Tab 4:

Project Narrative

RFA06H16GS1: Miami-Dade County – 2016
Criminal Justice, Mental Health, and Substance Abuse
Reinvestment Grant Program
Miami-Dade County Jail In-Reach Team Project

PROJECT NARRATIVE

Project Summary: In recent years, progress has been made around the development of innovative strategies and interventions that aim to reduce or avoid unnecessary involvement of people with serious mental illnesses (SMI: e.g., schizophrenia, bipolar disorder, major depression) in the criminal justice system. Examples include crisis intervention team (CIT) training that teaches law enforcement officers to better recognize and respond to psychiatric emergencies in the community and problem-solving courts that provide opportunities for diversion from the justice system, as well as judicial monitoring of treatment linkages and engagement.

While these approaches have proven effective in helping to address the overrepresentation of people with SMI in the justice system, correctional populations continue to demonstrate disproportionate numbers of people with mental illnesses. Part of the reason for this is that, while individual components of these interventions may incorporate evidence based practices, too often the infrastructure that links different components of systems and serves as the foundational framework for coordination and continuity of care is underappreciated or overlooked altogether.

One of the most critical areas of need, and perhaps the most commonly neglected among criminal justice/mental health problem solving approaches, is the period of transition from the community to incarceration and back to the community again. Because of disconnected organizational processes and missions, as well as lack of information sharing between community and correctional settings, there tends to be relatively little communication or accountability between the "inside" and "outside" worlds.

The proposed project represents a collaborative effort among a well-established and nationally recognized mental health jail diversion program, a county correctional department and correctional health care provider that has recently implemented significant improvements in screening, identification, and treatment for individuals with mental illnesses while incarcerated, and a local managing entity responsible for providing comprehensive planning, coordination, and oversight for behavioral health prevention and treatment services in the Southern Region. Project partners include:

1. The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP)

2. The Miami-Dade Corrections and Rehabilitation Department (MDCR)

3. Jackson Health Systems – Corrections Health Services (CHS)

4. The South Florida Behavioral Health Network (SFBHN).

The CMHP was established in 2000 to divert individuals with SMI and co-occurring SMI and substance use disorders, who are involved in or at risk of becoming involved in the justice system, into community-based treatment and support services. The Project

incorporates pre-booking and post-booking jail diversion programs, as well as a program to divert individuals from admission to state forensic treatment facilities. The CMHP was awarded CJMHSA Reinvestment Grants in 2008 and 2010 which allowed expansion of diversion services to include individuals charged with lower level felonies and implementation of a specialized entitlement benefits unit to expedite access to SSI/SSDI, Medicaid, and other means of economic self-sufficiency for individuals re-entering the community from the criminal justice system. Both projects were very successful and were sustained with recurring annual funding following completion of the grant periods.

Project partners will build upon the success of the CMHP's post-booking jail diversion programs by implementing a best-practice model – known as the *APIC Model* – of community reentry and transition planning for individuals with SMI who are arrested and booked into the county jail. Utilizing core concepts and empirical underpinnings of effective transition and reentry planning the project aims to integrate processes between the criminal justice and behavioral health treatment systems to achieve more effective and efficient treatment linkages and services delivery. The goals are to improve assessment, referral, diversion, and care coordination among individuals with SMI reentering the community from the criminal justice system.

The proposed project will create a specialized *Jail In-Reach Team* that will be guided by shared commitment to cross-system collaboration and division of responsibilities among criminal justice and community partners to:

1. Efficiently gather and review information necessary to make determinations regarding eligibility for participation in diversion programs,

2. Develop and implement evidence-based transition and reentry plans emphasizing continuity and coordination of care,

3. Monitor ongoing linkages to evidence-based treatment and services in the community, and

4. Measure outcomes to facilitate performance improvement and demonstrate impact on criminal justice, behavioral health, and recovery outcomes.

The target population includes adults with SMI who are frequent recidivists to the justice and acute care treatment systems. All project participants will be assessed using validated, evidence-based risk and need assessment tools (*MHSF-III, TCUDS V, and ORAS-CST*). Those identified to be at moderate to high risk of future recidivism to the justice and/or acute care treatment systems, and who are eligible for CMHP services, will receive enhanced transition and reentry supports, as well as linkages to and monitoring of evidence-based treatment and support services in the community.

Anticipated outcomes include increased public safety, decreased demand for services in the criminal justice and acute care treatment systems, and improved access to

community-based treatment and recovery support services. It is hypothesized that more efficient identification, transition planning, diversion, and service linkages will result in improved access to treatment and support services in the community, which in turn will result in improved mental health, criminal justice, and public safety outcomes.

The proposed project has set a goal to screen a minimum of 400 individuals annually, providing enhanced transition and reentry planning, as well as ongoing monitoring of community linkages, to at least 125 individuals.

The CMHP, along with dedicated community partners, has been instrumental in reducing arrests and incarceration of people with SMI, diverting individuals from unnecessary involvement in the justice system, reducing crime in the community, reducing injuries to law enforcement officers and people with mental illnesses, reducing chronic homelessness, improving public safety, and reducing burdens on taxpayers. The proposed project will be undertaken to extend and enhance these outcomes, and serve as a model for other communities interested in strengthening and improving public health and public safety collaborations.

Statement of the Problem: People with SMI who become involved in the criminal justice system demonstrate substantial disparities in rates of access to community-based mental health and primary care treatment services. Patterns of service utilization tend to reveal disproportionate use of costly acute care services provided in hospitals, crisis units, and correctional facilities, with limited and inconsistent access to prevention and routine care in non-institutional settings.

According to the National Alliance on Mental Illness, 40% of adults who experience serious mental illnesses (SMI; e.g., schizophrenia spectrum disorders, bipolar disorder, major depressive disorder) will come into contact with the criminal justice system at some point in their lives. Unfortunately, these contacts result in the arrest and incarceration of people with SMI at a rate vastly disproportionate to that of people without mental illnesses. According to the most recent prevalence estimates, 16.9% of all jail detainees (14.5% of men and 31.0% of women) experience serious mental illnesses.[1] Considering that more than 11 million bookings into local jails occur in the United States annually,[2] this suggests nearly 1.9 million involve people with SMIs. Roughly three-quarters of these individuals also experience co-occurring substance use disorders, which increase the likelihood of becoming involved in the justice system. In Florida alone, it is estimated that 130,000

[1] See Steadman et al (2009): https://csgjusticecenter.org/wp-content/uploads/2014/12/Prevalence-of-Serious-Mental-Illness-among-Jail-Inmates.pdf

[2] Based on FBI estimate of 11,205,833 total arrests in the United State in 2014: https://ucr.fbi.gov/crime-in-the-u.s/2014/crime-in-the-u.s.-2014/tables/table-29

people with SMIs requiring immediate treatment are arrested and booked into local jails annually.[3]

Although these national and statewide statistics are alarming, the problem is even more acute in Miami-Dade County, which has been described as home to the largest percentage of people with SMI of any urban community in the Unites States. Roughly 9.1% of the population (185,000 adults) experience SMI, yet fewer than 13% of these individuals receive care in the public mental health system. As a result, law enforcement and correctional personnel have increasingly become the lone responders to people in crisis due to untreated mental illnesses.

The impact of failing to provide adequate community-based treatment to those most in need is considerable: An analysis by the *Louis de la Parte Florida Mental Health Institute* at the *University of South Florida* found that, over a five year, period 97 individuals with serious mental illnesses in Miami-Dade County who were identified as "heavy users" of acute care and institutional services accounted for nearly 2,200 bookings into the county jail, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. On average, each individual was booked into the county jail between four and five times per year and spent nearly a quarter of their time incarcerated or in other institutional settings, only to eventually be returned to the streets. The cost to taxpayers for these services was conservatively estimated at nearly $14 million with little impact on reducing recidivism and virtually no return on investment.

Table 1. CMHP Heavy User Data Analysis – 5 Year Period

Event type (n=97):	Total events:	Cost/day	Total cost
Arrests	2,172	-	-
Jail days	26,640	$178	$4.7 million
Civil commitment initiations	710	-	-
Inpatient psychiatric days	7,000	$291	$2 million
State hospital days	3,200	$331	$1 million
Emergency room days	2,600	$2,338	$6 million
Total	**39,440**	**-**	**$13.7 million**

While the analysis of heavy user data demonstrates the way in which substantial costs and demand for services can be generated by a relatively small number of individuals, there's an even larger drain on resources and systems associated with the fact that the

[3] Based on FDLE report of 773,073 total statewide arrests in 2015: http://www.fdle.state.fl.us/cms/FSAC/UCR/2015/CIF_annual15.aspx

criminal justice system, and jails in particular, have become places where large numbers of people with mental illnesses spend significant amounts of time. For most individuals, admissions to jail tend to be much briefer and more episodic than those experienced by heavy users; however the sheer volume and chronic nature of individuals with untreated or undertreated mental illnesses cycling in and out of the justice system over time has resulted in staggering public costs, not to mention devastating impacts on individuals and families.

The Miami-Dade County jail currently serves as the largest psychiatric institution in Florida, containing nearly as many beds serving inmates with mental illnesses as all state civil and forensic mental health treatment facilities combined.[4] On any given day, the jail houses approximately 2,300 individuals requiring psychiatric treatment while incarcerated. The cost to taxpayers is $150 million annually, or more than $400,000 per day.[5]

Daily population statistics maintained by the Miami-Dade County Corrections and Rehabilitation Department (MDCR) demonstrate a dramatic increase in the number of inmates identified with mental illnesses in the county jail system over the past year and a half. This has occurred despite the fact there has been a decrease in the overall average daily inmate population. Between January 2015 and June 2016 the total jail population *decreased* by 10%, while the number of inmates with mental illnesses *increased* by 20%. The majority of growth in the mental health population is among inmates requiring placement on specialized mental health units within the jail which grew by 75%. Those experiencing acute or semi-acute treatment needs (the most intensive levels of care) demonstrated the largest growth at 84%.

Table 2: Average Daily Population (growth %)

	Total jail ADP	All MH ADP	Level 3+	Level 2+	Level 1
Jan-15	4,389 (n/a)	2,049 (n/a)	452 (n/a)	159 (n/a)	50 (n/a)
Jun-15	4,112 (-6%)	2,165 (6%)	556 (23%)	221 (39%)	70 (40%)
Sep-15	4,200 (-4%)	2,318 (13%)	643 (42%)	250 (57%)	69 (38%)
Dec-15	3,812 (-13%)	2,332 (14%)	650 (44%)	270 (70%)	76 (52%)
Mar-16	3,831 (-13%)	2,367 (16%)	724 (60%)	296 (86%)	87 (74%)
Jun-16	3,938 (-10%)	2,465 (20%)	793 (75%)	293 (84%)	86 (72%)

Level 1: Acute on MH Units, Level 2: Semi-Acute on MH Units, Level 3: Stable on MH Units

[4] There are approximately 1,500 civil beds and 1,100 forensic beds divided among 7 state funded treatment facilities, for a total of 2,600 state hospital beds: http://www.dcf.state.fl.us/admin/publications/docs/quickfacts.pdf

[5] Based on average daily cost per individual of $178.

RFA06H16GS1: Miami-Dade County – 2016
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The tragic and unnecessary consequences of the county jail serving as the *de facto* psychiatric hospital for the indigent have not gone unnoticed by local, state, and federal officials and advocacy organizations. In 2005, the Miami-Dade County Grand Jury released a report titled *Mental Illness and the Criminal Justice System: A Prescription for Disaster/A Recipe for Improvement*[6] detailing the crisis of people with untreated mental illnesses who become entangled in the criminal justice system. The report concluded that individuals with mental illnesses who lack resources to access treatment are faced with a woefully inadequate system of community-based care. In 2006, an affidavit[7] was filed by the organization Human Rights Watch which found that conditions under which inmates were housed at the county's Pre-Trial Detention Center grossly failed to meet basic international human rights standards for the treatment of prisoners. In 2008, the United States Department of Justice (DOJ) initiated an investigation under the *Civil Rights of Institutionalized Persons Act* of the conditions under which inmates were held in the Miami-Dade County jail, including a specific focus on inmates with mental illnesses.

Among other findings, the results of these inquiries revealed what many, particularly those who work in the criminal justice system, already knew:

> "We found the setting and conditions less than ideal for treating persons suffering from mental illness... Notwithstanding the bleak environment, we were also reminded that the primary function of the jail is to provide a secure facility to detain persons accused of committing crimes. The jail's primary goal of maintaining custody, providing security and preventing escape of inmates is at odds with providing medical care to very sick people." (Grand Jury report, p. 13)

Despite this dismal assessment, Miami-Dade County has made substantial improvements around how inmates with mental illnesses are now treated within the jail. The county entered into a consent decree with the DOJ[8] in 2013 which resulted in dramatic improvements in screening, assessment, and treatment of inmates with mental illnesses. Along with these advances has come recognition of the need to better identify and expand capacity to serve individuals who are be eligible to participate in mental health jail diversion programs operating within the county. In addition to helping to further alleviate burdens on the county jail, streamlining access to diversion when appropriate will help to minimize the amount of time people with mental illnesses remain in the justice system. Research demonstrates that even brief periods of involvement in the criminal justice system among people with serious mental illnesses can lead to disruptions in health and well-being sufficient to have long-term negative impacts on public health and public safety.

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[6] https://www.miamisao.com/publications/grand_jury/2000s/gj2004s.pdf

[7] http://www.pdmiami.com/Affidavit_of_Jennifer_C._Daskal.pdf

[8] https://www.justice.gov/sites/default/files/crt/legacy/2013/06/05/miami-dade_agreement_5-1-13.pdf

To address the need for mental health jail diversion services, the CMHP currently operates four different diversion programs:

1. Pre-booking jail diversion program involving crisis intervention team (CIT) training provided at no cost to all local law enforcement agencies.

2. Post-booking, pre-trial jail diversion program targeting individuals with SMI charged with misdemeanor offenses.

3. Post-booking, pre-trial jail diversion program targeting individuals with SMI charged with felony offenses.

4. Post-booking, state forensic treatment facility diversion program targeting individuals found incompetent to proceed to trial or not guilty by reason of insanity due to mental illnesses.

In addition, Miami-Dade County was awarded a CJMHSA Reinvestment Grant in 2010 to expand CMHP services to include individuals with SMI re-entering the community after completing jail sentences and to implement a specialized entitlement benefits unit to expedite access to Social Security and Medicaid benefits for individuals served by the CMHP's programs. The project has been sustained and is considered to be a model of excellence for the target population. Approvals on initial applications for SSA are more than 90% in approximately 40 days from time of application.

The current proposal will build upon the success of the CMHP and represents a collaborative effort among stakeholders in the criminal justice and behavioral healthcare systems in Miami-Dade County. This will be accomplished through the use of enhanced, evidence based transition and reentry planning leveraging cross-system collaborations, combined with linkages to and monitoring of effective criminal justice and behavioral health treatment interventions with the goals of reducing recidivism and promoting recovery.

Geographic environment and socio-economic factors. The project will be implemented in Miami-Dade County which has an estimated population of more than 2.7 million individuals. According to the United States Census Bureau (2015), 78.1% of the population is white and 18.9% is black; 66.8% of the population is of Hispanic origin; 51.5% of the population was born outside of the United States; and 72.2% of the population speaks a language other than English at home.

As of July 2015, the unemployment rate in Miami-Dade County was 5.1% (Bureau of Labor Statistics). In 2014, the median household income in Miami-Dade County was $43,099 with 20.4% of the population below the poverty level (U.S. Census Bureau, 2014).

Target population. The target population includes adults with serious mental illnesses who have histories of repeated involvement in the justice, acute care treatment, and/or homeless systems; and who are:

1. Arrested and booked into the county jail.

2. Eligible to participate in one of the CMHP's diversion programs.

3. Assessed to be at moderate to high risk of future recidivism to the justice system, acute care treatment, and/or other institutional settings.

4. Screened to ensure they do not have significant histories of violence and are not likely to pose public safety concerns.

Table 3 summarizes characteristics of populations currently served by the CMHP. The target population for the proposed project is anticipated to exhibit similar profiles.

Table 3. Diagnoses, Homelessness, Jail Bookings, and Co-Occurring Disorders among CMHP Participants

Primary Axis I Diagnosis	Misdemeanor Jail Diversion	Felony Jail Diversion	Forensic Diversion	All CMHP participants
Schiz Spectrum D/O	77.9%	54.3%	68.3%	68.6%
Bipolar D/O	13.3%	27.3%	19.5%	18.7%
Major Depressive D/O	4.3%	9.4%	4.9%	6.6%
Other Mood D/O	2.3%	6.8%	2.4%	3.6%
Cognitive D/O	1.1%	0.7%	0.0%	1.0%
Other Axis I D/O	0.5%	0.7%	0.0%	0.6%
Substance Use D/O	0.5%	0.0%	4.9%	0.6%
Anxiety D/O	0.2%	0.7%	0.0%	0.4%
Grand total	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Homeless at Arrest	76.3%	30.2%	56.5%	55.7%
Avg Prior Jail Bookings	16.1	6.3	17.1	11.6
Co-Occurring SUD	76.0%	78.3%	78.1%	77.7%

All participants will be assessed using validated, evidence-based risk and need assessment tools. Those identified to be at moderate to high risk of future recidivism to the justice and acute care treatment systems, and who are eligible for CMHP services, will receive enhanced transition and reentry planning services, as well as linkages to evidence-based treatment and support services in the community.

The majority of individuals served by the CMHP are diagnosed with schizophrenia or bipolar disorder. Slightly more than half of all individuals served by the CMHP are homeless at the time of arrest. Among the subset of individuals identified as heavy users, rates of homelessness at time of arrest are typically between 70 and 80 percent. An even higher percentage of individuals are not receiving any type of entitlement benefits and have no other means of economic self-sufficiency at the time of program entry. Not surprisingly, the vast majority of individuals served by the CMHP report they were not receiving any type of mental health treatment at the time of arrest. In fact, only about one quarter of participants report receiving mental health treatment at the time of arrest, and in most cases the treatment received is considered minimal at best.

Analysis of current jail population. Although the total jail population has decreased 39% since 2007-2008, the MDCR Average Daily Population (ADP) Report indicates that there has been a dramatic increase in the number of inmates housed on mental health units in the jail. From January 2015 to June 2016 there was a 20% increase noted in the Mental Health Average Daily Population (MH ADP). In that same time period, there was a 90% increase in Level 2 (semi-acute on mental health units) MH ADP and a 70% increase in MH Level 3 (stable on mental health units). Of the roughly 65,600 bookings into the jail in FY 2014-2015, it is estimated that 20% (more than 13,000) involved individuals with SMI requiring intensive psychiatric treatment while incarcerated. Jackson Health System-Corrections Health Service reports that on any given day, approximately 1,400 of the individuals detained in the county jail facilities receive psychiatric medications. It is estimated that three-quarters of individuals with SMI in the jail experience a co-occurring substance use disorder.

At least part of the increase in inmates identified with mental illnesses in the jail is due to improvements in screening and assessment that have been implemented within the jail. More comprehensive medical screening and assessment now begins with the intake process (please see attached Health Screening Tool and Medical and Mental Health Evaluation). At the time of booking, Jackson Health System-Corrections Health Services provides an initial health assessment. The assessment addresses past and present treatment for mental illnesses, use of psychotherapeutic medications, family history of mental illness, current need for treatment, treatment for drug or alcohol problems in the past six months, and suicidality. Individuals with mental illnesses, who are identified, classified and directed as necessary to CHS staff, including a psychiatrist or social worker as needed, where a more in-depth health assessment is completed.

Priority as community concern. Miami-Dade County has recognized and responded to the problems related to people with mental illnesses involved in the justice system by taking steps to improve the community's infrastructure and ability to respond to individuals more effectively and appropriately. In response to a 2005 Grand Jury report critical of the conditions in the county jail, the county mayor convened a task force to implement the Grand Jury's recommendations.[9] To date, more than 4,700 law enforcement officers

[9] See: http://www.pacenterofexcellence.pitt.edu/documents/Miami-Dade-County-Final-Report.pdf

representing every municipality in the county, as well as MDCR and Miami-Dade Public Schools, have completed 40-hour Crisis Intervention Team (CIT) training provided by the CMHP. The county has demonstrated the priority it places on the CMHP by sustaining multiple grant-funded projects that have expanded the role of the program. In addition, with the support of a voter approved general obligation bond, the county is currently in the process of developing a first-of-its-kind mental health facility which will provide treatment, diversion, and re-entry service to individuals involved in the justice system. By co-locating key services and resources (e.g., treatment and social services, social supports, access to benefits) it is anticipated that many of the barriers that contribute to system fragmentation, lack of accountability, and difficulty in accessing services will be minimized or eliminated.

In September 2014, The South Florida Behavioral Health Network (SFBHN), in collaboration with the CMHP, was awarded a planning grant from the Health Foundation of South Florida (HFSF) to convene a two-day, Criminal Justice/Mental Health Mapping and Summit. The event was attended by a broad array of community leaders and stakeholders, encompassing more than 100 participants, which were concerned about individuals with serious mental illnesses and co-occurring substance use disorders involved in, or at risk of becoming involved in, the criminal justice system. The Summit was designed to identify strengths, weaknesses and areas of unmet need across the community, and to develop comprehensive recommendations for system improvements. This final report to the community (please see attached report), hopes to serve as a community blueprint for effectively responding to people with behavioral health needs that come into contact with the justice system. The report includes the identified community priorities and recommendations that will serve to inform and drive policy and legislation.

As part of a nationwide effort to reduce the over-representation of individuals with mental illnesses in jails, Miami-Dade County has actively participated in the planning and implementation of the Stepping–Up Initiative[10] sponsored by the Council of State Governments (CSG) Justice Center, the National Association of Counties (NACo), and the American Psychiatric Association (APA) Foundation. To date, a total of 299 counties across the country have passed resolutions in support of this campaign. Miami-Dade County was selected as one of four launch sites for the nationwide initiative because of the strong progress our community has made on this issue. A County resolution was passed on May 5, 2015 committing to actions to address this issue that will institute system-wide change. Toward this goal, a new Behavioral Health/Criminal Justice Cooperative Statement 2015 was presented and signed by stakeholders at the Stepping-Up Initiative Press Conference in May 6, 2015. Signatories included leadership of elected officials from Miami-Dade County, the Eleventh Judicial Circuit of Florida, the Public Defender's Office, the State Attorney's Office, Jackson Health System, NAMI of Miami, the South Florida Behavioral Health Network, and the Miami-Dade County Association of Chiefs of Police.

[10] See: https://stepuptogether.org/

Tab 5:

Project Design and Implementation
Capability and Experience
Project Timeline
Performance Measures and Evaluation
Sustainability

PROJECT DESIGN AND IMPLEMENTATION

Planning Council: Dade-Miami Criminal Justice Council. The Dade-Miami Criminal Justice Council was jointly created by the City of Miami Commission and the Miami-Dade County Board of County Commissioners in 1978. This Council assumed all responsibilities formerly carried out by the Dade County Criminal Justice Advisory Council (established in 1972). The Council's purpose is to encourage and facilitate coordination and cooperation between and among the various agencies of the Criminal Justice System of Miami-Dade County and to provide advice, analysis, and technical assistance to criminal justice-related agencies. As part of the Council, The Public Safety Coordinating Council (PSCC) Committee is charged with carrying out the duties required by s. 951.26, F.S. and is independent from, and shall not be subject to, the modifications by the Council. The Committee Chairperson is Judge Nushin Sayfie, Administrative Judge for the Circuit Court Criminal Division of the Eleventh Judicial Circuit of Florida. The PSCC meets quarterly and the composition of the group includes all the necessary stakeholders to be in compliance with Florida Statue 394.657(2)(a). The Strategic Plan 2016 was reviewed by the PSCC on September 14, 2016, and the committee will remain involved in program implementation and expansion. A standing item will be added to the agenda of the PSCC and will be discussed at quarterly meetings.

Strategic Plan. There are multiple strategic plans that have been designed to address the over-representation of people with behavioral health needs that come into contact with the criminal justice system. Plans identify current strengths, opportunities for improvement, and areas of unmet need across the community and seek to develop comprehensive recommendations for system improvements. Please find the Miami-Dade County, Criminal Justice, Sequential Intercept Mapping and Summit, 2014, Community Blueprint Final Report, and the Miami-Dade County, Behavioral Health/ Criminal Justice, Cooperative Statement 2015 (please see attachments).

The Strategic Plan 2016 addresses the overarching goal to expand the CMHP to increase public safety, avert increased spending on the criminal justice system, and improve the accessibility and effectiveness of treatment services for adults who have SMI or co-occurring SMI and substance abuse disorders, which are in or at risk of entering the criminal justice system. There are 3 primary objectives:

1. Improve screening and identification of individuals booked into the jail who are eligible to participate in mental health jail diversion programs,

2. Strengthen partnerships and improve communication among justice system and community stakeholders through cross-system collaborations, and

3. Provide efficient and effective transition planning that will enhance public safety by increasing the possibility that individuals will participate in supervision and complete treatment requirements that will promote recovery and successful community integration.

RFA06H16GS1: Miami-Dade County – 2016
Criminal Justice, Mental Health, and Substance Abuse
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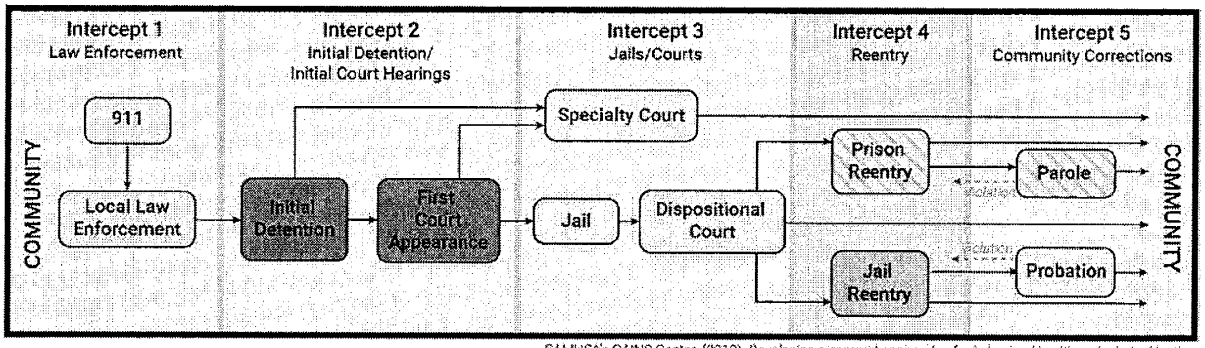
Miami-Dade County Jail In-Reach Team Project

Please see letter from the Chair of the Public Safety Coordinating Council, 2016 Strategic Plan, and completed Strategic Plan Format attached.

Interagency Communication. To establish on-going communication and collaboration among project partners (i.e, CMHP, MDCR, CHS, and SFBHN), bi-monthly meetings will be held to review project operations, explore opportunities for performance improvement, and streamline data sharing and information exchange. Project partners will have weekly staff meetings to address and review participant referrals, screening, assessments, transition plans, engagement, linkage to treatment/services, court issues, and ongoing community support. Stakeholders will also review and discuss program implementation and operations during quarterly PSCC meetings.

Intercept points. The Sequential Intercept Model (SIM) was developed in 2006 by the National GAINS Center as a conceptual framework to assist communities in examining the interface between the criminal justice and mental health systems, with the goal of minimizing unnecessary involvement of people with mental illnesses in the justice system. The SIM organizes justice system involvement along five key points, or intercepts, where there are opportunities to divert individuals from further penetrating into the system. The goal is to divert individuals as early as possible in the criminal justice process, with the hope that providing appropriate treatment and supports will decrease the numbers of people at each subsequent point. Figure 1 illustrates the various intercept points and where they occur along the continuum of criminal justice system involvement.

Figure 1. Sequential Intercept Model



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

Using the SIM as a conceptual framework, the proposed expansion will target individuals at the third (jail/courts) and fourth (re-entry) intercepts. These intercepts are selected because they provide opportunities to divert individuals from the jail pre-trial thereby reducing burdens on MDCR and CHS to expand services to address unmet re-entry needs.

Approach, design, and implementation. In recent years, progress has been made around the development of innovative strategies and interventions that aim to reduce or avoid unnecessary involvement of people with SMI in the justice system. Examples include crisis intervention team (CIT) training that teaches law enforcement officers to better recognize and respond to psychiatric emergencies in the community and problem-solving courts that provide opportunities for diversion from the justice system, as well as judicial monitoring of treatment linkages and engagement.

While these approaches have proven effective in helping to address the overrepresentation of people with SMI in the criminal justice system, correctional populations continue to demonstrate disproportionate numbers of people with mental illnesses. Part of the reason for this is that, while individual components of these interventions may incorporate evidence based practices, too often the infrastructure that links different components of systems and serves as the foundational framework for coordination and continuity of care is underappreciated or overlooked altogether.

One of the most critical areas of need, and perhaps the most commonly neglected among criminal justice/mental health problem solving approaches, is the period of transition from the community to incarceration and back to the community again. Because of disconnected organizational processes and missions, as well as lack of information sharing between community and correctional settings, there tends to be relatively little communication between the "inside" and "outside" worlds.

For many individuals, this process involves significant disruption and disintegration of life-health functioning. While incarcerated, ties to the community are often severed, lack of information sharing means treatment needs may go unmet, and illnesses are often made worse. Upon release, many individuals experience difficulty accessing services and supports (including necessities such as food, clothing, housing, and transportation) necessary to facilitate adaptive community re-entry and reintegration. As a result, even if referrals for follow-up treatment services are provided, it is unlikely individuals will follow through when they are struggling just to obtain basic survival needs.

Reentry into the community following a period of incarceration is a vulnerable and high risk time for people with SMI, particularly those who lack social and financial resources. The process is often marked by difficulties adjusting to the demands of the outside world (as compared to the institutional structure of a jail), inconsistent treatment compliance (e.g., forgetting to take medications on time), increased risk of drug and alcohol use, and a 12-fold increased risk of death in the first two weeks after release. Effective transition planning and implementation can minimize the risk of these hazards, enhance public safety by increasing the possibility that individuals will participate in and complete supervision and treatment requirements, and improve individual outcomes.

The proposed project will employ evidence-based transition planning, to expedite identification, assessment, and community reentry for adults assessed to be at moderate to high risk of future recidivism to the justice system, acute care treatment, and/or other

institutional settings. This initiative will also incorporate validated risk and needs assessment tools to assist in the development of re-entry and diversion planning. This is an emerging best practice for the targeted population and will match the individuals' level of risk and behavioral health needs with the appropriate levels of supervision and treatment. It is hypothesized that more efficient identification, transition planning, diversion, and service linkages will result in improved access to treatment and support services in the community, which in turn will result in improved mental health, criminal justice, and public safety outcomes.

The CMHP receives a daily Misdemeanor Mental Health Report from MDCR. There is currently an average of 10 people daily in jail custody that are waiting for review of eligibility. CMHP staff review the list for criminal holds and/or any information that would rule out diversion. The list is then returned to CHS to determine clinical eligibility for diversion. The case is then referred back to CMHP for diversion out of jail to the community. The process is slow, redundant, cumbersome, and offers multiple opportunities for errors and miscommunications.

The proposed project team will expedite, coordinate, and provide a structured framework to guide this process. The newly created in-reach team will work collectively, with input from project participants, to screen, assess, and develop an individualized transition plan for community reentry. This will serve to divert people from the jail as quickly as possible. Staff will "connect the dots" and ensure that all necessary requirements for re-entry from jail to the community are in place. Program participants will be offered to voluntarily engage in community-based treatment and services and staff will assist with the development of transition plans that will provide linkages to housing, psychiatric treatment, primary care, medication, access to entitlement benefits, and supportive services. In addition, the CMHP will assist clients with the navigation of the criminal justice system, manage the court requirements including collecting compliance reports and provide assistance throughout the participation in the program. The full continuum of behavioral health care, including evidence-based practices and programs geared toward the target population, will be provided by SFBHN through its contracted behavioral health organizations as well as existing Miami-Dade County services and private behavioral health providers.

The proposed project will create a specialized Jail In-Reach Team that will be guided by shared commitment to cross-system collaboration and division of responsibilities among criminal justice and community partners to:

1. Efficiently gather and review information necessary to make determinations regarding eligibility for participation in diversion programs; including the use of validated, evidence-based risk and need assessment tools (*MHSF-III, TCUDS V, and ORAS-CST*),

2. Develop and implement evidence-based transition and reentry plans emphasizing continuity and coordination of care using the *APIC Model*,

3. Monitor ongoing linkages to evidence-based treatment and services in the community, and

4. Measure outcomes to facilitate performance improvement and demonstrate impact on criminal justice, behavioral health, and recovery outcomes.

In addition to the in-reach team, program participants will be monitored by case management and peer support staff from the CMHP for at least one year following program enrollment. Monitoring will involve face-to-face, telephone, and other forms of electronic contact with project participants, treatment providers, and collateral contacts in the community.

Flexible funding will also be budgeted to provide for immediate access to essential services so that the participants who are indigent and/or homeless will be assisted to meet their basic needs upon community reentry. This would include but not be limited to, housing, transportation, legal identification, medical, and behavioral health treatment needs.

Table 4. Jail In-Reach Team key staff positions

Position	Agency	Funding Source	Role
Licensed Clinical Social Worker	CHS	Grant	Provide identification, screening, assessment and collection of any medical information necessary to expedite the release to the community from jail
Care Coordinator	SFBHN	Grant	Serve as a boundary spanner across jail and the community, will utilize validated risk and needs assessments to determine appropriate level of care, transition plans to the community, and provide active linkage and communication with existing and newly identified services and supports
Recovery peer specialist	SFBHN	Grant	Provide on-going, one-on-one and group support upon re-entry to the community and for quarterly follow up
Jail Diversion Corrections Specialist	CHS	In-kind	Engage program participants in jail and gather necessary information for release from jail
Re-entry Counselor	MDCR	In-kind	Provide engagement and support to program participants as well as gather necessary information for release from jail

Project assistant	SFBHN	Grant	Collect all necessary information and data to record outcomes for the grant performance measures report
CMHP Project Director	CMHP	In-kind	Provide administration, coordination and supervision

Describe the plan to screen potential participants and to conduct tailored, validated needs-based assessments. The importance of utilizing valid and reliable screening and assessment tools is indisputable. There are high prevalence rates of behavioral health and related disorders in justice settings. Programs that use comprehensive assessments have better outcomes and are less likely to experience people with undetected disorders who cycle back through the criminal justice system.

The process for screening/assessment, referral, transition planning, and diversion/linkage to services is as follows:

I. **Screening/assessment:** At the time of booking, Jackson Health System, Corrections Health Services provides an initial health assessment. The assessment will address past and present treatment for mental illnesses, use of psychotherapeutic medications, family history of mental illness, current need for treatment, treatment for drug or alcohol problems in the past six months, and suicidality. Individuals with mental illnesses, who are identified, classified and directed as necessary to CHS staff, including a psychiatrist or social worker as needed, where a more in-depth health assessment is completed.

II. **Referral:** Upon referral and acceptance of diversion program, the proposed project will utilize validated assessment tools to determine mental health, substance use and criminogenic risks/ needs to inform the transition plan and to determine the appropriate level of treatment, support services and community supervision, A two page summary is developed that is used to inform an individualized transition plan aimed at reducing criminal justice recidivism and improved psychiatric and recovery outcomes. The tools include:

    a. The Mental Health Screen Form III (MHSF-III) was designed specifically to screen for mental health problems.

    b. The Texas Christian University Drug Screen V (TCUDS V) includes 19 items that examine diagnostic symptoms of drug use.

    c. Ohio Risk Assessment: Community Supervision Tool (ORAS-CST) is a dynamic risk/needs assessment system to be used with adult offenders. It offers criminal justice stakeholders the ability to assess individuals at various decision points across the criminal justice system.

III. **Transition planning:** The project will utilize the *APIC Model*,[11] which is a best-practice approach for transition planning and community re-entry from jail for people with mental health and co-occurring substance use disorders. The model has been identified to promote the behavioral health and criminal justice partnerships necessary to successfully identify which people need services, what services they need and how to match these needs upon transition to the community. Unfortunately, the outcomes of inadequate transition planning may precipitate increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness and re-arrest. In contrast, effective transition planning can minimize the risks of reentry and can enhance public safety by increasing the possibility that individuals will access and participate in housing, treatment and services that promote improved individual recovery outcomes.

Table 5. The APIC Model

The APIC Model provides a set of critical elements that are likely to improve outcomes for the target population. APIC is an acronym standing for: *Assess, Plan, Identify,* and *Coordinate:*
Assess the clinical and social needs and public safety risks of the individual. Gather information, catalog needs, consider cultural issues, engage individual in self-assessment, and ensure access to and means to pay for services.
Plan for the treatment and services required to address the individual's needs. Address critical period following release from jail, as well as long-term needs, seek family input, address housing needs, arrange integrated treatment for people with co-occurring disorders, and ensure access to medications as needed.
Identify programs responsible for services. Specify appropriate referrals in the treatment plan, forward treatment summaries to the provider, and ensure the treatment plan reflects the individual's level of disability, motivation for change, and availability of community resources.
Coordinate the transition plan to ensure implementation and to avoid gaps in care. Utilize case management services, make referral and placement decisions cooperatively, provide consumers with specific contact information for providers, and follow up with consumers who miss scheduled appointments.

The APIC Model represents a transition plan that is individualized for each program participant. The goal of the plan is to support community living, reduce maladaptive behaviors, and decrease the chances that individuals will re-offend and reappear in the criminal justice system.

[11] See: https://csgjusticecenter.org/jc/publications/a-best-practice-approach-to-community-re-entry-from-jails-for-inmates-with-co-occurring-disorders-the-apic-model-2/

https://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-Successful-Transition.pdf

RFA06H16GS1: Miami-Dade County – 2016
Criminal Justice, Mental Health, and Substance Abuse
Reinvestment Grant Program
Miami-Dade County Jail In-Reach Team Project

APIC Model Implementation

Table 6: Assess

Objective #1.1:	Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk.			
	Task	**Performance Measure**	**Lead Agency(s)**	**Timeframe**
1.1.1	Regularly screen and rescreen individuals upon entry into the jail using valid and reliable screening instruments.	Health screening tool	CHS	Within 8 hours of jail admission and rescreened every 14 days
Objective #1.2:	For individuals with positive screens, follow up with comprehensive assessments to guide appropriate placement and service delivery, and to determine eligibility for participation in jail diversion program.			
	Task	**Performance Measure**	**Lead Agency(s)**	**Timeframe**
1.2.1	Assess demographics and pathways to criminal involvement	CJIS	CMHP	Upon referral
1.2.2	Assess clinical needs (e.g., identification of probable or identified diagnoses, severity of associated impairments, and motivation for change)	Medical and Mental Health Evaluation MHSF-III TCUDS V	CHS CMHP CMHP	Within 24-48 hours of booking Upon referral Upon referral
1.2.3	Assess strengths and protective factors (e.g., family and community support)	JDP Needs Assessment	CMHP	Upon referral
1.2.4	Assess social and community support needs (e.g., housing, education, employment, and transportation)	JDP Needs Assessment	CMHP	Upon referral
1.2.5	Assess public safety risks and needs, including changeable (dynamic) and unchangeable (static) risk factors, or behaviors and attitudes that research indicates are relating to criminal behavior	ORAS	CMHP	Upon referral

RFA06H16GS1: Miami-Dade County – 2016
Criminal Justice, Mental Health, and Substance Abuse
Reinvestment Grant Program
Miami-Dade County Jail In-Reach Team Project

Table 7: Plan

Objective #2.1:	Develop Individualized treatment and service plans using information obtained from the risk and needs screening and assessment process			
	Task	**Performance Measure**	**Lead Agency(s)**	**Timeframe**
2.1.1	Determine the appropriate level of treatment and intensity of supervision, when applicable, for individuals with behavioral health needs.	Transition plan	CMHP SFBHN	Within 24-48 hours of referral
2.1.2	Identify and target individuals' multiple criminogenic needs in order to have the most impact on recidivism.	Transition plan	CMHP SFBHN	Within 24-48 hours of referral
2.1.3	Address the aspects of individuals' disorders that affect function to promote effectiveness of interventions.	CMHP Risk and Need Assessment	CMHP SFBHN	Within 24-48 hours of referral
2.1.4	Develop strategies for integrating appropriate recovery support services into service delivery models.	Weekly team meetings Linkage to peer support	CMHP CMHP	Weekly Upon acceptance into diversion program
2.1.5	Acknowledge dosage of treatment as an important factor in recidivism reduction, requiring the proper planning and identification of what, where, and how intensive services provided to individuals will be.	Weekly team meetings Case plan reviews	CMHP SFBHN MDCR CHS	Weekly Weekly
Objective #2.2:	**Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.**			
	Task	**Performance Measure**	**Agency(s)**	**Timeframe**
2.2.1	Administer risk and need assessment to all program participants	CMHP Risk and Need Assessment	CMHP	Within 24-48 hours of referral
2.2.2	Staff cases with treatment team and develop transition plan.	Transition plan	CMHP MDCR CHS SFBHN	Within 24-48 hours of referral

2.2.3	Engage quarterly forensic stakeholders meeting to discuss issues relevant to project operations.	Forensic Stakeholders' Meeting	All community and CJ partners	Quarterly
2.2.4	Discuss forensic treatment needs and systems issues with SFBHN strategic planning committee	Strategic Planning Committee Meeting	SFBHN CMHP CBOs	Monthly as needed

Table 8: Identify

Objective #3.1:	Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with mental and co-occurring substance use disorders leaving correctional settings.			
	Task	**Performance Measure**	**Lead Organization (s)**	**Timeframe**
3.1.1	Identify reentry housing needs	Transition plan	CMHP	Upon referral
3.1.2	Identify treatment	Transition plan	CMHP	Upon referral
3.1.3	Identify economic self-sufficiency needs	SOAR assessment	CMHP	Upon referral
3.1.4	Assess need for trauma	CMHP Risk and Need Assessment	CMHP	Upon referral
3.1.5	Identify recovery support needs	CMHP Risk and Need Assessment	CMHP	Upon referral
Objective #3.2:	Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages (i.e., warm hand-offs) for post-release treatment and supervision agencies.			
	Task	**Performance Measure**	**Agency(s)**	**Timeframe**
3.2.1	Develop agreed upon referral protocols among project partners	Referral procedure	CMHP MDCR CHS SFBHN	Within 3 month of award. Review and update as needed
3.2.2	Develop referral protocol for community treatment linkages	Development of standard referral form	CMHP CBOs	Within 3 month of award. Review and update as needed
3.2.3	Develop court reporting protocols	Development of standardized court report	CMHP Judiciary PDO SAO SFBHN CBOs	Within 3 month of award. Review and update as needed

Table 6: Coordinate

Objective #4.1:	Support adherence to treatment plans and supervision conditions through coordinated strategies.			
	Task	**Performance Measure**	**Lead Organization (s)**	**Timeframe**
4.1.1	Provide a system of incentives and graduated sanctions to promote participation in treatment; maintain a "firm but fair" relationship style; and employ problem-solving strategies to encourage compliance, promote public safety, and improve treatment outcomes.	Court reports Program progress reports	CMHP Judiciary PDO SAO SFBHN CBOs	Based on frequency of court monitoring Monthly
4.1.2	Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions.	Court reports Program progress reports	CMHP Judiciary PDO SAO SFBHN CBOs	Based on frequency of court monitoring Monthly
Objective #4.2:	**Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.**			
	Task	**Performance Measure**	**Agency(s)**	**Timeframe**
4.2.1	Develop agreed upon referral protocols for communication and information sharing	Referral procedure	CMHP MDCR CHS SFBHN	Within 3 month of award. Review and update as needed
4.2.2	Identify release of information forms and other consent forms, as needed, to facilitate information exchange among project partners	Release forms	CMHP MDCR CHS SFBHN	Within 3 month of award. Review and update as needed

4.2.3	Review participant activity in criminal justice and behavioral health information systems		CMHP SFBHN	Upon initiation of program operations and ongoing thereafter
Objective #4.3:	Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with mental and co-occurring substance use disorders who are involved in the criminal justice system.			
	Task	**Performance Measure**	**Agency(s)**	**Timeframe**
4.3.1	Participate in community training opportunities	Attendance at trainings	CMHP MDCR CHS SFBHN	As available
4.3.2	Provide training and technical support to community stakeholders regarding project operations	Training and TA provided	CMHP SFBHN	As needed
4.3.3	Explore opportunities to expand community collaborations	Bi-weekly project operations meeting Quarterly forensic stakeholder meetings	CMHP MDCR CHS SFBHN	Bi-weekly Quarterly
Objective #4.4:	Collect and analyze data			
	Task	**Performance Measure**	**Agency(s)**	**Timeframe**
4.4.1	Evaluate program performance	Collection of outcome and performance measures	CMHP	Ongoing with monthly review
4.4.2	Identify gaps in performance	Weekly treatment team meetings Bi-weekly project operations meeting Quarterly forensic stakeholder meetings	CMHP MDCR CHS SFBHN	Weekly Bi-weekly Quarterly

4.4.3	Plan for long-term sustainability	Provide update on sustainability activities in quarterly PSCC report	CMHP MDCR CHS SFBHN	Quarterly

IV. **Diversion and Linkage to Evidence-based Treatment and Services.** Depending on individuals' needs, resources, and the availability of services, participants may be referred to one or more treatment providers. The Care Coordinator will work along with the program participant to ensure that the transition from the acute and restrictive environment of jail or Crisis Stabilization Unit, to the less restrictive community-based levels of care is in place. The APIC transition plan will provide the blueprint for successful engagement, treatment and services. The transition plan will provide identification of key service components addressing the recognized needs of the individual. Evidence-based approaches that are available in our community include:

a. Medication management

b. Intensive case management

c. Assertive community treatment

d. Outpatient services

e. Inpatient

f. Residential treatment services, including specialized co-occurring treatment focused on criminogenic risk factors

g. Peer Specialist support

h. Wellness, Recovery, Action, Plan – WRAP

i. Trauma Specific Treatment

j. Treatment for co-occurring SMI and substance use disorders

k. Cognitive behavioral interventions targeted criminogenic risk factors

l. Primary medical care

m. Clubhouse programs/Drop In Centers

n. Supportive housing

o. Supportive employment/education

p. Transportation

q. Access to entitlement benefits and other means of economic self-sufficiency

CAPABILITY AND EXPERIENCE

This proposal will build upon the success of the CMHP and represents a collaborative effort among stakeholders in the criminal justice and behavioral healthcare systems in Miami-Dade County. The collaboration will be among the CMHP, MDCR, CHS, and SFBHN. This effort will be accomplished through an enhanced cross-system collaboration focused on providing effective criminal justice and behavioral health treatment interventions with the goals of reducing recidivism and promoting recovery.

Criminal Mental Health Project (CMHP). The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP); a state and county funded, court based initiative which has developed innovative approaches to identifying and diverting individuals with SMI and co-occurring substance use disorders who become involved in the criminal justice system into community-based treatment and support services. The CMHP works by coordinating diversion services and helping to facilitate productive relationships among traditional and non-traditional stakeholders. The goal is to eliminate gaps in services and to improve communication across systems and stakeholders. The program operates two components. The pre-booking diversion, Crisis Intervention Team (CIT) training for law enforcement officers, provides training and collaborates with 36 police municipalities in Miami-Dade County. The post-booking diversion misdemeanor and felony programs serve individuals booked into the jail and are awaiting adjudication.

Miami-Dade Corrections and Rehabilitation (MDCR). The Miami-Dade Corrections and Rehabilitation Department operates the eighth largest jail system in the country. There are between 4,000 to 4,500 persons incarcerated daily in four detention facilities. These persons are awaiting trial or serving sentences of 364 days or less. The department maintains accreditation with the American Correctional Association (ACA) and the Florida Corrections Association Commission, Inc.

Jackson Health System (JHS), Corrections Health Services (CHS). JHS vigorously pursues its mission to build the health of the community by providing a single, high standard of quality care for the residents of Miami-Dade County. Facilitating enhanced access to healthcare is a core aspect of this mission, and JHS uses multiple strategies to improve community health over the long-term. Corrections Health Services is part of this strategy. CHS employs about 400 people to serve detainees' medical and mental health care needs at four main correctional facilities. The full gamut of healthcare professionals treat and care for them: Psychiatrists, Attending Physicians, Advanced Registered Nurse Practitioners, Physician Assistants, Clinical Staff Nurses, Practical Nurses, Medical

Assistants, Licensed Clinical Social Workers, Psychologists, Dental Assistants, Discharge Coordinator, Training, Quality Improvement and Support staff.

South Florida Behavioral Health Network (SFBHN). South Florida Behavioral Health Network is a nonprofit, managing entity that provides comprehensive planning, coordination, collaboration, advocacy, contract management and fiscal oversight of behavioral health prevention and treatment services in South Florida. The organization is committed to improving the lives of people with mental disorders and addiction problems. Their goal is to develop, implement and refine a coordinated system of behavioral health care within the community that enhances prevention, treatment and recovery services for those at risk of or who are suffering from mental health and substance abuse problems. Adults who have mental illness or co-occurring mental health and substance use disorders that are in, or at risk of entering the criminal justice system have been identified as a priority group and resources are made available to access the system of care.

Community Collaboration. The CMHP's success and effectiveness depends on the commitment of stakeholders throughout the community. Such cross-system collaboration is essential for the transition from the criminal justice system to the community mental health system. Program operations rely on collaboration among community stakeholders including: the State Attorney's Office, the Public Defender's Office, the Miami-Dade County Department of Corrections and Rehabilitation, the Florida Department of Children and Families, the Social Security Administration, Veterans Administration, United States Citizen and Immigration Service (USCIS), the Homeless Trust, public and private behavioral health providers, Jackson Memorial Hospital-Public Health Trust, law enforcement agencies, family members, and mental health consumers. CMHP staff takes an active role in supporting mental health recovery and community integration and participates on a variety of community forums, meetings and agency board of directors. This includes advocacy, consumer and family organizations such as NAMI of Miami, The Consumer Network, Florida Partners in Crisis and the Key Clubhouse. Please see attached letters of commitment from project partners as well as letters of support.

Proposed Staff. The grant funding will be utilized to expand the project and will implement the proposed Jail In-Reach Team, which will be comprised of staff that will be dedicated solely to the project:

- Licensed Clinical Social Worker (CHS 1 FTE) to provide identification, screening, assessment and collection of any medical information necessary to expedite the release to the community from jail
- Care Coordinator (SFBHN 1 FTE) will serve as a boundary spanner across jail and the community, will utilize validated risk and needs assessments to determine appropriate level of care, transition plans to the community, and provide active linkage and communication with existing and newly identified services and supports

- Recovery Support Peer Specialist (SFBHN 1 FTE) will engage program participants and provide community support for re-entry and follow-along in the community
- Research Assistant (SFBHN 0.50 FTE) will collect all necessary information and data to record outcomes for the grant performance measures report

The in-kind match will be drawn from existing positions that are currently serving the target population in jail (MDCR, and CHS) and the court system (CMHP):

- Project Director (CMHP 0.20 FTE) will coordinate and supervise team efforts
- MH Coordinator (CMHP 0.05 FTE) will coordinate outcome and performance measures
- Misdemeanor Team Leader (CHMP 0.20 FTE) will coordinate and supervise court case scheduling, monitoring, transition plans to the community
- Felony Team Leader (CMHP 0.20 FTE) will coordinate and supervise court case scheduling, monitoring, transition plans to the community
- Chief Clinical Social Worker (CHS 0.15 FTE) will coordinate and supervise CHS activities
- Jail Diversion Corrections Specialist (CHS 0.82 FTE) will engage identified program participants in jail and gather necessary information for release from jail
- Correctional Officer (MDCR 1 FTE, 0.50 FTE) duties to include maintaining various records, transportation of inmates to medical interviews and ensuring proper discharge
- Re-entry Counselor (MDCR 1 FTE) provide engagement and support to program participants as well as gather necessary information for release from jail

PROJECT TIMELINE

Goals	Objectives	Key activities	Milestones	Responsible partners
Establish on-going communication, collaboration, and partnerships among all relevant county partners with respect to people with mental illness, substance use disorders, or co-occurring	Continue to hold regular stakeholder meetings Develop reports summarizing project activities, processes, and outcomes	Meet with stakeholders to explore opportunities to improve or streamline data sharing and information exchange Submit semi-annual progress report	Ongoing, starting upon grant award Ongoing, beginning in month 6	CMHP, MDCR, CHS, SFBHN CMHP

disorders who are in, or at risk of entering, the criminal justice systems		Submit annual fiscal report Complete annual evaluation report	Ongoing, beginning in Month 12 Ongoing, beginning in Month 12	CMHP CHMP
Protect public safety Effectively divert and treat people with mental illness, substance use disorders, or co-occurring disorders who are in, or at risk of entering, the criminal justice systems Avert increased spending on criminal and/or juvenile justice Avert increased spending on F.S 916 Forensic Beds	Implement Community Transition and Re-entry Collaboration Utilize Information Tracking system Assist program participants in accessing treatment and support services Identify needs, strengths, and risk factors for program participants	Hire and train staff Implement standard operating procedures Develop monthly performance measure report Begin recruitment of program participants Begin administering risk and needs screening and assessment Begin linking program participants to community-based treatment services and supports and assist with	Ongoing, beginning in month 2 Ongoing, beginning in month 2 Ongoing, beginning in month 2 Ongoing, beginning in month Ongoing, beginning in month 2 Ongoing, beginning in Month 2	CMHP CMHP CMHP CHS, MDCR, SFBHN, CMHP CMHP, SFBHN CMHP, SFBHN

		community re-entry and reintegration. Monitor program participants' linkage and access to services Begin data collection and analysis	 Ongoing, beginning in Month 2 Ongoing, beginning in Month 2	 CMHP CMHP

Performance Measures and Evaluation
The Strategic Plan 2016 includes required performance measures as well as the additional measures requested for the project. These measures will be carefully compiled into a monthly report that will be utilized to disseminate information to project partners and stakeholders but also as a management tool to address performance. The plan will be utilized as a project roadmap to achieving successful project goals and objectives. In addition, the APIC Model Implementation (page 18-23) includes performance measures and time frames that will be included in the evaluation of the project.

An estimate of how the project will reduce expenditures associated with the incarceration can be determined by collecting information on the number of referrals that result in diversion from the county jail and the number of individuals formally enrolled in the project. Individuals that are diverted from the jail will have a lower average length of stay (LOS) that can be translated into a lower average cost. Based on past performance of the CMHP, it is estimated that the individuals enrolled in the project will have a 45% reduction in total annual jail days and costs.

Sustainability. The CMHP has been successful in demonstrating improved public safety, meaningful cost avoidance, decreased burdens on the justice system, and improved recovery outcomes among individuals served by its programs. To date, Miami-Dade County has demonstrated enthusiastic support for sustaining the CMHP and for the development of a more effective system of care. In 2006, the county sustained CMHP operations by providing funding to support staff positions created under a federal targeted capacity expansion grant. The Implementation/Expansion Grant received in 2008, to expand post-booking, pre-trial jail diversion to include individuals charged with lower level felonies was sustained by Miami-Dade County upon the grant completion. The Implementation/Expansion Grant of 2010 to develop a consolidated entitlement benefits access unit to expedite access to SSI/SSDI, Medicaid, and other means of self-sufficiency for individuals re-entering the community from the jail was sustained by the South Florida

Behavioral Health Network. In addition, through the Homeless Trust, the county has demonstrated a sustained commitment to provide housing and wraparound services to chronically homeless individuals served by the CMHP.

CMHP, MDCR, CHS and the SFBHN, will work with community partners and the county planning council to maximize strategic planning under the proposed expansion. Program information and program outcomes will be made available to county, state, and federal funding agencies and policy makers with the goal of demonstrating that ongoing investment in the types of services proposed under this expansion will result more cost effective and sustainable programs that make substantial contributions to improving public safety and public health. The collaboration on the proposed expansion will enhance efforts to sustain operations by lending broader applicability to the project and its outcomes, and by increasing the relevance of evaluation findings to various policymakers and funding entities.