(Tab 5: Project Design and Implementation)

3.8.5 Tab 5: Project Design and Implementation

3.8.5.1 For both Planning Grants and Implementation and Expansion Grants, a description of the planning council or committee, including:

3.8.5.1.1 Composition of the planning council or committee, including the role of each member as stakeholder, consumer, etc. demonstrating compliance with s. 394.657(2)(a), F.S. If the Council does not currently meet the statutory requirements, provide a detailed explanation of how and when the Council intends to rectify the deficiency; and

As set forth in s. 394.657(2)(a), F.S., the Hillsborough Board of County Commissioners designated the County Public Safety Coordinating Council (PSCC) established under s. 951.26. The PSCC, in coordination with the County offices of Criminal Justice, make formal recommendations to the Board of County Commissioners regarding how the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program may best be implemented within the community. Hillsborough County employs community liaisons specifically to work with African Americans, Hispanics, Asian Americans, the Disabled, and the criminal justice community. The Criminal Justice Liaison's mission is to facilitate communication, encourage collaboration and advance common interests of the adult and juvenile criminal justice systems to reduce crime. Criminal Justice Unit staff work with the PSCC, established under Chapter 951.26, Florida Statutes, and its membership of high level stakeholders including Hillsborough County Sheriff's Office, Chief Judge, State Attorney, Public Defender, Clerk of Court, citizens, substance abuse treatment providers, and the criminal justice community. The PSCC has expanded the DCF Reinvestment Grant Subcommittee to include community-based mental health providers, consumers, family members, faith-based organizations, the Florida Department of Children and Families Substance Abuse and Mental Health (SAMH) Office ("Mental Health Authority"), Agency for Health Care Administration (Medicaid), managed care networks, and County health and social service planners. The members' names, titles and roles are listed in the table below.

Table 5

DCF Reinvestment Grant Subcommittee	
NAME	**TITLE**
Mark Ober	State Attorney or Designee
Lawrence Lefler	County Court Judge
Gina Justice	Local Court Administrator or Designee
Kevin Beckner	County Commission Chair
David Gee	Sheriff or Designee
Antoinette Hayes-Triplett	Area Homeless or Supportive Housing Program Rep
Marcus Wilson	DJJ - Director of Detention Facility or Designee
April May	DCF- Substance Abuse & Mental Health Program Office Rep
Joe Rutherford	Community Mental Health Agency Director or Designee
Mary Ann Watson	Primary Consumer of Community-Based Treatment Family Member
Julianne Holt	Public Defender or Designee
Ronald Ficarrotta	Circuit Court Judge
Corlis Campbell	State Probation Circuit Administrator or Designee
Stephen J. Hogue	County Director of Probation
Eric Ward	Police Chief or Designee
David Gee	Chief Correctional Officer
Judy Roysden	DJJ - Chief of Probation Officer or Designee
Susan Lang	Primary Consumer of Mental Health Services
Mary Lynn Ulrey	Local Substance Abuse Treatment Director or Designee
Rick Buhl	Primary Consumer of Substance Abuse Services

3.8.5.1.2 Planning Council's activities, including the frequency of meetings for the previous 12 months and future scheduling of meetings.

The Hillsborough County PSCC has met quarterly since its establishment in 2007 and will continue to meet quarterly. The PSCC functions as the planning council and consists of 22 members whose names and roles are listed in Attachment A. The PSCC was established under 952.26 F.S. and is in compliance with 394.657(2)(a) F.S. Mental health and substance abuse consumers will be called upon for their vital input in the planning and efficacy of proposed programs. The PSCC has maintained the *DCF Reinvestment Grant Subcommittee* which has been pivotal in the establishment of jail diversion, re-entry, and treatment servicing programs instituted through grant mechanisms for this population. Defining a local assessment center concept, working towards ensuring reentry and diversion services are sustainable, and implementing a cross-system pre-arrest behavioral health system promoting diversion opportunities with providers have been strategic goals for this Committee and these efforts align with the Country's strategic plan.

3.8.5.2-4 Planning Grants Only Describe and provide a timeline for the proposed planning activities and expected milestones, including: NA

3.8.5.3 Implementation and Expansion Grants Only

3.8.5.3.1 Provide a copy of the existing Strategic Plan, which must include at minimum, all of the elements in Appendix A.

Please see Appendix A, and attached.

3.8.5.3.2 Provide a description of the Strategic Plan, including progress toward implementing the plan, when the plan was last reviewed or updated, and any challenges or barriers toward implementation.

In developing the 2006 Strategic Plan, Hillsborough County utilized the Sequential Intercept Model, redone in 2015 and reviewed in spring, 2016. This Model is based on the concept that there are various "windows of opportunity" where the system intercepts with community services, and people can be "filtered" out and provided appropriate community services and supports that will interrupt the recycling process within the criminal justice system. Using the Sequential Intercept Model, the County has moved systematically through the criminal justice process, making various system and service level changes at the intercept points and creating timely interventions that could possibly prevent people from entering or penetrating deeper than necessary into the criminal justice system. The last Sequential Intercept mapping was completed in January of 2015. It identified five priorities for local criminal justice and behavioral health systems; Develop a Central Receiving Facility, Expand Crisis Intervention Team training for law enforcement officers, Re-establish a short term residential diversion and step down program that had been previously closed, Improve co-occurring treatment capabilities across providers, and Re-establish a Court Liaison position. To date, stakeholders have made significant strides or achieved all but one of these priorities. Hillsborough County

has yet to be able to re-establish a short term residential diversion and step down program similar to the one that closed. Within funding under this grant, a Court Mental Health Liaison position will be established.

Grants from the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Bureau of Justice Administration (BJA) have allowed us to map the system and develop a strategic plan as well as implement a variety of programs to divert people with mental illness, substance abuse disorders, and co-occurring mental health and substance abuse disorders away from our criminal justice system and jail. To date, programs have been developed at four of the five sequential intercepts. The funds requested will be used to expand Mental Health Pre-trial Intervention services and work towards establishing a Mental Health Court to provide a multi-agency intensive case management team for persons suffering with severe mental health or co-occurring conditions who are at a high risk of re-offending.

3.8.5.3.3 Provide a description of the project design and implementation, including:

Approach: Individuals with mental illness and co-occurring mental health and substance abuse disorders often cycle repeatedly between the criminal justice system and community services. Hillsborough County Criminal Justice has worked in collaboration with system stakeholders and community partners to introduce and better integrate systems and implement service level changes designed to interrupt this recycling process and prevent people with mental illness and co-occurring disorders from entering or penetrating the criminal justice system deeper than necessary. Using the Sequential Intercept Model, the County has moved systematically through the criminal justice process, making various system and service level changes at the intercept points and creating timely interventions that prevents people from entering or penetrating deeper than necessary into the criminal justice system. Grants from NIMH, Substance Abuse and Mental Health Services Administration (SAMHSA), and Bureau of Justice Administration (BJA) have allowed the community to map the system and develop a strategic plan as well as implement a variety of programs to divert people with mental illness, substance abuse disorders, and co-occurring mental health and substance abuse disorders away from the criminal justice system and jail.

This proposal targets a pre-trial, sometimes incarcerated population (with Jail as one of the intercept points) where securing Court sanctions as necessary to initially engage recidivistic, voluntary persons (Tier One felony offenders with an option for Tier Two misdemeanants and ordinance violations) with mental health or co-occurring mental health and substance abuse disorders (identified in Quadrants II and IV earlier), and to provide for their on-going Court supervision through their return to the community. It is anticipated that the initiation of the proposed programming will coincide with the expansion of a specialty Mental Health Court in Judicial Circuit 13. In accordance with priorities established through Hillsborough County Sequential Intercept Mapping, the intent of the proposed treatment oriented services, a contracted modified Intensive Case Management (ICM) Model that utilizes a multi-disciplinary team approach to clinical and support service delivery contracted to Agency for Community Treatment Services, Inc. (ACTS) and Gracepoint, is to provide the Court with a predictable, sustainable means to

access and manage diversionary placements utilizing a social rehabilitation outpatient model. ACTS, Hillsborough County's identified Agency for administering diversion services, will work in collaboration with Gracepoint to provide a Court Mental Health Liaison who will affect and monitor diversion activities. This organizational relationship (County, ACTS and Gracepoint) will serve to ensure that the team programming is integrated into and functions in a complementary fashion with other diversion activities. This structure will also serve to facilitate the incorporation of the case management tracking and one-year follow-up documentation into the Unity Information System utilized by ACTS to support program evaluation and contract reporting across County funded diversion programs. Services provided through this Grant will be coordinated with Central Florida Behavioral Health Network, Inc. (DCF Managing Entity), the agency responsible for the local Coordinated System of Care.

Entitled, "Mental Health Court - Enhanced Offender Diversion Initiative (MHC-EODI)", the services provided under this grant will serve as a "treatment home," providing team-based services and intensive case management for difficult to treat individuals who have serious mental illnesses or substance use disorders or both, coupled with a history of offending. The Program will adopt features from the intensive case management model that emphasizes engagement, integrated team approach, and intensive service delivery, including on-call staff. The majority of individuals served will have been charged with felonies. The team will offer basic outreach services to engage the participant and make appropriate referrals for deeper end treatment. Those individuals with more complex illnesses and/or co-occurring disorders served by the specialists receive more intensive case management services. Most of those enrolled are referred to area providers' regular service programs. Participants who meet Program criteria will be referred to the team at and spend little time in custody. Those who successfully complete their treatment plans will be expected to have their charges dropped or will be sentenced to time served. The team will coordinate services to enhance participants' opportunities for appropriate judicial disposition and assure access to the comprehensive services necessary to their successful recovery. These services will include case management, psychiatric services, vocational services, benefits coordination and housing assistance. Further description of services can be found in the section, "3.8.5.3.3.6 Coordination of Care".

ACTS will provide a Jail In-reach Liaison position to engage participants and lead them through the determined treatment navigation. Gracepoint will hire a master's level Court Mental Health Liaison position to be located within Court Administration to focus primarily on improving case processes, communications, information availability, and problem resolution for MHPTI cases participating in the Mental Health Court once developed.

Once engaged, ACTS will work with the State Attorney's Office, the Public Defender, Court Administration and Probation Officers to provide pre-judicial planning and related services.

The Substance Abuse Mental Health Service Administration (SAMHSA) endorsed and advocated Recovery Model will serve as the overarching philosophy of the Program and will serve to organize and guide the delivery of the interventions and services made available to MHC-EODI participants, specifically that Model recognizes that:

"*Recovery* is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Four major dimensions of recovery, include:

Health: overcoming or managing one's disease(s) or symptoms;
Home: a stable and safe place to live;
Purpose: meaningful daily activities; and
Community: relationships and social networks that provide support, friendship, love, and hope."

Approached through the belief that:

"*Recovery emerges from hope:* the message of a better future;
Recovery is person-driven: wherein individuals define their own life goals and design their unique path(s) towards those goals;
Recovery occurs via many pathways: pathways are highly personalized and may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches;
Recovery is holistic: encompassing the individual's whole life- mind, body, spirit, and community;
Recovery is supported by peers and allies: wherein peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community;
Recovery is supported through relationship and social networks: the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement;
Recovery is culturally-based and influenced: culture and cultural background are keys in determining a person's journey and unique pathway to recovery;
Recovery is supported by addressing trauma: the experience of trauma is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues;
Recovery involves individual, family, and community strengths and responsibility: individuals, families, and communities have strengths and resources to serve as a foundation for recovery that include: the individual's personal responsibility for self-care; families and significant others responsibilities to support their loved ones in recovery; and communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery; and
Recovery is based on respect: community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems." (SAMHSA)

ACTS will provide intensive case management, linkage, and reporting. A treatment episode of care will be individualized and include, as indicated, residential, peer support, outpatient, and aftercare. Peer support services will be offered with a peer run social rehabilitation program to support this effort. Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other

based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery. Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives. Services will include: Peer mentoring or coaching—developing a one-on-one relationship in which a peer leader with recovery experience encourages, motivates, and supports a peer in recovery.

- Peer recovery resource connecting—connecting the peer with professional and nonprofessional services and resources available in the community
- Recovery group facilitation—facilitating or leading recovery-oriented group activities, including support groups and educational activities
- Building community—helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support

The team will work with the understanding that persons with mental illness can and do lead normal, productive lives. The treatment setting will provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing, including:

- a work-ordered day in which the talents and abilities of members are recognized and utilized;
- participation in consensus-based decision making regarding all important matters;
- opportunities to obtain paid employment in the local labor force
- assistance in accessing community-based educational resources;
- access to crisis intervention services when needed;
- evening/weekend social and recreational events; and,
- assistance in securing and sustaining safe, decent and affordable housing.

Individuals will be welcomed into a setting that offers people who have mental illness and/or co-occurring disorders hope and opportunities to achieve their full potential. The Program is designed to be more than simply a program or a social service, but a community of people who are working together to achieve a common goal. During the course of their participation, individuals gain access to opportunities to rejoin the worlds of friendships, family, employment and education, and to the services, treatment and support they may individually need to continue their recovery. The Program will provide a restorative environment for people whose lives have been severely disrupted because of their mental illness and/or substance abuse, and who need the support of others who are in recovery and who believe that mental illness is treatable.

Individuals will be seen as valued participants, a colleague and as someone who has something to contribute to the rest of the group. Each person is a critical part of a

community engaged in important work. Each member will be given the message that he or she is welcome, wanted, needed and expected at each interaction. The message that each individual's involvement is an important contribution to the community is a message that will be communicated through services, support and engagement.

Services will be developed in a way that ensures that there is ample opportunity for human interaction. Staffing levels will be purposefully kept low to create a perpetual need for the involvement of the individuals in order to accomplish their jobs. Relationships between individuals and staff develop naturally as they work together side by side. Working closely together, members and staff learn of each other's strengths, talents and abilities.

Working together to formulate a plan, Program participants and team members will work to link to services and treatment based on the participant's assessed risks and level of intervention required.

Evidence Based Practices utilized through ACTS services:

All clinical staff adhere to the Comprehensive Continuous Integrated System of Care (CCISC) Model based on the awareness that co-occurring disorders occur frequently and both disorders can be successfully treated. It is recognized that co-occurring or substance abuse problems are not homogeneous as they differ in intensity, duration, effects, and other important dimensions. The primary purpose of ACTS services is to improve the functioning or prevent further deterioration of persons with co-occurring or substance abuse problems. This is accomplished by assisting consumers to move toward an abstinent lifestyle with sufficient community involvement to promote recovery and resiliency. Treatment services are individualized, with different types and intensities tailored to the consumer's presenting problem(s) and characteristics within the array of services offered by the team. Where appropriate, consumers are referred for ancillary services to address needs outside the capacity or capabilities of the staff. Assessment is viewed as an ongoing process. The need for additional treatment is continually evaluated based on the individual's performance. When subsequent treatment recommendations are made, the consumer's preferences are considered in placement discussions. The team utilizes the Motivational Enhancement Therapy (MET), and Motivational Interviewing (MI). The MET approach views motivation for change as a key component in addressing substance abuse, is consumer centered, and focuses on the consumer's strengths. Cognitive Behavioral Therapy (CBT) is also used by therapists trained in this modality in conjunction with Role Recovery. Consumers are introduced to the 12 Step Program Model in the community and encouraged to utilize the benefits 12 Step Programs offer to support long-term abstinence. Throughout the treatment process, awareness and respect for the consumer's cultural values are acknowledged and respected. They are guided to utilize the benefits that 12 step programs have to offer to support long-term abstinence. Individuals with co-occurring disorders are provided with two weekly 12 step support groups in the facility which are especially designed for co-occurring disorders (Recovery Times 2, RX2). Furthermore, at admission, the U.R.I.C.A.

is completed to determine the stage of change the person is in. Programming utilizes Seeking Safety in gender specific groups to resolve trauma issues. Each person completes a Personal Safety Plan (PSP) and a Strength, Needs, Abilities, and Preferences (SNAP) questionnaire, and the Adverse Childhood Events (ACE) trauma screening tool with corresponding goal is added to their individualized treatment plan. Cognitive Behavioral Therapy (CBT) strategies assist individuals to correct distorted thinking patterns and is based on the Criminal Conduct and Substance Abuse manual. The Suncoast Practice and Research Collaborative (SPARC) manual educates individuals on the interrelation of substance abuse and mental disorders and focuses on relapse prevention skills for both disorders. Intensive strength-based case management; assistance with SSI/SSDI benefit applications/reinstatements (SOAR approach) facilitates the person served to move towards independency and self-sufficiency. To address the special challenges of the chronic relapsing individual, MAT can be implemented that includes an ongoing VIVITROL Pilot Program.

3.8.5.3.3.1 Project goals, strategies, milestones, and key activities toward meeting the objectives outlined in Section 2.2. Applicants must include at least one objective in addition to those outlined in Section 2.2 and may propose tasks in addition to those specified in the RFA;

2.2.4.1 Objective 1 – Establish Programs and Diversion Initiatives

The objective is to establish programs and diversion initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for the Target Population(s) within three (3) months of execution of the final Grant Agreement.

2.2.4.1.1 Tasks (Objective 1)

2.2.4.1.1.1 Establish legally binding agreements with all participating entities to establish programs and diversion initiatives for the Target Population;

2.2.4.1.1.2 Provide, directly or by agreement, an information system to track individuals during their involvement with the Program and for at least one year after discharge, including but not limited to, arrests, receipt of benefits, employment, and stable housing.

2.2.4.1.1.3 Implement strategies that support the Grantee's project, examples of which are provided in Section 3.8.5.3.4.

2.2.4.2 Objective 2 – Collaboration- The objective is to create and encourage collaboration among key stakeholders in implementing and providing ongoing oversight and quality improvement activities of the Grantee's project.

2.2.4.2.1 Tasks (Objective 2)

2.2.4.2.1.1 Participate in planning council or committee meets regularly;

2.2.4.2.1.2 Assesses progress of the project based on established timelines and review attainment of goals; and

2.2.4.2.1.3 Makes necessary adjustments to implementation activities, as needed.

2.2.4.3 Objective 3 - Stakeholder Participation in County Needs Assessment

Have relevant stakeholders participate in the Hillsborough County needs assessment related to the community receiving system plan development as required by the provisions of SB12 to ensure that appropriate diversion options are established and maintained for persons with behavioral health disorders at risk of penetration into further criminal justice involvement.

2.2.4.3.1 Tasks (Objective 3)

2.2.4.3.1.1 Hillsborough County stakeholders will convene and attend meetings to discuss the development of the community receiving system plan.

2.2.4.3.1.2 Stakeholders will collaboratively assist in the development of the community receiving assessment tool.

2.2.4.3.1.3 Stakeholders will assist in the development of a community receiving system plan.

3.8.5.3.3.2 Organization and key stakeholder responsible for each task or key activity necessary to accomplish the objectives;

Indicate key activities, milestones, and responsible partners, as well as the resources available for the proposed project (e.g., facilities, equipment, etc.).

Please refer to timeline attached, Attachment C and Appendix A.

ACTS is the Lead Agency for the treatment and intensive case management services component of the Program including transport, shelter, and other wrap around services in partnership with community partners to the extent resources are available within the community. ACTS is responsible for managing, administering, and providing or contracting behavioral health treatment services, to include: Maintaining the utility and fidelity of the Program's information technology system and to incorporate clinical assessment, service planning, referral matching, consumer tracking, claims submissions and financial management, and coordination with community partners and resources for wrap around services, providing or arranging, as appropriate, secure or non-secure transportation for diverted offenders to sites established to initiate needed behavioral health, healthcare and social support services, recruiting, engaging, and credentialing a panel of community treatment and support services providers, contracting with behavioral health providers who: meet credentialing standards; and to participate in the program design, data submission, and Program activities necessary to implement, monitor, refine and sustain the system of care. Specifically, those responsibilities include, but are not limited to: Utilizing Program specific clinical screening and assessment instruments,

clinical pathways, referral protocol and service planning and client matching and tracking activities; Securing authorization by offenders for information sharing through a Program specific, universal release of information format; Employee case management responses with varying levels of intensity that match the needs and requirements of persons served to the level of engagement required for them to remain successfully in the community, and Coordinating with available community agencies and resources to advocate and provide for social supports and the purchasing of incidentals for Program participants necessary to their success in the community (temporary medications, clothing, housing rental and utility, bus passes and cab fares, fees related to securing identification cards, direct services not covered by other payors, etc.).

Gracepoint will provide a Court Mental Health Liaison (1 FTE) focused primarily on improving case processes, information availability, and problem resolution for cases involving mentally ill defendants. Gracepoint will also provide behavioral health treatment services as indicated in individual's plan.

3.8.5.3.3.3-4 How the planning council or committee will participate and remain involved in Program implementation or expansion on an ongoing basis; and agency communication

Collaborative Structure and Key Stakeholders: This project features collaboration between key stakeholders and community partners designed to facilitate communication and problem-resolution both in terms of strategic planning and implementation by establishing interlinking bodies at both the systems and service delivery levels.

Systems Level: On September 5, 2007 the BOCC passed a resolution appointing the Hillsborough County Public Safety Coordinating Council (PSCC) as the planning and advisory group for the Criminal Justice Reinvestment Grant Program; requested that the PSCC formulate project recommendations for funding consideration under the Grant Program; and authorized the County Administrator to sign and submit the non-binding grant application based on PSCC recommendations. The PSCC designated their DCF Reinvestment Grant Subcommittee to serve as the planning group for the Criminal Justice Reinvestment grant, added additional representatives to be in compliance with the membership as required by CS/CS/HB 1477, and asked the Committee to prepare this grant application and update the 2006 Strategic Plan to fit the SAMH Model. The DCF Reinvestment Grant Subcommittee is represented by consumers, advocates and family members. Consumers, advocates, and family members will participate fully and equally with all other members of the committee and their opinions will be respected as would those of any other member. Their role on the committee has been and will continue to be to promote sensitivity concerning the attitudinal and structural barriers that consumers can experience in the forensic system. Their participation will provide knowledge, reduce stigma and promote positive mental health outcomes for consumers participating in the project and, we believe, help us to transform our local system so that it is more recovery-based and client-centered.

Service Delivery Level: The key stakeholders involved in this project on the service delivery level are Hillsborough County Criminal Justice, Agency for Community Treatment

Services, Public Defender's Office, State Attorney's Office, Court Administration, and Gracepoint. The qualifications of each organization, the staffing pattern for the project, and the roles of project are described herein. A project management team composed of the Program Director, Project Managers, Court Mental Health Liaison and Jail In-reach Liaison will meet twice a month to review the project's progress. The management team will report the project's progress each month to the DCF Reinvestment Grant Subcommittee through the Project Manager, who will also keep the PSCC apprised of the status of the project. Problems identified at the service delivery level will be brought to the attention of the DCF Reinvestment Grant Subcommittee for resolution. In particular, the Project Manager will bring problems of systemic impact to the DCF Reinvestment Grant Subcommittee, such as gaps, duplications, and barriers that are identified during implementation.

In addition to the formal activities of the PSCC, the Director of Health Care Services for the County, which funds the pre-booking misdemeanor diversion case management program, convenes monthly meetings to monitor Program performance and address any barriers to Program operations or opportunities presented to enhance Program performance. That workgroup is comprised of a County Commissioner and high level operations staff of ACTS, HCSO jail services, the Public Defender's Office and the State Attorney's Office, the County staff and contract managers (who will oversee this Program and manage ACTS' contract), and the Tampa Hillsborough Homeless Initiative. The population eligible for MHPTI has been a significant focus of discussions for the work group on the basis of the extent of the unmet need represented by this population. As a result, the workgroup has been instrumental in influencing the design of the model proposed in this application for the MHPTI programming. It is ACTS' intent, in its diversion lead agency role, for the County to expand the use this forum to include guidance and assistance in implementing the MHPTI Program.

3.8.5.3.3.5 The plan to screen potential participants and conduct tailored, validated needs-based assessments. Include the criteria to be used, specific screening tool(s) and validity specific to the Target Population. If specific tool(s) have not yet been selected, describe the process by which tool(s) will be selected;

Potential participants will be screened for eligibility for MHPTI based on their legal history and symptomatology. Participants will receive a variety of evidence based biopsychosocial assessments measuring their service needs, including, housing, mental health symptoms, substance use, employment, education, relationships and history of trauma. Exact instruments will be determined by providers, with input from stakeholders, at the time of contract award and execution. Information garnered from these assessments will be used to develop participants' treatment plans and assigned services.

Building upon Dr. Roger Peters' (consultant to the project) work is assessing risk of recidivism for persons with behavioral health needs involved in the criminal justice system, the Program will recognize the importance of risk level, treatment needs, responsivity, matching supervision and treatment to offenders' level of risk and needs as well as proximal and distal goals for different levels of risk and treatment needs. Dr. Peters will serve as a consultant to the project, providing staff training, technical assistance and

monitoring of fidelity of evidence-based practices. Staff will be trained in the Risk-Need-Responsivity Model (RNR), use of incentives and sanctions, and other evidence-based practices. Using the principles of Andrews and Bonta[9], this Program will utilize an evidence based screening tool that will incorporate the principals of the Risk Need Responsivity Model. The specific tool will be determined by service providers, with the guidance of Dr. Peters, upon award and execution of an agreement.

With resources focused on moderate to high risk cases (risk for recidivism), interventions will target nine dynamic risk factors and tailor services to enhance engagement in evidence-based interventions. Screening and assessments will match level of services to risk level. Level of risk (for recidivism) will be determined by that the selected evidence based tool identified to measures static and dynamic risk factors. Dynamic risk factors for criminal recidivism include:

1. Antisocial attitudes
2. Antisocial friends and peers
3. Antisocial personality pattern
4. Substance abuse
5. Family and/or marital problems
6. Lack of education
7. Poor employment history
8. Lack of prosocial leisure activities
9. Post-Traumatic Stress Disorder

Staff will identify "problematic patterns of use, leading to significant impairment or distress (DSM-V)". In order to translate risk assessment to service planning, treatment and supervision plans will be aligned to focus on areas of high need. Risk assessments will be re-administered based on individual need with revisions of service goals, incentives and sanctions as needed. The higher the severity of substance use and/or mental health problems, the higher the level of treatment services will be required. High and low level individuals will not be mixed in treatment and service settings. Within the Model, needs that are often times overlooked such as attitudes, beliefs, peer networks, social relationships, education, employment and leisure skills will be addressed.

Services will be adjusted for high risk and high need offenders with tracks such as:

- Residential Treatment
- Outpatient, Peer Support and Aftercare treatment
- Longer duration of treatment and supervision
- Criminal thinking groups through Social Rehabilitation Outpatient
- Frequent supervision
- Drug testing (as indicated/required), and
- The implementation of proximal goals (engagement in treatment and other services to address criminal risk factors).

[9] Andrews, D; Bonta, James (1998)

3.8.5.3.3.6 How the Program will coordinate care to increase access to mental health, substance abuse and co-occurring treatment and support services and ancillary social services (i.e., housing, primary care; benefits, etc.);

Dr. Peters espouses that criminal behaviors lend themselves to identifying risk level, treatment needs and responsivity in designing interventions. This Model recognizes the relationship between mental health disorders and crime and allows for the matching of supervision and treatment to level of risk and needs. Team members will develop proximal and distal goals for different levels of risk and treatment needs based on each participant.

With the Risk Need Responsivity Model, Cognitive Behavioral Therapy (CBT) is utilized to:

- Focus on current risk and needs factors
- Teach skills to reinforce learning through practice
- Utilize an interpersonally warm, firm, and consistent approach to reinforce prosocial behavior.

Services provided will be co-occurring and trauma-informed competent, bilingual when required, gender specific, life skills oriented, and American with Disabilities Act (ADA) compliant care.

Upon notice of hearings, individuals referred by the criminal courts will be transported to and from court or arrangements will be made for their transportation. Staff will appear in court with the necessary records to inform the Court of individual treatment progress as permitted by Federal and State law. ACTS will not require that a court summons be issued provided that one day's advance notice is given.

As staff identifies, screens, assesses and places individuals, ACTS will be engaged through their Social Rehabilitation Outpatient Program to provide enhanced services based upon individual need. As an added enhancement, utilizing a social rehabilitation outpatient model, ACTS will offer a model with principles including:

- A community drop-in center, open to members/peers to assist in skill attainment, gainful employment, finding quality housing, obtaining community services and continuing education.
- Members will have opportunities to work with staff and peers each day to operate the peer run services, learning job skills in the process.
- Voluntary participation: Membership is voluntary once eligible.
- No time limits. Members are welcome to attend as long and as often, as necessary.
- Members of the group work side-by-side with staff to operate the peer-run services.

Care Coordination: The proposed team will manage services through a Care Coordination approach in concert with, and inclusive of, the Court and Court Administration (MHPTI Care Coordination Unit). Care Coordination is the implementation of deliberate and planned organizational relationships and service procedures that improve the

effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure services access. The purpose of Care Coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations. It is a collaborative effort to efficiently target treatment resources to needs, effectively manage and reduce risk and promote accurate diagnosis and treatment using consistently shared information. Care Coordination activities in the community will be addressed through a treatment team based on a thorough assessment of needs, inclusive of a level of care determination, and active linkage and communication with existing and newly identified services and supports. ACTS' Intensive Case Management staff will be able to leverage new, expanded and existing behavioral health, residential, transportation, medical, housing, entitlements, social and trauma informed services provided by the County, Department of Corrections, DCF, managing entities, Centers for Medicare and Medicaid, and the Court in order to enhance access to treatment, ancillary services and support services for participants. The treatment team will continuously assess for and address behavioral health issues as well as medical, social, housing, and interpersonal problems/needs that impact the individual's status. The team will provide the MHPTI Care Coordination Unit with a single point of accountability, engagement, standardized assessment, shared decision-making, community based services and supports in the most inclusive, responsive, accessible and least restrictive settings as possible. Coordination will be provided across a continuum of care including all aspects of health. ACTS will ensure compliant information sharing, effective transitions, culture and linguistically competent, outcome based care. Please refer to the attached flow chart (Attachment A) for a visual of the team process.

Referrals to the Program: Participants will be identified by defense council and screened by the State Attorney's Office for legal eligibility for MHPTI. Once deemed legally eligible, participants will be given a clinical evaluated by the Court Mental Health Liaison in order to establish a treatment plan and service conditions of the contract with the Court. ACTS will work with the State Attorney's Office to make transfers as smooth and efficient as possible. Once the written notice of transfer is received and arrangements have been finalized, ACTS' Intensive Case Management staff will be notified by the Court Mental Health Liaison as to the date of release/transfer and provided with any and all required documents.

3.8.5.3.3.7 How law enforcement will assess their current process at intercept points, capacity, and how they intend to implement or expand diversion initiatives (e.g., processes, training, etc.); and

The Hillsborough County Sheriff's Office (HCSO), along with other local law enforcement agencies, continues to be invested and involved in educating and training staff on the importance of recognizing and being sensitive to behavioral health needs. HCSO continues to offer Crisis Intervention Training (CIT) multiple times a year to recruits, deputies and other law enforcement agencies, as space allows. This training has been offered through the Sheriff's office since at least 2010 and over 800 people have been trained in just the last 2.5 years.

Local law enforcement has also recently been able to make community based criminal justice diversions by having the new opportunity to take a person exhibiting a behavioral health crisis directly to ACTS for evaluation and stabilization rather than taking them to jail for an ordinance violation included in an existing MOU between the County and various other parties. Persons who are brought to ACTS under this new diversion pathway are able to avoid going to jail and being booked and have the opportunity to receive funded behavioral and medical services through ACTS and paid for by the County. Since its inception, there have been a handful of clients diverted monthly from the criminal justice system using this pathway.

For the purposes of this grant, our Tier One, first priority, participants will be already involved in the criminal justice system and be post-booking when enrolled. They will be assigned to a Court division and their referral, assessment, services and dispositions will be handled by the State Attorney's Office, public and private defense attorneys, Court Administration and community service providers. However, for our Tier Two, second priority, participants, law enforcement will be making the decision on whether to divert a participant straight from the community to ACTS, bring the participant to jail but ask that they be screened to determine if they can be diverted pre-booking, in accordance with the conditions of the existing pre-booking misdemeanor MOU between the County and various other agencies, or booked into the jail and possibly diverted later because their charges or history are not consistent with the existing MOU for misdemeanor diversion. The Assistant State Attorneys, also considered law enforcement, will be assessing their current process and criteria for MHPTI enrollments. Services under this Program will be able to accommodate enrolling of participants who have similar service needs but would not otherwise qualify for MHPTI under existing criteria and limitations. In this Program's ability to increase available services, establish a singular point of accountability and provide comprehensive Care Coordination, the State Attorney's Office will be able to serve more clients under MHPTI and help to lay the groundwork for the development of processes for a centralized Mental Health Court.

3.8.5.3.3.8 If the Applicant is a consortium of counties, describe the collaboration and the relationship between the partner counties. NA

3.8.5.3.4 A description of the strategies an Applicant intends to use to serve the Target Population, including a description of the services and supervision methods to be applied and the goals and measurable objectives of the new interventions.

Linkages to community-based, evidence-based treatment programs for the served Target Population; New Court programs, including pretrial services and specialized dockets; Specialized diversion programs;

The courtroom is a critical arena for the therapeutic process in the current Hillsborough Mental Health Pre-Trial Intervention. Borrowing again from the method of drug courts, the MHPTI was designed to be informal, often involving interaction and dialogue between the judge and the participant about problems and treatment options. Just as the drug court model involves a therapeutic view of the addict and employs clinical terminology about addiction and recovery, the MHPTI incorporates a respectful and helpful manner toward

participants, makes careful use of language that is sensitive to the issues related to mental illness, and is informed by an understanding of the nature and treatment of mental illness. Under this grant, as the 13th Judicial Circuit works to establish a Mental Health Court, all MHPTI agreements will be formalized in the Mental Health Court division. The court proceedings under Mental Health Court will adopt a supportive, instructive, problem-solving and understanding style in presiding over the special calendar of mental health defendants, and avoids threatening or punitive language, or language that might contribute to labeling or stereotyping. In other words, the informal style of the mental health docket proceedings will be designed to reflect the methods of mental health treatment and to contribute to the improved mental health of its participants.

The current MHPTI program will expand to employ a team model based on a great deal of consultation and cross-disciplinary input, although there is no doubt that the judge is the leader of the group problem-solving that transpires and has final responsibility for all decisions. The Court personnel are not rotated into the assignment on a short-term basis, but rather will be specialists in dealing with the mentally ill in the justice setting. In addition to the judge, Court personnel include a prosecuting attorney, a representative of the jail, the Public Defender, the Court Mental Health Liaison, a forensic licensed clinician, and a Case Manager. The team approach will contribute to an active courtroom that seems to have a variety of activities going on simultaneously, rather than a one-case-at-at-time orientation. The judge may be dealing with several cases simultaneously and asking various staff to investigate, interview, make calls for placements, or compile necessary information to resolve the statuses of persons appearing before him or her, some for the first time, others for regular status reviews. With each of the appropriate agencies and functions represented in the courtroom, the judge will be able to craft and implement a response and to request necessary action and follow-up on the spot.

In the expanded MHPTI Program, understanding and communication will be viewed as part of the problem-solving process. The Court will utilize both County and private service providers to respond to the treatment needs of its participants, as identified by the Court Mental Health Liaison and Case Managers. At the initial stages, once a referral is made, the Court Mental Health Liaison interviews the defendant. He/She will check to see if the defendant is already involved in mental health treatment and, if so, consults with their caseworker about the nature of their illness and treatment needs and progress. If the defendant is not already in treatment, they will be screened to determine whether they meet the mental health eligibility requirements. The Court Mental Health Liaison has access to most area providers, but the two major sources of care will be ACTS and Gracepoint. Services provided include short and long-term residential treatment, including supportive housing, substance abuse treatment, and assertive community treatment. The proposed framework will utilize a community-based, interdisciplinary, intensive case management team, which will include a peer support, supportive service linkage and licensed staff. The team will work on a 24-hour basis with a small group of defendants to support them as they address their criminogenic risk and behavioral health needs.

Screening and assessment will match level and types of services to criminogenic risk level. Risk for recidivism will be determined by use of an evidence based risk assessment

tool, consistent with Andrews and Bonta's Risk, Need, Responsivity Model, to be selected by the treatment provider with the support of Dr. Peters. The tool selected will measures static and dynamic risk factors. Dynamic risk factors for criminal recidivism include:

1. Antisocial attitudes
2. Antisocial friends and peers
3. Antisocial personality pattern
4. Substance abuse
5. Family and/or marital problems
6. Lack of education
7. Poor employment history
8. Lack of prosocial leisure activities
9. Post-Traumatic Stress Disorder

Programming to address these recidivism risk factors will include ACTS Social Drop-In services and evidence based practices such as, but not limited to: Cognitive Interventions Program (addressing antisocial attitudes), Relapse Prevention (addressing substance abuse), or The Creating Lasting Family Connections Fatherhood Program: Family Reintegration (CLFCFP) (addressing family relationships).

Community services and programs designed to prevent high-risk populations from becoming involved in the criminal or juvenile justice system;

<u>Case Management and Intensive Case Management</u>**:** Upon admission, a standard intake screening and an in-depth bio-psychosocial assessment will be conducted by a clinician to obtain information regarding behavioral health issues, both past and present, to determine a participant's immediate needs and establish a plan for further assessment and treatment. The multidisciplinary team will work towards further stabilizing the participant, identifying treatment and housing options, and facilitating connections to appropriate and available services.

The intake screening and bio-psychosocial assessment forms will be created mirroring information that is gathered in the Electronic Health Record system (EHR). Besides demographic data, the assessments will capture information including: presenting problems, collateral reports, living environments, ability to maintain current placement, history of living situations, source of transportation, education status and history, current employment status and history, military status, participation in recreational activities, relationships with significant others, family and friends, cultural customs, religious/spiritual beliefs for coping, gender identity, legal issues and forensic history, primary care physician information, barriers to activities of daily living skills, medical conditions including dental, current substance use, abuse and treatment, history of substance abuse and treatment, current mental health status, developmental history, current developmental status, history of trauma and effects of individual's past and present functioning, current abuse, neglect or exploitation (including screening for victims of human trafficking), stages of change, strengths, needs, barriers and preferences. They will be linked with a Licensed Clinical Social Worker or other professional allowed to evaluate, which opens up access to medical care, education, and other social services.

Services will include the provision of direct services and the coordination of ancillary services designed to: (1) Assess the participant's needs and develop a written treatment plan; (2) Locate and coordinate any needed additional services; (3) Coordinate service providers; (4) Provide participants access to needed services; (5) Monitor service delivery; (6) Evaluate individual outcomes to ensure each participant is receiving the appropriate services; (7) Coordinate medical and dental health care; (8) Support basic needs such as housing and transportation to medical appointments, court hearings, or other related activities outlined in the participant's treatment plan; (9) Coordinate participant's access to eligible benefits and resources; (10) Address educational service needs; and (11) Coordinate legal services and Court representation needs.

Case Management, Discharge Planning, Crisis Counseling, and Referrals: Upon admission, Case Managers will see participants to begin discharge planning. Individual sessions will focus on treatment plans and discharge plans, and address the presenting problems that caused the admission, the participant's goals during treatment, and interventions to achieve those goals. Case Managers will be SOAR trained, competent in the use of Tampa Hillsborough Homeless Initiative's UNITY information system and trained in linking to the Hillsborough County Health Care Plan and the State of Florida's Access system.

As part of case management, the needs of each participant will be discussed among the team and a case plan will be developed and implemented using a strength based approach. Participants will actively participate in selecting treatment options, developing a case plan and developing greater self-determination.

Strategies to achieve these objectives include providing linkages to housing options, job training, job opportunities, access to benefits and health care such as: Social Security Medicaid, Medicare, and Veterans benefits, medication monitoring, supportive therapy, individual and family psycho-education, self-help groups, and life skills training. Case Managers will be cognizant of trauma recovery and empowerment techniques incorporating motivational interventions based on the stage of change of the participant. Linking people with needed services reduces the likelihood that they will reappear in the justice system which reduces the impact on the local jail and court systems.

The Case Manager will develop, within 30 calendar days of admission, a Recovery Plan, along with the participant, based on assessment data; identifying the participant's clinical, rehabilitative and quality of life/enrichment service or recovery needs; the strategy for meeting those needs; documented treatment and recovery goals and objectives; criteria for terminating the specified interventions; and documented progress in meeting specified goals and objectives. The plan will be reviewed every 30 calendar days for the first 12 months and every 60 days thereafter.

The Case Manager will provide an array of services including service planning, service linkage, service coordination, monitoring of service delivery and evaluation of service effectiveness. Case Managers assigned to forensic individuals on conditional release will

be responsible for monitoring compliance in accordance with the Court-ordered conditional release plan, providing early intervention to avoid revocation of conditional release and reporting to the Court on progress/compliance as required by the Court. The Case Manager will adhere to the Court-ordered plan for providing appropriate outpatient care and other treatment as needed for participants. The Conditional Release Plan will:

- Be developed with input from the team of partner providers and others as applicable
- Be a comprehensive plan and include all of the components required
- Be reviewed by the team, including the participant

The components will include:

- General conditions that apply to all participants on Conditional Release
- Specific conditions related to each participant's recovery plan
- Specific provisions for residential treatment or adequate supervision
- An agency agreement to treat
- A plan to monitor compliance
- A Statement of Understanding and Consent

Linkage to Supportive Housing: Linkage to housing for participants recovering from drug or alcohol addiction or crisis that provides an alcohol and drug-free living environment, peer support, assistance with obtaining drug addiction services, mental health treatment and other recovery assistance will be provided to participants. Housing services will not limit a participant's duration of stay to an arbitrary or fixed amount of time. Instead, each participant's duration of stay shall be determined by their needs, progress, and willingness to abide by the recovery housing's protocols, in collaboration with the provider. Tampa Hillsborough Homeless Initiative has dedicated 20 beds to support participants who are homeless through permanent supportive housing vouchers. Providers, under these vouchers, will utilize the Housing First Model, an evidence based approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible and then providing services as needed. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve.

Partnered community treatment providers also operate supportive living arrangements available for participants engaged in outpatient care. These will be low-cost, substance-free housing environments, loosely based on the Housing First Model, with a level of peer supervision and support for recovery. Other options available will be residential treatment facilities, transition treatment centers, halfway houses, sheltered living situations, and the participant's own home.

Employment: Case Managers will help participants link to job training and job readiness preparation, skills identification and assessment, role playing for future interviews and job situations, and reach-in programs that serve as quasi-internships or offer transferable pre-employment experience. Case Managers will develop a resource directory of

employers that are willing to hire the population served. There are often many available partners in the community ready to help with employment.

Education: Participants will be helped to develop not only basic skills but also a realistic plan for furthering their education. They can be provided with continuing education opportunities and financial aid information. If ready for college, grant and scholarship information is important and will be provided. Linkage to GED testing is available; a Case Manager will help the participant resolve this and other barriers to continued education efforts (such as poor time management).

Strategies to achieve these objectives include providing linkages and assistance in obtaining services such as to housing, job training, job opportunities, access to benefits and health care such as: Social Security Medicaid, Medicare, and Veterans benefits, medication monitoring, supportive therapy, individual and family psycho-education, self-help groups, and life skills training. Case Managers will be cognizant of trauma recovery and empowerment techniques, incorporating motivational interventions based on the stage of change of the participant.

The Peer Recovery Support Specialist[10], will provide mutual assistance in promoting recovery. Services may be offered by other persons who have experienced similar mental health and/or substance abuse challenges. These services will focus more on wellness than illness. Mentoring will include peer mentoring which refers to services that support recovery and are designed and delivered by peers, people who have shared the experiences of behavioral health recovery. Recovery support will be included here as an array of activities, resources, relationships, and services designed to assist a participant's integration into the community, participation in treatment, improved functioning or recovery.

- Life Skills: Life skills services address activities of daily living, such as budgeting, time management, interpersonal relations, household management, anger management, and other issues.
- Spiritual and Faith Based Support: These services assist an individual or group to develop spiritually. Activities might include, but are not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Faith-based services include those provided to individuals and using spiritual resources designed to help persons in recovery to integrate better their faith and recovery. Such services are usually provided in a religious or spiritual setting by spiritual leaders or other staff who are knowledgeable about the spiritual values of the community and are equipped to assist individuals in finding spirituality. Services include, but are not limited to, social support and community-engagement services, faith, or spirituality to assist individuals with drawing on the resources of their faith tradition and community to support their recovery, mentoring and role modeling, and pastoral or spiritual counseling and guidance.

[10] ACTS will develop a "Corp" of Certified Recovery Peer Specialists

- Peer Based Employment Services: These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.

Recovery supports may continue for a maximum of 18 months from Program admission, regardless of other referrals to behavioral health services provider(s); it is expected that the utilization of Peer Recovery Support Specialists for Care Coordination will include:

- Increased sense of empowerment and personal responsibility of persons served as they partner in a process rather than being directed;
- Individualized care plans and increased follow through with identified services;
- Effective service coordination and utilization and engagement in community services and supports;
- Improved social functioning, use of natural supports, and community integration; and
- Increased individual benefits including stability, self-efficacy, and self-management.

ACTS will train and develop a "Corp" of Certified Peer Recovery Support Specialists to employ through this Program and ultimately lead peer-run services in the social rehabilitation component of the Program.

Staff will be trained by Dr. Roger Peters in evidence based practices and treatment based on criminogenic risk. In addition, therapists will match participant's level of services to his or her criminogenic risk level. Higher risk offenders require greater structure, and more intensive treatment and supervision. Staff will be trained in the Risk, Need and Responsivity Model and use of incentives and sanctions. Individualized service plans will address areas of high needs, reassessing risk and updating of plans.

Post-Booking Alternatives to Incarceration.

Tier Two (second priority) participants will have access to all the same services and supports as the Tier One (first priority; MHPTI) participants as listed above. Tier Two participants will be diverted from jail for pre and post-booking misdemeanor or ordinance violation offenses identified under a current MOU between the County and various other agency partners. Hillsborough County's existing misdemeanor diversion program has been unable to serve these clients because of their severe mental health needs and limited resources in the community. Under this Program, they will be eligible to be included in this diversion because they will have access to all the services and treatment available to the MHPTI participants.

3.8.5.4 Performance Measures

Identified performance measures under this grant will be regularly monitored to determine the success of the Program and the effectiveness of the diversion on recidivism and obtaining applicable needed services for participants. ACTS, the sub-recipient, will be responsible for providing monthly and quarterly reports to the County including, but not be limited to, information on each of the identified performance measures during each time period. The information included in these reports will be disseminated to stakeholders and used to monitor the progress of the diversion Program and to problem solve any deficiencies as needed. The sub-recipient will also undergo an annual formal monitoring process by the County where a participant and Program level evaluation will be performed. Progress on these performance measures will be included in the County's quarterly reports to the grantor.

3.8.5.4.1 A description of the process for collecting performance measurement data, and any other state or local outcome data to measure project effectiveness;

Performance measurement data will be collected by the sub-recipient, ACTS, and reported to the County on a monthly and quarterly basis during the term of the grant. Arrest data will be collected using the on-line arrest inquiry available through the Hillsborough County Sheriff's Office website. Hillsborough County has a central intake point for all municipal law enforcement agencies who have placed a person under arrest. The central intake point is run by our Sheriff's office and information on all persons booked into that location are recorded in their system and available on-line. ACTS will be using this resource to determine which participants have been arrested while in the Program and at one year after Program discharge (performance measures 2.4.2.1 and 2.4.2.2).

ACTS staff will be collecting information about participant homelessness at Program entry and throughout their involvement with the Program. This information will be recorded in an established Microsoft Access database that has already been developed for ACTS and in the Tampa Hillsborough Homeless Initiative's HMIS Unity data system (Unity) that is used and shared by all homeless community service providers in Hillsborough County. ACTS will be using these two systems to record housing and housing stability information for their participants during the Program and will be using this information to determine what percentage of participants who were not residing in stable housing at Program admission, are residing in stable housing after 90 days in the Program (performance measure 2.4.2.3). One of the purposes of this grant is to get participants of Mental Health Court's Pre-Trial Intervention (MHPTI) into appropriate community based ongoing services. As participants continue services with community providers, even after discharge from the diversion Program, their housing and housing stability will continue to be updated in the Unity system. ACTS will report previously homeless participants' housing stability at one-year post discharge using the Unity system. If current housing stability information is not included in the Unity system for specific participants at one-year post discharge, ACTS will then make their best efforts to complete a diligent search for each participant missing updated information to determine their updated housing