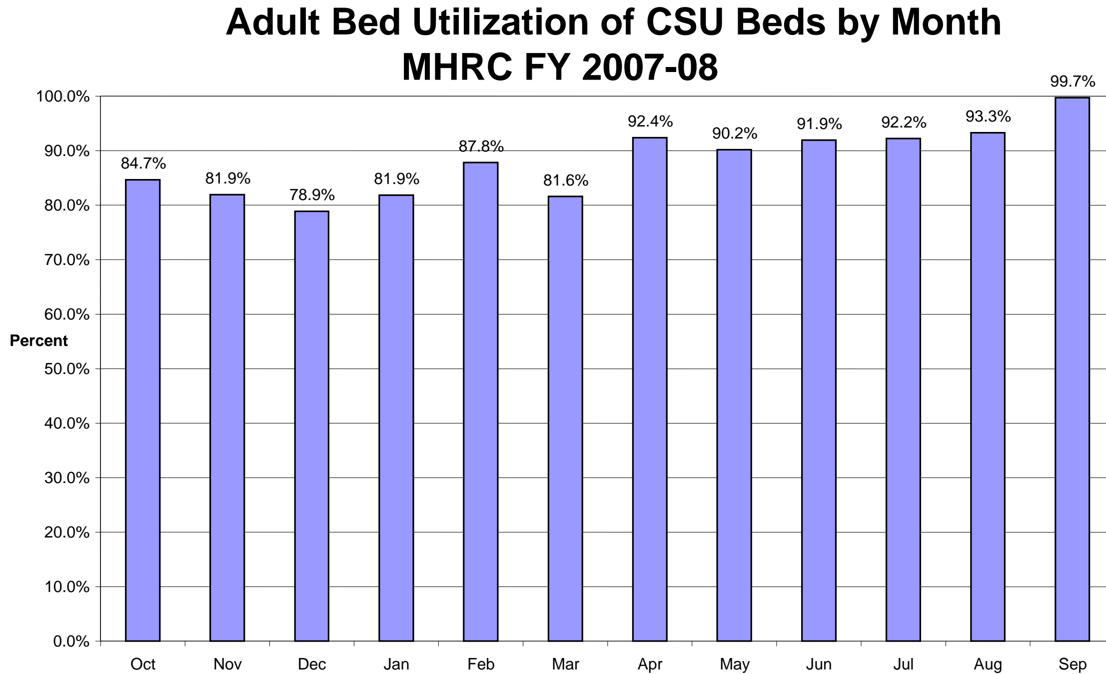


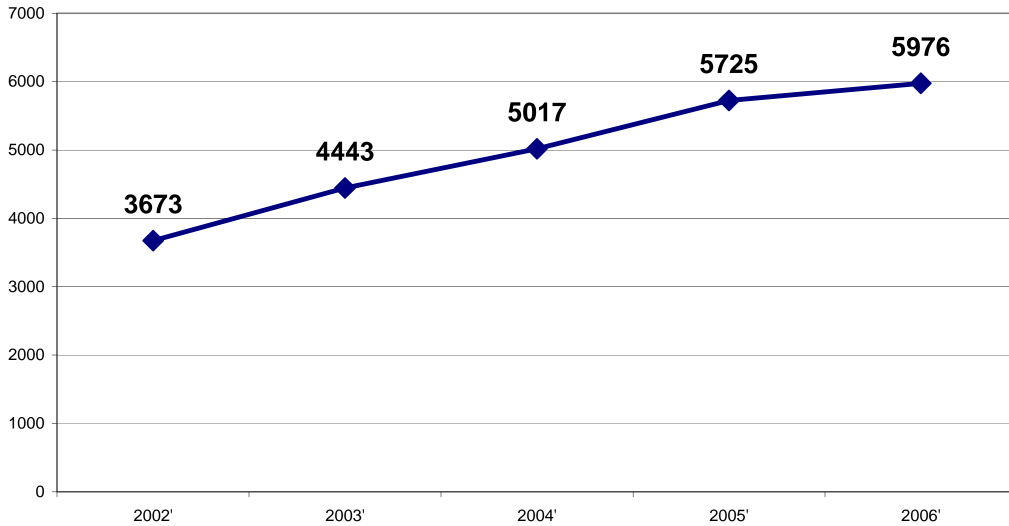
Figure 4.



As depicted below (Figure 5), Duval County has increased the number of involuntary exams from 3673 to 5976 in five years (2002 – 2007). However, these graphs should be interpreted cautiously. One of the reasons for the increase is that the reporting from the receiving facilities has improved. In fiscal year 2007 – 2008, $3.67 million dollars was spent to finance CSU beds at Renaissance Behavioral Health System's two facilities at a rate of $291. per bed day.

Figure 5.

Number of Baker Act Involuntary Exam Initiations
Duval County Residence 2002-2006



*Duval County receiving facilities had a past problem with reporting county of residence data. Completion and submission of cover sheets has increased in recent years. Thus, examination counts from earlier years were artificially low.
Source: 2006 The Floirda Mental Health Act (The Baker Act) Report
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, 2-5-09

c. **Gateway Detoxification** is held in a non-secure facility. There are 20 beds for medical detoxification (approx. 5-7 days). Of these, a percentage of beds is held for people brought in by police (Marchman Act, below). There are 10 beds for non-medically assisted detoxification. These beds are only used for 23 hours. Clients receive an assessment that is mainly focused on substance abuse, with some mental health questions. Treatment is recommended, but depending on service capacity and insurance status, individuals may not be able to get appropriate treatment. Data from 2007 (Table 4) suggest that few individuals are taken to Detoxification by police.

Table 4.

Gateway Detox Program Profile,2007

Profile	Number per month
Screenings for Detox	156
Total Admissions	156
Police Admissions	19

d. Marchman Act – description.

- Admission Types
  - Voluntary Admissions
  - Involuntary Admissions:
- Publicly funded providers cannot deny access to services based solely on inability to pay, *if* space and state resources are available.
- Involuntary Admissions Criteria
  - Good faith reason to believe person is substance abuse impaired and because of the impairment:
  - Has lost power of self-control over substance use; **and either**:
    - Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on self or others, **or**
    - Is in need of substance abuse services and, by reason of substance abuse impairment, his/her judgment has been so impaired the person is incapable of appreciating the need for services and of making a rational decision in regard thereto. (Mere refusal to receive services not evidence of lack of judgment)
- Protective Custody
  - Law enforcement may implement for adults or minors when involuntary admission criteria appears to be met.
  - Who is in a public place **or** is brought to attention of Law Enforcement Officer (LEO)
  - Person may consent to LEO assistance to home, hospital, licensed detox center, or addictions receiving facility, whichever the LEO determines is most appropriate.
- Protective Custody **Without** Consent
  - Law enforcement officer may take person to:
    - hospital, detox, or ARF, **or**
  - An adult may be taken to jail. Not an arrest and no record made.
- Jail Responsibility
  - Jail must notify nearest appropriate licensed provider within 8 hours and shall arrange transport to provider with an available bed.
  - Must be assessed by jail's attending physician without unnecessary delay but within 72-hours
  - Must be released by a qualified professional* when:
    - Client no longer meets the involuntary admission criteria, or
    - The 72-hour period has elapsed; or
    - Client has consented to remain voluntarily, or
    - Petition for involuntary assessment or treatment has been initiated. Timely filing of petition authorizes retention of client pending further order of the court.
- Court Involved Involuntary Assessment/Stabilization **Petition**
  - **Adult**: petition may be filed by: Spouse, Guardian, Any relative, Private practitioner, Service provider director/designee, or Any three adults having personal knowledge of person's condition.

- o **<u>Minor</u>**: petition may be filed by: parent, legal guardian, legal custodian, or licensed service provider.

e. Indigent Drug Program (IDP) – Approximately 350 people are assisted with medications through the Indigent Drug Program at MHCJ/MHRC. This figure does not include people served through population-specific, grant-funded programs, such as MHRC's homeless programs (LINK/Quest). The IDP is significantly challenged in that individuals prescribed most of these drugs must be medically managed by physicians at a substantial cost, which is not funded under this program. Further, the IDP is historically under-funded.

Gaps identified at intercept:

a. No viable alternatives to jail/CSU
- In responding to mental health service calls, police have just two choices in where to transport the individual, jail or CSU
- Yet some (unknown number) do not require such intensive attention and could benefit from substantially less expensive programs

b. CSU, Baker Act ("Breakdown in the system")
- Many patients are released after 24-72 hours
- May be unable to stabilize patients due to short stays
- Uninsured individuals are released from the CSU with 21 days of medication and a referral to an agency that is not accepting new (uninsured) clients (Shands and Sulzbacher Center for the Homeless) – leaving the client without follow-up care and likely to be out of medication in three weeks time
- In one month alone, December 2008, 233 such individuals were discharged from one area the CSU (note: this information is neither routinely collected nor reported.)

c. Indigent persons in need of medication and psychiatric services
- The IDP routinely turns people away from public mental health centers because DCF funding for psychiatric medications and medication management is insufficient to meet demand.

d. No mechanism for electronic data sharing system exists

e. CIT
- JSO/CIT officers are unable to identify individuals with mental health issues in response to service calls due to HIPAA regulations
- Not all mental health calls are responded to by CIT officers, dependent on availability
- Police officer sensitivity to mental health / substance abuse-related service calls is variable (supported in focus group interviews)
- Patrol CIT Officers would be unlikely to divert to "other" social services, should they exist, primarily due to liability concerns (supported in focus group interviews)

Possible strategies to implement at intercept: Alternatives to CSU; BARS program; increase IDP funding; EHR System; CIT improvement; Low Demand Triage Center; Central Receiving Facility; Mobile Crisis Unit.

a. Several alternatives to the CSU were reviewed. These alternative programs vary in the degree to which they are peer, or consumer, run and in the degree to which they provide residential facilities. All are voluntary.

- **Short-term (Respite) Crisis Center**
  - Short-term, acute stay facility
    - May be run by peers (Greenfield et al., 2008) or individuals with advanced professional degrees (Hawthorne et al., 2005)
    - The number of licensed beds varies by organizational structure
    - The **Living Room** (below) is one model for a peer-run respite crisis center
    - Staffing at the Adult Crisis Alternatives Program (ACAP), the crisis home in Clay County, includes one coordinator (8-4) ~ $30k and two other 8 hr shifts mental health technician (no degrees necessary). Staffing is minimal, but it is flexible (PRN pool) and can increase if ACAP is full or patients have a high level of acuity.
    - Clients see a therapist Monday through Friday, and the therapist calls in on the weekend. DCF funds $210,000 which covers about 50 to 76% of actual cost.
    - Randomized trials have shown greater improvement on self-reported psychopathology and service satisfaction (Greenfield et al., 2008) in participants in CSU alternative programs and equivalent improvements in symptoms and functioning among program participants in comparison with participants in an in-patient facility, with significant cost saving s for the alternatives program participants (Hawthorne, et al. 2005).

Living Room (Hutchinson et al, 2006):

- Non-secure crisis intervention facility staffed with Peer Specialists, who focus on the person, not the problem.
  - Creates a less clinical, more comfortable, natural environment
  - For people in crisis, who do not meet criteria for involuntary commitment under the Baker Act and do not want to be placed in a CSU.
  - The person can have a larger role in developing a recovery plan.
  - Some facilities allow 24 hour or up to 5 day stay, depending on organizational structure
  - It can be operated in conjunction with a **Clubhouse** (below).
  - Focus group findings from one study (Hutchinson et al 2006) indicate that consumers want a place that…
    - Can give them <u>immediate</u> help with life crises (no waitlists)
    - Has a holistic approach instead of a singular focus on illness and medication
    - Is accessible with regular transportation (they'd rather be picked up by the facility, not the police)
    - Family and friends can visit
    - Nice enough that they aren't embarrassed to be there

        - Where they feel safe (no involuntary aspects)
        - Where they can make a sandwich for themselves or others
        - Has a rigorous recovery program to quickly get their lives back on track

Clubhouse (International Center for Clubhouse Development, www.iccd.org)

- Peer run "voluntary community" organized to support individuals living with the effects of mental illness.
- Multiple randomized clinical trials consistently showed that clubhouse is effective in reducing hospitalization
- Membership is offered to anyone with a mental illness, who comes to use the services. "To have membership in an organization means to belong, to fit in somewhere, and to have a place where you are always welcome."
- Provides a variety of services and supports: –Employment, Community Support Services, Outreach, Education, Housing, Advocacy, Social Supports, Wellness Activities, Substance Use Supports, and linkage to other services when necessary
    - Work-ordered Day
        - Opportunities for members in a rehabilitative environment that parallels a typical business workday.
        - Not presented as a service, rather as an opportunity for members to contribute to the clubhouse.
        - Sends a message to members that they are capable, competent, and needed by fellow members and staff (Macias, Barreira, Alden, and Boyd, 2001).
    - Over 316 clubhouses currently belong to the International Center for Clubhouse Development (ICCD; (www.iccd.org)), involving 55,000 active members.
        - Clubhouse memberships (US averages)
        - Average daily attendance: 48
        - Total active: 141
        - ICCD certified clubhouses have a minimum of 40% of the average daily attendance employed in TE, SE, & IE
        - Average annual budget between $400,000 and $500,000
        - Mean annual cost per member in US (excluding housing): $3203 (McKay, Yates, & Johnsen, 2007)

b. The MHRC Baker Act Recovery and Support (BARS) Program

- The purpose of the program was to provide diversionary interventions and intensive follow-up services upon discharge from the Crisis Stabilization Units. The program consisted of a multidisciplinary team that provided the following services: crisis counseling, support services, education, service linkages, psychiatric consults, peer support, and crisis support.
- The program was eliminated in Duval County last year due to budget cuts.
- The program assisted people who had multiple admissions to the CSU and provided follow-up medication and medical management

- The program was for adults, age 18 and older, who have had two or more CSU admissions within the last six months. If a person meets criteria, staff meets with them to conduct a needs assessment and to identify necessary interventions and supports. Every 30 days the team conducts a review to determine if services should be continued, modified, or terminated based on the individual's needs. A Peer Counselor makes follow up calls 30 60, and 90 days after discharge to assess if services are being utilized and if additional services are necessary.

c. Increase IDP funding

d. Electronic health record system

- Electronic Health Record System – several systems are currently in development in northeast Florida (Appendix IX)
- System to link DCF client information with JSO system (i.e. to identify that Mary Smith is a MH consumer). The systems would not allow diagnosis or treatment information to be released.

e. CIT

- Limit to volunteers
- Offer refresher modules for officers
- Educate the public to ask for a CIT officer, when necessary

f. Low Demand Triage Center (Lee County (Fl) model)

- Provides all law enforcement agencies an alternative to incarceration for individuals experiencing a behavioral health crisis who come into contact with law enforcement and are at risk of being charged with a minor ordinance violation or non-violent offense (specifically open container, disorderly conduct, disturbing the peace, loitering/prowling, and trespass charges). Individuals may have come to the attention of law enforcement due to a variety of presenting problems, which may include homelessness, substance use disorders, or a mental illness.
- The Triage Center/Low Demand Shelter serves 175 individuals per month. On any given night 10-12 individuals may sleep in the common room of the Low Demand Shelter (operated by the Salvation Army) with another 10 individuals housed in semi-private rooms waiting to be transferred to community based mental health or substance use treatment facilities.
- *Jail data for the past three years shows that an average of 22,174 jail days per year were served by individuals committing the categories of low level crimes which are targeted in this program.*
- Low Demand Shelter is not locked, and will only accept individuals on a voluntary basis (this facility is not used in lieu of Baker Act)
- The triage center and low demand center is staffed by multiple partners, including, a mental health center, a substance abuse center, and other health or social service centers.

g. Jacksonville Central Receiving Facility (based on - Orange County Central Receiving Facility)

- Opened April 2003 in Orlando to serve law enforcement as central point of access for Baker/Marchman Act emergency evaluation
- Developed through community partnership among public substance abuse and mental health providers, public/private hospitals, Orange County Health and Family Services and District 7 Department of Children and Family Services Substance Abuse and Mental Health (SAMH) office, and local law enforcement agencies
- Required DCF and county approval of a written “Transportation Exception Plan” as outlined by the Florida Mental Health Act (Baker Act), Florida Statute 394.462 (2)
- Cross-trained substance abuse and mental health professionals and medical personnel housed under one roof to provide assessment/triage
- An independent administrative agency provides facility oversight which includes locating the appropriate (insurance status/client choice/rotation) vacant bed in the system, arranging transfer of the patient to the appropriate bed (Crisis Stabilization Unit, private/public hospital, detoxification unit/Addictions Receiving Facility), resolving complaints/disputes, and evaluating quality and performance issues
- Patients may be held for up to 23 hours in a designated waiting area while bed is located and van (non-ambulance) transport is arranged (food is provided and patients are supervised at all times)
- An average of 412 persons are brought by law enforcement to the CRC each month and approximately 6% are sent out for medical clearance
- Financial support is provided by private and public hospitals in addition to local/state government and public treatment providers
- Systems’ collaboration established a list of high users which led to intensive case management services targeting the “20% who use 80% of the services”
- An active governing board includes hospital CEOs, the Chief Judge, Sheriff, State Attorney, Public Defender, DCF, Orange County officials, NAMI/MHA, etc.

“Phase II” plans include developing housing for the homeless through Shelter Plus Care and other grant opportunities

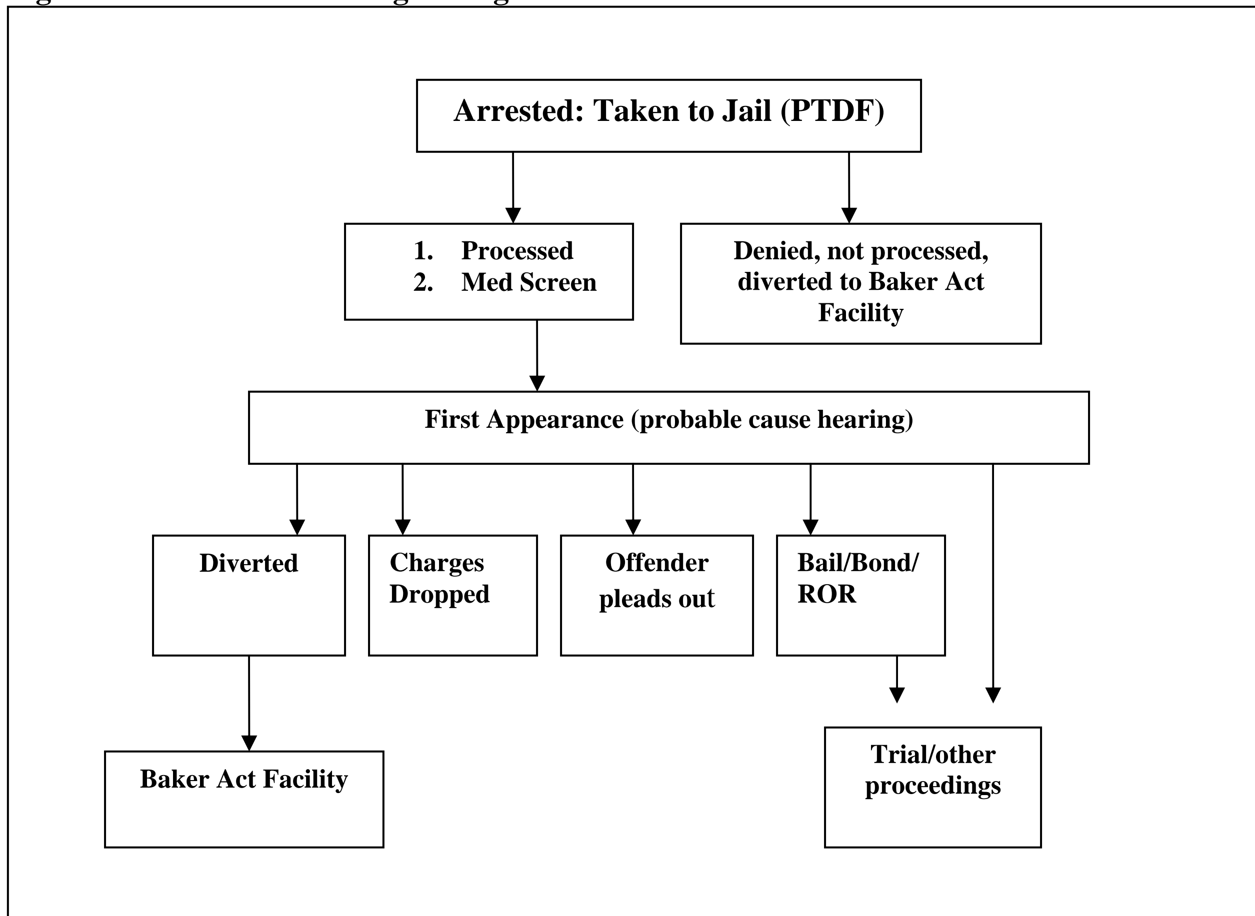
h. Mobile Crisis Unit

- Mobile crisis teams that respond to police calls for service that involve people with a mental health crisis
- Units can consist of: mental health professionals, employed by a mental health provider who respond to referrals from the community and from the police, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specially trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls thought to involve people with mental disorders.

2. Initial Detention and Initial Hearings

Intercept 2 is the second encounter that a mentally ill and/or substance dependent individual has with the criminal justice system. This second encounter occurs after the individual is arrested. Figure 6 illustrates how arrestees are processed through the Duval County Pre-trial Detention Facility (PTDF, or jail). There are many possible courses of action, including: denial of acceptance by jail, booking and hold for first appearance, diversion from first appearance, dropped charges and options for release prior to trial.

Figure 6. Arrestee Processing through the PTDF



At this intercept, the individual has been brought to jail. Possible outcomes for individuals with mental health and/or substance dependence issues here are diversion, release or further court action. Diversion is defined in this intercept as the removal of a person from the criminal justice system and placement in Baker Act facility on an involuntary hold. The process for diversion includes:

1. Appearance in first appearance court proceedings
2. Identification by a mental health professional as a person who is not appropriate for the jail setting
3. Completing an assessment with a mental health professional

   a. The criteria for diversion includes:
      i. Do they understand the court proceedings (competent)?
      ii. Is their charge a non-violent, minor offense?
      iii. Was their crime a symptom of their mental illness?
4. If the person is found to not be appropriate for the jail setting, the mental health professional works with the State Attorney's Office to have the individual's charges dropped.
5. If their charges are dropped, the offender is then involuntarily committed to a Baker Act facility (Mental Health Resource Center or Mental Health Center of Jacksonville).

Existing programs include:

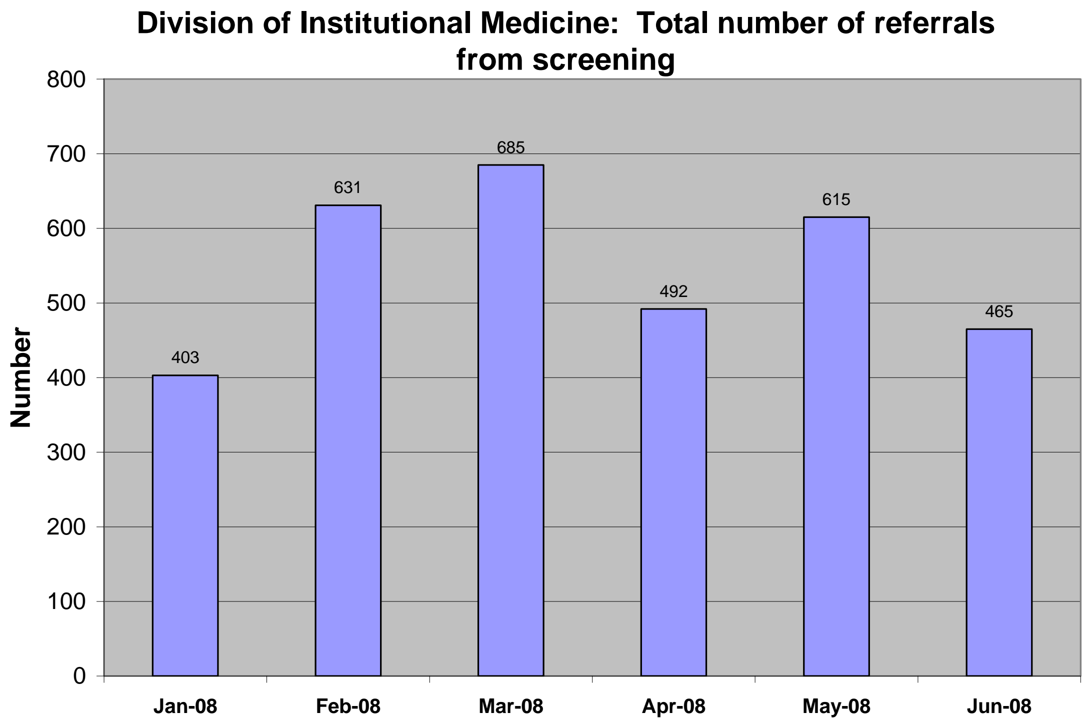
a. Mental Health Assessment at PTDF
b. Ex Parte Order under the Baker Act
c. Treatment Accountability for Safer Communities (TASC, River Region)

a. Mental Health Assessment at PTDF

- The Duval County Health Department (DCHD), Division of Institutional Medicine (IM) provides health services at the jail
- The DCHD/IM screens all individuals brought to the jail for health issues, including mental health issues
- Staffing is provided by psychiatrist, an ARNP, 4 LMHCs, and an RN

The chart below (Figure 7) describes the number of mental health referrals identified at screening into the facility for the time period January through June 2008.

Figure 7. PTDF/DIM Mental Health Referrals from Screening at Intake



b. Ex Parte Order under the Baker Act: An RBHS Diversion Specialist housed at the jail, evaluates new intakes to identify eligible individuals inappropriately brought to the facility for referral to RBHS CSU. The following steps are taken for diversion:

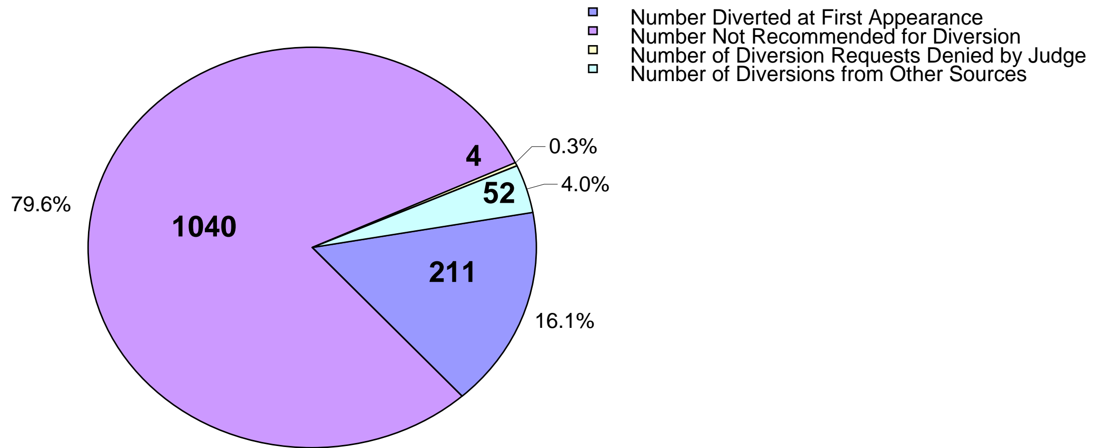
- Attendance at first appearance court, review booking reports
- A mini-mental health assessment is used to screen those offenders out that cannot understand the court proceedings
- Can only divert those who fit criteria for Baker Act (Florida Statute 394.463, Involuntary Examination)
- Contracted to divert only to MHRC and MHCJ (RBHS, public receiving facilities)
- Approximately 20-25 people are diverted per month, however, this number represents some individuals diverted multiple times (ie not unique individuals)
- Individuals who are charged with felonies or violent crimes are not eligible for diversion
- Individuals who are mentally ill, but stable, are not diverted

There were over 28,000 arrests reviewed in 2007. Of these, 1,307 people were assessed for diversion in 2007 - meaning they were flagged by the medication the client was taking, the client was known to the jail staff, the client mentioned suicide, etc.(Figure 8). Of these 20% (263) were diverted to a Baker Act Facility. The second graph (Figure 9), shows that there were 972 people assessed for diversion in 2008 (through August). Of those 16.5% (160) were diverted to a Baker Act Facility. Although more data are needed to show a trend, this two-year time frame shows a reduction in diversions. This could be an

indication that more people are diverted at the time of arrest or contact and before first-hearing.

Figure 8

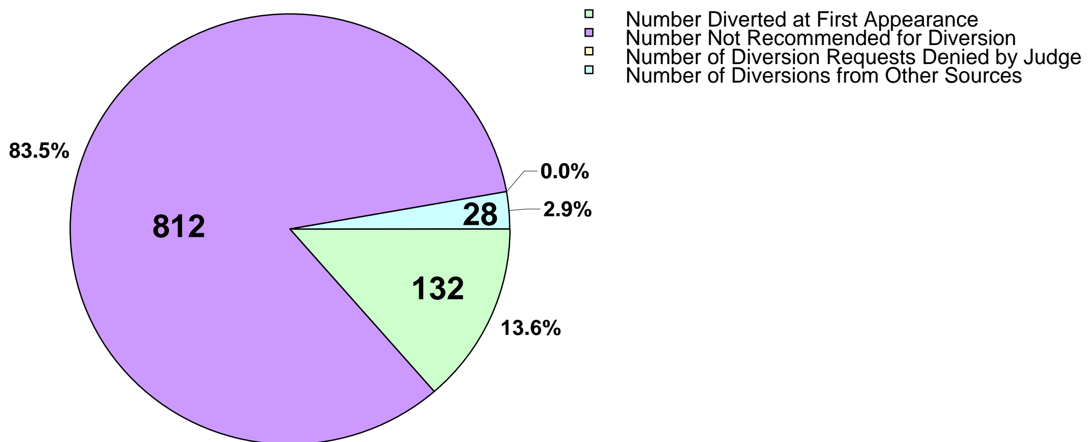
Assessments for Diversion by Results
Duval County 2007



N= 1307
Source:Mental Health Center of Jacksonville, Jessica Johnson, October 2008
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, February 2009

Figure 9

Assessment for Diversion by Results
Duval County 2008 (thru Sep.)



N= 972
Source:Mental Health Center of Jacksonville, Jessica Johnson, October 2008
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, February 2009

c. Treatment Accountability for Safer Communities (TASC, River Region)

- Screen and identify offenders who have mental health or substance abuse issues, and make recommendations for treatment.
- Offenders are referred from court, SAO, judges, private attorneys
- Generally only assess non-violent felonies, with some misdemeanors
- Assessment is provided only upon request
- Data unavailable

Gaps identified at intercept:

a. Individuals new or recent to the criminal justice system charged with minor releases are often released without penalty or intervention (supported through stakeholder interviews)
b. Other individuals with mental health and/or substance abuse issues who are released for other reasons – charges dropped, post bail, etc (Figure 6, above) do not receive treatment/interventions
c. Individuals with non-acute mental health issues who remain at the PTDF need treatment/intervention
d. DCHD/IM intake screen is limited to identify only individuals who self-report significant mental health issues (Appendix X)
e. Individuals are not screened for substance abuse at intake
f. Unnecessary arrests ("slipping through the cracks") – weekend/nights The diversion specialist position is 8-5 (or 4:30), M-F not 24/7 and about 1/3 of possible diverted offenders, can "fall through the cracks" since first appearance court is held 7 days per week

Possible strategies to implement at intercept: staff RBHS Diversion Specialist position at jail 24/7; expand mental health screening at intake to identify individuals with non-acute mental health issues (not only severe and persistently mentally ill) and substance abuse issues; implement Early Intervention Offender Program; use peer specialists when possible (education).

a. Early Intervention Offender Program (Model program: Non-specialty First Appearance Program, Clark, 2004)

- Individuals with mental illness (varying degrees of severity) and substance abuse issues are identified through screening at intake and diverted into appropriate treatment/intervention programs
- Individuals early in illness trajectory / criminal justice involvement can be targeted for early intervention
- Interventions at various levels of contact – from referrals to treatment oversight
- Use peer specialists when possible

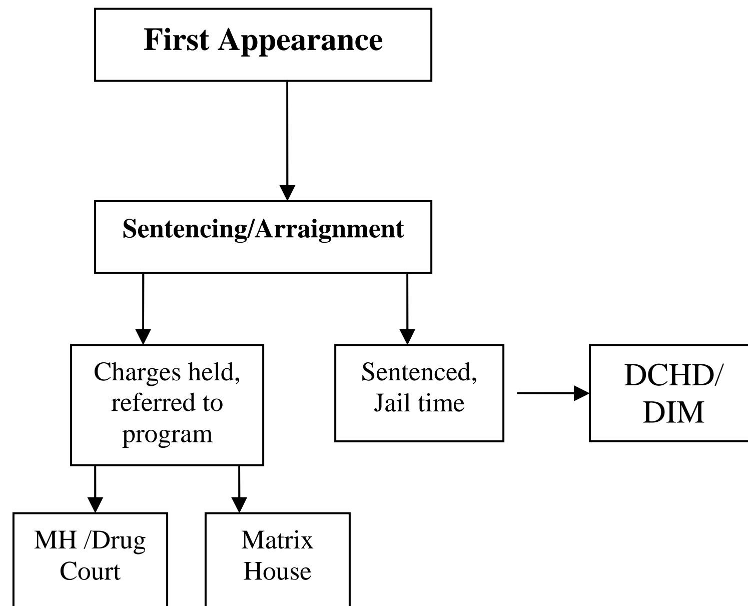
b. Expand mental health screening at intake to identify individuals with non-acute mental health and substance abuse issues (in support of Early Intervention Offender Program)

c Staff RBHS Diversion Specialist position at jail 24/7

3. Post-initial Hearings: Jails, Courts, Forensic Evaluations and Commitments

Intercept 3 is the third encounter that a mentally ill and/or substance dependent individual has with the criminal justice system. In this intercept, an offender has been sentenced to jail or had their charges held and are referred to a program, such as mental health court or a drug rehabilitation center.

Figure 10. Offender Processing if Sentenced to Duval County Correctional Facility



If a person is sentenced to one of the correctional facilities in Duval County (Pre-trial Detention Facility, Montgomery Correctional Facility, or the Community Transition Center), they may be able to receive mental health or drug treatment from a program or provider in the facility. In Duval County, individuals with mental health and/or substance abuse issues may also be eligible for two specialized court programs that my be used in place of jail time: Mental Health Court or Drug Court.

Existing programs include:

a. Mental Health Court
b. Drug Court
c. Drug Dependency Court
d. Matrix House
e. Habitual Misdemeanor Offender (HMO) Program
f. DCHD/IM Mental Health Services in Jail
g. SSI/SSDI Outreach, Access, and Recovery (SOAR) training
h. Health Care Surrogate

a. Mental Health Court - The Duval County program is currently considered a "pilot" program and is not funded. In general, participants have committed misdemeanors due to mental health issues, but are not eligible for Baker Act. The types of charges appearing before the Court include: disorderly intoxication – public disturbance, prostitution, false 911 calls, carrying a concealed weapon, trespass on property / defies order to leave or endangers property and other low level petty crimes. To qualify for Mental Health Court an individual must:

1. Be a resident of Duval County
2. Be charged with a misdemeanor or non-violent 2nd or 3rd degree felony (case by case review of prior record with violence)
3. Have a mental health diagnosis of schizophrenia, bipolar, or anxiety with or without co-occurring disorder
4. Be a repeat offender
5. Be competent / understand the process
6. Volunteer for the program

Clients check-in weekly and receive intensive case management for 1 – 3 years. In February 2009, the Mental Health Court in Duval County had 11 clients: Male (7) Female (4); Black (5), Hispanic (2), White (4); ages 29-58. The lack of participants is not related to offenders not wanting to participate, but is limited due to funding and space. Although insurance (private or Medicaid) is not mandatory for participation, there are few "indigent care slots" at mental health facilities in Jacksonville. Participating providers work closely with the court.

b. Drug Court – Offenders have committed a drug-related crime, but those who have been convicted of selling drugs for profit are not eligible. River Region is the treatment provider. The program operates similarly to Mental Health Court, but with some significant exceptions. The program is funded (< $300,000. per year) and has a case load of about 100 clients.

c. Drug Dependency Court - Gives parents a chance to regain custody of their children after they have been removed from them because of a drug-related conviction. The program includes substance abuse treatment and case management for approximately one year. Strong supervision from both the Court and case managers is provided.
The program usually runs about a one year.

d. Matrix House, run by River Region Human Services (RRHS)
Volunteers are accepted by the program, but inmates who are court-ordered receive priority for the drug rehabilitation (secure treatment) program operated by River Region inside the Community Transitions Center. If an offender is sentenced to the Matrix House they must complete a 120-day treatment program. There are 135 beds available (85 men and 50 women). This jail-based modified therapeutic community is housed at the Community Transitions Center. The inmates are court ordered or volunteer for the program.

There are three components to the In-Jail Drug Treatment Program: education in the jail; therapeutic community at CTC and aftercare. Case managers follow participants for one year after their release from the Matrix program. Housing and assistance with job placement is included in Aftercare piece. The clients remain in Aftercare for one year after release date. The program reportedly runs at or near capacity continuously – court-order offenders and Habitual Misdemeanor Offenders (below) receive priority placement. RRHS also provides substance abuse education classes at each facility through the same COJ contract that funds Matrix House.

e. Habitual Misdemeanor Offender (HMO) Program. If person is arrested four or more times in a year for a misdemeanor, they are referred to River Region to screen for criteria for placement in Matrix House. If they are not placed in Matrix House they will be sentenced to incarceration. If they are eligible for Baker Act they will be diverted. Or they can receive an extended sentence of six months to a year (a usual sentence would be shorter for crimes of this type) if they fit the criteria.

f. DCHD/IM Mental Health Services in Jail. As noted previously, the DCHD, Division of Institutionalized Medicine provides health services at the county correctional facilities. IM only provides treatment to inmates who are actively psychotic, not those who have not developed into full psychosis. The Division's main priorities are suicidal behaviors or ideation (self-harm, Figure 11), bipolar, schizophrenia and those with other Severe and Persistent Mental Illness.

Figure 11. Mentally Ill Offenders Screened as Self Harm by Gender

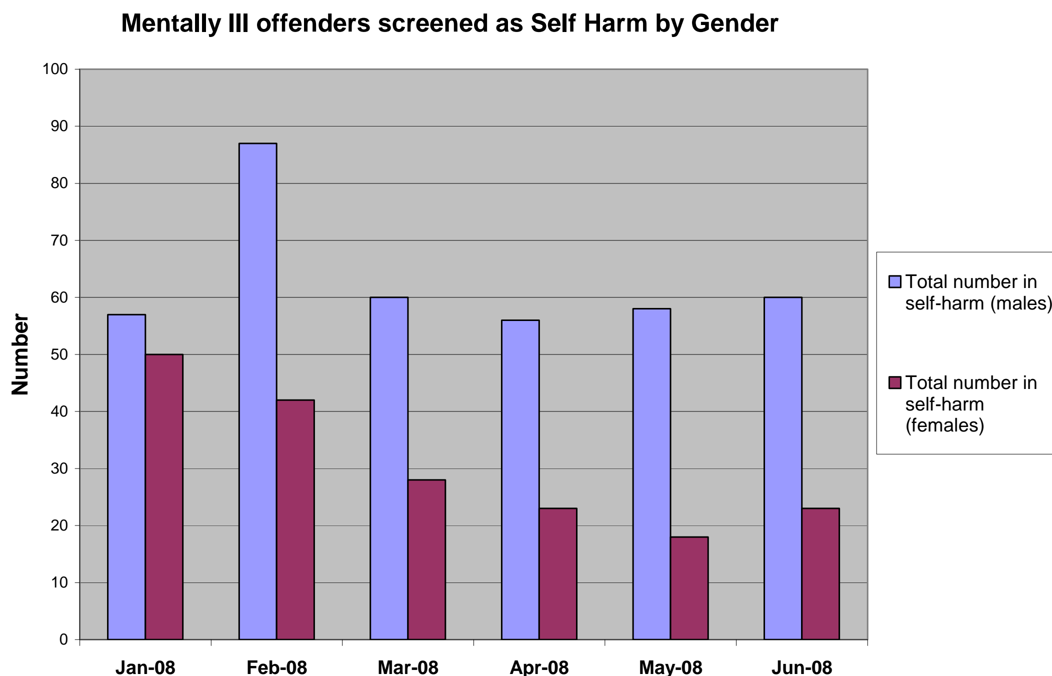
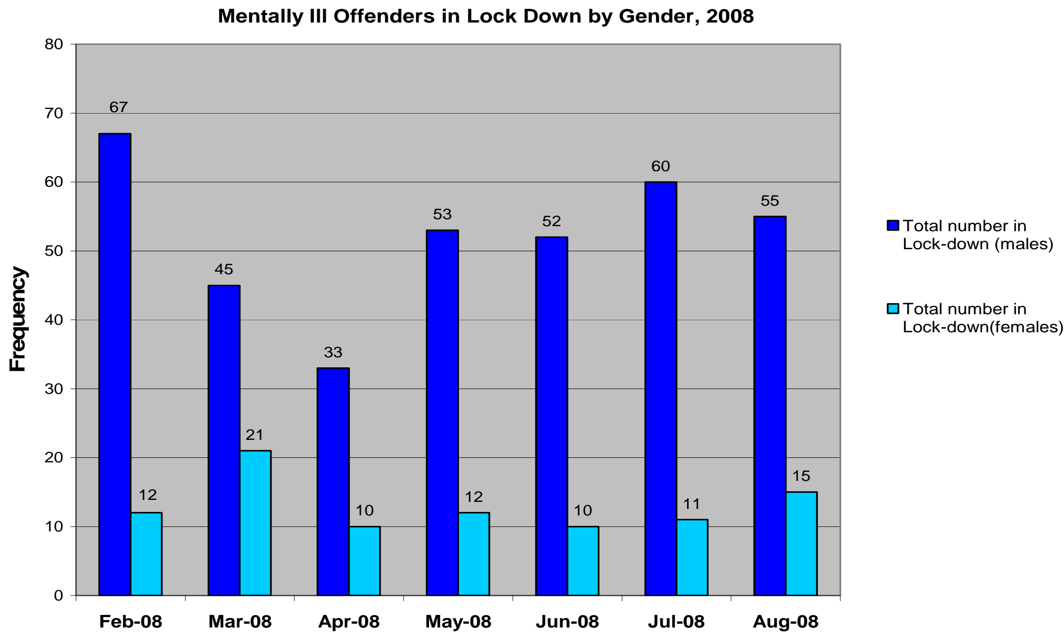


Figure 12. Mentally Ill Offenders in Lock down by Gender



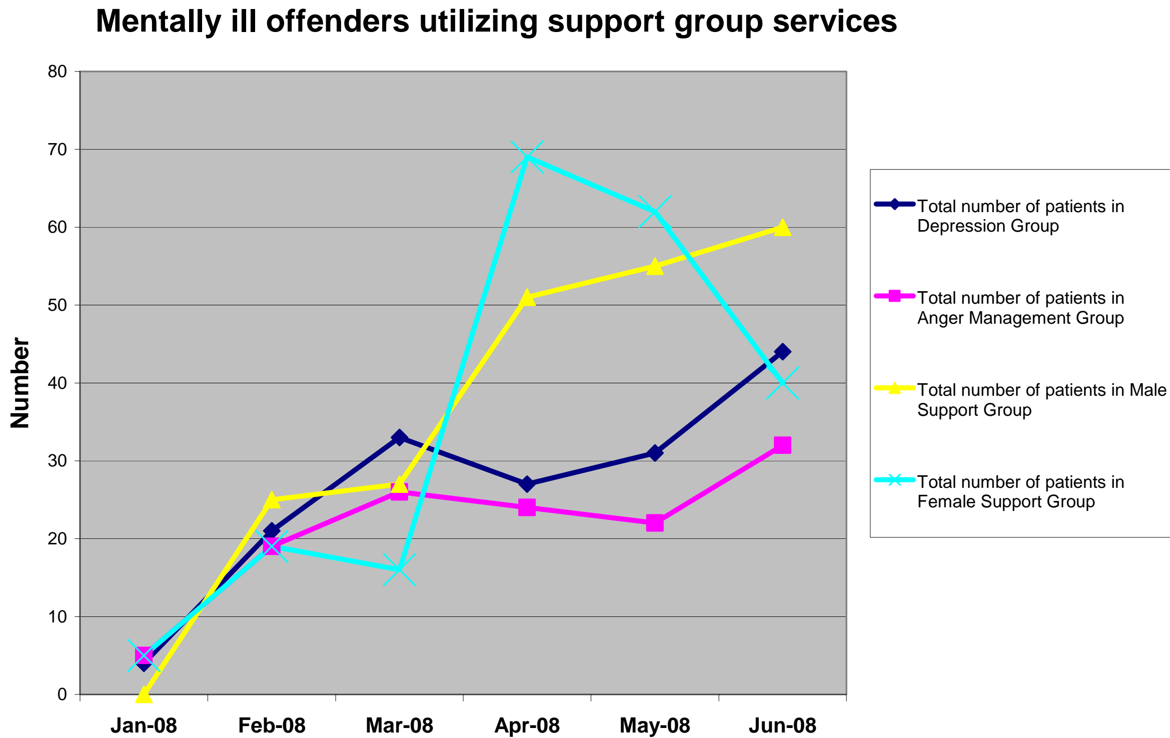
Actively psychotic or self-harm inmates are held in lock down (Figure 12) with an average of 259 patients receiving psychotropic medications monthly.

Treatment services include

- Assessment, diagnosis, and medication, or psycho-therapy.

Weekly groups offered by licensed mental health counselors include groups for depression, anger management, support, women's-high functioning or low functioning (Figure 13).

Figure 13. Mentally Ill Offenders Utilizing Support Group Services



g. SSI/SSDI Outreach, Access, and Recovery (SOAR) program training

- SOAR teaches case managers, peers, and others how to assist disabled persons with application for Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)

h. Health Care Surrogate

Individual identified and authorized by consumer to make health care decisions for them when they are incapacitated

Gaps identified at intercept:

a. Mental Health Court

- The Court is not currently funded
- Uninsured offenders cannot pay for services and are thus practically excluded from participation (providers currently absorb these costs on a limited basis)
- There are no or limited guidelines for sentencing
- The value of the Court is not shared by all court officers
- The program focuses on those with multiple arrests (i.e. not an early intervention program)

b. The Habitual Misdemeanor Offender Program appears to limit treatment options to recidivists with substance abuse issues, but not mental health issues.

c. In practice, Matrix House does not address co-occurring disorders

d. Mental health services in jail are primarily limited to individuals who have been identified as severe and persistently mentally ill, not non-acute mental illness

e. SOAR training – In-depth interviews suggested that a single agency specializing in benefits applications is more successful in obtaining timely benefits in comparison with multiple agencies applying infrequently. Can be used at multiple intercepts

f. Health Care Surrogate – limited awareness of process/benefits; underutilized. Can be used at multiple intercepts.

Possible strategies to implement at intercept:

a. Expand Mental Health Court
b. Screen and treat offenders in the Habitual Misdemeanor Offender program for mental health conditions
c. Increase mental health services in-jail to address non-acute mental health issues
d. Partner DCHD/IM and River Region around individuals with co-occurring disorders held and treated at Matrix House
e. Use in-jail peers for education (eg health care surrogates), encouragement, referrals
f. Recommend SOAR training and application processing through a single agency, especially for agencies that process few applicants
g. Education to providers/consumers on the benefits of engaging health care surrogates

4. Re-entry from Jails, State Prisons, and Forensic Hospitalizations

Intercept 4 is the re-entry intercept. It is the fourth encounter that a mentally ill and/or substance dependent individual has with the criminal justice system. According to (Munetz & Griffin, 2006) the focus at this intercept is on assessing, planning, identifying, and coordinating transitional care and the objectives are to (1) facilitate continuity of care and (2) stop the cycle of recidivism.   At this intercept, an offender has served time in jail, prison or a state hospital, and is being released back into the community.

Existing programs include:

a. Florida Assertive Community Treatment (FACT) Team
b. Jacksonville Re-entry Center (JREC)
c. Duval County Health Department, Division of Institutional Medicine, Community Transition Team (CTT)
d. Renaissance Behavioral Health Services (RBHS) referral coordinator

a. Florida Assertive Community Treatment (FACT) Team

- This is a best practices program (Lamberti, et al. 2004; Phillips et al. 2001), which was designed to keep individuals with severe and chronic mental health diagnoses in the community rather than the state hospital.
- Treatment, rehabilitation, and support services are provided by a multidisciplinary team and include: crisis assessment and intervention, symptom assessment and management, individual supportive counseling, substance abuse services, work-related vocational services, support with activities of daily living, training with social and leisure time activities, case management, arrangements for housing, and other support services.
- Team services are available 24 hours a day, seven days a week, 365 days a year.
- Two teams in Jacksonville serve 100 participants each at a cost of $1 million dollars per year, per team
- Eligibility criteria include diagnoses, hospitalizations, basic functioning skills
- All clients have mental health issues and ~90% have co-occurring substance abuse issues. Diagnoses are generally severe (e.g. schizophrenic, schizoaffective)
- Discharge criteria include: moving out of the area, demonstrating an ability to perform on a continued basis in major role areas (i.e., work, social, self-care) without requiring assistance from the FACT team, being sentenced to a State or Federal facility for a period of more than one year, being hospitalized for a period of one year or more with no foreseeable discharge plan, or the person is deceased.

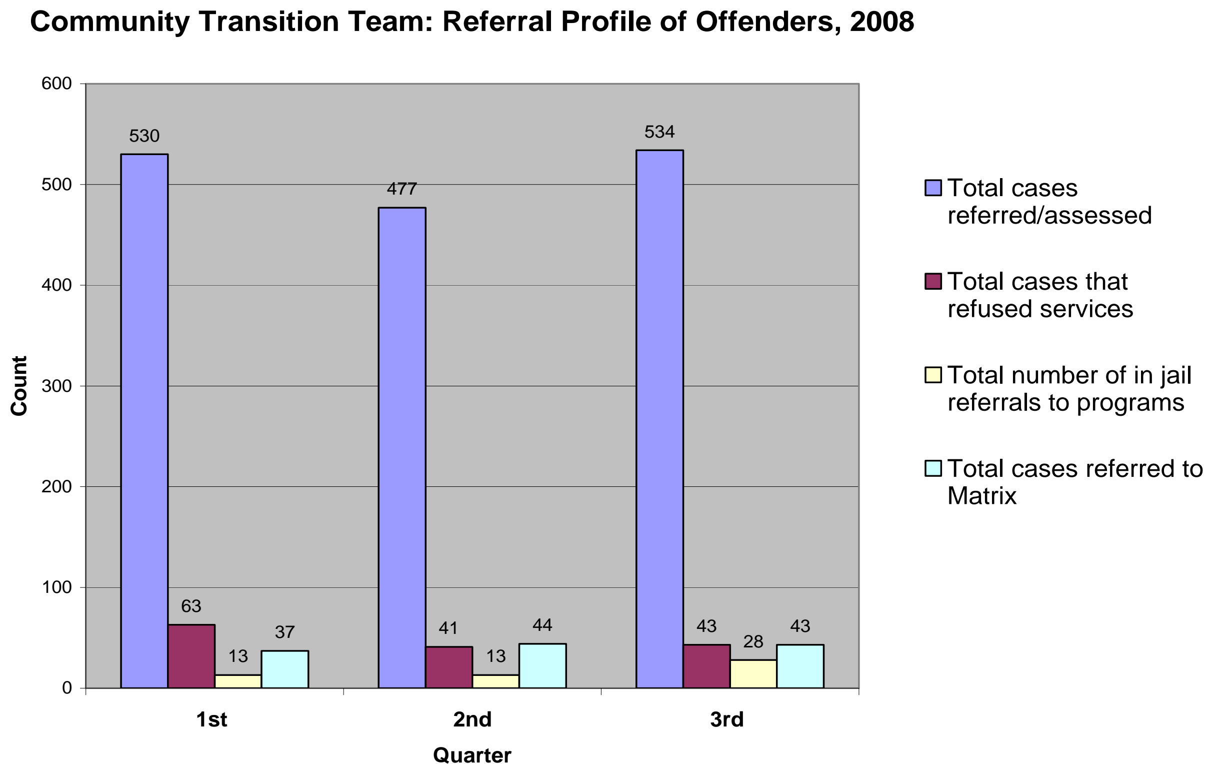
b. Jacksonville Re-entry Center (JREC)

- Jacksonville Sheriff's Office, Department of Corrections initiative
- The Jacksonville Journey provided $277,500 for mental health, substance abuse treatment, and transitional housing for local and state level participants
- Accepts inmates convicted of felony offenses that are being released from local jails or state prison (only those who lived in Duval, committed a crime in Duval, and are coming back to Duval County)
- Information and referral source

c. Duval County Health Department, Division of Institutional Medicine, Community Transition Team (CTT)

- Provides intensive diversionary interventions and intensive follow-up services upon release from the jail.
- The staff functions as a team rather than as individual case managers, where any team member may provide services to any participant to ensure timeliness and accessibility of the service.
- Assess the needs of the inmate while in jail to develop a discharge plan, setting up what services will be needed to successfully transition to the community.
- Assist inmates to transition from jail to the community by linking to services such as: housing, food, medical treatment, medication management, financial assistance, establishing entitlements, clothing, daily living skills training, vocational rehabilitation, counseling, transportation, and other available social supports services to assist the person to remain successfully in the community.
- Furnish referrals to community providers such as Gateway, RBHS, or Sulzbacher

Figure 14. Community Transition Team Referrals



The data in the chart above (Figure 14) describe referrals made by the CTT for three quarters in 2008. These referrals include all clients, not only those with mental health and substance abuse issues

d. Renaissance Behavioral Health Services (RBHS) referral coordinator RBHS staffs a referral coordinator at the PTDF who attempts to provide continuity of medical care, alerts case managers that their clients have been arrested and screens inmates for eligibility and provides discharge referrals. Tables 5 and 6 (below) summarize data for 2006 – 2008.

Table 5. RBHS Community In-Jail Annual Report

Program	Referrals to Case Management		Currently in Case Management	
	2006-2007	2007-2008	2006-2007	2007-2008
Link	85	29	12	50
MHRC	0	1	16	39
MHCJ	0	1	47	58
RRHS	0	0	26	11
NBHS	0	0	35	16
SJC	0	0	0	1
CCBHS	0	0	0	2
Quest	0	1	1	1
NEFSH	0	0	1	1
ACT Program	0	0	18	14
FACT	8	0	34	44
Forensic (OTT)	0	0	59	61
Total	**93**	**32**	**249**	**298**

Source: Duval County Jail, Mental Health Center of Jacksonville
Prepared by: Duval County Health Department, Institute of Health Policy and Evaluation

Table 6. Community in-Jail Annual Report

Fiscal Year	2006-2007	2007-2008
Screened for Community Mental Health Services	208	294
Identified as Mentally ill	743	878
Currently in Mental Health System	388	479
Referrals to Medical Management	96	63
Refused all Mental Health Referrals	96	119

Source: Duval County Jail, Mental Health Center of Jacksonville
Prepared by: Duval County Health Department, Institute of Health Policy and Evaluation

Gaps identified at intercept:

a. FACT teams cannot accommodate the number of people who are eligible for the program.
b. Most re-entry programs are for the prison population or the few 2nd and 3rd degree felons released from the PTDF.
c. Individuals on psychotropic medications, but without insurance are released from PTDF with a 21 day supply of medication and a referral to programs already at capacity. This represents a critical health risk for the individual, risk for recidivism, and potential safety risk for the community
d. CTT only assist inmates who stay at least 14 days.

Possible strategies to implement at intercept:

a. Funding for more FACT teams
b. Intensive Case Management (ICM) for deep-end users who cannot access FACT - ICM is used as a less resource intense alternative to the (F)ACT model (Addy, et al. 2008)
c. Reentry programs for individuals with mental health and or substance abuse issues released from the PTDF
d. SOAR (as above in Post-initial Hearings: Jail)
e. Health Care Surrogate (as above in Post-initial Hearings: Jail)
f. Peer counselors

5. Community Corrections and Community Support Services

Intercept 5 is the community corrections and community support services intercept. It is the fifth encounter that a mentally ill and/or substance dependent individual has with the criminal justice system. In this intercept, an offender has been released from jail or prison under some form of community supervision. Several types of programs exist:

Existing programs include: misdemeanor probation; felony probation; parole and conditional release; courts – these programs/services occur after the individual has been sentenced, served time and been released. Other community supervision programs, such as Pre-trial Services and Pre-trial Intervention occur *before* the individual is convicted and may act as alternatives to incarceration.

a. Misdemeanor Probation

- Supervised by Salvation Army Corrections, provides supervision to people who have committed misdemeanors such as: DUI, petty theft, trespassing, battery, worthless checks, etc.
- Offenders can be sentenced to: 3, 4, 6 or 12 months of probation. In that time they will have to report to the Salvation Army Corrections once per month to show they are completing conditions of their probation.
- Conditions can include: Fees or fines incurred from the court system, or restitution to their victims; anger management classes, parenting classes; mental health or substance abuse evaluations.

- The individual must pay for all of these services, unless otherwise waived by the court system. If an individual is unable to pay they may ‘work something out” with the judge (via the probation officer/state attorney and public defender)
- Those who are not receiving treatment are at increased risk of violating their probation & returning to jail.
- The Salvation Army provides varying degrees of social services and case management (supported through interviews).
- Fees increase stress and are reportedly counterproductive (supported through interviews).

b. Felony Probation

- Supervised by the Florida Department of Corrections, which is tasked with enforcing probation, parole & conditional release orders.
- Implicit in sentencing certain conditions for probation is the belief that the offender will be successful in completing all the conditions and “get their life together.” Sometimes this includes being evaluated for mental health or substance abuse issues and following treatment plans put in place by a provider.
- DOC works closely with providers, to get progress reports on clients. They monitor for compliance until the provider says the client has reached the maximum benefit or has failed to comply, which is then reported back to the sentencing authority in the form of a VOP/Technical Violation Letter.
- Stakeholders report in qualitative interviews that if the courts know the person will not be capable of successfully completing probation conditions they will simply not get probation as part of their sentencing.
- FL DOC contracts with the Salvation Army for:
  - Non-secure substance abuse treatment (court ordered):
    - Residential treatment (6 months); DOC initially pays for treatment until the client moves into a work release program (last 4 months), they will then pay a small subsistence fee to Salvation Army for housing/food)
    - Last 4 months they are on a work release program. (this is when they start contributing payment for the program)
  - Probation Restitution (PRC) (men only)
    - Focus on client finding and maintaining gainful employment
    - Supervise men who need to pay restitution to their victims
  - Faith-based Transition Program
    - Men who are in the FL State Prison, transitioning back to the community. There are other faith-based transitional beds in Jacksonville other than the Salvation Army, including Prisoners of Christ, Sisters Program, Thorminic House and the Hope House

FL DOC reports that for Fiscal Year 2008:

1) Number of clients enrolled:

Non Secure Residential Drug Program - 159
PRC - 60

Faith-based - 59

2) Cost:

Non Secure Residential - $1,018,255.17

PRC - $232,664.31

Faith-based - $117,345.86

Table 7. Annual Profile of Offenders on Probation - 4th Circuit (Clay Duval Nassau)

Year	Average Number of offenders on supervision	Number of "Successful" terms during the year	Number of "Un-Successful" terms during the year
2006	6,200	1,240	1,438
2007	6,500	1,310	1,289
2008	6,550	1,383	1,364

c. Parole & Conditional Release. These supervision services exist only for ex-offenders released from prison.

- Parole is only for older cases that had parole as part of their sentencing
- Conditional release- Release from prison to serve out the rest of the sentence in the community under certain conditions. Released as result of serving 85% of sentence, however this must be at least their second conviction and prison sentence
- Florida Parole Commission determines conditions of these releases.
- Mental health and substance abuse evaluation and/or treatment can be included in these conditions

d. Courts

- Have authority/jurisdiction for creative sentencing
- Conditions of probation are from the Circuit Courts' decisions.
- Attorneys and clients have the responsibility to ask for specific conditions that will be beneficial to client, (ie. waiving certain fees)

e. Pre-Trial Services (PTS) (administered by JSO as an alternative to incarceration): acts essentially as conditional release or probation before the individual is tried and sentenced in court. The program offers the opportunity for an individual to be released to the community to await trial, and also provides a system to monitor them. The person will be ordered to report to the pretrial services facility to be monitored and managed until trial. If the individual does not comply with the conditions of this "release", the PTS office will submit a violation form against them and the judge will sentence accordingly (either go back to jail to await trial, or assign different conditions, etc.).

- Eligibility Criteria: non-violent, 3rd degree or less felonies. The judge ultimately decides who should be released on ROR or a small bond. The program cannot serve homeless people, because there must be a method for contact.
- Services provided: job placement, referrals for mental health or substance abuse assessments and treatment, and minor case management for other social services.
- The charges are not automatically dropped. The individual still has the possibility of serving time according to their charges and trial outcome.

- There are currently about 300 active clients. The program is funded through the Sheriff's Office and the City of Jacksonville.

f. Pre-trial Intervention (PTI) (administered by FLDOC as an alternative to incarceration)

- Generally for first time offenders
- Felony offense – eg Burglary, Grand theft, Auto theft
- State Attorney's Office examines case and considers prosecution v Pre-trial Intervention
  a. Sanctions, such as:
     i. Could be community service
     ii. Could be required to go through drug treatment
     iii. Education program
     iv. Victim restitution
     v. Report monthly
     vi. Pay fees
  b. If the individual demonstrates compliance with sanctions, the charges will be dropped
  c. If offender is not compliant with sanctions, the charges will not be dropped and the individual will be prosecuted

Gaps identified at intercept:

a. Individuals with mental health and substance abuse issues often find it difficult to meet the conditions of their release because of their illness. In addition, if they are not insured their ability to pay for court mandated treatment is questionable, further increasing the risk of violating their conditions of release. If individuals self-identify as having mental health and/or substance abuse issues, their conditions can be taken into account, however stigma often prevents this.

Possible strategies to implement at intercept:

Non-Specialty First Appearance Program, administered through (PTS) – see Intercept 2;

Local Mental Health System

Munetz and Griffin (2006: 545) describe the local mental health system as the "ultimate intercept" observing that, "An accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness," but go on to note that few communities in the U.S have such a system. Jacksonville is no exception. Publicly funded prevention and early intervention programs are virtually nonexistent and, where they do exist, are grant-funded (i.e. require specific eligibility criteria and are of limited duration, and/or operate at or near capacity).

Existing programs include:

a. Drop-in Centers River House and Springfield (run by River Region)
b. National Alliance on Mental Illness (NAMI) Courses
c. Indigent Drug Program
d. Star Program, Gateway Community Services
e. Sulzbacher Center for the Homeless
f. Shands-Indigent Care

a. Drop-in Centers River House & Springfield (run by River Region)

- Daytime facilities that allow individuals with mental health and substance abuse issues to "drop-in" and socialize, watch T.V., use computers, etc.
- Hold groups such as AA and other support groups
- Peer-run

b. National Alliance on Mental Illness (NAMI) Courses

- NAMI Family to Family Educational Course
  - Free 12 week course for family members/loved one of people with mental illnesses
  - Provides tools for understanding the illness & support for the person with the illness.
  - NAMI Peer to Peer Educational Course
    - Free 9 week course for people diagnosed with a mental illness
    - Provides tools for understanding the illness & developing a recovery plan.

c. Indigent Drug Program

In FY 2008 IDP funding was approximately $420,000. ($44,173 in cash and $382,590 from a line of credit with Florida State Hospital). This level of funding was not sufficient to support the demand.

d. **STAR Program, Gateway Community Center**; federally funded for 5 years, currently in year 2

- Integrated substance abuse and mental health treatment for homeless individuals, with case management
- Tailored to the individual (not a one size fits all program)
- Capacity: 50
- Criteria:
  - Individuals who have co-occurring substance use and mental health disorders.
  - At least 75% meet HUD's criteria for chronically homeless.
  - If client is admitted, they will receive substance abuse/mental health counseling and treatment, intensive case management, assistance with housing, linkage to community services, psychiatric and medical services. Client will be followed for a minimum of six months.

e. Sulzbacher Center for the Homeless

Table 8. 2007 Patient Visits to Sulzbacher Center

Types of Visits	New Patients	Established Patients	Total Patients
Primary Care	1900	7021	8921
Mental Health	419	1626	2045
Dental	1347	1337	2684

Source: Sulzbacher Center, 2007; Prepared by: Duval County Health Department, Institute of Health Policy and Evaluation Research

f. Shands – Indigent Care

b. No information available

Gaps identified at intercept:

Systemic Gap: Lack of local coordinated, evidence-based system of care for individuals with mental health and/or substance abuse issues

Possible strategy to implement at intercept: Local Mental Health Authority

A Local Mental Health Authority (Authority) would be charged with administering public funds for mental health and substance abuse services in Duval County. These funds would be administered by assessing and responding to the needs of the community.

We envision that the Authority would have the following characteristics:

1. Locally constituted – with high constituent involvement, particularly by consumers and their families
2. Comprehensive – across child and adult, as well as civil and forensic systems
3. Decision-making power regarding funding based on:
    d. Local needs assessment
    e. Locally-defined priorities
    f. Service and outcome data
    g. Program evaluation
    h. Provider use of evidence-based practices
4. Other characteristics to be defined by a workgroup convened for this purpose

Currently, the Department of Children and Family Services (DCF) is designated the "Mental Health Authority" for Florida per the Florida Statutes (394). DCF and the Agency for Health Care Administration have executive and administrative supervision over all mental health facilities, programs, and services. Nonetheless, DCF has the power to contract to provide…services and facilities in order to carry out its responsibilities with departments, divisions, and other units of state government (394.457); moreover, municipalities or counties cannot be prohibited from "owning, financing, and operating a substance abuse or mental health program by entering into an arrangement with the district

to provide, and be reimbursed for, services provided as part of the district plan" (394.74 Part 5).

It should be noted, however that DCF is currently promoting a *Managing Entity*, which is defined as, "a corporation that is organized in this state, is designated or filed as a nonprofit organization under s. 501(c)(3) of the Internal Revenue Service, and is under contract to the Department to manage the day-to-day operational delivery of behavioral health services through an organized system of care State of Florida, 2009). It is unclear if the operating costs of a managing entity will be funded through funds received from the department and savings and efficiencies achieved by the managing entity or financed with a percentage of services dollars (currently anticipated at 4% – 8% of the total budget).

The following goals of proposed DCF Managing Entities are excerpted from the recently published, "State Of Florida, Department of Children and Families, Substance Abuse And Mental Health Program, Invitation To Negotiate, ITN # SNR0809ME01, To become the Community-Based Managing Entity for Substance Abuse and Mental Health Services in Miami-Dade and Monroe Counties" (available at: http://vbs.dms.state.fl.us/vbs/ad.view_ad?advertisement_key_num=77592):

The **goals** of the managing entity are to:

- Improve financial and programmatic accountability to achieve performance outcomes and standards in the most cost effective and efficient manner possible;
- Plan and deliver a locally accessible full continuum of care through needs assessments inclusive of individuals served, families, and community stakeholders;
- Continuously improve the quality of care through the systematic use of evidence based practices;
- Provide early diagnosis, prevention, intervention, and treatment to enhance recovery and prevent hospitalization;
- Promote specialized services to residents of assisted living facilities;
- Ensure co-occurring disorders are assessed and treated effectively;
- Promote innovative services to elder adults enabling them to live in the least restrictive care settings;
- Work in collaboration with the state and community stakeholders to reduce admissions and length of stay for children and adults in residential treatment facilities and state hospitals;
- Develop and implement administrative efficiencies throughout the service array;
- Redirect funds from restrictive care settings to community-based recovery services;
- Enhance the continuity of care for children, adolescents and adults, including the elderly, entering the publicly funded behavioral health service system;
- Improve the assessment of community needs for behavioral health services; and
- Participate with the department's interagency agreements as appropriate.

VII. RESULTS: SWOT ANALYSIS

1. Law Enforcement and Emergency Services

Possible enhancements and strategies to implement at intercept: Alternatives to CSU (Respite Crisis Center, Living Room, Clubhouse); CIT; Central Receiving Facility; Mobile Crisis Unit; Low Demand Triage Center; BARS program; Data Sharing; Indigent Drug Program (IDP)

Alternatives to CSU: Respite Crisis Center, Living room, Peer-run Clubhouse

a. Respite Crisis Center

Strengths

- Randomized trial (Greenfield et al. 2008) compared an unlocked, mental health consumer-managed, crisis residential program (CRP) to a locked, inpatient psychiatric facility for adults civilly committed for severe psychiatric symptoms. Concluded that CRP-style facilities are a viable alternative to psychiatric hospitalization for many individuals facing civil commitment
- May be more cost effective than locked facilities
- Viable alternative to CSU

Programs in Nassau and Clay counties, Florida, are currently testing the model. Preliminary data from Nassau County indicates that this program has significantly reduced CSU admissions and reduced the necessity for law enforcement to transport people to Jacksonville. The cost of the program is about two thirds that of a crisis stabilization unit but could be reduced if the facility was not free standing. 65

Crisis services can also be provided to individuals in the homes of families that are specially trained in crisis support services. District 8 Mental Health Program Office has been supporting this model of care for a number of years and currently has 50 individuals in care, about 10 of whom are in forensic status. The individuals receive services through mental health providers. The cost for the home setting is **less than $50 per day** (Florida Supreme Court, 2007).

Weaknesses

- Costs associated with start-up

Opportunities

- May use existing facility through Renaissance Behavioral Health Systems

Threats

- Competing priorities

b. Living Room

Strengths

- Preventive
- Peer-run

Weaknesses

- May be resistance to peer-run facilities

Opportunities
- Could build on current programs – River House and Springfield
- Convert existing facility (River House)

Threats
- Competing priorities

c. Peer-Run Clubhouse

Strengths
- Preventive
- Peer-run

Weaknesses
- May be resistance to peer-run facilities

Opportunities
- Could build on current programs – River House and Springfield
- Convert existing facility (River House)

Threats
- Competing priorities

d CIT

Strengths
- Recommended program (Hill, et al. 2007)
- Can facilitate special needs of individuals with mental health issues

Weakness
- Some officers claim, they don't really get a choice, they're expected to volunteer for CIT designation, consequently not all officers "buy-in"
- Not all officers CIT trained respond
- Liability issues - Most officers feel a duty to ensure the safety of Baker Act eligible people, and also do not want the responsibility of deciding what should happen to these people (liability issues)
- Observation from ride-along: the officer that was known for receiving the most "mental health calls" has not been through CIT training, and expressed that she would like to have the training.

Opportunity
- Marketing to consumers/families
- Will work well w/CSU alternatives program

Threat
- No alternatives to CSU
- Liability issues
- Consumers/families don't know to ask for CIT officer

e. Jacksonville Central Receiving Facility

Strengths
- A 2007 report by the COJ Behavioral Services Division summarized the benefits of a CRC:

- Reduced impact on Central Booking and jail beds/costs
- Focus on assessment information, client tracking, and coordination of services

- Dual Diagnosis Issues addressed
- Reduced impact and costs associated with hospital ER admissions
- Reduced officer down-time, simplified options, and reduced CJS cycle
- Individuals with mental illness are more likely to be integrated into the mental health treatment system, and not back on the streets

Additional benefits include:

- Appropriate placement – eg detoxification, CSU, alternative to CSU (if available)
- Better communication with providers and family

Weakness

- Cost
- Not widely supported by stakeholders

Opportunity

- Convert an existing facility to a central receiving facility

Threat

- Jacksonville's size can make transportation to a central location (rather than nearest facility) a challenge
- Lack of alternatives to CSU

f Mobile Crisis Unit

Strengths

- Appropriate assessment / intervention at time of crisis

Weakness

- Generally not supported by stakeholders
- JSO officers report that they are not especially delayed by response and transport

Opportunity

- --

Threat

- Jacksonville's size can make response time a challenge (this strategy was tried in the past, but the program was eliminated through budget cuts)
- Lack of alternatives to CSU

g Low Demand Triage Center

Strengths

- Provides an alternative to jail/CSU
- Expected to eliminate a significant burden on jail processes
  - Lee County Jail Data showed *that an average of 22,174 jail days per year were served by individuals committing the categories of low level crimes which were targeted for the Low Demand Triage Center.*

Weakness

- Cost, especially associated with start-up

Opportunity

- May use existing facility through Renaissance Behavioral Health Systems

Threat

- Competing priorities

h. The MHRC Baker Act Recovery and Support Program

Strengths

- Important missing component in continuum of care
- Involves peer-counselor contact
- History of implementation

Weakness

- Cost

Opportunity

- --

Threat

- Competing priorities

i. Electronic Health Records System

Strengths

- Will allow for continuity of care
- Improve quality of care
- Elimination of redundancies

Weakness

- --

Opportunities

- Several EHR systems in development in the community
- DCHD/IM has EHR system in place

Threats

- Provider resistance

j. Increase Indigent Drug Program funding

Strengths

- Provides drugs for medically needy individuals

Weakness

- --

Opportunities

- --

Threats

- Competing priorities

2. Initial Detention

Possible strategies to implement at intercept: Implement Early Intervention Offender Program; use peer specialists when possible (e.g. education); expand mental health screening at intake to identify individuals with non-acute mental health issues (not only SPMI) and substance abuse issues; and staff RBHS Diversion Specialist position at jail 24/7.

a. Early Intervention Offender Program (Non-specialty First Appearance Program)

Strengths

- Early intervention program – apprehends individuals early in criminal justice involvement
- May identify individuals early in illness trajectory who may still have support – tangible (eg. health insurance) and/or emotional (eg familial)
- Good models exist (Clark, 2004)
- Modeled after GAINS Center program

Weaknesses

- Costs necessary to develop infrastructure
- Requires mechanism for oversight

Opportunities

- Provide additional screening at intake through DCHD/IM
- DCHD/IM uses electronic health record system – allows immediate flag for services
- Follow-up/oversight through Pre-trial Services (JSO) or Pre-trial Intervention (DOC)
- Individuals identified early in illness trajectory may still have resources available to them (i.e. insurance, family/friend support)
- Can develop multiple levels of intervention – education, referral, alternate sentencing
- Can use peers
    - SAMHSA endorses peer specialists
    - Reduced costs of paraprofessionals in comparison with other staff
- Describing epidemiology of full spectrum of burden of mental illness in population will allow design of multiple interventions (education, peer, etc), including early intervention
- Several brief assessment tools are available to screen for mental health and substance abuse issues

Threats

- Competing priorities
- Cost

b. Use peer specialists for education, to encourage referrals, and promote recovery

Strengths

- Peer-support is recommended and supported through SAMHSA's Recovery Community Services Program
- Low cost

Weaknesses

- --

Opportunities

- Local, trained peer specialists available

Threats

- May be provider resistance

c. Expand mental health screening at intake to PTDF

Strengths

- Progressive health care provider in the jail
- Will allow development of epidemiological profile of individuals with these conditions at intake
- Will allow for early intervention

Weakness

- Will extend processing by up to 20 minutes
- Will add some additional cost to cover oversight

Opportunities

- Evidence-based screening tools available
- May be self-administered on stand alone computers

Threats

- May be provider resistance to broader screening without available services or and/or treatment

d. Staff RBHS Diversion Specialist position at jail 24/7

Strengths

- One additional FTE (7 days a week 8 hours a day) would yield an additional 96 cases. (1 full-time staff M-F (40 hr) existing; 1 part-time staff S-Su (16 hr) @ $16)

Weekend coverage would yield on average eight additional diversions a month or 96 a year. This was tried in 2007 for only a few months until the funding ran out. The part-time employee was provided by another company, Community Rehabilitation Center. It is not known if the program yielded a benefit. Cost to fund the pilot was ~$40,000.

Weakness

- Cost
- May not be cost effective

Opportunity

- --

Threat

- Competing priorities

3. **Post-initial Hearing: Jails, Courts, Forensic Evaluations and Commitments**

Possible strategies to implement at intercept: Expand Mental Health Court; screen and treat offenders in the Habitual Misdemeanor Offender program for mental health conditions; increase mental health services in-jail to address non-acute mental health issues; partner DCHD/IM and River Region around individuals with co-occurring disorders held and treated at Matrix House; use in-jail peers for education, encouragement referrals; recommend SOAR training and application processing through a single agency, especially for agencies that process few applicants; education to providers on the benefits of using health care surrogates

a. Expand Mental Health Court

Strengths

- Findings support prediction that participation in Mental Health Court reduces the number of new arrests and the severity of such re-arrests among mentally ill offenders.
- Findings support the prediction that among "completers" and "non-completers", the participants who received a "full dose" of mental health treatment and court monitoring produce even fewer re-arrests.
- Some studies show programs are cost-effective (Ridgely, et al., 2007)

Weaknesses

- Cost
- No resources for uninsured

Opportunities

- Grant funding

Threats

- Judges and SAO don't always release offender into program

b. Screen and treat offenders in the Habitual Misdemeanor Offender program for mental health conditions

Strengths

- High prevalence of co-occurring conditions in the jail population. The prevalence of substance use disorders among those with severe mental disorders has been estimated at 72% for male and female detainees (Abram & Teplin, 1991; Abram et al., 2001).

Weaknesses

- --

Opportunities

- Current provider may partner with DCHD/IM or expand their own services

Threats

- May be provider resistance

c. Increase mental health services in-jail to address non-acute mental health issues

Strengths

- Prevention strategy
- Can use peer specialists

Weaknesses

- Jail is not the appropriate setting for mental health treatment

Opportunities

- DCHD/IM contracts for health services in JSO correctional facilities – can provide integrated program oversight

Threats

- Competing priorities

d. Partner DCHD/IM and River Region around individuals with co-occurring disorders held and treated at Matrix House

Strengths

- Addresses issue of co-occurring disorders
- Maximizes strengths of both agencies in collaborative treatment option
- No or low cost

Weaknesses

- --

Opportunities

- Matrix House may be adding beds

Threats

- May be provider resistance

e. Use in-jail peers for education, encourage referrals, promote recovery

Strengths

- Peer-support is recommended and supported through SAMHSA's Recovery Community Services Program
- Low cost

Weaknesses

- --

Opportunities

- Local, trained peer specialists

Threats

- May be provider resistance

f. Recommend SSI/SSDI Outreach, Access, and Recovery (SOAR) training and application processing through a single agency, especially for agencies that process few applicants

Strengths

- No cost
- Greater success rate for dedicated application specialists

Weaknesses

- --

Opportunities

- Several local agencies specialize in applications

Threats

- Provider resistance to use of single agency

g. Education to providers and consumers on the benefits of using health care surrogates

Strengths

- No or low cost
- Provides necessary, missing element of care
- Can be done by peer educators

Weaknesses

- --

Opportunities

- Can be done by peers

Threats

- ---

4. **Re-entry**

Possible strategies to implement at intercept: Funding for more FACT teams; Intensive Case Management (ICM) for deep-end users who cannot access FACT; Reentry programs for individuals with mental health and or substance abuse issues released from the PTDF; SOAR (as above in Post-initial Hearings: Jail); Health Care Surrogate (as above in Post-initial Hearings: Jail); Early intervention for acute and non-acute individuals in-jail and at release through health educators and peer counselors, in-reach and outreach with consumers and their families.

a. Funding for more FACT teams

Strengths

- FACT has been widely reported as effective (e.g. Lamberti et al., 2004)

Weaknesses

- Two teams in Jacksonville are always at/near capacity
- Deep-end program

Opportunities

- Intensive Case Management may be a viable alternative

Threats

- Very expensive
- Competing priorities

b. Intensive Case Management for deep-end users who cannot access FACT

Strengths

- Viable, less costly, alternative to individuals who cannot access FACT
- Existing models exist (Addy, et al., 2008)

Weaknesses

- Deep-end program

Opportunities

- Participants can be identified through JSO

Threats

- Competing priorities

c. Coordinate reentry programs for individuals with mental health and or substance abuse issues released from the PTDF

Strengths

- Preventive

Weaknesses

- Potentially large population to be served

Opportunities

- Grant funding
- JREC may provide a model

Threats

- Funding is currently focused on JREC, which addresses issues specific to felons
- Competing priorities

d. SOAR – as above in Post-initial Hearings: Jail

e. Health Care Surrogate – as above in Post-initial Hearings: Jail

f. Peer Specialists – as above, 3.e.

5. Community Corrections and Community Support Services

Possible strategy to implement at intercept: Early Intervention Offender Program (Non-Specialty First Appearance Program) (Pre-trial Services) – see above

6. Local Mental Health System

Possible strategies to implement at intercept: Local Mental Health Authority

Strengths

- Requires no additional funding, instead existing funds would be directed by the Authority, rather than DCF
- Cost-benefit to the City of Jacksonville, via control of funding and instituting programs that will save the City money over time, as well as minimizing duplication of services
- Supported by a recommendation made by the COJ Adult Mental Health Task Force in January 2006
- Locally defined needs, priorities, and advocacy driven by data and transparency

Weaknesses

- Resources/costs associated with start-up including:
  - Level of staffing, physical location, legal support, training, supplies, travel, consultation fees

Opportunities

- Local precedence in the Jacksonville Municipal Codes to establish such an Authority, with the primary example being the Jacksonville Children's Commission
- Several good models for local Authorities in other states including
  - California, which has a decentralized mental health service delivery program, with most direct services provided through the county mental health system; and
  - Ohio where the department is guided, in part, by the Mental Health Act of 1988, which emphasized local direction rather than state control
- DCF is currently outsourcing administrative services

Threats

- DCF's preferred organizational structure for the provision of administrative services is a Managing Entity
- DCF has officially begun promoting a Managing Entity in Northeast Florida

VIII. SUMMARY OF RESULTS

Intercept 1: The most significant service gaps in the continuum of care occur early in the intercept model. At Intercept 1, these include a lack of viable alternatives (such as Clubhouses and Living Rooms) to jail or the Crisis Stabilization Unit, insufficient Indigent Drug Program medications and medical oversight for the medically needy and lack of follow-up programs at release from the Crisis Stabilization Unit, such as the Baker Act Recovery and Support program. At **Intercept 2**, there is a clear absence of early intervention programs. Taken together, expanding Mental Health and Substance Abuse screening at the Pre-Trial Detention Facility, along with implementation of an Early Offender Intervention Program would allow the community to identify the prevalence and severity of mental health and substance abuse issues at intake to the PTDF, as well as evaluate resources available to eligible offenders. Multiple levels of intervention, including education, referral, and treatment, with oversight by Pre-Trial Services and involvement of peer specialists, are suggested here. **Intercept 3** is characterized by opportunities to implement several low- or no-cost services or service enhancements. These include addressing co-occurring disorders through the Habitual Misdemeanor Offender and Matrix House programs, using peer specialists as educators around health care surrogacy (to inmates and providers) and resources and referrals (to inmates), and processing Medicaid/Medicare applications through a central agency with SOAR-trained staff. **Intercept 4**, the re-entry intercept, could be enhanced by focused attention to the *jail population*, in addition to the returning prison population attended to by JREC. In this regard, jail can be understood as antecedent, or a point of intervention preliminary, to prison. Because FACT programs are so costly, and have very limited openings, Intensive Case Management for frequent, mentally ill recidivists may provide a more fiscally viable alternative. **Intercept 5,** Community Services and Supervision provides an opportunity for early intervention through Pre-Trial Services (JSO) or Pre-Trial Intervention (through FL DOC).

A local Mental Health Authority is suggested to provide community resources and support conducive to the primary prevention of mental illness and substance abuse and effective and responsible treatment of these conditions when they do arise. Providing an effective mental health system is the best approach to diverting people with mental illness and/or substance abuse issues from inappropriate placement in jail to effective community treatment and recovery programs.

Gaps and suggested interventions, structured around the Sequential Intercept Model are summarized in Appendix XI.

IX. STRATEGIC PLAN AND RECOMMENDATIONS

Strategic Plan: Local Mental Health Authority

Steadman and colleagues (1995; 1999; 2004) called attention to the fact that effective jail diversion programs are predicated on two critical elements:

1. An informed and enlightened criminal justice system; and
2. The presence of a comprehensive, responsive, and accountable behavioral health system.

These authors further noted that, "Without such a community-based behavioral health system, diversion efforts result in individuals being diverted "FROM" jail without the infrastructure of programs and services that allow the individual to be diverted "TO" effective community-based treatment."

The second of these two elements is not present in Jacksonville. Rather, the COJ Adult Mental Health Task Force concluded in 2006 that the local mental health system is, "…fragmented, unresponsive to client needs and serves less than 20% of those with even the most severe mental illnesses" and "Jacksonville's publicly funded mental health system accounts for over $56 million in direct costs alone. The $56 million is only about 20% of the cost of an adequate service system, which could run over $282 million if fully implemented" (2006: vii). The Task Force went on to recommend the establishment of a local Mental Health Authority, "empowered to affect the distribution of mental health funding, recommend statutory changes, hold public hearings, act as legislative liaison for mental health issues, and to provide standards and practices oversight" (2006: ix).

Our findings support the conclusions of the Task Force. The results of the 10 month planning process conducted by an agency outside the regular scope of providers, funders, and other key stakeholders revealed a host of systemic problems that not only obstructed the planning process, but cripple any potential for real systems change, including diversion planning, despite an extraordinarily dedicated workforce. Systemic problems include:

1. A lack of transparency
2. Limited data, which when they exist, are difficult to obtain and are primarily restricted to some cost and service data
3. Outcome data are virtually nonexistent
4. Contracts based on historic relationships, rather than performance
5. Strong competition for scarce resources
6. No coordinated system for seeking outside funding or advocating for Duval County interests
7. An absence of funded, coordinated local leadership across systems (mental health v substance abuse, adult v juvenile, civil v forensic)
8. No effective means of communication across systems of care
9. Community disenfranchisement

Consequently, decision-making, including treatment and funding decisions, is not driven by data. And collaboration, including data- and resource-sharing, as well as collaboration around grant opportunities is inhibited. Local interests are lost in an inefficient and costly bureaucracy and ultimately, the consumer and the community suffer.

For these reasons **our foremost recommendation for fundamental system change** is the development of a **local Mental Health and Substance Abuse Authority**, hereafter referred to as "the Authority."

Such an Authority would require no additional funding; instead existing funds that currently support DCF administration would be requested to support the Authority. In addition, such an Authority may free up jail space and/or reduce expenses for the JSO and make better use of county dollars for criminal justice and behavioral healthcare needs because they will be used in a planned and coordinated system. We envision that the Authority would have the following characteristics:

1. Locally constituted – with high constituent involvement, particularly by consumers and their families
2. Comprehensive – across child and adult, as well as civil and forensic systems
3. Decision-making power regarding funding based on:
    - Local needs assessment
    - Locally-defined priorities
    - Service and outcome data
    - Program evaluation
    - Provider use of evidence-based practices
4. Other characteristics to be defined by a workgroup convened for this purpose

A similar recommendation was made by the COJ Adult Mental Health Task Force in January 2006. That task force recommended the establishment of a Mental Health Coalition and a Mental Health Authority and further recommended that:

"The Mental Health Authority be an independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, recommend statutory changes and act as legislative liaison" (2006, 54).

Primary administrative duties of the Authority would include oversight of:

- Budget
- Contracts
- IT, data collection and reporting
- Planning
- Quality assurance
- Continuous Quality Improvement
- Education and advocacy
- Special initiatives
- Resource development

Currently, the Department of Children and Family Services (DCF) is designated the "Mental Health Authority" for Florida per the Florida Statutes (394). DCF and the Agency for Health Care Administration have executive and administrative supervision over all mental health facilities, programs, and services. Nonetheless, DCF has the power to contract to provide…services and facilities in order to carry out its responsibilities with departments, divisions, and other units of state government (394.457); moreover, municipalities or counties cannot be prohibited from "owning, financing, and operating a substance abuse or mental health program by entering into an arrangement with the district to provide, and be reimbursed for, services provided as part of the district plan" (State of Florida Statutes; 394.74 Part 5, 2009).

There is local precedence in the Jacksonville Municipal Codes to establish such an Authority, with the primary example being the Jacksonville Children's Commission (City of Jacksonville, Municipal Codes, 2009). Additionally, several good models for local Authorities have been implemented in other states including California (City of San Francisco, 2009), which has a decentralized mental health service delivery program, with most direct services provided through the county mental health system and Ohio (State of Ohio, 2009).

The Department of Children and families is currently promoting a Managing Entity, which is defined as, "…a corporation that is organized in this state, is designated or filed as a nonprofit organization under s. 501(c) (3) of the Internal Revenue Service, and is under contract to the Department to manage the day-to-day operational delivery of behavioral health services through an organized system of care. (State of Florida, 2009)

It is unclear if the operating costs of a managing entity will be financed through funds received from the department and hypothesized savings and efficiencies achieved by the managing entity and/or financed with a percentage of services dollars (currently anticipated at 4% – 8% of the total budget).

It is the consensus of this planning body that a Managing Entity, as proposed by DCF, is not the best solution for Jacksonville. Instead, our strategic planning process has directed us to lobby for the local Authority, which would allow maximum local control over local needs, priorities, and resources.

SECONDARY RECOMMENDATIONS

Much of the problem of incarcerating individuals with mental illness is related to their inability to pay for services and a lack of early intervention programs. These problems together lock us into a crisis-driven system.

Jail diversion programs can be thought of as occurring either *pre*-booking or *post*-booking. Pre-booking programs divert the individual prior to arrest, while post booking programs divert the individual from prosecution and incarceration after arrest. The remaining

recommendations are grouped into four areas: global (recommendations that can be implemented throughout the system); crisis; recovery; and prevention.

GLOBAL

- SOAR Training and Central Referring Agency (multiple intercepts)
- Peer Educators/Support (multiple intercepts)
- Health Care Surrogate (multiple intercepts)
- Electronic Health Record system (multiple intercepts)

CRISIS

- Respite Crisis Center (pre-booking)
- Peer-run Living Room/Club House (prebooking)
- Triage Center / Low Demand Shelter (pre-booking)

RECOVERY

- Baker Act Recovery and Support Services (BARS) (preventive)
- Mental Health Court (post-booking)
- Intensive Case Management for habitual offenders unable to secure placement in FACT (post-booking)

PREVENTION

- Expand Mental Health/Substance Abuse Screening at the JSO/DOC PTDF to identify individuals with non-acute mental illness (post-booking)
- Create a Non-Specialty First Appearance Program for Early Intervention (post-booking)
- Peer-run Living Room/Club House (preventive)

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APPENDICES

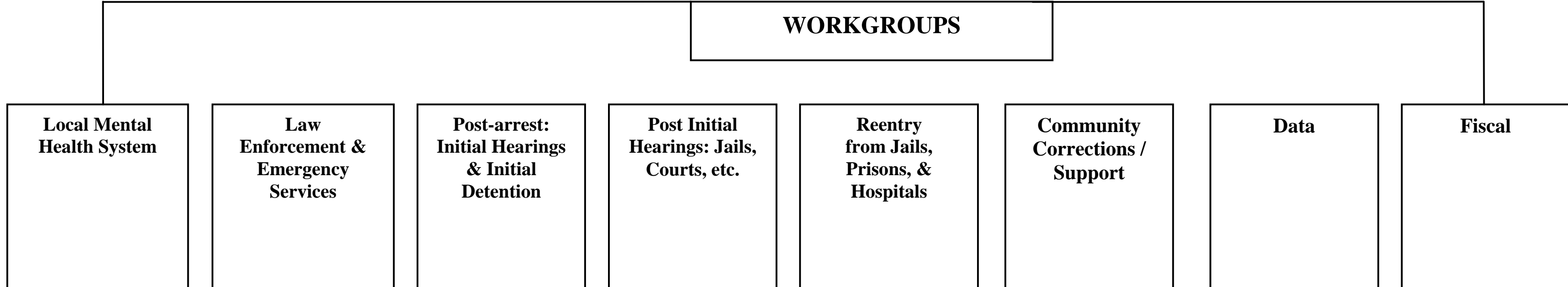
Appendix I: Organizational Structure

COUNTY PLANNING COUNCIL (Criminal Justice Coordinating Committee)
Project Liaison: Gordon Bass, JSO Director of Corrections

MEMBERSHIP: State Attorney, Harry Shorstein; Public Defender, Bill White; Circuit Court Judge, Fourth Judicial Circuit of Florida, Chief Judge Donald R. Moran; County Court Judge, Pauline Drayton; Sheriff, John Rutherford; State Probation Circuit Administrator, Patrice Bryant; Local Court Administrator, Joseph Stelma; City Council Chair, Ronnie Fussell; County Director of Probation, Colleen Reardon, Salvation Army; Local Substance Abuse Treatment Director, Gloria Hanania, River Region HS; Community Mental Health Agency Director, Gregory Sikora; DCF – Substance Abuse Program Office Representative, Cindy Vallely; Primary Consumer of Mental Health Services, Julie Livesay; Primary Consumer of Substance Abuse Services, Carlos Gill; Primary Consumer of Community-based Treatment Family Member, Marion Moore; Area Homeless Program Representative, John Bowls, The Sulzbacher Center; DJJ – Director of Detention Facility, Stepheny Durham; DJJ – Chief of Probation Officer, Edgar Mathis

OVERSIGHT COMMITTEE
Chair, Marion Moore
MENTAL HEALTH COALITION, CRIMINAL JUSTICE SYSTEM WORKGROUP

MATCHED MEMBERSHIP: Law Offices of Jenna Lopes, PA, Jenna Lopes; JSO, Chief of Jails Division, Chief Tara Wildes; Support Services Captain of the Jails Division, Tammy Morris; Classification Lieutenant of the Jails Division, David Kilcrease; Program Sergeant of the Jails Division, Wanda Boyd; DCHD, Director of Institutional Medicine, Dr. Max Solano; Medical QA Director, DCHD, Division of Institutional Medicine, Paula Burns; Renaissance Behavioral Health Systems, Greg Sikora; Gateway Community Services, Kathy Estlund; COJ, Behavioral & Human Services Division, Linda Reuschle/Tom Garwood; DCF , Gene Costlow / Karen Dixon; IM Sulzbacher Center for the Homeless, Clinic Manager, John Bowls; State Attorney's Office, 4th Circuit, Debbie Garret & Tina Bernardi; 4th Judicial Circuit of Florida, Joe Stelma or Stacey Cobbin; **Other Members:** Christine Small; Cindy Vallely; Julie Livesay, Robin Spires, Paul Stasi, Angela Vickers, Vicki Abrams, JSO, Chief Sloan Butler.



Appendix II: Duval County Safety Council, October 2007

DUVAL COUNTY
CRIMINAL JUSTICE, MENTAL HEALTH &
SUBSTANCE ABUSE REINVESTMENT GRANT
PLANNING COUNCIL

PLEASE PRINT

Honorable Harry Shorstein
STATE ATTORNEY OR DESIGNEE

Honorable Bill White
PUBLIC DEFENDER OR DESIGNEE

Honorable Donald R. Moran
CIRCUIT COURT JUDGE

Honorable Pauline Drayton
COUNTY COURT JUDGE

Gordon Bass, JSO Director of Corrections
POLICE CHIEF OR DESIGNEE

Honorable John Rutherford, Sheriff
SHERIFF OR DESIGNEE

Patrice Bryant
STATE PROBATION CIRCUIT ADMINISTRATOR

Joseph Stelma
LOCAL COURT ADMINISTRATOR

Honorable Ronnie Fussell
CITY COUNCIL CHAIR

Colleen Reardon, Salvation Army

COUNTY DIRECTOR OF PROBATION

Gloria Hanania, River Region Human Serv.

LOCAL SUBSTANCE ABUSE TREATMENT DIRECTOR

Gregory J. Sikora, Senior VP, RBHS

COMMUNITY MENTAL HEALTH AGENCY DIRECTOR

Cindy Vallely, Circuit 4 SAMH Program Supervisor

DCF - SUBSTANCE ABUSE PROGRAM OFFICE REPRESENATIVE

Julie Livesay

PRIMARY CONSUMER OF MENTAL HEALTH SERVICES

Carlos Gill

PRIMARY CONSUMER OF SUBSTANCE ABUSE SERVICES

Marion Moore, NAMI

PRIMARY CONSUMER OF COMMUNITY-BASED TREATMENT FAMILY MEMBER

John Bowls, The Sulzbacher Center

AREA HOMELESS PROGRAM REPRESENTATIVE

Stepheny Durham

DJJ - DIRECTOR OF DETENTION FACILITY

Edgar Mathis

DJJ – CHIEF OF PROBATION OFFICER

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Appendix III: Florida Technical Assistance Center Data

County Population and Social Characteristics	Duval 2006	Florida 2006
2010 Population	922775	19308066
2015 Projected Population	989908	20955858
Unemployment (%)	4.40	4.50
Uninsured (%)	13.70	4.67
Below Poverty (%)	12.10	12.80

Demographics within County	Duval 2006	Florida 2006
Male (%)	48.50	51.10
Female (%)	51.50	49.06
African American (%)	25.73	12.79
Asian (%)	2.51	0.90
White (%)	60.84	72.41
Other (%)	3.38	4.42
Hispanic (%)	3.79	7.83

Utilization of Mental Health, Substance Abuse, and/or Dual Diagnosis Services within County Population	Duval 2006	Florida 2006
Number of Individuals Utilizing Mental Health (MH) Services	16665	370499
Percentage of Individuals Utilizing Mental Health (MH) Services	1.81	1.92
Number of Individuals Utilizing Substance Abuse (SA) Services	5545	75750
Percentage of Individuals Utilizing Substance Abuse (SA) Services	0.60	0.39
Number of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	2792	65514
Percentage of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	0.30	0.34
Number of Individuals Utilizing Services for MH, SA and/or DDs Disorders	25002	511763
Percentage of Individuals Utilizing Services for MH, SA and/or DD Disorders	2.71	2.65
Number of Females Utilizing Mental Health and/or Substance Abuse Services	14473	295796

http://www.floridatac.org/files/countydata/0891381c-67e2-4c28-85b8-07d794e77f86.pdf

Percentage of Females Utilizing Mental Health and/or Substance Abuse Services	1.57	1.53
Number of Males Utilizing Mental Health and/or Substance Abuse Services	10528	212294
Percentage of Males Utilizing Mental Health and/or Substance Abuse Services	1.14	1.10
Percentage of African Americans Utilizing Mental Health and/or Substance Abuse Services	0.74	0.42
Percentage of Whites Utilizing Mental Health and/or Substance Abuse Services	0.97	1.24
Percentage of Others Utilizing Mental Health and/or Substance Abuse Services	0.93	0.48
Percentage of Hispanics Utilizing Mental Health and/or Substance Abuse Services	0.06	0.51
Number of Medicaid Enrolled Individuals	65254	1333928
Percentage of Medicaid Enrolled Individuals	7.07	6.91

Baker Act within County Population	Duval 2006	Florida 2006
Total Number of Baker Act Initiations	4673	94191
Number of Individuals	3416	70893
Number of Females	1696	33690
Percentage of Females	49.65	47.52
Number of Males	1665	36856
Percentage of Males	48.74	51.99

Crime Data	Duval 2006	Florida 2006
County Crime Rate (crimes per 100,000)		
Number of Arrests in County	94636	1574635
Number of Individuals Arrested in County	38839	638275
County Incarceration Rate (crimes per 100,000)		

Baker Act Amoung Arrestees within County from July 1, 2001 to Year of Arrest	Duval 2006	Florida 2006
Total Number of Baker Act Initiations	3023	60637
Number of Individuals	2714	49407
Number of Females	913	16836

Percentage of Females	33.64	34.08
Number of Males	1801	32571
Percentage of Males	66.36	65.92

Demographics of Arrestees within County	Duval 2006	Florida 2006
Male (%)	73.33	77.04
Female (%)	26.24	22.61
African American (%)	52.46	32.70
White (%)	46.28	66.24
Other (%)	1.27	1.06
Number of Medicaid Enrolled Individuals	12933	199631
Percentage of Medicaid Enrolled Individuals	33.30	31.28

Utilization of Mental Health, Substance Abuse, and/or Dual Diagnosis Services of Arrestees within County from July 1, 2001 to Year of Arrest	Duval 2006	Florida 2006
Number of Individuals Utilizing Mental Health (MH) Services	2565	43322
Percentage of Individuals Utilizing Mental Health (MH) Services	6.60	6.79
Number of Individuals Utilizing Substance Abuse (SA) Services	3124	44585
Percentage of Individuals Utilizing Substance Abuse (SA) Services	8.04	6.99
Number of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	5261	101341
Percentage of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	13.55	15.88
Number of Individuals Utilizing Services for MH, SA and/or DDs Disorders	10950	189248
Percentage of Individuals Utilizing Services for MH, SA and/or DDs Disorders	28.19	29.65
Number of Females Utilizing Mental Health and/or Substance Abuse Services	3771	58766
Percentage of Females Utilizing Mental Health and/or Substance Abuse Services	9.71	9.21
Number of Males Utilizing Mental Health and/or Substance Abuse Services	7179	130482
Percentage of Males Utilizing Mental Health and/or Substance Abuse Services	18.48	20.44
Percentage of African Americans Utilizing Mental Health and/or Substance Abuse Services	10.96	8.10
Percentage of Whites Utilizing Mental Health and/or Substance Abuse Services	9.42	11.64
Percentage of Others Utilizing Mental Health and/or Substance Abuse Services	7.31	5.81

Percentage of Hispanics Utilizing Mental Health and/or Substance Abuse Services	0.50	4.09

Baker Act of Arrestees with Severe Mental Illness (SMI) within County from July 1, 2001 to Year of Arrest	Duval 2006	Florida 2006
Total Number of Baker Act Initiations	1340	28602
Number of Individuals	1126	22344
Number of Females	404	8451
Percentage of Females	35.88	37.82
Number of Males	722	13893
Percentage of Males	64.12	62.18

Utilization of Mental Health, Substance Abuse, and/or Dual Diagnosis Services of Arrestees with Severe Mental Illness (SMI) within County from July 1, 2001 to Year of Arrest	Duval 2006	Florida 2006
Number of Individuals Utilizing Mental Health (MH) Services	665	12158
Number of Individuals Utilizing Substance Abuse (SA) Services	.	.
Percentage of Individuals Utilizing Substance Abuse (SA) Services	.	.
Number of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	1589	32633
Percentage of Individuals Utilizing Dual Diagnosis Disorders (DD) Services	70.50	72.86
Number of Individuals Utilizing Services for MH, SA and/or DDs Disorders	2254	44791
Number of Females Utilizing Mental Health and/or Substance Abuse Services	946	17961
Percentage of Females Utilizing Mental Health and/or Substance Abuse Services	41.97	40.10
Number of Males Utilizing Mental Health and/or Substance Abuse Services	1308	26830
Percentage of Males Utilizing Mental Health and/or Substance Abuse Services	58.03	59.90
Percentage of African Americans Utilizing Mental Health and/or Substance Abuse Services	42.19	26.45
Percentage of Whites Utilizing Mental Health and/or Substance Abuse Services	48	54.87
Percentage of Others Utilizing Mental Health and/or Substance Abuse Services	7.94	7.48
Percentage of Hispanics Utilizing Mental Health and/or Substance Abuse Services	1.86	11.20
Number of Medicaid Eligible Individuals	1669	30947
Percentage of Medicaid Eligible Individuals	74.05	69.09

Appendix IV: DCF Funding for Duval County

DUVAL COUNTY
SUBSTANCE ABUSE & MENTAL HEALTH
Contracted Providers

Agency Name	Programs	Activity	Contract Amt	Cost Centers
Gateway Community Services	Adult Substance Abuse	Detox	1,120,894	SA Detox
		Prevention	98,065	Prevention, Information & Referral
		Treatment and Aftercare	2,340,459	Assessment, Case Management, Crisis Support/Emergency, Day Care, Day/Night, Intervention, Outpatient, Outreach, Residential Level II, Residential Level IV, Respite, Aftercare, Room and Board with Supv. II
	Children's Substance Abuse	Detox	840,646	SA Detox
		Prevention	195,564	Prevention
		Treatment and Aftercare	1,925,961	Assessment, Case Management, Intervention, Outpatient, Residential Level II, Aftercare,
		TOTAL	**6,521,589**	
River Region Human Services	Adult Substance Abuse	Prevention	281,272	Prevention
		Treatment and Aftercare	2,258,323	Assessment, Case Management, Crisis Support/Emergency, Day/Night, Intervention, Methadone, Outpatient, Outreach, Residential Level II, Residential Level IV, TASC, Aftercare
	Children's	Prevention	723,964	Prevention

	Abuse	Treatment and Aftercare	235,836	Case Management, Intervention, Outpatient, Aftercare
	Adult Mental Health	Recovery & Resiliency	1,083,028	Room and Board with Supv, Case Management, Outpatient, Intervention, Drop In Center, Outreach, Supproted Housing/Living, Incidental Expense
		TOTAL	**4,582,423**	
Mental Health Resource Center	Adult Mental Health	Emergency Stabilization	4,852,505	Crisis Stabilization, Crisis Support/Emergency
		Recovery & Resiliency	5,075,650	Residential Level IV, Case Management, Intensive Case Management, Intervention, Medical Services, Outreach, Supported Employment, Information and Referral, Incidental Expense, FACT and Self Directed Care
	Children's Mental Health	Emergency Stabilization	1,369,323	Crisis Stabilization, Crisis Support/Emergency
	Children's Substance Abuse	Treatment and Aftercare	110,177	Crisis Support/Emergency, Intervention and Outpatient
		TOTAL	**11,407,655**	
Northwest Behavioral Health	Adult Mental Health	Recovery & Resiliency	1,004,814	Comprehensive Community Service Team, Case Management, Medical Services, Outpatient and Incidental Expense
	Children's Mental Health	Recovery & Resiliency	214,075	Case Management and Outpatient
		TOTAL	**1,218,889**	
Child Guidance Center	Adult Mental Health	Recovery & Resiliency	66,491	Case Management, Outpatient, In Home and On Site
	Children's Mental Health	Emergency Stabilization	346,747	Crisis Support/Emergency (Diversion)
		Recovery &	329,370	Case Management, Medical Services, Outpatient, In

		Resiliency		Home and On Site, Respite and Incidental Expense
		TOTAL	**742,608**	
United Way of NE Florida	Children's Mental Health	Recovery & Resiliency	71,956	Information and Referral
	Children's Substance Abuse	Treatment and Aftercare	71,957	Information and Referral
		TOTAL	**143,913**	
Community Rehabilitation Center	Adult Mental Health	Recovery & Resiliency	260,824	Residential Level IV, Drop In Center, Incidental Expense
		TOTAL	**260,824**	
Volunteers of America	Adult Mental Health	Recovery & Resiliency	234,950	Supported Housing
		TOTAL	**234,950**	
Lutheran Social Services	Adult Mental Health	Recovery & Resiliency	304,738	Rep Payee
		TOTAL	**304,738**	
Urban Jax	Adult Mental Health	Recovery & Resiliency	214,926	Guardianship, UAC
		TOTAL	**214,926**	

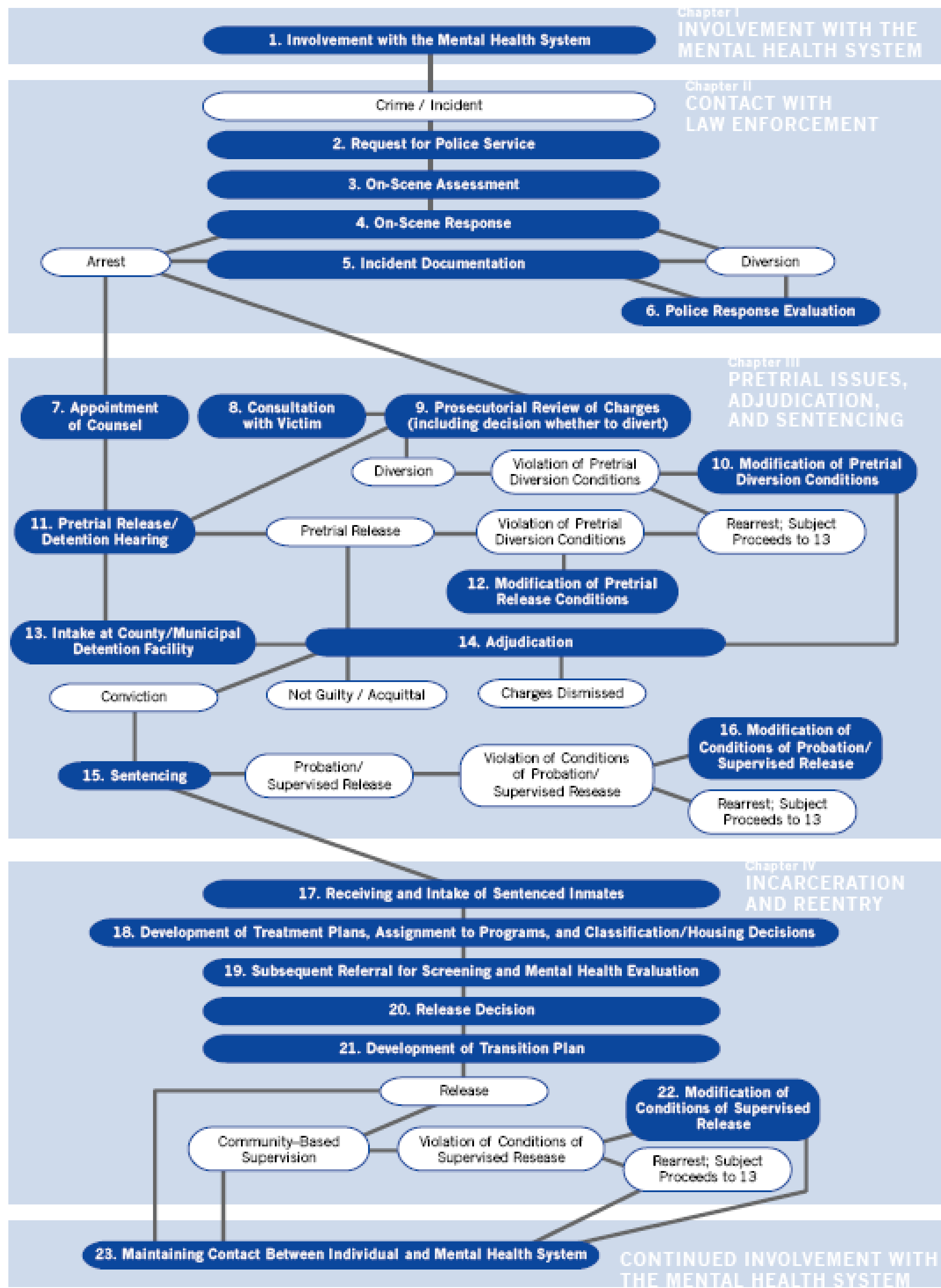
FY 08-09

COJ Funding		Agency Budget
***Renaissance Behavioral Health Systems** (743-1883)*		
Mental Health Center of Jacksonville-------3333 W. 20th St. (695-9145) North & West Jax		
Emergency Evaluation/Services-ES (City funds portion of staff salaries and benefits)	$298,570	$668,098
Crisis Stabilization Unit (CSU)---Operating 35 beds-licensed for 60 (Funding for portion of budgeted expenses)	$455,304	$4,278,432
Forensic (Chapter 916) Case Management-countywide (Funding for portion of staff salaries)	$56,350	$376,480
In-jail Team-Diversion/Continuity of care (City funds majority of expenses including 2 staff positions)	$87,341	$93,367
Medication Management-Psychiatric Outpatient Services (Funding for portion of staff salaries/benefits)	$407,301	$1,129,924
Subtotal	**$1,304,866**	$6,546,301
Mental Health Resource Center----------11820 Beach Blvd. (642-9100) Arl., SS., Beaches		
Emergency Evaluation/Services-ES (City funds portion of staff salaries/benefits)	$95,657	$542,580
Crisis Stabilization Units-Total beds 52		
Adult beds (24)	$168,399	$3,174,233
Children's Beds (28)	$308,732	$2,922,022
Medication Management-Psychiatric Outpatient Services (Funding for portion of staff salaries)	$194,470	$1,003,239
LINK/Homeless Mentally Ill Program-PATH grant through state (Funding for portion of staff salaries)	$63,269	$459,786
Homeless Reentry-START-Enhancement for LINK--Med Man. (Began in 06-07 thru City funding)	$167,000	$167,000
RCI Employment Services-Vocational Outreach (Position funded by the City)	$43,535	$44,233
Subtotal	**$1,041,062**	$8,313,093
***River Region Human Services** (899-6300)*		
Consumer Drop-in Centers: Springfield Center (359-2511) and the River House (726-0026)	$45,543	$281,164

(City funds peer salaries)

Northwest Behavioral Health Services *(781-7797)*		
Supported Housing/Community Support (Funding for portion of staff salaries and housing stipends)	$42,263	$383,521
Community Rehabilitation Center *(358-1211)*		
Therapeutic Foster Care Program (Housing) Last funded in FY 06-07	$0	
United Way of Northeast Florida *(390-3200)*		
2-1-1 telephone information, referral, and crisis intervention (Funding for portion of staff salaries/benefits)	$125,984	$656,979
TOTAL	**$2,559,718**	

Appendix VI: Consensus Project Flow Chart



Source: Consensus Project

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Other Materials:

- The Florida Crisis Intervention Team (CIT) Program (document)
- Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program. Bureau of Justice Assistance. (document)
- SOAR: A Case Manager's Manual for Assisting Adults Who Are Homeless, with Social Security Disability and Supplemental Security Income Applications
- Lee County Triage/Low Demand Shelter

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Appendix IX: Electronic Health Exchange/ Health Information Network Powerpoint Presentation

Data Sharing

Radley Remo
Institute for Health, Policy and Evaluation Research
February 11, 2009

1

Defined

- The academic/research definition – that allows for transparency and replication of studies and results.
- For our purposes, we ultimately want to improve client/individual care and reduce cost.
  - Program planning and evaluation

2

Critical Points

- Timeliness
  - Immediate
  - Delay
- Level of data
  - Aggregate
  - Individual
- Community Participation
  - All providers/stakeholders involved

3

Benefits

- Increased pool of information resources available to all projects and agencies
- More time and resources freed up (less time spent on gathering information)
- Ability to use data produced by other programs can encourage collaboration
- Reduce Cost (long run)

4

Challenges

- Cost (immediate)
  - Expensive
- Willingness to share
- Legal Issue
  - HIPAA

5

Legislation (1)

- Chapter 163.62 Florida Statute, **163.62 Collaborative client information system; establishment.--** Notwithstanding any general or special law to the contrary, the agencies of one or more local governments may establish a collaborative client information system. State agencies and private agencies may participate in the collaborative information system. Data related to the following areas may be included in the collaborative information system, although the system is not limited to only these types of information: **criminal justice**, juvenile justice, education, employment training, **health**, and **human services**.

6

Legislation (2)

- Allows governmental and certain private agencies to share information.
- It was created with the mission of enhancing the delivery of services/programs to Florida residents by encouraging communication and collaboration among all related community providers, organizations, interested government agencies, and educational institutions.

7

What's going on in the state?

- Pinellas County Data Collaborative
- Currently the Pinellas County Board of County Commissioners, the Pinellas Clerk of Circuit Court, the Pinellas Office of County Attorney, the Pinellas County Sheriff Office, the Sixth Judicial Circuit Court of Florida, the Pinellas Department of Social Services the Juvenile Welfare Board of Pinellas County, the Florida Department of Children and Families SunCoast Region, Florida Department of Juvenile Justice, and the Louis de la Parte Florida Mental Health Institute (FMHI), a part of the University of South Florida, are the primary members of the collaborative.
- Used for planning and evaluation (not individual level data exchange)
- http://psrdc.fmhi.usf.edu/pinellas.htm

8

What's going on locally?

- NEFIN
  - Social services
  - Homeless database
  - Operational
- JHIN
  - Uninsured and Medicaid health data
  - Operational
- NEFRHO
  - Insured health data
  - Not operational

9

Recommendations

- Get involved
- Determine who should represent the MH Coalition
- Create a data subcommittee
- Recruit decision makers to formulate data sharing plan (what data to share, with what agencies etc.)

10

Appendix X: PDTF, DCHD/IM Mental Health Screening Tool

Division of Institutional Medicine's Mental Health screening Tool

	Question		
☐	Have you been diagnosed with Major Depression, Bipolar Disorder or Schizophrenia? (Specify)	Yes	No
☐	Have you ever been in a hospital for emotional or mental health problems, besides overnight stay?	Yes	No
☐	Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems besides Zanax, Valium, Ativan or Klonopin?	Yes	No
☐	Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?	Yes	No
☐	Do you currently feel that other people know your thoughts and can read your mind?	Yes	No
☐	Have you currently lost or gained as much as two pounds a week for several weeks without even trying?	Yes	No
☐	Have you or your family or friends noticed that you are currently much more active than you usually are?	Yes	No
☐	Do you currently feel like you have to talk or move more slowly than you usually do?	Yes	No
☐	Have there currently been a few weeks when you felt like you were unless or sinful?	Yes	No
☐	Have you ever attempted suicide?	Yes	No
☐	Have you ever considered suicide?	Yes	No
☐	Have you recently experienced a significant loss (job, relationship, death of family member/close friend, etc.)?	Yes	No

☐ Do you feel that there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)? Yes No

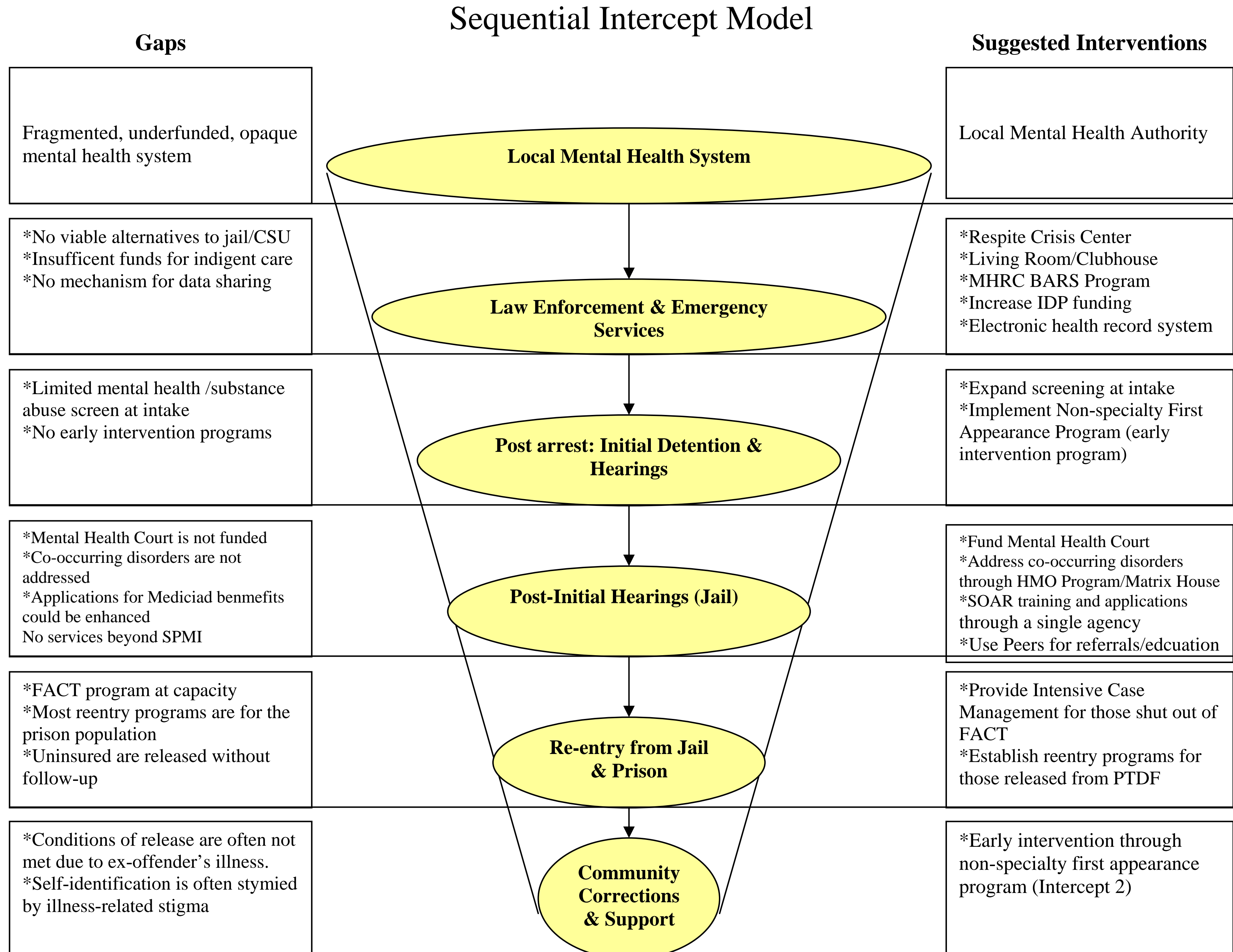
☐ Are you thinking of killing yourself? Yes No

In the last 48 hours, have you taken an overdose of any medications, including OTC? (Specify)

☐ If yes to Question 1 and 2; or 1 and 3; or to at least 4 of the questions 4-9; or if you feel it is necessary for any other reason, check here to refer to Mental Evaluation

☐ If yes to Question 14; or to at least 2 of Questions 10-13; or you feel it is necessary for any other risk factor identified during the Intake Process - check here and refer patient to Self-Harm

Appendix XI: Sequential Intercept Model



Appendix XII: Additional Resources

- Florida Council for Community Health. Available at: http://www.fccmh.org/
- Florida Partners in Crisis. Available at: http://www.flpic.org/index.php
- The Consensus Project. Available at: www.consensusproject.org
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Appendix XIII: SOAR Power Point Presentations

Part I

Starting A SOAR Project – A Tool To Reduce Homelessness

…For State or Local Agency Administrators

Revised 4/18/07

http://www.dshs.state.tx.us/mhpac/documents/Starting%20a%20SOAR%20Project%204_18_07.ppt

1

SSI and SSDI

- SSI: Supplemental Security Income; federal benefit rate is $623 per month in 2007; provides Medicaid in most states
- SSDI: Social Security Disability Insurance; amount of benefit dependent on earnings put into SSA system; Medicare provided after two years of eligibility in most instances
- The disability determination process for both programs is the same; when one applies for SSI, they are usually review by SSA for their eligibility for SSDI as well.

2

Why is Access to SSI and SSDI Important for Homeless Recipients?

- SSA disability benefits can provide access to:
  - –Housing
  - –Income
  - –Health insurance

3

Why Is Access to SSI and SSDI Important for State and Localities?

- Homeless people are frequent users of expensive uncompensated health care.
- Providers can recoup the cost of uncompensated health expenses from Medicaid for up to 3 months prior to date of SSI application.
- States that fund health care for low income and/or disabled persons can save state dollars once Medicaid is approved.

4

Why Is Access to SSI and SSDI Important for State and Localities?

- States and localities can recoup from SSA the cost of public general assistance provided to homeless applicants during the SSI/SSDI determination period.
- SSI, SSDI and Medicaid bring federal dollars into states, localities and community programs.

5

The Problem

- The SSI application process is difficult for people who are homeless, many of whom have mental illnesses and co-occurring substance use disorders
- Only about 10-15 percent of those who apply are typically approved on initial application
- Appeals take years and many potentially eligible people give up and do not appeal

6

Why Is Access To SSI So Difficult?

- People who are homeless need assistance to apply for SSI
- They need adequate assessment and documentation of how their disabling conditions limit their ability to work
- Providers who assist SSI applicants need staff who understand the disability determination process and who have time to assist in all aspects of developing the application
- Relationships with SSA, the state Disability Determination Service (DDS), community medical providers and others are essential to changing the outcomes of SSI/SSDI applications

7

What We Know Is Possible…

Approval rates of 65-95%

on initial application

for homeless applicants

8

SOAR Technical Assistance Initiative

- SOAR stands for "SSI/SSDI Outreach, Access and Recovery"
- Strategy to help States and communities increase access to SSI and SSDI for people who are homeless through training, technical assistance and strategic planning
- Includes use of SAMHSA's *Stepping Stones to Recovery* training curriculum

SOAR States

- Arizona
- Colorado
- Connecticut
- District of Columbia
- Florida
- Georgia
- Hawaii
- Indiana
- Kentucky
- Los Angeles County*
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Montana
- Nevada
- New Jersey
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Tennessee
- Utah
- Virginia
- Washington

Stepping Stones to Recovery Training Curriculum

- Based on success of University of Maryland Medical System Baltimore SSI Outreach Project
- Over a 10 year period, achieved success rate on application of 96% for those project staff believed to be eligible
- Comprehensive approach to individual's needs with income as the "hook"
- Engagement, relationship, assessment are integral parts of project and curriculum

How Is This Model Different?

- Case managers actively assist applicants
- Step-by-step explanation of SSI application and disability determination process
- Focuses on the initial application – "Get it right the first time!"
- Avoids appeals whenever possible
- Focuses on documenting the disability

What Does It Take?

- Ensure adequate staffing
- Use the SOAR Critical Components (www.prainc.com/SOAR/about/CriticalComponentsChart.pdf)
  - Focus on the initial application
  - Become an applicant's representative (SSA Form 1696)
  - Work closely with community medical providers
  - Reach out to hospital and clinic medical records departments
  - Reduce the need for consultative exams
  - Develop medical summary reports signed by a physician or psychologist
- Provide training and quality control
- Collaborate with SSA and DDS
- Collect and report on outcomes

13

How Do You Make This Happen?

1. Reallocate existing resources. Try it on a small scale.
   - Serving people who have an income and health insurance makes it easier and quicker to access housing, treatment, and other supportive services.
   - Being able to get people on SSI and/or SSDI and Medicaid in 90 days or less frees up resources to assist other individuals.
   - Time spent up front on assessment and benefits acquisition can be an effective way to engage people who are homeless for long periods of time; and to organize and provide housing, treatment and other services to them

14

How Do You Make This Happen?

2. Look for partners that stand to benefit from increased access to SSI, SSDI and Medicaid:
   - Mental health centers and primary care clinics
   - Hospitals – public or private
   - Jails or prisons that are focused on reentry
   - State or County general assistance programs
   - Housing programs – public and private
   - Local 10-year plans to address

15

SSI Outreach Can Make A Big Difference…

In Denver, without a comparable SOAR model…

- Only 10% of homeless applicants were approved for SSI/SSDI on initial application
- With a designated DDS staff person focused on applications from homeless adults, this rose to 20%
- With a community provider assisting applicants, the rate rose to 75%

16

Initial SOAR Impacts

- 24 States are implementing local SSI outreach initiatives with State-level support for training and tracking outcomes
- 92 new trainers certified to conduct Stepping Stones to Recovery trainings
- 129 trainings in 79 cities in first year
- More than 4,000 direct service staff trained

17

Preliminary SOAR Outcomes

- In Nashville, 97% of their first 33 applications were approved in an average of 59 days
- At NY's Sing Sing prison, 46 of the 52 (88%) pre-release SSI applications were approved in 93 days on average
- Across 11 states, 506 SSI applications – 62 percent of those assisted – were approved in an average of 96 days or less.
- On average, the people receiving these benefits had been homeless 33 months.
- Approval rates are highest in places where more SOAR critical components are in place.

18

SSI Improves Access to Housing

- In Covington, KY, 71% of homeless persons approved for SSI were housed in 7 days or less.
- In Columbus, GA, 100% of successful SSI applicants were housed
- In Nashville, TN, 56% of SSI recipients were housed within 30 days after being homeless an average of 77 months.

19

Cost Savings

- Utah recovered $170,000 in general assistance from SSA during the first four months of SOAR in one area of the state
- In Covington, KY, a local hospital partially funded the local SSI outreach project recouping its initial investment in less than a year by recovering uncompensated care from Medicaid
- San Francisco Dept. of Public Health estimates that for every $1 invested in SSI outreach, they recoup $5 in Medicaid reimbursement for uncompensated care
- In *one year* in Baltimore, 20 newly approved SSI recipients received $300,000 in Medicaid reimbursed care from *one* hospital system that would otherwise have

20

Conclusion

- Focusing on expediting benefits works!
- Its a win-win for the individual, for states and localities, and for community programs
- A major tool in recovery from homelessness

21

For More Information on SOAR and *Stepping Stones to Recovery*

Visit the SOAR website at
www.prainc.com/soar

Or contact:
Deborah Dennis,
Vice President/SOAR Project Director
Policy Research Associates, Inc.
Delmar, NY
518-439-7415, ext. 238
ddennis@prainc.com

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Texas Homeless Network

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Part II

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STARTING A SOAR PROJECT:

A TOOL TO REDUCE AND PREVENT HOMELESSNESS

Revised March 2009

http://www.ncceh.org/attachments/contentmanagers/27/StartingSOARProject3-09.ppt#330,9,SSI Improves Access to Housing

North Carolina Coalition to End Homelessness: NC SOAR

SSI and SSDI

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	SSI	SSDI
Program	Supplemental Security Income	Social Security Disability Insurance
Program Type	Need	Entitlement
Federal Income Benefit	$674/month	Dependent on earnings paid into SSA system
Associated Insurance Benefit	Medicaid	Medicare after 2 years

- While eligibility requirements are different for each program, the disability determination process for both programs is the same; one may apply for both programs simultaneously.

Why is Access to SSI and SSDI Important for Homeless Recipients?

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- Disability benefits can provide access to:
  - Income
  - Health Insurance
  - Housing
  - Stability

Why Is Access to SSI and SSDI Important for State and Localities?

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- Uninsured homeless people with chronic illnesses are frequent users of expensive uncompensated health care.
- Providers can recoup the cost of uncompensated health expenses from Medicaid for up to 3 months prior to date of SSI application.
- Institutions that cover indigent health care costs can save state dollars once Medicaid is approved.
- SSI, SSDI and Medicaid bring federal dollars into states, localities and community programs.
- Cost-benefit studies have proven that communities can save money when individuals are housed and can access less costly services.

The Problem

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- The SSI application process is difficult for people who are homeless, many of whom have mental illnesses and co-occurring substance use disorders
- Only about 10-15 percent of those who apply are typically approved on initial application
- Initial applications are often denied because they lack vital medical and functioning information
- Appeals take years and many potentially eligible people give up and do not appeal

Why Is Access To SSI/SSDI So Difficult?

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- The application process is complex and can be difficult to navigate. People who are homeless need assistance in order to complete a successful SSI/SSDI application
- Medical records for transient persons are often hard to track down or are insufficient for documenting disability. Adequate assessment and documentation is needed explaining how one's disabling conditions limits one's ability to work
- Providers who assist SSI/SSDI applicants need staff who understand the disability determination process and who have time to assist in all aspects of developing the application
- Relationships with the Social Security Administration (SSA), the state Disability Determination Service (DDS), community medical providers and other key players are essential to changing the outcomes of SSI/SSDI applications

What We Know Is Possible…

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Approval rates of 70-98%
on initial application
for homeless applicants and begin to receive benefits within 60-90 days of application

Preliminary SOAR Outcomes

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- In Nashville, 98% of their first 87 applications were approved in an average of 56 days
- At NY's Sing Sing prison, 89 (88%) pre-release SSI applications were approved in 59 days on average
- In North Carolina, 73% of our first 38 applications were approved in an average of 70 days
- On average, the people receiving these benefits had been homeless 33 months.
- Approval rates are highest in places where more SOAR critical components are in place.

SSI Improves Access to Housing

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- In Covington, KY, 71% of homeless persons approved for SSI were housed in 7 days or less.
- In Columbus, GA, 100% of successful SSI applicants were housed in 30 days.
- In Nashville, TN, 56% of SSI recipients were housed within 30 days after being homeless an average of 77 months.

Cost Savings

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- In Covington, KY, a local hospital partially funded the local SSI outreach project recouping its initial investment in less than a year by recovering uncompensated care from Medicaid
- San Francisco Dept. of Public Health estimates that for every $1 invested in SSI outreach, they recoup $5 in Medicaid reimbursement for uncompensated care
- In *one year* in Baltimore, 20 newly approved SSI recipients accounted for $300,000 in Medicaid reimbursable care from *one* hospital system.

How Is This Model Different?

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- Case managers actively assist applicants
- Provides step-by-step explanation of SSI application and disability determination process
- Focuses on the initial application – "Get it right the first time!"
- Avoids appeals whenever possible
- Focuses on documenting the disability

What Does It Take?

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Work towards NC SOAR Community Certification

- Ensure adequate staffing
- Use the SOAR Critical Components
  - Focus on the initial application
  - Become an applicant's representative (SSA Form 1696)
  - Work closely with community medical providers
  - Reach out to hospital and clinic medical records departments
  - Develop medical summary reports signed by a physician or psychologist
- Provide quality control
- Collaborate with SSA and DDS
- Collect and report on outcomes

How Do You Make This Happen?

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1. Reallocate existing resources. Try it on a small scale.
   You will begin to see these benefits:
   - Being able to get people on SSI and/or SSDI and Medicaid in 90 days or less frees up resources to assist other individuals.
   - Serving people who have an income and health insurance makes it easier and quicker to access housing, treatment, and other supportive services.
   - Time spent up front on assessment and benefits acquisition can be an effective way to engage people who are homeless for long periods of time; and to organize and provide housing, treatment and other services to them.

How Do You Make This Happen?

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2. Involve all partners that stand to benefit from increased access to SSI, SSDI and Medicaid:
   - Mental health centers and primary care clinics
   - Hospitals – public or private
   - Jails or prisons that are focused on reentry
   - State or County general assistance programs
   - Housing programs – public and private
   - Local 10-year plans to address homelessness

For More Information…

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Visit
www.ncceh.org/soar

Or contact:

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ACKNOWLEDGEMENTS

This work was facilitated and greatly improved by the generous participation of the following behavioral health advocates:

Gene Costlow
Julia Dorcey
Kathy Estlund
Wesley Evans
David Hale
Jessica Johnson
David Kilcrease
Julie Livesay
Jenna Lopes
Marion Moore
Rusty Park
Linda Reuschle
Greg Sikora
Christine Small
Tara Wildes