DCF RFA 2021 001

APPENDIX C – COVER PAGE FOR GRANT APPLICATION

Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant

PROPOSAL INFORMATION	
Type of Grant:	Planning Grant ☐ Implementation and Expansion Grant ☒
Project Title:	Helping Achieve Targeted Comprehensive Healthcare
County(ies):	Polk County, Florida
Preferred Project Start Date:	October 1, 2021
APPLICANT INFORMATION	
Type of Applicant	County Government ☒ Consortium of County Governments ☐ Managing Entity ☐ NFP Community Provider ☐ Law Enforcement Agency ☐
Applicant Organization Name:	Polk County, a political subdivision of the State of Florida
Contact Name & Title:	Sarah Campbell, Grants & Project Development Specialist
Street Address	330 West Church Street
City, State and Zip Code:	P. O. Box 9005, Drawer # AS07
Email:	sarahcampbell@polk-county.net
Phone:	863-519-2049
ADDITIONAL CONTACT	
Participating Organization Name:	
Contact Name & Title:	
Street Address	
City, State and Zip Code:	
Email:	
Phone:	

FUNDING REQUEST AND MATCHING FUNDS		
	Total Amount of Grant Funds Requested	Total Matching Funds:
Program Year 1	$400,000	$400,000
Program Year 2	$400,000	$400,000
Program Year 3	$400,000	$400,000
Total Project Cost	$1,200,000	$1,200,000

CERTIFYING OFFICIAL	
Certifying Official's Signature:	
Certifying Official's Name (printed):	William D. Beasley
Title:	County Manager
Date:	2/24/2021

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APPENDIX D – STATEMENT OF MANDATORY ASSURANCES

		Initial
A.	**Infrastructure:** The Applicant shall possess equipment and Internet access necessary to participate fully in this solicitation.	
B.	**Site Visits:** The Applicant will cooperate fully with the Department in coordinating site visits, if desired by the Department.	
C.	**Non-discrimination:** The Applicant agrees that no person will, on the basis of race, color, national origin, creed or religion be excluded from participation in, be refused the benefits of, or be otherwise subjected to discrimination pursuant to the Act governing these funds or any project, program, activity or sub-grant supported by the requirements of, (a) Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended which prohibits discrimination the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in employment or any program or activity that receives or benefits from federal financial assistance on the basis of handicaps; (d) Age Discrimination Act 1975, as amended which prohibits discrimination on the basis of age, (e) Equal Employment Opportunity Program (EEOP) must meets the requirements of 28 CFR 42.301.	
D.	**Lobbying:** The Applicant is prohibited by Title 31, USC, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," from using Federal funds for lobbying the Executive or Legislative Branches of the federal government in connection with a specific grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal funds if grants and/or cooperative agreements exceed $100,000 in total costs (45 CFR Part 93).	
E.	**Drug-Free Workplace Requirements:** The Applicant agrees that it will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76.	
F.	**Smoke-Free Workplace Requirements:** Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library projects to children under the age of 18, if the projects are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's projects provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.	
G.	**Compliance and Performance:** The Applicant understands that grant funds in Years 2 and 3 are contingent upon compliance with the requirements of this grant program and demonstration of performance towards completing the grant key activities and meeting the grant objectives, as well as availability of funds.	
H.	**Certification of Non-supplanting:** The Applicant certifies that funds awarded under this solicitation will not be used for programs currently being paid for by other funds or programs where the funding has been committed.	
I.	**Submission of Data:** The Applicant agrees to provide data and other information requested by the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the Florida Mental Health Institute to enable the Center to perform the statutory duties established in the authorizing legislation.	
J.	**Submission of Reports:** The Applicant agrees to submit quarterly progress reports and quarterly fiscal reports, signed by the County Administrator, to the Department.	

Appendix H (cont.)

BASIS OF VALUATION

Building/Space

1. Donor retains title:
   a. Fair commercial rental value - Substantiated in provider's records by written confirmation(s) of fair commercial rental value by qualified individuals, e.g., Realtors, property managers, etc.
   b. (1) Established monthly rental of space $_____
   (2) Number of months donated during the contract _____
   Value to the project [b.(1) X b.(2)] $_____
2. Title passes to the County:

   Depreciation
   a. Cost of Fair Market Value (FMV) at acquisition (excluding land) $ 8,856
   b. Estimated useful life at date of acquisition _____ yrs.
   c. Annual depreciation (a./b.) $_____
   d. Total square footage _____ sq. ft.
   e. Number of square feet to be used on the grant program _____ sq. ft.
   f. Percentage of time during contract period the project will occupy the building or space _____ %
   Value to project (e./d. X f. X c.) $_____

   Use Allowance
   a. To be used in the absence of depreciation schedule (i.e., when the item is not normally depreciated in the County's accounting records).
   b. May include an allowance for space as well as the normal cost of upkeep, such as repairs and maintenance, insurance, etc.

Equipment

1. Donor retains title: Fair Rental Value
2. Title passes to County:
   a. FMV at time of donation $_____
   or
   b. Annual value to project (not to exceed 6 2/3% X a.) = $_____

Goods or Supplies

FMV at time of donation $166,024

Personnel Services

1. Staff of another agency or organization:
   Annual Salary Number of hours 2080 X to be provided = $ 1,025,120
2. Volunteer -- Comparable annual salary $ _____
   Annual Salary Number of hours 2080 X to be provided = $_____

Appendix I - MATCH SUMMARY

(for the entire grant period)

Date - March 1, 2021

County - Polk County, a Political Subdivision of the State of Florida

Type of Grant - CJMHSA Reinvestment

Match Requirement Percentage - 100%

Total Match Required for the Grant $ 1,200,000

Match Committed:

Cash	$ 372,900
In-Kind	$ 827,100
Total	$ 1,200,000

Comments: _____

Prepared By Sarah Campbell

Approved By Kelvin Almestica 3.3.2021

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APPENDIX H – COMMITMENT OF MATCH DONATION FORMS

(FOR THE ENTIRE GRANT PERIOD)

TO: (name of county) Polk County, a political subdivision of the State of Florida

FROM: (donor name) Keystone Challenge Fund, Inc.

ADDRESS: 4200 South Florida Avenue
Lakeland, Florida 33813

The following ___ space, ___ equipment, ___ goods or supplies, and ___ services, are donated to the County _____ permanently (title passes to the County) _____ temporarily (title is retained by the donor), for the period _____ to _____.

Description and Basis for Valuation (See next page)

Description	Value
(1) Financial Literacy & Counseling	$22,830.00
(2) Program Specifically for Polk	$_____
(3) CJMHSA Program	$_____
(4) _____	$_____
	TOTAL VALUE $ 22,830.00

The above donation is not currently included as a cost (either direct or matching) of any state or federal contract or grant, nor has it been previously purchased from or used as match for any state or federal contract.

(Donor Signature)	2-24-2021 (Date)	(County Designee Signature)	3.8.2021 (Date)

Polk County CJMHSA Basic Financial Literacy and
Counseling Services Program provided by
Keystone Challenge Fund, Inc.:

Anticipated Class Attendance – 40 per year.

	2021 – 2022:	2022-2023:
Books & Supplies:	$ 450.00	$ 450.00
Coordinator:	$ 750.00	$ 750.00
Instruction, Keystone Staff:	$ 600.00	$ 600.00
Instruction, other, Bill Lavender:	$ 150.00	$ 150.00
1-on-1 Referrals @ $150.00 each (anticipate 30):	$4,500.00	$4,500.00
Refreshments:	$ 300.00	$ 300.00
Subtotal of Hard Costs:	**$6,750.00**	**$6,750.00**
Resource Development:	$ 250.00	$ 250.00
Administration and Recordkeeping:	$ 720.00	$ 720.00
Total Costs:	**$7,720.00**	**$7,720.00**

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APPENDIX H – COMMITMENT OF MATCH DONATION FORMS

(FOR THE ENTIRE GRANT PERIOD)

TO: (name of county) Polk County FL

FROM: (donor name) Tri-County Human Services, Inc

ADDRESS: 1815 Crystal Lake Drive
Lakeland, FL 33801

The following X space, ___ equipment, ___ goods or supplies, and ___ services, are donated to the County ____ permanently (title passes to the County) _____ temporarily (title is retained by the donor), for the period _____ to _____

Description and Basis for Valuation (See next page)

Description	Value
(1) Medical Detoxification Facility	$ 523512.00
(2)	$
(3)	$
(4)	$

TOTAL VALUE $ 523,512.00

The above donation is not currently included as a cost (either direct or matching) of any state or federal contract or grant, nor has it been previously purchased from or used as match for any state or federal contract.

(Donor Signature)	(Date)	(County Designee Signature)	(Date)
	3/2/2021		3.8.2021

Appendix H (cont.)

BASIS OF VALUATION

Building/Space

1. Donor retains title:
   a. Fair commercial rental value - Substantiated in provider's records by written confirmation(s) of fair commercial rental value by qualified individuals, e.g., Realtors, property managers, etc.
   b. (1) Established monthly rental of space $ 14542.00
      (2) Number of months donated during the contract 36
      Value to the project [b.(1) X b.(2)] $ 523512.00
2. Title passes to the County:

   Depreciation
   a. Cost of Fair Market Value (FMV) at acquisition (excluding land) $_____
   b. Estimated useful life at date of acquisition _____ yrs.
   c. Annual depreciation (a./b.) $_____
   d. Total square footage _____ sq. ft.
   e. Number of square feet to be used on the grant program _____ sq. ft.
   f. Percentage of time during contract period the project will occupy the building or space _____ %

   Value to project (e./d. X f. X c.) $_____

   Use Allowance
   a. To be used in the absence of depreciation schedule (i.e., when the item is not normally depreciated in the County's accounting records).
   b. May include an allowance for space as well as the normal cost of upkeep, such as repairs and maintenance, insurance, etc.

Equipment

1. Donor retains title: Fair Rental Value
2. Title passes to County:
   a. FMV at time of donation $_____
   or
   b. Annual value to project (not to exceed 6 2/3% X a.) = $_____

Goods or Supplies

FMV at time of donation

Personnel Services

1. Staff of another agency or organization:
   Annual Salary Number of hours 2080 X to be provided = $_____
2. Volunteer – Comparable annual salary $ _____
   Annual Salary Number of hours 2080 X to be provided = $_____

Broadway Real Estate Services
100 South Kentucky Avenue I Ste 290
Lakeland, Florida 33801

BROADWAY
REAL ESTATE SERVICES

August 30, 2017

Via Email (dvanstee@TCHSonline.com)
Donn VanStee
Tri-County Human Services
1815 Crystal Lake Drive
Lakeland, FL 33801

Re: Opinion of lease rate for 2725 Highway 60 E, Bartow, FL 33830

Dear Don,

Based on our conversation, my knowledge of the property, and the current market conditions, I feel the monthly rent of $14,542 per month, for the above noted property, is in line with area market rents. I am basing this on the square footage of the building being 14,546 sf, and an annual lease rate of $174,504, which equates to $12 per sf. This would be an average modified gross rent for a property of this nature.

Please let me know if you should need any further information.

Best personal regards,

Jack A. Strollo, CCIM, CPM
Vice President, Broker

3.7.5 Tab 5: STATEMENT OF THE PROBLEM

Polk County, Florida is in the heart of central Florida between the metropolitan areas of Tampa and Orlando. Spanning 2,010 square miles, Polk is a diverse locality containing both urbanized population centers and profoundly rural areas. Polk County experiences many of the challenges facing the larger populations of Tampa and Orlando, including the high incidence of alcohol, drug abuse, poverty and unemployment. Further, its rural populations are often isolated from critical substance abuse and mental health treatment services as well as educational and job opportunities.

Before the eighties, Polk was essentially a rural county. Since then, the population has flourished, nearly doubling. Polk's population in 2019 was estimated at 724,777 or 3.4% of Florida's total population (http://www.city-data.com/county/Polk_County-FL.html). Polk County is Florida's fourth largest county with a land mass the size of Rhode Island. It has 17 incorporated cities and 24 unincorporated populated areas ranging from tiny remote villages to metropolitan cities. Its county seat is located in Bartow, FL. (U.S. Census Quick Facts 2014). Close to 7% of its population have less than a 9th grade education, and 10.1% do not possess a high school diploma. When comparing educational attainment, Polk County trails behind Florida and the nation in both high school graduates and college graduates. Polk County has the 15th highest unemployment rate compared to all Florida counties, with 6.7% unemployment.

In 2018, the median household income was $51,670, which is $10,000 less than the national average (Census Bureau). The median property value increased from $107,100 in 2014 to $161,300, today. Polk County has a disproportionately high number of low- and middle-income households while having a lower proportion of households with incomes greater than $100,000 in comparison to Florida and the nation. Polk County's average wage remains below the state levels. Polk County has historically lagged behind the nation, the state of Florida, and the larger cities of Miami, Jacksonville, Tampa and Orlando in hourly wages paid. When comparing income across geographies, Polk County averaged 84% of the national average median income. Further, the County experiences substantially higher poverty rates. Nearly 14% of Polk County's population lives in poverty. (U.S. Census Quick Facts 2019)

In terms of racial and ethnic distribution, Polk County's diversity is similar to Florida, except that it is underrepresented among Asians. Polk's racial and ethnic distribution is as follows: 78.8% are white alone (non-Hispanic white), 16.2% are black alone (non-Hispanic African American), 24.6% are Hispanic and 2.0% other (Asian, Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native). (U.S. Census Quick Facts 2019)

The economic, educational, transportation and housing challenges described above for the general population in Polk County are amplified for those with behavioral health conditions. Combine these challenges with a shortage of behavioral health resources and it is easy to understand why individuals affected by behavioral health disorders find themselves cycling through the criminal justice system.

The Sequential Intercept Map identified significant gaps/problems that hinder the provision of behavioral health services to individuals in Polk County. Some of these are:

- There is no secure Addictions Receiving Facility (ARF) in Polk County
- Peace River Center's Crisis Stabilization Unit (CSU) is at capacity 36% of the time and is on emergency status more than 50% of the time
- CSUs at Winter Haven Hospital and Lakeland Regional Health are consistently at capacity
- Peace River Center no longer has funding for jail in-reach
- Psychotropic medications are costly, and in some cases lead to restricted access
- Most individuals with mental illness do not have jail transition or discharge plans
- The county needs additional supportive housing options for Substance Abuse Mental Health individuals
- There is no follow-up for county probationers with mental health issues
- There is a need for more peer specialists

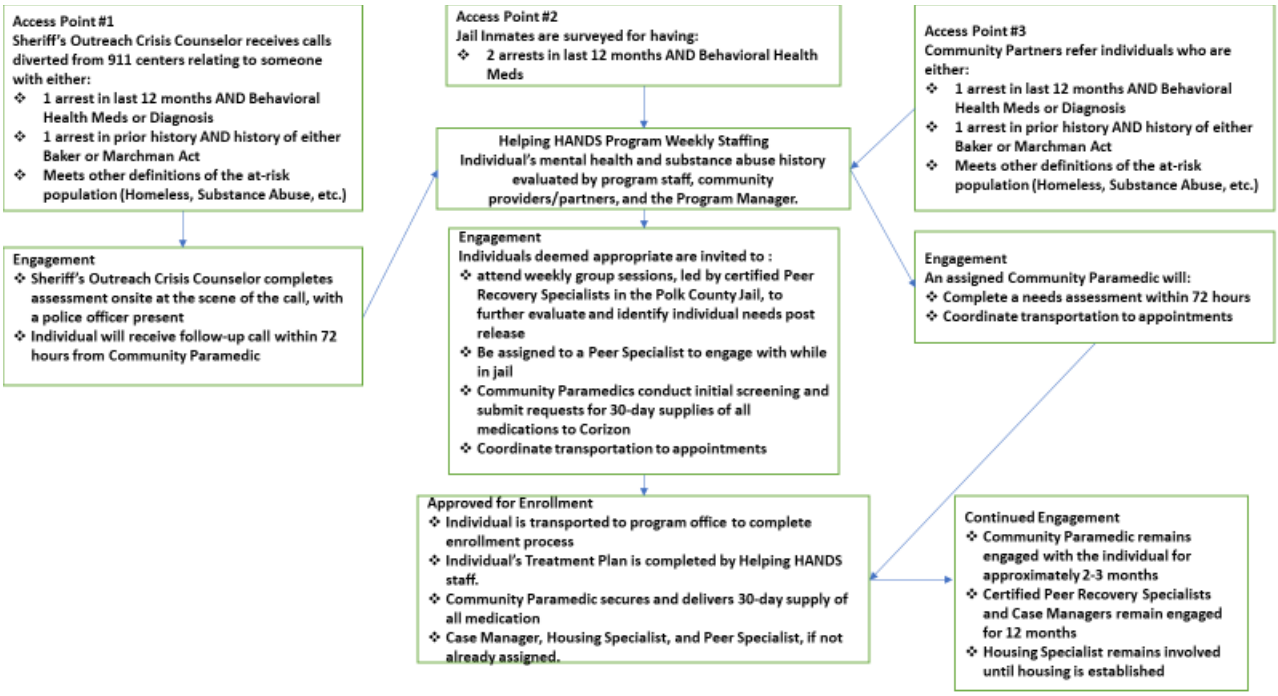
In 2020, 20,230 inmates were booked in the Polk County Sheriff's Office (PCSO) jails, with a cost of $58,170,777. According to the PCSO, the cost per day for housing an inmate is $68.26, and 60.5% of inmates have a dual diagnosis. There is a need to divert the at-risk population from jail and reroute them to substance use disorder treatment facilities and/or mental healthcare professionals. Those struggling the most often can't afford extensive treatment. This project will support the costs related to treatment along with incidentals necessary for each participant to reach success, such as housing, medication, transportation, clothing, apartment start-up costs, educational application fees, and car registration or a bicycle to get to work.

3.7.5.2.1 TARGET POPULATION & SCREENING PROCESS

The proposed CJMHSA Reinvestment Grant Expansion Project will target adults age 18 or older who have a mental illness, substance abuse disorder or co-occurring mental health and substance abuse disorders who are at risk of entering or reentering the criminal justice system. The expansion will focus on early prevention and reduced recidivism rates for the population served, with three different access points available.

The biggest component of the expansion requested in this application is the addition of the Sheriff's Outreach Crisis Counselor, who will act as a new access point for the at-risk population. Community Paramedics will continue monitoring referrals from community partners and engage potential program participants served by the Sheriff's Outreach Crisis Counselor. Three Case Managers will serve up to 70 individuals per year with each case manager limited to a maximum case load of 25 participants, on a level-tiered system. The focus for case management and peer recovery specialists will be on reduced jail recidivism and the prevention of individual placement in state hospitals. There will be continued staff training throughout the grant period such as USF TAC webinars, motivational interviewing, and trauma informed care certification.

This program will strive to improve the quality of life for all program participants. The following flow chart will be used to implement the Helping Achieve Targeted Comprehensive Healthcare (HATCH) program:



The HATCH program will expand as an arm of the developed Polk County Helping HANDS jail transition program, which is an acronym for Healthcare: Access, Navigation, Delivery and Support. In order to understand this new proposal, one must first understand the Helping HANDS concept as it exists today.

The Helping HANDS program is a newly developed, innovative project unique to Polk County. County funding for the Helping HANDS program has been approved for FY20/21 in the amount of $924,488. The program projects to build on a strong foundation and serve 100 individuals annually. The Board of County Commissioners along with the Polk County Sheriff and the Citizen's Health Care Oversight Committee called for and approved the development of a jail transition program to engage inmates with mental illness or substance use. That program, funded by Polk County Indigent Health Care ½ cent sales tax, is designed to align behavioral health services under one umbrella and streamline healthcare access for individuals leaving jail. In addition, it builds a reliable and easily accessible support system within the community as a safety net for those in transition.

For those not currently in jail, the HATCH program will allow for eligible participants to be referred from community partner organizations and 911 call centers for better reach. Once in our program, participants will have increased opportunities for receiving mental health and substance use disorder counseling and support services, which can lead to a decrease in the inadequately housed population entering or re-entering the criminal justice system. Unfortunately, without more significant local programming, a large percentage of the previously incarcerated and other at-risk populations will have no access to mental healthcare or substance use treatment facilities. Provided limited support, our target population might no longer have access to necessary psychotropic

medications or might choose to reengage with dangerous substances, which can result in incarceration.

This project anticipates enrolling 70 individuals after successful screenings each program year, totaling 210 participants. The structure for the program is already in place and the team will be prepared to serve comparable numbers during the first, second, and third years. It is anticipated that the average length of enrollment in the program will be one year.

The promising Frequent Users Systems Engagement (FUSE) model of cross system data matching will be used to identify at risk program candidates, and it will provide a conceptual framework consisting of data driven problem solving, policy and system reform, and targeted housing and services. The model demands more comprehensive intervention with a coordinated system response, so it will be noticed when an individual is requesting services from more than one local organization. The tool screens for basic eligibility requirements and risk factors including homelessness, criminal justice involvement, mental illness, substance use and veteran status.
(A copy of Polk County Eligibility Screening Tool is attached as Attachment 1, page 70)

Corizon Health, the medical provider within the Polk County Sheriff's Office (PCSO), screens each inmate entering the jail using a 50-question health screening that includes questions about mental health and substance use. It also records if an inmate takes psychotropic medication and arranges for continuation through assignment to a Mental Health Unit. Others identified to have serious mental health concerns are also placed in the Mental Health Unit.
(A copy of the health screening conducted at the jail is attached as Attachment 2, page 76.)

According to the Corizon Health Services Administrator for the PCSO jail, there are between 500-600 inmates who daily are administered psychotropic medication while in jail – this is **23%** of the total jail population. According to screenings administered by health providers in two Polk County jails, approximately 60.5% of the population has a co-occurring disorder.

The needs identified are consistent with priorities in the development of Polk Vision's Behavioral Health Strategic Plan. The Plan addresses the importance of providing access to care, reducing stigma, increasing services for higher-risk groups, and breaking down silos. By responding to these needs, public safety is increased, criminal justice cost averted, and Mental Health Substance Abuse services are more accessible and effective.
(A copy of the Needs Assessment is attached as Attachment 3, page 83.)
(A copy of an Example Treatment Plan is attached as Attachment 4, page 116.)

Once screened and deemed eligible for the program, participants are given the more detailed assessment, to determine the best course of action for their treatment plan.

There has previously been a barrier for individuals who are denied admittance into our program based on long-ago violent arrest records. With many cases, once the role of mental health and substance abuse issues are recognized as precursors to that previous arrest and the individual is asking for help, there is hope for a positive life change. Our community partners and professionals working alongside program participants need to feel at ease regarding their own safety, but deeper discussion must be had to ensure participants are accepted or denied after all information is considered. In order to set a new standard, those participants approved at weekly staffing will be allowed to attend at least one (1) behavior modification group while in jail before admittance into the program is decided. This will allow a better understanding of each person's motives behind joining the program and their potential for success.

In October 2017 a data exchange was established between the Polk County Sheriff's Office (PCSO) and Central Florida Behavioral Health Network (CFBHN), the Managing Entity for the Department of Children and Families in Polk County. Each night PCSO sends the arrest data from the day to CFBHN who then compares arrest names and addresses to participants currently served by CFBHN providers in Polk County. Now we can identify how many of those arrested are currently known within our local behavioral health system. Baseline arrest data has also been captured for the past five years and the following information is now known:

Data:
In the charts that follow High Need/High Utilizer (HNHU) is defined as:

1. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. High utilization is defined as:

a. Adults with three (3) or more acute care admissions within 180 days; or

b. Adults with acute care admissions that last 16 days or longer.

3.7.5.2.2 DATA FOR INMATES KNOWN TO BEHAVIORAL HEALTH PROVIDERS

Arrested vs Served										
Fiscal Year	A	B	C	C/B	D	D/C	E	E/C	F	F/C
	Total Arrests	Persons Arrested	Served (BH)	Percent	Served (Homeless)	Percent	Served (HNHU)	Percent	Served (FACT)	Percent
15/16	23,761	18,592	1,657	8.91%	272	16.42%	58	3.50%	11	0.66%
16/17	28,011	21,115	1,786	8.46%	264	14.78%	60	3.36%	7	0.39%
17/18	28,581	21,647	1,999	9.23%	310	15.51%	78	3.90%	10	0.50%
18/19	24,017	18,783	1,743	9.28%	263	15.09%	80	4.59%	5	0.29%
19/20	21,296	16,861	1,569	9.31%	300	19.12%	85	5.42%	3	0.19%

During FY19/20 the total number of individuals arrested in Polk County was 21,296. Of those arrested, 1,569 were known to have received a state funded behavioral health (BH) service that year by a local BH provider. Of those arrested and known to a BH provider, 300 were homeless, 85 were deemed High Need/High Utilizers and 3 were FACT participants. Of those individuals known to the behavioral health system in FY19/20, 1,130 were arrested only once and 439 individuals were arrested two or more times. The Department of Children and Families (DCF) reported an average of 1,343 Floridians per month were on waiting lists for behavioral health services. This included 118 individuals who were homeless and 220 individuals who injected drugs.

Of those arrested and known to BH providers, the following data illustrates those with Crisis Stabilization Unit (CSU) admissions in addition to arrests. During FY19/20 nearly 25.43% had CSU admissions with an average of three (3) CSU admissions per person, per year. 18% had Detox admissions with an average of 3.4 detox admissions per person, per year.

Fiscal Year	A	B	C	D	E	F	G	H	I
	Persons Arrested	Served (Homeless)	CSU-unique admits	Percent CSU	CSU non-unique admits	DTX-unique admits	DTX Bed days	DTX non-unique admits	Co-Occurring
17/18	21,647	310	425	21.26%	1484	335	5662	1230	65
18/19	18,783	263	423	24.27%	1332	283	4661	1035	53
19/20	16,861	300	399	25.43%	1660	285	4342	958	34

Polk County recognizes the need to change our tactics when it comes to assisting those with limited access to mental healthcare and substance use services and we hope this program can set the stage for a nationwide transition. A program like this is crucial to those lacking a positive support system and/or the means to be successful, unassisted. In this proposal, our programming ideas will be analyzed with respect given to feasibility and steps for effective implementation.

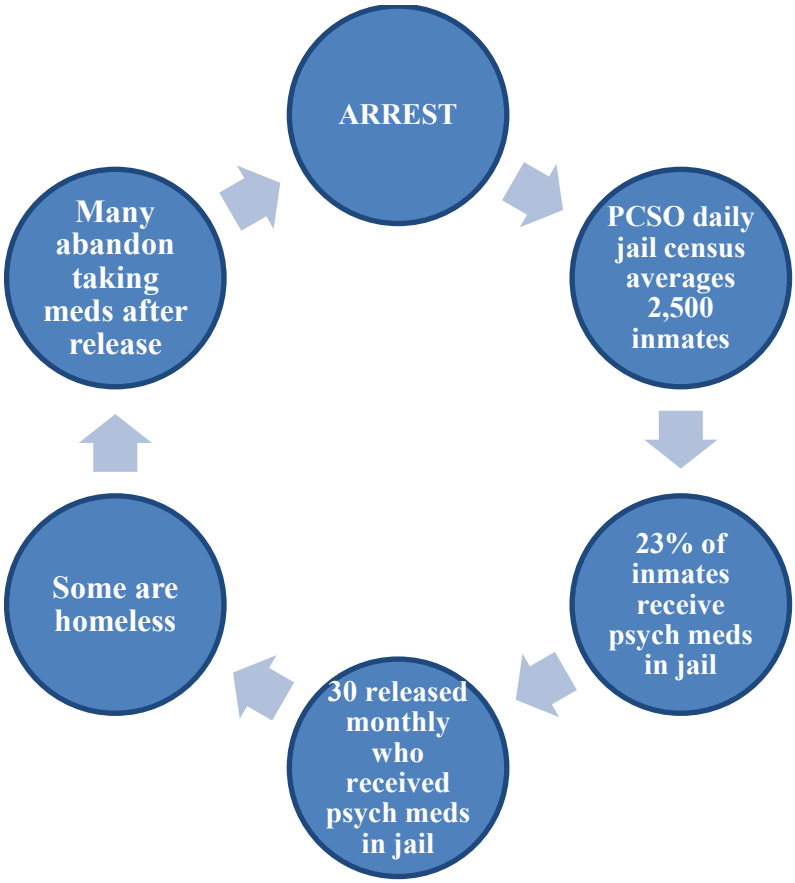
3.7.5.2.3 ANALYSIS OF OBSERVED FACTORS

To summarize the problem, recidivism among those with mental illness and substance abuse is well documented by the data recently gathered and presented in the previous pages. Polk County Sheriff Grady Judd and Chief Mike Allen, Chief of Detention from Polk County Sheriff's Office (PCSO), observed a trend among inmates receiving psychotropic medications while in jail. Once in jail their condition improves due to adherence to their medication and the structure provided in jail, but after release they struggle to maintain a schedule and may cycle back into the criminal justice system. On average, 30 inmates are released per month who were receiving psychotropic medications while in jail.

The risk factors identified for the Polk County target population are:

1. Lack of access to psychotropic medications
2. No linkage to behavioral health and other health services and
3. Lack of community support and accountability

The cycle of recidivism is illustrated as follows:



As we continue to refine our data collection and analysis, we are zeroing in on specific individuals who are touching and impacting multiple systems. We are currently working to secure the appropriate permissions to cross match the data presented in the tables above with our local Emergency Medical Services data, as well. As we move forward with this process, we expect to generate a list of specific individuals who represent offenders who also are high utilizers of crisis stabilization, detox, are homeless or any combination of these identified risk factors. By knowing who these individuals are, we will proactively seek engagement with them to offer them needed services.

We know that homelessness and other unstable living situations, a history of victimization or abuse and significant transitions such as a recent release from jail or reentry to the community from prison, places an individual at greater risk of entering or reentering the criminal justice system. An article from 2019 explains, **“**Numerous studies have documented greatly elevated risk of death when people are released from jail or prison with the leading cause of death being drug overdose. Because of the co-occurrence of SUDs and mental health conditions, post-release substance use may also worsen mental health status and prevent engagement in needed medical care.

Qualitative research suggests that substance use post-release may be due to poor mental health, environmental exposures (e.g., substance-using peer groups), or life stressors related to community re-entry, such as challenges finding work and stable housing. Individuals who are 'doubled-up' with friends or family members may be at particularly high risk for illicit substance use due to lack of institutional support or exposure to acquaintances also using substances."[1]

PCSO Chief Mike Allen said the mentally ill can become extremely costly for the county. He said many must be alone in a cell and constantly watched by a detention deputy. "It's not just jail costs," Allen said. "It's fire and EMS and Tri-County all dealing with the same population." (Chambliss, 2018 Ledgercity)

A snapshot of the current situation in Polk County for individuals with appropriate risk factors is as follows:

[1] https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-019-0136-6

3.7.5.2.4 Snapshot of Individuals with Risk Factors in Polk County

Risk Factor	Provider Stat	# Individuals	Additional comment
Frequent Crisis Admissions	State Hospital Referrals from Polk Co. FY 19-20	178 Referred	
	State Hospital Admissions from Polk County FY 19-20	117 Admissions 39 Civil / 78 Forensic	
	Currently waiting for State Hospital bed	24	
History of Arrests/ Jail Stats	Current Polk Jail Population	2,626	
	Average number inmates booked daily	80	
	Dual Diagnosis for Polk Jails general population	60.5%	
	Current inmates receiving psychotropic medications	452	
	Current adult inmates psychiatrist assessed for MHSA issues	164	78.5% dual diagnosed
	Recidivism: Top Offenders # arrests over past 2 yrs.		
	• 7 offenses	10	
	• 6 offenses	21	
	• 5 offenses	76	
	• 4 offenses	255	
Homelessness and unstable living situations	Homeless Coalition of Polk Co./Coordinated Entry Housing Wait List for past 12 months	1014 reported to coordinated entry	25% were housed 203 are on priority wait list
	Homeless students identified by Polk Co. HEARTH program	3738 homeless students	319 homeless students are 18 years or older
	Homeless families with students residing in shelter to date this 2020-21 school year	216 students in homeless shelter	# of related homeless adults unknown
	Homeless students receiving transportation to school of origin (residing in shelter or temp. housing)	492 students	By law homeless students are eligible for transportation to their school of origin
	Peace River Center Housing Emergency Solutions program FY15-16	53 families served	56 families turned away due to lack of funding

3.7.5.3.1 NUMBERS SERVED

Program participants are provided information about available services while they are already in jail. It is critical for individuals in the jail population to consider their options for after release and start engaging with our support team. The Program Manager has access to weekly lists of eligible participants and their release date. This allows for

Community Paramedics and Peer Specialists to intervene before release, providing an opportunity for a personal explanation of the program while building a trusted relationship. It is estimated that approximately 210 participants will be served as they transition out of jail or are referred by a community partner. For those in jail, many participants have a transition plan already in place by their release date so they can better navigate the system on their own.

3.7.5.3.2 SUBSET NUMBERS SERVED

The addition of the new Sheriff's Outreach Crisis Counselor funded by this program will reach a broader audience due to the ability to filter all calls made to local 911 centers and help our at-risk population. The new Sheriff's Outreach Crisis Counselor will only go to the scene if the emergency call is mental health or substance abuse related. HATCH information will be distributed, and potential program participants can interact with the Sheriff's Outreach Crisis Counselor for support and guidance. Individuals served by the Sheriff's Outreach Crisis Counselor will be assigned to a Community Paramedic, who will reach out within 72 hours as a second support. Successful program implementation will enroll 210 individuals during the grant cycle, with approximately 45 out of the total 210 coming from this more specific audience.

The HATCH project will merge beautifully with the goals of Polk Vision's Strategic Plan:

- Build capacity and increase access to care
    - Capacity and availability
    - Awareness of services and community education
    - Transportation and other logistics
    - Motivation and process of care
    - Improve system efficiency
    - Insurance and financial concerns
- Reducing stigma
    - Activities to address self-stigma, community stigma, and institutional stigma such as the following:
        - ▪ Enhanced public awareness and education
        - ▪ Suicide prevention activities, enhancing behavioral health wellness, and early intervention
- Increasing services for higher-risk groups
    - People experiencing homelessness
    - First responders
    - Individuals of lower socioeconomic status
    - Incarcerated individuals
- Breaking down silos
    - Increasing focus on public safety and jail-related issues, including community transitions
    - Collaboration and communications

3.7.6 Tab 6: PROJECT DESIGN & IMPLEMENTATION

3.7.6.1.1 COMPOSITION PLANNING COMMITTEE

The Public Safety Coordinating Council (PSCC) was designated the oversite committee for Polk County's original CJMHSA Reinvestment grant in 2006 and continues to meet today. Since Polk County received its original CJMHSA Reinvestment grant, the collaborations which began during that time have strengthened and have expanded into multiple councils/groups of stakeholders in which there is much crossover. In addition to the PSCC, the following stakeholder groups exist and are very active:

- Homeless Coalition of Polk County meets quarterly
- Circuit 10 Regional Council meets bi-monthly (local Behavioral Health leadership)
- Baker Act Review Committee meets monthly
- Trauma Informed Care Workgroup meets bimonthly
- Homeless Youth Task Force meets quarterly
- Polk Vision Quality of Life Committee meets monthly
- Citizen's Health Care Oversight Committee meets quarterly

On September 6, 2016 the Polk County Board of County Commissioners approved the establishment of the Collaborative Justice Committee within the Public Safety Coordinating Council. Although the committee's official list contains the names of only twenty (20) members, the number of individuals noticed for the meetings total ninety (90) which includes all the participants of the 2017 Sequential Intercept Mapping workshop and others. On average there are thirty (30) individuals who attend Collaborative Justice Committee quarterly meetings. Committee members represent a diverse range of our county's population so all voices can fairly be heard. Activities of the committee include hearing quarterly reports regarding grant-funded forensic program goals and success stories.
(The required members identified for this committee are listed in Appendix A, Attachment 5, page 120.)

3.7.6.3.2 PLANNING COUNCIL ACTIVITIES

Collaborative Justice Committee meetings took place on March 12, June 25, and August 7 in 2020. The regular quarterly meeting schedule was altered due to the COVID-19 pandemic.

The last meeting took place January 14, 2021 and included topics familiar to each meeting:

- Tenth Judicial Circuit Court Update
- Helping HANDS Jail Transition Update
- Education Committee Discussion
- & Other Business/ Announcements

Future council meetings are set on the 2021 calendar for April 15, July 15, and October 14. Collaborative Justice sub-committees will meet as needed and the council will review quarterly reports emailed by the Program Manager.

3.7.6.3.3 DESCRIPTION OF STRATEGIC PLAN
(A copy of the Strategic Plan is Attachment 6, page 121.)

Statement of Critical Issues
Critical issues noted in the strategic plan include but are not limited to the following:

- Treatment demand is increasing and driving telehealth and other service line changes.
- The comorbidity of substance use disorders with other behavioral health conditions is very high and efforts to address the issues must be coordinated and inclusive.
- Stigma is perceived as greatly restricting people's willingness to seek care for behavioral health issues (especially substance use disorder and schizophrenia-related issues).
- It is important to capitalize on school resources, allowing for greater reach to generations of families, catching problems earlier, and helping potentially avoid future Adverse Childhood Experiences (ACES).
- Approximately one in seven (about 15%) of Polk County residents indicate that they struggle with depression and/or are otherwise at risk for behavioral health challenges. Given the current (and growing) population, the percentage translates to approximately 100,000 people.

Challenges Include:

- Most stakeholders agree that demand for behavioral health, including substance use disorder services, outweigh the supply of providers.
- The perceived concentration of providers around the Greater Lakeland area (and subsequently fewer providers elsewhere in the County) creates a barrier to care for those living outside of Lakeland. The large geographic area of Polk County contributes to the difficulty of receiving care.
- A significant amount of red tape makes it challenging for people who need care to receive it in a timely manner.
- Interviewees stated that a lack of awareness of available financial support results in some individuals not seeking needed (and available) care.
- There is not good awareness of the first steps required to seek care. Awareness of a "central telephone number" or "no wrong door" policy appears to be lacking.

Regional Partnership and Participants
The attached Behavioral Health Strategic Plan Development & Sequential Intercept Mapping was published in December 2020 by Polk Vision after a highly diverse project leadership group engaged community members including:

- Criminal justice system
- Educators
- Business leaders

- Community members who have direct experience in the behavioral health system
- People experiencing homelessness
- Victims of intimate partner violence
- Disadvantaged youth
- Seniors facing social isolation
- Seniors with low income
- Behavioral healthcare providers
- Medical care providers
- Community service agency leaders
- Public health officials
- Public safety
- Elected officials
- High school students
- Young adults
- Foster children
- Parents in recovery from substance use disorder or other behavioral health issues
- LGBTQ community members
- LGBTQ family and support network members
- Peace River Center's Sheriff Outreach program
- Continuing education experts and people knowledgeable about Adverse Childhood Experiences (ACEs)

In the future, we plan to add committee members who are past program participants and can offer their lived experiences and feedback for continued program success.

IMPORTANT COMMUNITY PARTNERS	
10th Judicial Circuit	Lakeland Regional Health
Baycare Winter Haven Hospital	Office of the Public Defender
Central Florida Behavioral Health Network	Peace River Center
Consumer & Family Representatives	Polk County Board of Co. Commissioners
Corizon Health	Polk County Sheriff's Office
DACCO	Polk County Problem Solving Court
Department of Children and Families	Polk County Veteran's Affairs
Homeless Coalition of Polk County	Tri-County Human Services, Inc.
Lakeland Police Department	Bartow Police Department

Vision: Improve community behavioral health by engaging a broad-based set of community members and identifying helpful resources, access to care challenges, service gaps, and highly granular or unique needs based on various factors (e.g., demographics, location, lifestyle)

Mission: To improve the quality of life of Polk County residents by addressing the behavioral health needs in the community

Values: Accessibility, Quality Services, Innovation, Collaboration

3.7.6.3.4 PROJECT DESIGN AND IMPLEMENTATION

Goal #1: Staffing 225 referrals per year

Objective #1:	Make more opportunities for referrals			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**
1.1	Weekly Helping HANDS staff meeting with fair focus on potential program participants who could be successful	Number of participants evaluated/enrolled each week	Program Manager	Ongoing/ Weekly
1.2	Evaluate the list received twice weekly of anyone with 2 arrests and also receiving psych meds to combat recidivism	Number of participants evaluated/enrolled each week	Program Manager	Ongoing/ Weekly
1.3	Start contract with the new Sheriff's Outreach Crisis Counselor to reach those falling through the cracks	Number of participants referred from Sheriff's Outreach Program	Program Manager	Oct. 1, 2021
1.4	Refer potential family members and/or friends of program participants to community support services	Number of family and friends referred to community support services	Program Manager	Ongoing/ Weekly

Goal #2: 100% of eligible individuals who agree to participate will have an intake screening completed within 7 working days

Objective #1:	Quickly assess applicants so referrals can be made			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**
1.1	The HATCH Team quickly assesses each individual to determine if they are appropriate for the program	Number enrolled	Program Manager	Ongoing/ Weekly
1.2	New participants are immediately assigned to a case manager so the screening can get completed	Number enrolled with completed screening	Program Manager	Ongoing/ Weekly

Goal #3: 85% of participants will have a treatment plan within 30 days of enrollment into program

Objective #1:	Form individual treatment plans during the first 30 days of service			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**

1.1	The entire team will offer intense engagement within the first 30-days of service, ensuring participants have access to multiple support contacts including a case manager, community paramedics, and peer support	Number enrolled with completed screening	Program Manager	Ongoing/ Weekly
1.2	Explain options to participants for either meeting in person or using telehealth technology	Number enrolled with completed screening	Program Manager	Ongoing/ Weekly
1.3	Individual treatment plans are updated every 90 days by both the Case Manager and Peer Specialist	Number enrolled with completed screening	Program Manager	Ongoing/ Weekly

Goal #4: 85% of participants will actively participate in their Treatment Plan

Objective #1:	**Create opportunities for participant engagement**			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**
1.1	Case Managers will work with participants to ensure the treatment plan goals & objectives promote a stable lifestyle in the community	Number of participants meeting for case management sessions	Program Manager	Ongoing/ Weekly
1.2	Collaborate with public and private housing partners to identify safe, affordable, housing and leveraging community resources for securing permanent housing	Number of participants who have received housing	Program Manager	Ongoing/ Weekly
1.3	Wrap around services with community agencies to promote successful completion of case treatment plan goals & objectives. Participants will be linked with a behavioral healthcare provider, substance abuse treatment, as well as 12-step meetings, and a primary care provider.	Number of goals reached by participants	Program Manager	Ongoing/ Weekly

Goal #5: 10% of participants will be diverted from the Crisis Stabilization Unit (CSU)

Objective #1:	**Reduce arrests and rearrests in the population suffering from mental health and/or substance abuse disorders**			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**
1.1	Once this grant is awarded, hire and train Sheriff's Outreach Crisis Counselors through Peace River Center to answer calls diverted from 911	Numbers of individual contacts made by a Sheriff's Outreach Crisis Counselor after referral is made by the 911 call center	Program Manager	Ongoing/ Weekly

1.2	Sheriff's Outreach Crisis Counselors may accompany officers to the scene and explain the opportunity to participate in the HATCH Project	Number of screenings given by the Sheriff's Outreach Crisis Counselors	Program Manager	Ongoing/ Weekly
1.3	All participants will be linked with a behavioral healthcare provider within 60 days	Number linked to behavioral healthcare	Program Manager	Ongoing/ Weekly

Goal #6: 85% of enrolled participants will be linked with a behavioral healthcare provider during the program

Objective #1:	**Opportunities are given for better mental healthcare**			
	Task	**Performance Measure**	**Lead Person or Organization**	**Projected Completion Date**
1.1	Refer all enrolled participants to a behavioral healthcare provider immediately upon entering the program	Number of participants engaged with a Behavioral healthcare provider within 60 days	Program Manager	Ongoing/ Weekly

3.7.6.3.2.1 PROJECT GOALS & STRATEGIES

Goal #1:	**225 referrals per year**		
Objectives	**Strategy**	**Milestone**	**Key Activities towards meeting objectives**
Diversion	Identify individuals at risk of recidivism	Enrolling 70 individuals per year	The Assess, Plan, Identify, and Coordinate (APIC) Model
Collaboration	Working with community partners and peer support for referrals and using weekly arrest records as a pooling opportunity	Referrals from multiple community partners	Receiving a minimum of 225 referrals per year
Housing	To determine risk of homelessness	Immediate referral to emergency shelter	Linkage to the Coordinate Entry system
Transportation	Provide referrals to free community transportation or community paramedics, provide free	Transportation is immediately obtained	Purchase bicycles and set-up purchasing method for ride-hailing services

	bicycles, or provide free ride-hailing services to appointments		
Goal #2:	**100% of eligible individuals, who agree to participate, will have an intake screening completed within 7 working days.**		
Objectives	**Strategy**	**Milestone**	**Key Activities towards meeting objectives**
Diversion	Assess to determine appropriate participants	Meeting enrollment criteria	Consider leniency with past violent offenders and adjust vetting process, as needed
Collaboration	The HATCH team determines which service provider is the best fit/most appropriate case manager for each participant and peer support is provided to fill in the gaps	Assignment to a team member	Initiate relationship between case manager and participant
Housing	Identify housing needs	Assignment to a housing specialist team member	Ensuring participant has safe, affordable and appropriate housing within 90 days of enrollment into program
Transportation	Provide referrals to free community transportation or community paramedics, provide free bicycles, or provide free ride-hailing services to appointments	Transportation is immediately obtained	Purchase bicycles and set-up purchasing method for ride-hailing services
Goal #3:	**85% of participants will have a treatment plan within 30 days of enrollment into program**		
Objectives	**Strategy**	**Milestone**	**Key Activities towards meeting objectives**

Diversion	Intense engagement with participant, ensuring participants have access to multiple support contacts including a case manager, community paramedics, and peer support	Development of the case plan	Case plan goals & objectives promote stable lifestyle in the community
Collaboration	Wrap around services are set-up with community agencies to ensure a Treatment plan is made with goals & objectives to promote stable and safe housing arrangements	Positive interaction with the community agencies	Avert increased spending by leveraging community resources
Housing	Participant is assisted by the Housing Specialist to identify a place to live	Housing is obtained	Collaborate with public and private housing partners to identify safe, affordable housing and leveraging community resources for securing permanent housing
Transportation	Provide referrals to free community transportation or community paramedics, provide free bicycles, or provide free ride-hailing services to appointments	Transportation is immediately obtained	Purchase bicycles and ride-share passes

Goal #4:	**85% of participants will actively participate in their treatment plan**		
Objectives	**Strategy**	**Milestone**	**Key Activities towards meeting objectives**
Diversion	Intense engagement with participant, ensuring participants have access to multiple support contacts including a case manager, community paramedics, and peer support	Successful completion of goals & objectives established on the case plan	Case plan goals & objectives promote stable lifestyle in the community
Collaboration	Wrap around services are set-up with community agencies to ensure a Treatment plan is made with goals & objectives to promote stable and safe housing arrangements	Team members collaborate with community agencies for continuity of care	Avert increased spending by leveraging community resources
Housing	Participants maintain safe and secure housing in the community	No eviction during length of time in program and 6 months following discharge from program	Collaborate with community partners for home education/credit repair/financial literacy to maintain safe & affordable housing
Transportation	Provide referrals to free community transportation or community paramedics, provide free	Transportation is immediately obtained	Purchase bicycles and set-up purchasing method for ride-hailing services

	bicycles, or provide free ride-hailing services to appointments		
Goal #5:	**10% of participants will be diverted from the Crisis Stabilization Unit**		
Objectives	**Strategy**	**Milestone**	**Key Activities towards meeting objectives**
Diversion	Callers to the 911 hotline will be diverted to a Sheriff's Outreach Crisis Counselor to de-escalate the situation and help reduce unnecessary Baker Acts and jail bookings	Start contract with Peace River Center to implement the use of the Sheriff's Outreach Crisis Counselor	Train Crisis Counselors on diversion tactics
Collaboration	Once the Crisis Counselor has made contact with an individual, the Community Paramedic will be following up within 72 hours	Team members collaborate with community agencies for continuity of care	Collaborate with the Crisis Counselors and include them on regular staffing calls
Housing	Individuals can potentially be diverted from jail or the Crisis Stabilization Unit and can meet with the Housing Specialist after program admittance	Participants maintain safe and secure housing during length of time in program and 6 months following discharge from program	Maintain safe & affordable housing during length of time in program and 6 months following discharge from program
Transportation	Provide referrals to free community transportation or community	Transportation is immediately obtained	Purchase bicycles and set-up purchasing method for ride-hailing services

	paramedics, provide free bicycles, or provide free ride-hailing services to appointments		

The HATCH Project aspires to:

1. **Assist target population with mental health needs.** This project plans to link participants with behavioral healthcare providers 85% of the time by using the coordinative care system we have in place with our many community partners. Providing participants with a support system and potential diagnosis helps to make a successful treatment plan.
2. **Assist target population with substance use needs.** Successful case management and access to needed resources through our community referrals will enable participants to have better outcomes with maintaining sobriety. Participants will have access to substance use disorder treatment facilities, support groups, and a Peer Specialist to encourage them as they make progress.
3. **Assist target population in finding and accessing housing**. Finding housing will often be listed as an individual goal in each participant treatment plan, upon program entry. Program participants will then be offered assistance from the Housing Specialist to ensure they have all opportunities possible to establish safe and affordable housing in Polk County. This program can pay for housing deposits and monthly rent while participants focus on learning their new job.
4. **Assist family members of target population.** The at-risk population this project serves can accomplish more with a strong support system, including their family and friends. HATCH program team members will work to ensure referrals are made so those experiencing the mental health challenges or drug abuse of a loved one can find help. Keeping families together as they learn and grow will strengthen our community.

3.7.6.3.2.2 KEY STAKEHOLDERS

Objective: Expand Helping HANDS Diversion Program	
Task	Key Activity/ *Responsible Party*
Establish and/or update legally binding agreements with all participating entities to establish programs and initiatives for the Target Population	1. Develop Contracts for Partners/*BoCC*
Peace River Center will employ the Sheriff's Outreach Crisis Counselor, who will fill a gap in the system and connect with a large	1. Program logistics/*BoCC and PRC*

number of program candidates diverted from 911	
Relax previous program requirements restricting the admission of violent offenders and allow potential program participants an opportunity to attend behavioral sessions in jail prior to reviewing at staffing	1. Coordinate additional sessions/*BoCC and peer support*
Implement strategies that support the strategic plan for diverting the Target Population	1. Receive Technical Assistance training on APIC Model for Helping HANDS/*All partners* 2. Use SOAR process for assisting participants in accessing SSI/SSDI benefits 3. Use existing Coordinated Entry system for Helping HANDS program/*All partners* 4. Link participants to a behavioral health provider/*BoCC and Partners*
Objective: Collaboration	
Task	Key Activity/ *Responsible Party*
Participating in regular planning council meetings, committee meetings, and team staff meetings	1. Prepare agenda, reports and presentation for Collaborative Justice Committee meeting/*Program Manager* 2. Attend Baker/Act Marchman Act meetings/*All stakeholders* 3. Attend Circuit 10 Regional Council meetings/*All stakeholders* 4. Attend all HATCH team staff meetings/*BoCC, Tri-County Human Services, Inc., Peace River Center, Baycare, etc.*
Assessing project progress based on timelines and review attainment of goals	1. Hold monthly and/or quarterly stakeholder meetings/Program Manager *& Stakeholders*
Make necessary adjustments to expansion activities	1. Develop action steps when adjustments are needed/Program Manager 2. Assign person responsible for making the adjustments 3. Report changes to stakeholders*/BoCC*
Objective: Provide Training	
Task	Key Activity/ *Responsible Party*
Identify topics for needed trainings	1. Develop survey/Program Manager 2. Provide survey to stakeholders/*BoCC*
The Training and Education subcommittee will update members	1. Participate in ongoing recruitment for members at stakeholder meetings/*Program Manager*
Plan and host at least one training event or select appropriate training for staff to attend	1. Engage Training and Education subcommittee for planning 2. Secure trainer & venue

	3. Promote event

The key stakeholders responsible for expanding the Helping HANDS program are Polk County Board of County Commissioner's Health and Human Services Division, Peace River Center, and Tri-County Human Services, Inc. Polk County employs the Helping HANDS Program Manager, who provides oversight of grants related to the program. Tri-County Human Services, Inc. is a partner with Polk County in this grant application and employs the Case Managers, Peers, and Housing Specialist assigned to program participants. Peace River Center is also a valued partner and will administer the Sheriff's Outreach component of the HATCH program. Community Paramedics are from Polk County Fire and Rescue, which is funded by the BoCC's Indigent Health Care program.

Aside from jail and state hospital recidivism rates, Case Managers will focus on housing placement and obtaining social security and insurance benefits for participants. This focus will complement the overarching focus of Helping HANDS, which is engagement in behavioral health treatment and social supports. The Housing Specialist for this project will coordinate with a CFBHN funded PATH program: SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds services for people with serious mental illness (SMI) experiencing homelessness. SAMHSA's PATH program is a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH, the first major federal legislative response to homelessness, is administered by the SAMHSA Center for Mental Health Services (CMHS).

For program participants that are homeless or at-risk, the Case Manager will utilize the SOAR process for obtaining benefits. SOAR is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorders.

Expanding the current program with new Sheriff's Outreach Crisis Counselors from Peace River Center will reduce unnecessary Baker Acts and jail bookings as well as provide a connection to needed mental health resources. Counselors will work with law enforcement to provide mental health support to individuals and deescalate emotional distress resulting from behavioral health issues and/or substance use.

3.7.6.3.2.3 COLLABORATIVE JUSTICE COMMITTEE PARTICIPATION

Many Collaborative Justice Committee members were a part of the planning team involved in the research and development of this program. The Collaborative Justice Committee meets quarterly, when they receive updates and offer feedback on criminal justice programs and activities. Additionally, many Collaborative Justice Committee members serve together on other committees with overlapping purposes. These various committee meetings offer regular opportunities to communicate face to face. Other means of communication will include at minimum quarterly emails announcing

meetings, distributing reports and collecting responses to questionnaires. The HATCH team (including direct-service staff) will meet every other week under the direction of the Program Manager.

3.7.6.3.2.4 COMMUNICATION OF AGENCIES

Agencies will communicate during the life of the grant via many avenues. Communication between partners will include emailed correspondence, with quarterly reports, as well as conference calls and face to face meetings. Specific to this grant, the Public Safety Coordinating Council Planning Committee will meet face to face a minimum of twice a year and will include all required stakeholders including agency representatives. All agencies who are grant Program partners currently meet quarterly as a part of the Collaborative Justice Committee and will add quarterly HATCH Program Assessment Meetings to their calendars.

Weekly virtual staffings will occur among all HATCH Team members, where important decisions can be made regarding individual enrollment, placement, and program specifics. Additionally, there are monthly meetings with all stakeholders to discuss outcomes, retention rates, and concerns.

3.7.6.3.2.5 PARTICIPANT SCREENINGS, NEEDS ASSESSMENTS, AND TOOLS

The Program Manager, who is the central point of contact, will receive referrals and weekly lists from the jail. Once an individual is determined eligible the team (Program Manager, Case Managers, housing specialist, community paramedics, and sheriff's Crisis Counselors) will meet to review screening and a case manager will be assigned to ensure that all needs-based assessments are completed. A variety of needs assessments are included to address the multiple risk factors associated with the target population described in the Risk Factor Table.

Individuals in the criminal justice system who have mental health and/or substance use disorders (co-occurring disorders) are characterized by diversity in the scope and intensity of mental health, substance use, social, medical, and other problems. As a result, no single clinical approach and no single screening or assessment tool fits the needs of this population. Effective and comprehensive screening and assessment procedures are of paramount importance in defining the sequence, format, and nature of needed interventions.

Screening for co-occurring disorders (CODs) will be used to identify problems related to mental health, substance use, trauma/PTSD, criminal risk, other areas that are relevant in determining the need for specialized services (including treatment, case management, and community supervision), and the need for further assessment. Screening will also help to identify acute issues that require immediate attention, such as suicidal thoughts or behaviors, risk for violence, withdrawal symptoms and detoxification needs, and symptoms of serious mental disorders.

Screening for CODs is a brief, routine process designed to identify indicators, or "red flags," for the presence of mental health, substance use, or other issues that reflect an

individual's need for treatment and for alternative types of supervision or placement in housing or institutional settings. Screening may include a brief interview, use of self-report instruments, and a review of archival records. Brief self-report instruments are often used to document mental health symptoms and patterns of substance use and related psychosocial problems.

Assessment differs from screening in that it addresses not only immediate needs for services, but also informs treatment planning or case planning. Thus, assessment examines a range of long-term needs and factors that may affect engagement and retention in services, such as housing, vocational and educational needs, transportation, family and social supports, motivation for treatment, and history of involvement in behavioral health services.

The screening of potential participants begins in jail during book-in, where Corizon Health conducts a twofold health screen which includes a list of comprehensive health questions including behavioral health. If a behavioral health concern is suspected and additional behavioral health screen is administered. Program participants can also be identified and screened by the new Sheriff Outreach Crisis Counselor.
Both screening forms are included as Attachment 1.

Within the Helping HANDS program, further criteria will be in place to determine eligibility for the components specific to this program. One screening tool used for determining the need for housing is the Vulnerability Index-Service Prioritization Decision Assistance Tool. All participants will be referred to the Homeless Coalition for Coordinated Intake & Assessment.

Substance Use Assessment Tool
Michigan Alcoholism Screening Test (MAST)
www.projectcork.org/clinical_tools/html/MAST.html

The MAST (Selzer, 1971) is a self-administered screening instrument that consists of 25 items related to drinking behavior, symptoms, and consequences of use. The MAST is a public domain instrument that was developed through funding by the National Institute on Alcohol Abuse and Alcoholism. The screen uses a yes/no format to inquire about problematic alcohol use and addiction throughout the lifetime (Toland & Moss, 1989). A total score is used to determine alcohol use severity. The MAST is among the most frequently studied substance use screening instruments in clinical settings (Teitelbaum & Mullen, 2000).

Mental Health Assessment Tool
Correctional Mental Health Screen (CMHS)
(https://www.ncjrs. gov/pdffiles1/nij/216152.pdf)

The Correctional Mental Health Screen (CMHS; Ford & Trestman, 2005) is a brief self-report screening tool for mental disorders in correctional settings. The CMHS was developed using a large correctional inmate sample that included men (N = 1,526) and

women (N = 670). An original composite screening measure included 56 items that examined DSM-IV Axis I and II disorders. Separate screening versions were developed for male offenders (CMHS-M; 12 items) and female offenders (CMHS-F; 8 items) and consist of dichotomous (yes/no) items. Six items are identical in both versions, and the remaining two to six items are unique to each version of the CMHS. The shortened item pool in the two CMHS screens was found to significantly predict depression; anxiety; PTSD; and DSM-IV Axis II disorders, excluding antisocial personality disorder.

Suicide Assessment Tool
Beck Scale for Suicide Ideation (BSS)
http://www.pearsonclinical.com/psychology/ products/100000157/beck-scale-for-suicide-ideation-bss.html

The BSS (Beck & Steer, 1991) is a 21-item self-report scale that examines thoughts, plans, and intent to commit suicide and includes five screening items. The BSS items inquire about the desire to live, suicidal intent, plans and preparation for suicide, and openness about sharing suicidal thoughts with others.

Posttraumatic Stress Disorder Assessment Tool
Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)
http://www.ptsd.va.gov/professional/assessment/ adult-sr/ptsd-checklist.asp

The most recent version of the PCL, the Posttraumatic Stress Disorder Checklist for DSM- 5 (PCL-5; Weathers et al., 2013), includes 20 items that examine the expanded DSM-5 PTSD criteria. The PCL-M queries about symptoms related to traumatic military experiences and may be used with veterans or active service personnel.

The PCL-5 has been widely used with offenders (Ball, Karatzias, Mahoney, Ferguson, & Pate, 2013; Owens, Rogers, & Whitesell, 2011; Pankow et al., 2012; Rowan-Szal, Joe, Bartholomew, Pankow, & Simpson, 2012; Wolff, Frueh, Shi, & Schumann, 2012), to monitor change in PTSD symptoms while offenders are involved in treatment (Ball et al., 2013; Wolff et al., 2012) All HATCH team members are trained in Trauma Informed Care techniques and the screening process helps identify those suffering from trauma or Post Traumatic Stress Disorder.

Readiness for Treatment and Change Assessment Tool
Circumstances, Motivation, Readiness, and Suitability Scale (CMRS)
http:// www.emcdda.europa.eu/html.cfm/index3597EN. html

The CMRS (DeLeon & Jainchill, 1986) was developed to assess risk for dropout from a therapeutic community (TC) program and to identify participants most likely to remain in substance use treatment. The CMRS is a 42- item scale that takes approximately 30 minutes to complete. The instrument has four subscales: Circumstances, Motivation, Readiness, and Suitability, that measure (1) external pressures to seek treatment; (2) internal reasons to seek change; (3) perceived need for treatment to achieve change; and (4) acceptance of the TC approach, reflected by the willingness to make major

lifestyle changes, long-term commitment to an intensive treatment program, and rejection or exhaustion of other treatment modalities or options. A shortened 18-item version of the instrument (CMR) includes three subscales: Circumstances, Motivation, and Readiness.

3.7.6.3.2.6 COORDINATION OF CARE

The coordination of care for treatment will be the responsibility of the entire HATCH Team. The HATCH Team sits under the umbrella of the Helping HANDS program and consists of a Program Manager, Peer Recovery Support Specialists, Case Managers, a Housing Specialist, Community Paramedics, and the new Sheriff's Outreach Crisis Counselor position. Each partner brings resources unique to the needs of the target population. Participants are served in the HATCH program when financial support for their individual treatment, along with incidentals, is necessary for their success.

Along with case management and referral services, the HATCH component will provide funding for first month's and last month's rent and/or safe temporary placement. The Case Managers will add participants to the coordinated entry list so their housing needs can be realized. They will assist participants with locating and securing housing and receiving approval for life sustaining benefits such as SSI/SSDI, and SNAP.

Polk County's Indigent Health Care Program (IHC) section will house the Program Manager and will play an essential role in coordination of care, as well. IHC reports the most significant healthcare problems in our county include behavioral health needs and limited access to care due to a lack of transportation combined with a healthcare provider shortage. In response to these needs IHC has created unique partnerships to help address these challenges.

One of these partnerships is with Florida's 10th Judicial Circuit, which operates Polk County Behavioral Health Court for adjudicated individuals with diagnosable behavioral health conditions. IHC provides funding to Behavioral Health Court for case management services. Also funded is a residential transition treatment center for drug and alcohol abusers. These programs aid individuals in developing healthy lifestyles and stability while breaking the cycle of judicial involvement.

The largest percentage of IHC funding is spent on the Polk HealthCare Plan. The Plan provides access to healthcare for permanent county residents at or below 100% of FPL, who have no health insurance. IHC manages a network of over 150 providers for the Plan that includes primary care and specialty care physicians, four urgent care centers and five area hospitals. Sponsored services include primary and specialty care services, routine diagnostic testing, lab, radiology, hospital inpatient, outpatient and emergency room services, and a pharmacy formulary.

The HATCH Team's specialized knowledge and unique relationship with IHC will improve communication and coordination between personnel in the judicial system and personnel in the community behavioral health and indigent health care programs. Also, the enhanced communication and coordination will increase the number of diversions

and improve the facilitation of their re-entry upon release for people suffering with mental illness and substance use addictions in the local jails.

3.7.6.3.2.7 LAW ENFORCEMENT INTERCEPT POINTS/CAPACITY

The Kenneth C. Thompson Institute of Public Safety at Polk State College is the primary source of training for local law enforcement officers. The Institute has been awarded the "Accreditation with Excellence" award by the Commission on Accreditation for Law Enforcement Agencies, Inc. (CALEA). The Institute is only one of five law enforcement training academies in the nation to earn this award and was the first Institute to earn the Public Safety Training Academy Accreditation Program (PSTAA) from CALEA in 2007 becoming the first criminal justice training academy in the nation to earn this accreditation. Fortunately, the Institute offers Crisis Intervention Training certification.

Sherriff Grady Judd has made Crisis Intervention Training (CIT) a priority in Polk County. Sheriff Judd believes that CIT training helps the deputies de-escalate crisis situations and know how to assess whether the person should be taken to jail or be diverted to a community treatment facility.

He said there was a time when law enforcement officers would have said that intervening with people with mental illnesses and taking them to treatment facilities was not their job. But, today, he said it's not unusual for CIT-trained deputies to respond to a call from a family member concerned because someone isn't taking their meds and needs help in getting treatment.

"Our goal is to serve the people of Polk County every day. If we can defer the mentally ill into treatment, that's a win for us, a win for the community and a win for the person with a mental illness."

"I'm a tough on crime guy," Judd said. "I believe that when you violate the law, you ought to go to jail, but, I'm just as passionate about not having those who are mentally ill in the jail. We need to have programs to help them and get them out of our jail and out of the criminal justice system." (Florida Partners in Crisis, http://flpic.org/success-stories/2009/8/31/sheriff-judd-and-polk-county-partnerships-create-success.html)

The PCSO has a great capacity and is a key partner in this program. PCSO has agreed to assist with the screening process for this program by noting criminal history on the Baker Act and Marchman Act documentation. Armed with this information, Crisis Unit staff will be able to make a referral to this program for individuals who are released from crisis facilities. PCSO has also agreed to work with the Program Manager to identify lists of high risk /high use offenders. Additionally, the manager of the Mental Health Unit has agreed to work with us to identify potential program candidates.

The newly contracted Sheriff's Outreach Crisis Counselor will add an additional intercept point for participants potentially entering the program by participating in a 911 emergency call. Counselors will provide support via phone or may go on a call out with

law enforcement, where they can complete a needs assessment with the individual and potentially divert them from jail or a state hospital.

Law enforcement is constantly assessing their current practices to include processes that facilitate making referrals to the Helping HANDS program. They have designed a system that will notify the Helping HANDS program when an inmate is scheduled for release. This notification triggers the order for the 30-day supply of medications and alerts the Community Paramedic when to expect the release to occur.

Police Chief Mike Allen calls this program invaluable to the citizens of Polk County and has seen many success stories from program participants. He continues to support our alliance and the goals we share to support this at-risk population.
(A copy of a participant success story is attached as Attachment 7, page 200.)

3.7.6.3.2.8 PEER SPECIALISTS

The Polk County BoCC has a contract with Tri-County Human Services, Inc. to provide peer support services to the target population. While the case manager will focus on assisting participants with finding a job, applying for benefits, and finding transportation, the peer specialist will focus on linking them to a 12-Step program and sobriety.
Peers will work with the participant while communicating with their case manager to develop an individualized and comprehensive recovery support plan utilizing an array of services that include continuous encounters from the Jail Transition team during three phases: Pre-enrollment, Enrollment and Aftercare. Peer Specialists caseloads shall not exceed 30 participants. During Pre-enrollment, the participant is deemed eligible and appropriate for services. The Enrollment phase begins when the participant is either released from jail or is referred from another outlet for an initial screening and continues until they have reached one year in the program. Aftercare includes one-year post-discharge and includes additional participant screening during the 2nd and 4th quarters.

Recovery Support Services Include:

- Substance abuse or mental health education in individual or group settings including Coaching/promoting accountability/mentoring of participants
- Assistance with coordination of participant services specific to effective linkage to clinical and non-clinical treatment and supports and Peer Support
- Skills training
- Consistent engagement with participants including quarterly updates to treatment plan during enrollment. Engagement may include attending participant appointments and court hearings as needed for support.

Outreach Services include:

- Jail in-reach for program promotion
- Leadership of, or assisting with group meetings in jail setting
- Aftercare Surveys – 2 aftercare surveys completed with each participant during Aftercare.

3.7.6.3.3 INTERVENTIONS

The HATCH Project plans to intensify transition services that are directed to the designated populations while also enhancing the ability to reach a broader audience for service distribution.

Over the past year, the Helping HANDS program has seen these incredible rates of success:

	1 Year Pre-Enrollment	1 Year Post-Release
Jail Cost	$705,888	$26,163
CSU	$27,953	$0
Detox	$15,862	$39,614
Mental Health Intervention	$22,269	$44,046
Sub. Abuse Interventions	$40,309	$79,891
Mental Health Residential	$7,962	$0
Substance Abuse Residential	$66,828	$100,129
Emergency Room Cost	$192,432	$148,122
EMS Transports	$33,000	$39,000
Total Cost	$1,112,503	$476,965

Central Florida Behavioral Health Network pulls weekly data from Coizon Health, the healthcare provider within the Polk County jail, to identify inmates with Serious Mental Illness who are receiving psychotropic medications. A list of those inmates will be sent to the Helping HANDS Program Manager who will determine if the inmate meets all eligibility requirements. Those who meet eligibility requirements and are approved during staffing will then be assigned to a Community Paramedic (CP) and a Peer Specialist (PS) who will provide in-reach into the jail and will enroll interested participants into the program. These two will function as a support team for everyone choosing to participate in the program.

Upon release from jail this program will purchase a 30-day supply of the participant's psychotropic medications from Corizon Health, along with any other medically required medication. The first 30-day supply of medication will be delivered to them by their Community Paramedic (CP) within 48 hours of release from jail, when they will also be given a paper prescription for an additional 30-day supply. In addition, the CP provides a thorough health assessment, reviews all medications for drug interactions, counsels the participant on health related issues and provides up to 2-3 months of initial case management while helping them establish connections in the community and navigate various healthcare systems. The CP will conduct needs assessments during the first six weeks and will make referrals to community resources.

The CP is also responsible for providing a thorough needs assessment and for referring participants to local resources like this program or the Specialized Community Treatment Team (SCCT) for those who need more intensive services. Both programs are dedicated to meeting the needs of this population. Polk County provides funding to the SCCT for fifty (50) spots in that program which are prioritized for jail transition participants. Both HATCH and SCCT will provide intensive case management to their

participants. Community Paramedics, Peer Specialists, SCCT counselors, and Case Managers work together to link participants to all available community resources. In addition, HATCH Team members have monthly multi-agency staffings to discuss each participant's progress and barriers.

The Community Paramedics are available 9am-9pm seven days a week and are on call 24 hours a day. Participants know that "their" paramedic is always available in a time of crisis and are encouraged to reach out even after the initial 6-week period has passed. Peer Specialists maintain contact with the participant and provide on-going support beyond the 6-week period.

Each person is assigned a case manager, who assists them for one year as they set and reach goals based on finding safe housing, appropriate work, and meeting their medical needs. A new level-tiered system will start program participants out at weekly case management meetings and progressively taper down as goals are met. This system will allow for the three Case Managers to increase their case load from 15 to potentially 25, serving up to 210 over the three-year grant cycle.

The Case Managers will serve as the link to assist individuals in accessing benefits through the SSI Outreach Access and Recovery (SOAR) process (for those eligible) and to access services, when appropriate, through the CFBHN provider network. All three Case Managers will be allowed to screen participants for SOAR, but only one will be fully trained in SOAR. The Program Manager will integrate other funding and/or grants into service provision as they come available, including this CJMHSA Reinvestment grant if funded.

The newly contracted Sheriff's Outreach Crisis Counselor will expand the reach of our program by engaging eligible participants who catch our attention through a 911 call, based on a request for Baker and/or Marchman Acts. Our strong partnership with local law enforcement allows for the Sheriff's Outreach Crisis Counselor to accompany an officer to the scene, where they can offer support and referral information. The Sheriff's Outreach Crisis Counselor would conduct the screening and the Community Paramedics would provide an onsite follow up within 72 hours after the crisis. Those cases would be included in the weekly staffing to determine acceptance into the program.

Adjustments such as adding this Sheriff's Outreach Crisis Counselor are done to align more with the Co-Responder Model of service. The promising co-responder model improves how community professionals engage with people experiencing behavioral health crises. Co-Responder Models vary in practice, but generally involve law enforcement and clinicians working together in response to calls for service involving a person experiencing a behavioral health crisis. The model provides law enforcement with appropriate alternatives to arrest as well as additional options to respond to non-criminal calls. Communities and local leaders can use the model to develop a crisis continuum of care that results in the reduction of harm, arrests, and use of jails and

emergency departments and that promotes the development of and access to quality mental and substance use disorder treatment and services.

One of the main tasks of the Community Paramedic (CP) and Peer Specialist (PS) is to successfully link the participant to their community behavioral health provider. The CP and PS work to facilitate the participant's first outpatient appointment within 60 days following release from jail.

Polk County funds a variety of healthcare programs for the indigent population. The Helping HANDS program is one of ten programs funded under Polk County's Behavioral Health category of funding. Case Managers and Community Paramedics can provide referrals to telehealth services for participants who are unable to reach in person appointments. We currently use the Jail-Mail system to communicate with jail inmates before their release, so progress is already made by a release date.

Thanks to the ½ cent sales tax generated Indigent Health Care funding, Polk County is ahead of many counties in the availability of healthcare resources. However, options for securing behavioral healthcare, substance use disorder treatment, and safe housing are still too limited to adequately meet the needs of the at-risk population in this county. Individuals need assistance like the HATCH program to truly put down roots in the community and become self-sustaining.

3.7.6.4 PERFORMANCE MEASURES

3.7.6.4.1 PROCESS FOR COLLECTING DATA

Data will be collected for this project to ensure outcomes are met. Central Florida Behavioral Health Network, Inc. (CFBHN) (Suncoast Region's Managing Entity) provides contractual agreements for funding services as a safety net for indigents. Polk County Sheriff will provide their data to CFBHN to analyze cross systems of indigents who have received mental health and co-occurring disorder services and are incarcerated in the Polk County judicial system. Service, outcome, and satisfaction data are collected from CFBHN's subcontracted service providers.

This project will utilize FAMCare to capture the relevant participant data. The advantage of using FAMCare is the flexibility of adoption. FAMCare is HIPPA compliant, utilizing encryption, log in credentials, record security and security groups which limit access. FAMCare is the electronic records system already in use by Polk County's Indigent Health Care program. Project partners are familiar with FAMCare, as it is a system that is funded to track services provided by contracted community partners.

FAMCare staff will work with the Program Manager and project partners to design a unique product application for tracking HATCH performance measures including number of arrests/rearrests, housing status and activity, employment status and activity, status of benefits eligibility and activity, and diversions from State Mental Hospital. FAMCare will also track all service contacts with the participant. FAMCare staff will be responsible for training HATCH providers in the use of FAMCare.

3.7.6.4.2 METHODOLOGIES

Collecting data on participants served will show a broader picture of program impact when looking at the percentage who are arrested or rearrested within 6 months following program completion, percentage who acquire stable housing while enrolled, percentage who maintain stable housing after program completion, percentage who gain employment after program enrollment, and percentage maintaining employment 6 months following program end date. Our multifaceted system of care will provide a strong support system for participants and encourage successful program outcomes.

3.7.6.4.3 PERFORMANCE MEASURES

Performance measures proposed for tracking during this project include:

- Percent of arrests or re-arrests among program participants while enrolled in the program – 50%
- Percent of arrests or re-arrests among program participants within 6 months following program discharge – 20%
- Percent of program participants not residing in a stable housing environment at program admission who reside in a stable housing environment within 90 days of program admission – 25%
- Percent of program participants who reside in a stable housing environment 6 months following program discharge – 25%
- Percent of program participants not employed at program admission who are employed full or part time within 6 months of program admission – 25%
- Percent of program participants employed full or part time 6 months following program discharge – 25%
- Percent of program participants the grantee assists in obtaining social security or other benefits for which they may be eligible but were not receiving at program admission – 85%
- Percent of program participants diverted from a state mental health treatment facility – 10%
- Percent of Program participants engaged in behavioral health treatment – 50%
- Percent of Program participants linked up with a behavioral healthcare provider – 85%
- Percent of Program participants diverted from the Crisis Stabilization Unit – 10%

3.7.6.5 CAPABILITY AND EXPERIENCE

Polk County is distinctive in that it has a local sales tax which funds Indigent Health Care for qualified residents. For this current FY20/21, $84,937,392 has been budgeted by the County for Indigent Health Care. The main provision for care is the Polk HealthCare Plan (PHP), which serves qualifying residents that have no other means for healthcare or insurance. The Plan provides members with access to a network of primary care, specialty care, urgent care, inpatient and outpatient services.

For those Polk County residents who are at or below 200% FPL the County funds a network of community partners who provide primary care, specialty care, dental care, and behavioral health services. The number of residents served by Indigent Health Care funding for FY19/20 was 24,471 uninsured individuals.

Polk County Board of County Commissioners manage various funding sources to include federal, state, and local dollars. Governmental accounting procedures are utilized and adhered to all federal, state and local regulations. The applicant is in a fundable status for all grant making purposes with no outstanding legal, technical, or financial issues. Polk County has extensive experience successfully managing grants including three previously awarded CJMHSA Reinvestment grants in 2007, 2016, and 2018. Important program partnerships have been cultivated over the past 14 years to ensure this program finds success.

3.7.6.5.1 KEY PARTICIPATING ORGANIZATIONS

Polk County Board of County Commissioners (BoCC)
The Polk County BoCC will act as the managing entity for this grant and will ensure proper completion of all reporting and documentation, led by the Program Manager. In addition, the team at the BoCC will keep everyone on task by maintaining a regular meeting schedule.

Central Florida Behavioral Health Network (CFBHN)
Central Florida Behavioral Health Network (CFBHN) is the first and largest of Florida's seven Managing Entities (ME) for behavioral health services. It was founded over 20 years ago as an organization charged with managing State child and adult mental health and substance abuse treatment, prevention, and social service contracts on the west coast of Florida. For this project, they pull data from the county sheriff's office and Corizon Healthcare twice a week to identify people with two or more arrests and on psychotropic medications within the jail. This allows for the HATCH team to discuss potential participants and their needs in advance. CFBHN also assists with gathering data for the project's return on investment to determine the cost savings for the county.

As stated, CFBHN was specifically created to serve as the Managing Entity for child and adult mental health and substance abuse funding. The organization can be considered "grassroots" in the sense that it was created initially by community-based mental health and substance abuse providers. As part of its evolution as a manager of behavioral health services, CFBHN has also been involved with child welfare systems, justice-based programs, Medicaid match, and primary health care delivery.

Tri-County Human Services, Inc. (TCHS)
Tri-County Human Services, Inc. is a 501(c)(3) nonprofit community behavioral health organization that has provided Polk, Hardee and Highlands Counties with quality behavioral health care services for over 20 years in variously located licensed residential and outpatient co-occurring treatment settings. Additionally, Tri-County Human Services, Inc. coordinates with other community health service providers. Tri-County Human Services, Inc. is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).
Tri-County Human Services, Inc. is committed to providing the following to Polk County HATCH participants: Case Management, Co-Occurring Residential Treatment,

Outpatient Services, Prevention Services, Psychiatric Services and Medically Assisted Treatment Services.

Peace River Center (PRC)
Peace River Center is a 501(c)(3) nonprofit organization licensed by the State of Florida and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (TJC). Serving over 24,000 individuals a year across Polk, Highlands and Hardee Counties, Peace River Center (PRC) offers a variety of treatment options to individuals of all ages (children, adults and seniors) in many different settings. As a comprehensive integrated behavioral system of care our mental health, substance use and medical services have been designed to meet a wide range of community needs through: Inpatient Crisis Stabilization and Residential Treatment, Group Homes, Outpatient Therapy and Counseling (individual, group and family), Outpatient Psychiatry, Family Preservation Services, Psychiatric Medication Management, Case Management, Forensic Case Management, Targeted Case Management, Psychosocial Rehabilitation and Vocational Services, Club Success, Domestic Violence Shelters, Rape Recovery Resource Center and Rape Crisis Services, Florida Assertive Community Treatment Team (FACT), CAT Team (Community Assertive Treatment), FITT (Florida Intensive Treatment Team) and Mobile Crisis Response Team services and Critical Incident Stress Debriefing Services.
PRC has been a forerunner in providing wrap-around and recovery services for many years including vocational/supported employment, educational and transportation services, independent living skills, discharge planning, medication management, wellness and recovery, and assistance in obtaining income support and benefits. Group therapy, individual therapy, family therapy services are provided utilizing the environment in which individuals live.
Services offered by Peace River Center to Polk County Problem Solving Court participants include Inpatient Crisis Stabilization Unit, Outpatient Counseling, Psychiatric/Medical Integrated Services, Adult Residential Treatment, Case Management, Forensic Case Management, Substance Abuse, Domestic Violence and Rape Recovery programs, and 24-hour Crisis Hotline services.

For the project expansion aspect of our application, we are relying on Peace River Center to employ and train the new Sheriff's Outreach Crisis Counselors, who will be an access point for individuals calling 911.
(Sheriff's Outreach Program Scope of Work attached as Attachment 8, page 201)

Keystone Challenge Fund (KSC)
Keystone Challenge Fund is a non-profit organization established in 1991 in Lakeland, Florida. For 25 years, Keystone has maximized the availability of affordable housing for low and moderate income homebuyers to connect families with homeownership. Through construction, rehabilitation and down payment assistance, Keystone has participated in over $400 million in residential real estate development. As a result, nearly 4,000 families have become homeowners. Keystone is committed to serving the community by improving lives through homeownership. Among the families who received assistance, more than 1,200 were single parents. The programs offered by

Keystone have been possible through longstanding partnerships with local governments and agencies including the City of Lakeland, Pasco County, Polk County, City of Winter Haven, and the Housing Finance Authority of Polk County.

Local Law Enforcement
Sheriff Grady Judd has been a strong advocate for the work progressively accomplished by the planning council and has voiced his opinion in favor of a new Sheriff's Outreach Crisis Counselor. Communication with the Helping HANDS team and law enforcement has improved over the years to everyone's benefit. Law enforcement now provides Helping HANDS with a weekly list of potential participants being released from the local jail system. This greatly improves our information and referral system by allowing our team members to potentially assess program participants before they are even released.

3.7.6.5.2 AVAILABILITY OF RESOURCES

Foundations for this project have already been laid and required steps to meet our expansion goals should be relatively simple. Partnerships are already in place for necessary budgeting & contracts, and the planning council has set a good precedent for community cohesiveness. Weekly team staff meetings ensure everyone has a voice and there is fair access to services for all participants.

The U.S. Department of Housing and Urban Development has just awarded $2.3 million to four nonprofits operating homeless assistance programs in Polk County. The Agency for Community Treatment Services Inc. (ACTS) received three grants totaling about $649,000. ACTS, based in Tampa, operates a range of programs in five counties that include substance abuse treatment, recovery support and housing. The HUD grants for Polk County are dedicated to "scattered site" housing programs for people who have disabilities and are homeless. (White, The Ledger: Feb. 5, 2021) These available local funds to support the homeless population will make it easier to permanently house participants in the HATCH program.

3.7.6.5.3 ANTICIPATED PEER SUPPORT ROLES

The Polk County BoCC has a contract with Tri-County Human Services, Inc. to provide peer support services to the target population. Peers will work with the participant to develop an individualized and comprehensive recovery support plan utilizing an array of services that include continuous encounters from the Jail Transition team during three phases: Pre-enrollment, Enrollment and Aftercare. Peer Specialists caseloads shall not exceed 30 participants. During Pre-enrollment, the participant is deemed eligible and appropriate for services. The Enrollment phase begins when the participant is either released from jail or is referred from another outlet for an initial screening and continues until they have reached one year in the program. Aftercare includes one-year post-discharge and includes additional participant screening during the 2nd and 4th quarters. The community paramedics conduct the screenings for the 1st and 3rd quarters.

Recovery Support Services Include:

- Substance abuse or mental health education in individual or group settings including Coaching/promoting accountability/mentoring of participants
- Assistance with coordination of participant services specific to effective linkage to clinical and non-clinical treatment and supports and Peer Support
- Skills training
- Consistent engagement with participants including quarterly updates to treatment plan during enrollment. Engagement may include attending participant appointments and court hearings as needed for support.

Outreach Services include:

- Jail in-reach for program promotion
- Leadership of, or assisting with group meetings in jail setting
- Aftercare Survey – 2 surveys with each participant during Aftercare.

3.7.6.5.4 PROPOSED STAFF

The Program Manager, provided by the Polk County BoCC, is considered the Project Director and is already in place as the Helping HANDS lead, with a cohesive team assembled. Helping HANDS will act as an umbrella for HATCH, streamlining participants into the program who could benefit from added financial support. The entire HATCH Team will discuss and assign those who meet eligibility requirements to a case manager and a peer specialist based on the initial risk factors identified on the eligibility screening. Participants identified with housing needs will also be assigned to the housing specialist.

The Sheriff Outreach Crisis Counselor will be a second point of contact for an individual after they have called 911 and requested assistance. Although unlicensed, they will be qualified to provide an initial screening, which will be up for discussion at the weekly staffing meeting.

Case Managers will use the FAMCare system to assist with and track program referrals to community resources and services. Case Managers will coordinate access to needed services with community providers, tracking provider contacts in FAMCare.

The Housing Specialist for this project will work collaboratively with a CFBHN funded PATH program: SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds services for people with serious mental illness (SMI) experiencing homelessness. SAMHSA's PATH program is a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH, the first major federal legislative response to homelessness, is administered by the SAMHSA Center for Mental Health Services (CMHS). The PATH program will provide additional expertise and resources for housing placement and benefit application. For project participants that are homeless or at-risk, the Case Manager will utilize the VISPDAT coordinated entry system through our partners at Tri-County Human Services, Inc.

The goals of the SOAR program speak directly to one of SAMHSA's Strategic Initiatives- Recovery Supports. SOAR seeks to end homelessness through increased access to SSI/SSDI income supports, directly addressing SAMHSA's assertion: "To

recover, people need a safe stable place to live." This is essential, and for many persons in recovery accessing benefits is a first step. But SOAR extends beyond and also encourages employment as a means to increase individual income and promote recovery in line with the SAMHSA assertion that: "to recover, people need meaningful work and the ability to enhance their skills through education."

SOAR is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorders.

3.7.6.6 EVALUATION AND SUSTAINABILITY

Internal and external evaluations will be used to monitor the progress of this project. Polk County and HATCH staff will work with the USF Technical Assistance Center for support and evaluation. The Program Manager will be the main point of contact for the program and will be responsible for the oversight of data collection and analysis. The Program Manager will present data and reports based on following timelines and will review attainment of goals with stakeholders quarterly. Stakeholders will recommend necessary adjustments to implementation activities as needed based on these reports. Stakeholders include the Public Safety Coordinating Council's Grant Planning Committee, Partner Agencies, and Polk County Board of County Commissioners (BOCC).

Polk County BOCC will also provide an evaluator who is outside the HATCH program to evaluate processes and determine compliance with contract requirements. We will be using an internal monitor for performing operational and compliance reviews on contractors providing services under the HATCH program.

3.7.6.6.2.1 REDUCING EXPENDITURES

Many factors will shape the long-term sustainability of the HATCH project, including effectiveness and efficiency of program implementation, the commitment of the partnerships involved, the strength of the community's support, and continued diminished economic adversities.

In 2020, 20,230 inmates were booked in the PCSO jails, with a cost of $58,170,777, 33.6% of PCSO's budget. This did not include the cost of Court Services which totaled $7,391,692 or Law Enforcement which totaled $107,669,556. Although Sheriff Judd is known for his cost-effective approach to detention, more effective diversion programs such as HATCH will further drive costs down.

The proposed strategy to achieve maximum impact in the system is to identify our community's frequent users, matching data across corrections, homeless services, and crisis unit admissions to develop a list of shared participants who meet the specified thresholds of high service use. To have the greatest impact in reducing system use and realizing cost savings we will focus on outreach to those with multiple risk factors or multiple episodes of recidivism.

According to the Polk County Sheriff's Office, the cost per day for housing an inmate is $68.26. The average number of days in jail is estimated to be 90 days. We anticipate that 140 of the 210 individuals served by HATCH will be individuals at risk of reoffending. The estimated cost of each episode of incarceration is $68.26 per day x 90 days resulting in a cost of $6,143 per episode. Of the 140 at risk of reoffending, we expect to successfully divert 105. The cost avoidance of successfully treating and diverting one offender with history offending 7 times in 2 years is $43,001. For an individual with a history of 4 offenses in 2 years the cost savings is $24,572. If participants average recidivism rate is 1 offense per year the cost savings for this part of the project is projected to be $645,015.

The cost of treating an individual with mental illness in a State Hospital in 2019 was $293 per day for civil commitment and $350 per day for forensic commitment. The average length of stay of persons discharged from the Florida State Hospital is 467 days and the Median Length of stay is 299 days. At the Civil state hospital daily cost ($293.00) the estimated cost savings per admission (at 299 days) = $87,607. Our anticipated success with this population is dependent upon our local Short-term Residential Treatment program, operated by Peace River Center. Peace River Center will have one of the HATCH staff who will work closely with the Baker Act Receiving Facilities to identify and divert those who are at risk. Using the calculations above, diverting 21 individuals from State Hospital Admission will yield a savings to the system of $1,839,747.

The Program Manager will keep monthly statistics regarding enrolled participants and their rates of success. Combining the projected cost savings from jail diversions and hospital diversions, the total cost savings over the period of the project is $4,568,886. With savings that large, Polk County will be able to reinvest even more on providing services to the at-risk population. This on-going project will adjust as needed to best fit the needs of that population, such as adding an additional case manager now. Expanding the program by adding a Sheriff's Outreach Crisis Counselor will expand our reach for referrals and educate an additional audience on our services.

The Collaborative Justice Committee, along with the BoCC, will be proactive in seeking new funding for sustaining this effort and have appointed a Finance Subcommittee to focus on identifying potential funding sources to support, sustain and expand the capacity of treatment, housing, and transportation for the CJMHSA target population. A finance sub-committee has been formed to research potential alternate program funding sources and engage with grant writers from all stakeholder agencies. Their last meeting took place February 25, 2021 and current sub-committee members include Sarah Campbell, Judy Tewksbury, Andrea Clontz, Kelvin Almestica, and Paula McGhee, from the Polk County Board of County Commissioners. The Grants and Project Development Specials for Polk County will use eCivis grant management software to identify future sources of grant funding. The primary mission of the Finance Subcommittee will be to steadily scan the environment and evaluate these potential funding streams.

Whereas the Finance Subcommittee will work to leverage local funding, it recognizes that other governmental funding will likely be a major financial support over time for mental health treatment and other support services. These allocations will almost certainly include federal funding through block grants or other special funding to the state in future monies. Committee members will continuously check for newly released proposals for funding at Grants.gov, the Office of Criminal Justice, the University of South Florida, and our eCivis search database.

Participants of this implementation project are constantly learning and growing so we can best meet the needs of our target population. We plan to reduce the number of at-risk population arrests and reduce individuals judicially committed to a state mental health treatment facility by diverting them and using intensive case management and referral services. When mental health needs and housing needs can be met, program participants can finally work on self-improvement and ending the incessant cycle of criminal justice involvement that is all too common today.

3.7.7 TAB 7: PROJECT TIMELINE

Year One Timeline				
Action	**Type**	**Responsible Party**	**Start Date**	**Completion Date**
Establish HATCH Program	Objective	Polk Co. BoCC	October 1, 2021	Ongoing
MOU's established	Activity	Polk Co. BoCC	October 1, 2021	Dec. 31, 2021
Hire HATCH Staff	Milestone	1) Polk Co. BoCC 2) Tri-County Human Services, Inc.	October 1, 2021	Jan. 31, 2022
HATCH Staff Meeting	Activity	HATCH Program Manager	October 1, 2021	Ongoing/ weekly
Public Safety Council & Collaborative Justice Committee meetings	Activity	Polk Co. BoCC	January 2022 March 2022 September 2022	January 2022 March 2022 September 2022
Schedule for old SIM evaluation with USF TAC	Activity	Polk Co. BoCC	January 2022	January 2022
Train Staff in FAMCare Tracking System	Activity	Polk Co. BoCC	October 1, 2021	Ongoing
Outreach/Marketing HATCH Program	Activity	HATCH Program Manager	October 1, 2021	Quarterly/ongoing
Identify Potential HATCH Participants	Activity	HATCH Program Manager	October 1, 2021	Ongoing weekly
Refer 225 Participants to HATCH	Goal	Community Partners and HATCH Team	October 1, 2021	Sept. 30, 2022
Enroll 70 HATCH Participants	Milestone	HATCH Program Manager	October 1, 2021	Sept. 30, 2022
Complete Needs Assessments within	Goal	HATCH Case Managers	October 1, 2021	Ongoing

7 days of enrollment				
Treatment Plans Developed within 30 days	Goal	HATCH Case Managers	October 1, 2021	Ongoing
Participants Active in Treatment Plan Development	Goal	HATCH Team and Participant	October 1, 2021	Ongoing
Assess Progress	Objective/ Collaboration	Polk BoCC, PSCC and Partners	March 2022	March 2022
Training 2- day Workshop	Objective/ Collaboration	Polk BoCC	October, 2021	October, 2021
Program Status Report Submitted	Activity	HATCH Program Manager	January 15, 2022	Ongoing quarterly
Financial Report Submitted	Activity	HATCH Program Manager	January 15, 2022	Ongoing quarterly
Track & Report performance measures	Activity	HATCH Case Managers & Program Manager	Participant Enrollment Date	6 months following participant discharge date
Homeless Coalition Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Baker & Marchman Act Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Circuit 10 Court Team Meetings	Activity	HATCH Program Manager	October 1, 2021	Quarterly
USF TAC Quarterly Webinar	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Collaborative Justice Committee meetings	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Point in Time Count	Activity	HATCH Program Manager	January, 2022	Annually

Year Two Timeline				
Action	**Type**	**Responsible Party**	**Start Date**	**Completion Date**
HATCH Staff Meeting	Activity	HATCH Program Manager	October 1, 2022	Ongoing/ weekly
Public Safety Council & Collaborative Justice Committee meetings	Activity	Polk Co. BoCC	January 2023 March 2023 September 2023	January 2023 March 2023 September 2023
Train Staff in FAMCare Tracking System	Activity	Polk Co. BoCC	October 1, 2021	Ongoing
Outreach/Marketing HATCH Program	Activity	HATCH Program Manager	October 1, 2021	Quarterly/ongoing
Identify Potential HATCH Participants	Activity	HATCH Program Manager	October 1, 2021	Ongoing weekly

Refer 225 Participants to HATCH	Goal	Community Partners and HATCH Team	October 1, 2022	Sept. 30, 2023
Enroll 70 HATCH Participants	Milestone	HATCH Program Manager	October 1, 2022	Sept. 30, 2023
Complete Needs Assessments within 7 days of enrollment	Goal	HATCH Case Managers	October 1, 2021	Ongoing
Treatment Plans Developed within 30 days	Goal	HATCH Case Managers	October 1, 2021	Ongoing
Participants Active in Treatment Plan Development	Goal	HATCH Team and Participant	October 1, 2021	Ongoing
Assess Progress	Objective/ Collaboration	Polk BoCC, PSCC and Partners	March 2023	March 2023
Program Status Report Submitted	Activity	HATCH Program Manager	January 15, 2023	Ongoing quarterly
Financial Report Submitted	Activity	HATCH Program Manager	January 15, 2023	Ongoing quarterly
Track & Report performance measures	Activity	HATCH Case Managers & Program Manager	Participant Enrollment Date	6 months following participant discharge date
Homeless Coalition Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Baker & Marchman Act Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Circuit 10 Court Team Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
USF TAC Quarterly Webinar	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Collaborative Justice Committee meetings	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Point in Time Count	Activity	HATCH Program Manager	January, 2023	Annually

Year Three Timeline				
Action	**Type**	**Responsible Party**	**Start Date**	**Completion Date**
HATCH Staff Meeting	Activity	HATCH Program Manager	October 1, 2021	Ongoing/ weekly
Public Safety Council & Collaborative Justice Committee meetings	Activity	Polk Co. BoCC	January 2024 March 2024 September 2024	January 2024 March 2024 September 2024
Train Staff in FAMCare Tracking System	Activity	Polk Co. BoCC	October 1, 2021	Ongoing
Outreach/Marketing HATCH Program	Activity	HATCH Program Manager	October 1, 2021	Quarterly/ongoing

Identify Potential HATCH Participants	Activity	HATCH Program Manager	October 1, 2021	Ongoing weekly
Refer 225 Participants to HATCH	Goal	Community Partners and HATCH Team	October 1, 2023	Sept. 30, 2024
Enroll 70 HATCH Participants	Milestone	HATCH Program Manager	October 1, 2023	Sept. 30, 2024
Complete Needs Assessments within 7 days of enrollment	Goal	HATCH Case Managers	October 1, 2021	Ongoing
Treatment Plans Developed within 30 days	Goal	HATCH Case Managers	October 1, 2021	Ongoing
Participants Active in Treatment Plan Development	Goal	HATCH Team and Participant	October 1, 2021	Ongoing
Assess Progress	Objective/ Collaboration	Polk BoCC, PSCC and Partners	March 2024	March 2024
Program Status Report Submitted	Activity	HATCH Program Manager	January 15, 2024	Ongoing quarterly
Financial Report Submitted	Activity	HATCH Program Manager	January 15, 2024	Ongoing quarterly
Track & Report performance measures	Activity	HATCH Case Managers & Program Manager	Participant Enrollment Date	6 months following participant discharge date
Homeless Coalition Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Baker & Marchman Act Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
Circuit 10 Court Team Meetings	Activity	HATCH Program Manager	October 1, 2021	Monthly
USF TAC Quarterly Webinar	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Collaborative Justice Committee meetings	Activity	HATCH Program Manager	October 1, 2021	Quarterly
Point in Time Count	Activity	HATCH Program Manager	January, 2024	Annually
Submit Final Program Status & Financial Reports to BoCC for approval	Activity	HATCH Program Manager	Within 60 days following the ending of the date of the Grant Agreement	Within 60 days following the ending of the date of the Grant Agreement
Submit Final Program Status & Financial Reports to DCF	Milestone	HATCH Program Manager	Within 60 days following the ending of the date of the Grant Agreement	Within 60 days following the ending of the date of the Grant Agreement

Summary of Letters of Commitment

	Organization	Project Role
1.	Polk County Board of County Commissioners	Lead Agency, funded partner providing project manager and electronic tracking system; Providing 100% match
2.	Sheriff Grady Judd (PCSO)	Diversion activities, referrals & collaboration
3.	Keystone Challenge Fund	Unfunded partner providing in-kind match
4.	Tri-County Human Services	Funded partner providing staff
5.	Winter Haven Hospital, Center for Behavioral Health	Collaboration, referrals, membership on planning committee
6.	Homeless Coalition of Polk County	Collaboration, referrals, membership on planning committee

William D. Beasley
County Manager

Deputy County Managers:
Todd J. Bond
Joe N. Halman, Jr.
Ryan J. Taylor

POLK COUNTY

Board of County Commissioners
330 West Church Street
PO Box 9005 • Drawer CA01
Bartow, Florida 33831-9005

PHONE: 863-534-6444
FAX: 863-534-7069
www.polk-county.net

March 4, 2021

Department of Children and Families
1317 Winewood Boulevard Building 2, Room 204-X
Tallahassee, FL 32399-0700

RE: Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant

To Whom It May Concern:

Please accept this letter in support of the Board of County Commissioners' application for the Criminal Justice, Mental Health and Substance Abuse (CJMHSA) Reinvestment grant funding request. The addition of a Sheriff's Outreach Crisis Counselor and Case Manager will help identify more project participants and more quickly offer referral services to divert them from the criminal justice system or future involuntary commitments. This expansion would build on the strong foundation already in place, where the Board of County Commissioners works closely with local mental health providers, substance abuse facilities, housing initiatives, law enforcement, and the homeless coalition to serve the at-risk population.

The Helping HANDS program is an innovative program that targets inmates with behavioral health diagnoses to assist them with transition from jail back into the community. By design, this program ensures that participants continue receiving their psychotropic medications after release from jail by providing a 30-day supply delivered to their home by a Community Paramedic (CP). A Community Paramedic and a Peer Specialist are also assigned to assist the individual in navigating the systems of care and in accessing community resources needed for a successful transition. Their teamwork with the Sheriff's Outreach Crisis Counselor, Case Manager, Housing and Benefits Specialist, and other coordination of care members will enhance services and improve rates of success for program participants.

This expansion will help realize additional benefits to the community by way of reduced participant jail days and a reduced number of crisis unit admissions. Jail costs for program participants one year following program enrollment saw a 96% reduction from their costs one year before program enrollment. In addition, crisis stabilization unit costs went down 100% and emergency room costs were reduced by 23% for the population served. This requested expansion of the Helping HANDS program will be called the Helping Achieve Targeted Comprehensive Healthcare (HATCH) program and we lend our support to this effort by way of providing a local match.

Sincerely,

William D. Beasley, County Manager

Sheriff Grady Judd
Polk County
1891 Jim Keene Blvd. • Winter Haven, FL 33880-8010 • Phone: 863.298.6200 • www.polksheriff.org

March 4, 2021

Department of Children and Families
1317 Winewood Boulevard Building 2, Room 204-X
Tallahassee, FL 32399-0700

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Sincerely,

Grady Judd
Sheriff

KEYSTONE

4200 S. Florida Ave.
Lakeland, FL 33813
P: 863-682-1025
F: 863-687-2863
www.keystonechallenge.org

February 24, 2021

Joy Johnson, Director
Indigent Healthcare Division
Polk County Board of County Commissioners
Drawer AS07, Post Office Box 9005
Bartow, Florida 33831-9005

RE: Letter of Support/Commitment – Polk County Criminal Justice, Mental Health and Substance Abuse (CJMHSA) Reinvest Grant Program

Dear Ms. Johnson:

Keystone Challenge Fund, Inc., hereinafter referred to as Keystone, strongly supports Polk County's application for the CJMHSA Program. As an Affordable Housing and Community Housing Development Organization, Keystone also commits to lending its expertise to the supportive housing element of the grant.

We are an experienced affordable housing developer with almost 30 years of experience. Keystone has developed over 500 housing units in central Florida, including scattered site, multi-family rental units and smaller rental developments in Polk County. The rentals were developed in partnership with Polk County and social service agencies that provide supportive services for very low income families. In addition, our office has administered $27 million in down payment and closing cost assistance through the State Housing Initiative Partnership (SHIP), which resulted in over 4,400 first time homebuyers realizing their dream of homeownership. Also, we have educated 23,500 people in our Homebuyer Education Classes.

Keystone is a HUD approved Housing Counseling Agency and provides basic financial literacy and counseling services. One-on-one counseling is also available as needed and currently, we are providing this service to 200-300 annually. We will make any of these services available to program participants.

We look forward to working with Polk County, and the other partners, to bring this program to Polk County Residents.

Sincerely,

KEYSTONE CHALLENGE FUND, INC.

Jeff Bagwell,
President and Executive Director
JB/lpt

Polk County Sheriff Grady Judd
2021 Friend of Tri-County

Tri-County Human Services Inc.

Provides Help and Hope to All Persons Affected By Behavioral Health, Substance Abuse, and Other Life Challenges

March 2, 2021

Mr. Rick Wilson, Chairman
Polk County Board of County Commissioners
330 West Church Street
Bartow, FL 33830

RE: DCF RFA 2021001 Grant

Dear Chairman Wilson,

I am pleased to write this letter detailing the commitment Tri-County Human Services, Inc., is making to Polk County in relation to the application for renewal of the Criminal Justice Mental Health and Substance Abuse Reinvestment Grant.

Tri-County remains a leader in the State of Florida for quality behavioral healthcare since 1976. Since then, the agency has grown and in 1998, innovated a successful and long-standing substance abuse treatment program in our Polk County jails for incarcerated individuals. The agency has established strong, evidence-based practices to treat the individual and their family, making significant progress in stabilizing families and to reduce generational addiction. Tri-County has made significant strides in serving this population; however, there is still significantly more which can be done to reduce substance abuse related crime within our communities in Polk County.

This proposal is providing Forensic Case Management services to individuals at high risk of incarceration or recidivism. The program will provide the opportunity to reduce jail time, possibility diverting some from ever entering the justice system, which allows for more jail bed space for more serious offenders or reducing the need to build new jail facilities. The program will also assist in protecting the public from the possibility of unplanned and unwanted interaction with an offender influenced by substance use disorders. This grant will allow us to invest time, implement prevention strategies and engage this population in building and strengthening their commitment to a sober and directed life.

Tri-County is committed to providing well trained, ethically strong, and knowledgeable staff to work side-by-side with incarcerated and newly released inmates; to assist them to establish solid community ties and successful substance free living.

The agency commits to provide in-kind match resources which are required as part of the proposal package. Included in this match are state-of-the-art therapeutic services to provide education, clinical intervention, and cognitive behavioral therapy. We commit to participate in program development, consultation services and training to ensure the successful implementation of this grant.

In closing, the agency always commits to serve the community with strong, affordable, and quality treatment in pleasant surroundings, treating all participants with the dignity and respect they deserve. With your support, together Tri-County will remain a strong loyal leader and a reliable service provider that Polk County resident have come to know and trust.

We appreciate the opportunity to continue to participate in the vital program grant and the opportunity to serve our community with excellent behavioral health care.

Sincerely,

Robert. Rihn
CEO
Tri-County Human Services, Inc.

Enclosure: Commitment of Matched Donations

cc: File
Sarah Campbell

Winter Haven Hospital
BayCare Health System

Center for Behavioral Health

March 2, 2021

Bill Beasley, County Manager
Polk County Board of County Commissioners
330 W. Church Street
Bartow, FL 33830

Dear County Manager Bill Beasley,

The Winter Haven Hospital, Center for Behavioral Health supports Polk County Board of County Commissioners in your application for funding from the Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant. The Winter Haven Hospital, Center for Behavioral Health will be a partner in your Forensic Intensive Case Management (FICM) Project by receiving recipients of the program as referrals for behavioral health care.

Providing intensive case management for those with mental illness, substance abuse or co-occurring disorders that are cycling through the criminal justice system and crisis units is greatly needed. Breaking the cycle of repeated incarceration and hospitalizations benefits not only the individual and his/her family, but the community as a whole. We know that stabilizing a person with mental illness results in fewer arrests and hospitalizations and provide cost savings to the community. This FICM project will focus on connecting those deemed most at risk of reoffending with the supports needed to establish and maintain stability while living safely in the community.

The Winter Haven Hospital, Inc. (WHH) is a comprehensive, 501(C)(3) not-for-profit, health service organization that provides care through its regional healthcare delivery system. The Center for Behavioral (CBH) as a department of WHH, provides comprehensive, community based behavioral health services for individuals and families. Our mission is to improve the health of the communities we serve by providing high quality, cost effective care and services.

Sincerely,

Jeff Ware LMHC
Clinical Director
Winter Haven Hospital, Inc.
Center for Behavioral Health
Jeff.ware@baycare.org
(863) 293-1121 ext. 5762

Homeless Coalition of Polk County, Inc.
328 W. Highland Drive ♦ Lakeland, FL 33813 ♦ (863)687-8386

March 2, 2021

John E. Hall, Chairman
Polk County Board of County Commissioners
330 W. Church Street
Bartow, FL 33830

Dear Commissioner Hall,

We are pleased to be a partner in the expansion of the Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant initiative in Polk County. The project will provide diversion from the criminal justice system and from forensic state hospital placements by identifying individuals who are frequent offenders or frequent users of crisis services who are at risk of offending. Often homeless individuals are among those who are at a higher risk of entering the Criminal Justice System.

HCPC will participate by referring individuals known to HCPC who may be eligible for the Forensic Intensive Case Management (FICM) Project. We will work to provide linkage between our Coordinated Entry program and the FICM program to help link individuals to vital case management services designed to break the cycle of incarceration, crisis events and homelessness.

Sincerely,

Laura Lee Gwinn
Executive Director

Attachment #1

POLK COUNTY FIRE RESCUE DIVISION
COMMUNITY MEDICAL SERVICES

Helping HANDS Program Screening Form

Patient Information		
Screening Date:	Date of Birth:	Age:
Patient Name:		
Address:		
Contact Phone:	Gender:	Court Date:
Attorney or Public Defender:		Release Date:
Emergency Contact Information		
Name:		Phone:
May we contact this individual?		Relationship:

Mental Health/Substance Abuse History
Have you been admitted to/spent time in any of the following?

	YES	FREQUENCY	COMMENTS
Baker Act	☐	0	
Crisis Stabilization Unit	☐	0	
Residential/Inpatient Treatment	☐	0	
State Hospital	☐	0	
Marchman Act	☐	0	
Detox Center	☐	0	

Forensic History			
	YES	FREQUENCY	LOCATION
Arrested	☐		
Date & Nature of Charges:			
Incarcerated – Jail	☐		
Date & Nature of Charges:			
Incarcerated – Prison	☐		
Date & Nature of Charges:			

Trauma/Personal Safety *Have you ever experienced any of the following?*			
	SELF	WITNESSED	COMMENTS
Domestic Violence	☐		
Rape	☐		
Physical Assault	☐		
Combat or Exposure to War Zone	☐		
Suicide and/or Homicide	☐		
Drug/Alcohol Addiction	☐		
Criminal Behavior	☐		

Polk County Helping HANDS Jail Transition Program
Screening Form

Housing *Have you ever experienced any of the following?*			
	PAST	PRESENT	COMMENTS
Homelessness	☐	☐	
Housing Instability	☐	☐	
Shelter	☐	☐	
Do you have a safe place to stay (family member, friend, etc.) when you're released from jail?			

Academic & Employment History	
	COMMENTS
Most Recent Employer *Still employed?*	
Past Employers	
Highest Education Level Achieved	
College/University/Technical Training/Trade School	
Hobbies/Skills/Experience	
Interested in technical/vocational training and/or intend on seeking employment post-release?	

POLK COUNTY FIRE RESCUE DIVISION
COMMUNITY MEDICAL SERVICES

Helping HANDS Program Screening Form

Social Service Benefits *Healthcare Coverage, Disability Benefits, etc.*	
	COMMENTS
Eligible for Medicaid and receiving benefits prior to incarceration?	
Eligible for Medicare and receiving benefits prior to incarceration?	
Receiving SSI/SSDI and/or food stamps prior to incarceration?	
Estimated annual income & number of household members	
Transportation *Personal vehicle, public transit, etc.*	

Past Medical History	
Medical Conditions	
Current Medications	
Issues with current medications? *If so, why?*	
History of medication non-compliance? *Please explain*	
Primary Care Provider	
Mental Health Provider/Therapist/Counselor *Include name of provider, nature of services, and location*	

POLK COUNTY FIRE RESCUE DIVISION
COMMUNITY MEDICAL SERVICES

Helping HANDS Program Screening Form

Self-reported Needs

CP Identified Concerns

CP Identified Needs & Encounter Narrative

POLK COUNTY FIRE RESCUE DIVISION
COMMUNITY MEDICAL SERVICES

Helping HANDS Program Screening Form

Helping HANDS Program Service Agreement

By signing this form, I, _____, Date of Birth _____, voluntarily agree to participate in the Helping HANDS Program. I agree to meet with the Community Paramedics and Peer Specialists as scheduled and follow up with recommendations, services and appointments scheduled for me by the program. I will follow up with recommendations from my physician and/or psychiatrist, therapist or other organizations, supports or resources that I am linked to by Community Paramedics and Peer Specialists.

Signature of Consumer: _____

Consumer (print):_____ Date form signed: _____

Community Paramedic (print):_____

Attachment #2

CORIZON HEALTH

POLK COUNTY JAIL
INTAKE AND RECEIVING SCREENING:

Name: _____

ID: _____

BookingID: _____

Date: _____

Time: _____

DOB: _____

Age: _____

Sex: _____

Prior Incarceration:
Yes or No; Most Recent Where/When - _____
Interpreter Used:
Yes or No; Name of interpreter_____

Inmate Transfer:
Yes or No;
Were medical records included? Yes or No

Private Insurance:
Yes or No
Name of Insurance Company: _____

VITAL SIGNS:
Weight: _____ lbs

Height: _____

BMI: _____

BSA (Mosteller): _____

BSA (DuBois): _____

Blood Pressure: _____

Temperature: _____

Pulse: _____

Respiration: _____

Pulse Oxygen: _____

LMP:_____

Weight - Actual or Reported
Height - Actual or Reported
Pulse - Dynamap or Pulse or Apical

Physical Build/Characteristics:
Average or Abnormal; Explain:_____

CRITICAL OBSERVATIONS:
Clearance: Accept or Reject

Urgent/Emergent Medical Referral:
Yes or No; Why:_____

Urgent/Emergent Mental Health Referral:
Yes or No; Why:_____

Responsiveness:
Alert or Lethargic; Explain:_____

Orientation:
Yes or No

Skin Observations:
Tattoos/sores/blisters/wounds/needle marks;

Describe:_____

_____

Mobility Restrictions/Physical Disabilities/Impairments:
Yes or No; Explain:_____

HISTORY:
Major Surgery/Hospitalization - Past Year:
Yes or No; If yes, explain:

_____

Female History:
LMP:_____
Pregnant? Yes or No

MEDICATIONS REPORTED:
Yes or No; If yes, list medication; dosage; last time taken; reason;

prescriber._____

_____

ALLERGIES:

Yes or No; If yes, list allergy and reaction.

SUBSTANCE USE/ABUSE:
Hospitalized for substance abuse:
Yes or No; If yes, when.

Detoxification or outpatient treatment:
Yes or No; If yes, when.

Alcohol Use:
Drink Alcohol: Yes or No; If yes, list alcohol; frequency; last drink.

Substance / Drug Use / Rx:
Use drugs: Yes or No; If yes, list type of drug; frequency; last use.

COMMUNICABLE DISEASES:
HIV Infection or AIDS:
Yes or No. If yes, list any treatment or medications.

TB Symptoms:
Do you have any of the following:

Weight Loss:	Yes or No
Night sweats:	Yes or No
Appetite loss:	Yes or No
Fever:	Yes or No
Persistent Cough 3+ weeks:	Yes or No
Coughing up blood:	Yes or No
Weak/tired:	Yes or No

TB Skin Test:

Prior positive PPD:	Yes or No
Plant PPD now:	Yes or No

MEDICAL PROBLEMS:

Have current medical problems we should Know about: Yes or No. If yes, list medical problem and all detailed information regarding problem. Take blood sugar for diabetics and perform peak flow for patients with asthma/COPD.

Explain: _____

_____

_____

_____

_____

BEHAVIORAL HEALTH (IF YES TO ANY ANSWERS BELOW, EXPLAIN IN DETAIL):

Have current mental health complaints:	Yes or No
Ever diagnosed with mental illness:	Yes or No
History of outpatient treatment:	Yes or No
History of psychotropic medications:	Yes or No
History of psychiatric hospitalization:	Yes or No
History of hearing things:	Yes or No
History of seeing things:	Yes or No
History of suicide attempts:	Yes or No
Are you thinking about suicide now:	Yes or No
Family/friends history of suicide:	Yes or No
Recent significant loss:	Yes or No
Feel like there is nothing to look forward to (hopeless/helpless):	Yes or No
Ever hurt yourself on purpose:	Yes or No
Thinking of hurting yourself now:	Yes or No
Thinking of hurting others now:	Yes or No
Ever hospitalized for head trauma:	Yes or No
Criminal history of violent behavior:	Yes or No
History of sexual victimization:	Yes or No
History of sex offense:	Yes or No

Explain any yes answers to mental health questions here:

_____

_____

_____

_____

_____

Veteran:
Yes or No

INTAKE MENTAL HEALTH SCREENING:
Is mental health screening needed for patient? Yes or no;

Explain: _____

_____

PERSONAL INFORMATION:
Identifies self as/Perceived to be
Straight or heterosexual; gay; bi-sexual; transgender; gender non-conforming; intersex

ADDITIONAL OBSERVATION:
General Appearance: _____

Oral Screening : _____

DISPOSITION:
Placement: General Population; infirmary; SMED; observation; medical

REFERRALS
Any referrals needed (bp checks; drug watches; mental health; etc.)?
Explain: _____

_____

Treatment Consent:

Consent for treatment signed: Yes or No

Access to Care Reviewed: Yes or No

Grievance process explained: Yes or No

ADDITIONAL COMMENTS:

_____

_____

_____

_____

I understand that withdrawal from alcohol and other drugs could be fatal. I have been provided with information related to alcohol and drug withdrawal and the information I provided related to my alcohol and drug use is accurate and complete.

I acknowledge that I have answered all questions truthfully to the Medical History and Screening truthfully. I understand that it is my responsibility to furnish all information about my medications, current or pre-existing medical conditions to the medical department.

I have also been informed on how to obtain medical, dental and psychiatric services for routine and/or emergency care that is provided by the facilities health care professionals. I consent to the provision of medical, dental and mental health care provided by facility healthcare professionals.

I understand that I will be charged a set fee for medications, providers, dental and nursing services. I understand that I will not be denied medical services or medications due to an inability to pay.

I give my authorization to Corizon Health Medical Staff to utilize the prescription verification system to process my personal information in order to obtain my medication verification.

I understand and have been informed of the process of acquiring a 3-day supply of medication from Walgreens upon my release. I also understand that if I do not approach the medical staff at intake prior to my release for the Walgreens 3 day supply form I will still have 7 days from my release date to contact the medical department in order to obtain my medications from Walgreens.

If I do not follow the above, I am accepting responsibility for obtaining my medications from another healthcare provider and understand that this will be considered a refusal for a 3-day supply of prescription medications to be provided from Corizon Health. In refusing the 3-day supply of prescription medication from Corizon Health, I assume responsibility for any adverse health outcomes I may endure.

Patient Signature:_____

Screened By:_____

Reviewed By:_____

Attachment #3

1/25/2019 Questions

Person Served Information

Assessment completed with the following input:*

- Referral Source
- Recipient
- Recipient's Guardian/Family
- Internal Agency Staff
- External Agency Staff
- Record Information
- Other - Specify:

Referral Source Name and Agency:

Referral Phone number:

Presenting Problem:*

Person Served and Family's Assessment of Situation:

Person Served Preferred Name (if applicable)

Gender
---SELECT---

Race

Marital Status

Living Arrangement at Time of Assessment

- Independent living
- Biological Parent(s)
- Family/Relatives
- Foster Care
- Therapeutic Foster Home
- Group Home - Name:
- Residential - Name:
- Other - Explain:

Length of Time at Current Living Arrangement:
---SELECT---

Any additional comments on Living Arrangements?

Any Safety Concerns?

- Yes (Describe)
- No

Has the P/S ever lived with anyone else?

- Yes (if yes, who, when and how long?)
- No

History of different living environments: (Explain)

- No other living arrangements
- Biological parents
- Foster care
- Grandparents
- Family / Relatives
- Other

What environment works best for the P/S?

Does the P/S/family have reliable transportation?

- Yes
- No

Complete

Economic Resources

Recipient's, parent's or guardian's monthly income ($)

Does the Recipient Have a Social Security Representative Payee

- Yes
- No
- Needs One

Sources of Income

- None
- Employment
- Public Assistance
- TANF
- SSI
- SSDI
- Private Pension
- VA Benefits
- Unemployment
- Social Security
- Trust Funds
- Alimony/Child Support
- Other

Other Resources

- Food Stamps
- OSS
- Medicaid
- Medicare
- Subsidized Housing
- Section 8 Housing
- Other Housing

Assets

- None
- Own Home
- Car
- Savings
- Real Estate
- Other

Bank Accounts

- None
- Checking
- Savings
- Other

Complete

Estimated Monthly Expense

Rent/Mortgage Amount ($)

Electricity Amount ($)

Water Amount ($)

Phone Amount ($)

Food Amount ($)

Insurance Amount ($)

Medication Amount ($)

Miscellaneous Amount ($)

Total Expenses

Does the recipient, parent or guardian express any needs / problems in this area

- Yes-explain
- No

Complete

Work History

Employed

- Full Time
- Part Time
- ☐ Not Employed

Work History

- Yes
- ○ No

Does recipient do volunteer work?

- Yes
- ○ No

If recipient wishes to seek employment, indicate desired vocational/employment areas

Complete

Education

Reading Skills Per Client Report —SELECT—

Writing Skills Per Client Report —SELECT—

Math Skills Per Client Report —SELECT—

Verbal Skills Per Client Report —SELECT—

Highest Grade Completed —SELECT—

Last Year Attended

Last School Attended

Attending School

- Yes
- No

Other Comments in this Area

Complete

Mobility

How Does Recipient Get to Appointments, Store, etc.

Can Recipient Use Public Transportation

- [x] Yes
- [ ] No

Who Provides Transportation for Consumer

- [ ] Self
- [ ] Friends/family
- [ ] ALF/Group Home
- [ ] Handy bus
- [ ] PRC

Does the recipient report any problems in this area

- [ ] Yes
- [ ] No

Complete

Mental Health & Devel. Hx

Mental Health Diagnoses (per chart)

List Mental Health Diagnoses (per recipient).

Does the family have a history of mental illness? (check all that apply)

- [ ] No history
- [ ] Unknown
- [ ] Depression
- [ ] Anxiety
- [ ] Bipolar disorder
- [ ] Schizophrenia
- [ ] Gambling problems
- [ ] Suicidal behaviors
- [ ] Attempted suicide (explain method)
- [ ] Other (explain)

Does the family have a history of substance abuse?

- [ ] No history
- [ ] Unknown
- [ ] Alcohol
- [ ] Cannabinoids (Marijuana, Hashish)
- [ ] Opioids (Heroin, Opium)
- [ ] Stimulants (Cocaine, Amphetamine, Methamphetamine)
- [ ] Club Drugs (Ecstasy, Roofies, GHB)
- [ ] Dissociative Drugs (Ketamine, PCP, Salvia, DXM)
- [ ] Hallucinogens (LSD, Mescaline, Mushrooms)
- [ ] Other Compounds (Anabolic steroids, Inhalants)
- [ ] Prescription Medications (List Type)

Was mothers pregnancy normal?

- ( ) Yes
- ( ) No

Was mothers labor and delivery normal?

- ( ) Yes
- ( ) No (Please specify)

Type of Labor:

- [ ] Spontaneous
- [ ] Induced

Were there any complications during pregnancy OR labor?

- ( ) Yes (Please specify)
- ( ) No

Did Mother use substances during pregnancy?

- ( ) Yes (List substances)
- ( ) No

Was birth mother exposed to X-rays during pregnancy?

- ( ) Yes
- ( ) No

Was birth mother under emotional stress during pregnancy?

- ( ) Yes (Explain)
- ( ) No

Developmental Milestones

1 year - Did the child:

- [ ] Triple the birth weight
- [ ] Walk with help or alone
- [ ] Sleeps 8-10 hours a night and 1-2 naps

- [ ]
- [ ] Responds to his/her own name
- [ ] Understands simple commands
- [ ] Have any other issues

2 Years - Did the child:

- [ ] Able to communicate (thirst, hunger, potty, etc.)
- [ ] Can organize phrases of 2-3 words
- [ ] Able to turn door knob
- [ ] Pick up objects without losing balance

3 Years - Did the child:

- [ ] Daytime control with bowel/bladder functions
- [ ] Can dress self with little/no help
- [ ] Frequently asks questions
- [ ] Feeds self without difficulty
- [ ] Have any other issues

4 Years - Did the child:

- [ ] Has vocabulary of more than 1,000 words
- [ ] Can use past tense
- [ ] Tries to be independent
- [ ] Throws ball overhand with coordination
- [ ] Have any other issues

5 Years - Did the child:

- [ ] Skipping, jumping, hopping with good balance
- [ ] Responds to why questions
- [ ] Uses sentences with 6-8 words, using all parts of speech
- [ ] Have any other issues

What services has recipient received

- [ ] Counseling/Therapy
- [ ] Psychosocial Rehabilitation
- [ ] Medication Management
- [ ] Self-Help Support Group
- [ ] Targeted Case Management
- [ ] Residential Tx
- [ ] Supported Employment
- [ ] Supported Housing Living
- [ ] Club House
- [ ] Other

Is recipient currently prescribed psychotropic medication

- [ ] Yes
- [ ] No

Has recipient taken PAST psychotropic medications?

- ◯ Yes
- [ ] No

Does anyone supervise the recipient when taking medications?

- [ ] Yes (list who)
- [ ] No

How many suicide attempts has the P/S made in

his/her lifetime

Has a family member/significant other ever completed suicide?

- Yes

Has the recipient ever had a desire to harm themselves or others?

- No
- Yes (Describe circumstances)

Does the P/S report currect ideations of harming self or others?

- Yes
- No

Complete

Psychiatric Hospitals

Has recipient received hospitalization due to mental illness

- Yes
- No

Complete

Mental Status

Mental Health Status

Appearance
- Dishelved
- Poor hygiene
- Bizarre/Odd
- Normal & appropriate
- Other (Describe)

Insight/Judgement
- Mature - on target for age
- Immature (for age)
- Mildly impaired
- Moderately impaired
- Grossly impaired

Mood
- Happy
- Depressed
- Agitated
- Frustrated
- Tired/Sleepy
- Manic
- Other:

Affect
- Angry
- Sad
- Bright
- Calm
- Anxious
- Flat
- Mood swings
- Quiet
- Bored
- Sociable
- Irritable
- Defiant
- Full & normal
- Other (Describe)

Cognition
- Slow processing
- Confused
- Illogical
- Flight of ideas
- Poor concentration
- Hallucinations
- Circumstantial
- Disorganized
- Normal
- Loose associations
- Inattentive

Motor Activity
- Abnormal movements
- Decreased
- Increased

- Normal
- Tremors/Tics
- Others

Thought Content
- Suicidal ideation
- Homicidal ideation
- Grandiose
- Persecutory
- Delusions
- Self depreciation

Memory
- Intact
- Imparied

Sensorium
- Alert
- Confused
- Oriented
- Disoriented

Characteristics
- Responsible
- Withdrawn
- Dishonest
- Antisocial
- Manipulative
- Paranoid
- Impulsive
- Aggressive

Notes:

Complete

ADLs Per Recipient Report

Recipient needs assistance with the following

- [ ] Eating
- [ ] Taking Medication
- [ ] Handling Money
- [ ] Shopping for Food
- [ ] Completing Household Chores
- [ ] Personal Hygiene
- [ ] Dressing Self
- [ ] Planning & Preparing Meals
- [ ] Shopping for Clothes & Household Items
- [ ] Using the Telephone
- [ ] Seeking Emergency Services
- [ ] Seeking Non-emergency Services
- [ ] Transportation

Other comments in this area

Complete

Sexuality

Age at first experience

Person served identifies self as --SELECT--

Does recipient display age appropriate interactions

- Yes
- No-explain

Problems expressed in this area

Complete

Nutrition / Allergies

Diet

- Regular
- Special - explain

Does the recipient drink caffeinated beverages (coffee, tea, colas)

- Yes
- No

Allergies

Any additional information regarding allergies

Complete

Family/Social Relations

Name

Age

Relationship to Recipient —SELECT—

Contact Frequency —SELECT—

Recipient's assessment of relationship —SELECT—

Add Relationship

Yes

Is person served comfortable with his/her social network system?

Yes–explain

No–explain

Sometimes–explain

Does the person served have someone he/she can trust and confide in?

Yes

No

Complete

Leisure/Sprit//Strengths

Current & Potential Strengths

- [ ] Gets along well with others
- [ ] Has friends
- [ ] Does well in school/work
- [ ] Respectful of others
- [ ] Follows rules
- [ ] Respects property
- [ ] Respects authority
- [ ] Good personal hygiene
- [ ] Involved in out of school activities (sports, church, clubs)
- [ ] Has creative talent
- [ ] Goal oriented
- [ ] Willing to show emotion
- [ ] I understand my role in treatment is very important
- [ ] I have resources (time, transportation) to bring my child to appointments
- [ ] Other (List)

Does P/S participate in spiritual activities?

- [ ] Yes; describe P/S beliefs, denomination and their desire to be involved
- [ ] No

Leisure activity and frequency

Socializing (with Friends/Peers)	—SELECT—
Family Involvement	—SELECT—
Attending Events (Sports/Concerts)	—SELECT—
Attending Meetings	—SELECT—
Playing Sports	—SELECT—
Reading	—SELECT—
Writing Letters	—SELECT—
Playing Games	—SELECT—
Going to a Movie	—SELECT—
Watching TV	—SELECT—
Shopping	—SELECT—
Listening to Radio	—SELECT—
Walking	—SELECT—
Exercising	—SELECT—

Other / Frequency

What resources are available to the P/S through their natural suppost system?

- [ ] School
- [ ] Home
- [ ] Psychiatric/Counseling
- [ ] Medical
- [ ] Other

Long term view: how would the person served like to see themselves in the next 1 to 5 years? Quote P/S.

Living:

Learning/education:

Working/Vocational:

Leisure/social:

Complete

Physical Health

Primary Care Physician / Phone #

Date of last physical exam

Height

Weight

Does recipient have concerns about height / weight

- Yes
- No

Vision Quality (per recipient report) —SELECT—

Hearing Quality (per recipient report) —SELECT—

Recipient Report of Any Physical Disabilities —SELECT—

Last time the recipient went to dentist (per recipient report)

Dentist Name / phone #

Recipient report of any dental problems

Describe all conditions for which person served is receiving or may need medical intervention (i.e. chronic illness, Hep B, TB, STD, Diabetes, etc.). This should correspond with Axis III

List Medications for Medical Conditions

Referred for follow up with Primary Care Physician

- Yes
- No

Check Any of the Following Assistive Devices Recipient Reports Using

- Cane/Tripod-Tip Cane
- Kidney Dialysis Machine
- Eyeglasses
- Catheter
- Leg Brace
- False Teeth
- Contacts
- Arm / Wrist Brace
- Hearing Aid
- Walker
- Wheelchair
- Sleep Apnea Device (CPAP)
- Back Brace
- Colostomy Equipment
- Artificial Limb
- Other

How does recipient rate overall health at this time

—SELECT—

Hospitalizations (with dates) for Medical Reasons

List major surgeries & dates

Brief History of Medical Care

Complete

Substance Use

Person served report of drinking alcohol —SELECT—

Person served report of current abuse of illegal substances —SELECT—

Person served report of current abuse of legal substances —SELECT—

List substances used:

Does person served report history of abuse of legal substances?

- Yes
- No

Does person served report history of abuse of illegal substances?

- Yes
- No

Has person served received treatment for a substance abuse problem?

- Yes
- No

Is person served currently receiving treatment for substance abuse?

- Yes
- No

Does the person served smoke cigarettes?

- Yes
- No

Does the person served have a family history of substance abuse?

- Yes
- No

Has the person served use of substances resulted in loss of housing?

- Yes - explain
- No

Has the person serveds use of substances resulted in loss of job?

- Yes - explain
- No

Has recipien'ts use of substances resulted in loss of relationship

- Yes - explain
- No

Other results of use

- intoxication
- blackouts
- increased tolerance
- overdose
- relationship problems
- medical problems
- legal problems

- Person served view on addiction (What is an addict)

Minkoff's Four Quadrant Model of Concurrent Disorders

- Quadrant 1: Low Severity of both Mental Illness and Addictive Disorder
- Quadrant 2: High Severity of Mental Illness and Low Severity of Addictive Disorder
- Quadrant 3: High Severity of Addictive Disorder and Low Severity of Mental Illness
- Quadrant 4: High Severity of both Mental Illness and Addictive Disorder

Stages of Change

- Pre-contemplation: The client is not considering change, is aware of few negative consequences, and is unlikely to

take action soon.

Contemplation: The client is aware of some pros and cons of substance abuse but feels ambivalent about change. This client has not yet decided to commit to change.

Preparation: This stage begins once the client has decided to change and begins to plan steps toward recovery.

Action: The client tries new behaviors, but these are not yet stable. This stage involves the first active steps toward change.

Maintenance: The client establishes new behaviors on a long term basis.

Relapse: The client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.

Complete

Legal

Has the recipient designated someone to manage his/her personal affairs (i.e. pay bills, power of attorney, advanced care directives, etc.)

- Yes
- No

Has the recipient voluntarily appointed someone to help make decisions about his/her health care

- Yes
- No

Does recipient have a court appointed guardian (Legal Guardian) responsible for affairs related to property

- Yes
- No

Does recipient have a court appointed guardian (Legal Guardian) responsible for affairs related to his/her person

- Yes
- No

Has the recipient ever been arrested

- No
- Felony - explain
- Misdemeanor - explain

Has the recipient ever been convicted

- No
- Felony - explain
- Misdemeanor - explain

Is recipient currently on probation or parole

- Yes
- No

Is recipient involved in any current legal proceedings or civil actions

- Yes - explain
- No

Complete

Functional Assessment

Each domain should address the person served's current skill/knowledge level; if there are needs in this area or not; their willingness to work on the identified needs and how; and the role of the TCM to assist in meeting their needs.

Daily Living Skills

Current Functioning*

Needs *

Economic Resources

Current Functioning*

Needs*

Food & Clothing

Current Functioning*

Needs*

Mobility

Current Functioning*

Needs*

Educational / Vocational

Current Needs*

Needs*

Employment

Current Functioning*

Needs*

Legal

Current Functioning*

Needs*

Leisure Time

Current Functioning*

Needs*

Living Environment/Housing

Current Functioning*

Needs*

Mental Health

Current Functioning*

Needs*

Physical Health

Current Functioning*

Needs*

Social Relationships

Current Functioning*

Needs*

Substance Abuse

Current Functioning*

Needs*

Dental

Current Functioning*

Needs*

Family Support/ Family Education

Current Functioning*

Needs*

Indicates required field

Complete

Summary & Recommendations

Person Served Personal Strengths/Resources

Person Served Personal Needs/Challenges

Strengths of Person Served Support System:

Challenges of Person Served Support System

Person Served Identified Needs that TCM can address:

- [ ] Clothing
- [ ] Food
- [ ] Budgeting
- [ ] Employment
- [ ] Transportation
- [ ] Safety in home
- [ ] Hygiene/ADLs
- [ ] Parenting
- [ ] Mental Health
- [ ] Day Care/After school programs
- [ ] Legal
- [ ] Education
- [ ] Housing
- [ ] Medical Insurance
- [ ] Furniture
- [ ] Medical/Dental Care
- [ ] Community Linkages
- [ ] Substance Abuse
- [ ] Other-explain

Activities of daily living

Check what recipient needs assistance with:

- [ ] Attending school
- [ ] Eating
- [ ] Taking medications
- [ ] Following directions
- [ ] Completing homework
- [ ] Completing household chores
- [ ] Personal hygiene
- [ ] Dressing self
- [ ] Communicating needs
- [ ] Socializing with peers
- [ ] Attending medical and therapy appointments
- [ ] Other: (Explain)

What preferences do you have that would most likely help you achieve your goals?

Prognosis:

Recommendations

Is Person Served Deaf or Hard of Hearing **OR** was a language interpreter used?*

No

Yes

340.003.001

**** Indicates required field***

Complete

TCM Referral Form

Diagnosis:

What MH services does the person served require in order to live in the home/community and/or be sucessful in school:

Duration of disability:

---SELECT---

Is the individual currently in an out of home mental health placement?

- Yes; where?
- No

If individual is currently NOT in an out of home placement, are they AT RISK of an out of home placement?

- Yes, explain
- No

Individual is at risk for out of home placement in:

- Residential
- Baker Act
- Hospital

Specify the individuals service providers:

Medical

Dental

Psychological

Social

Behavioral

Educational

Recreational

Substance abuse

Residential

Rehabilitative

Reason for referral:

TCM approval:

---SELECT---

340.003.001

Complete

Attachment #4

3/2/2021

TxPlus Plan:

Start Target End Program Helping Hands

Problem/Skill Deficit: Legal Obligations
Start Date: **Target Date:** **End Date:**
Description: Person served lacks the ability to comply with legal obligations.

Goal: Legal Requirements
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will comply with criminal and/or civil legal requirements. Person served states:

Objective: Legal Process
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to gain necessary knowledge/understanding of the legal processPerson served will be responsible to gain necessary knowledge/understanding of the legal process.

Objective: Probation
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to comply with probation requirements.

Objective: Court
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person Served will be responsible to attend required court appearances.

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Healthy home environment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks the ability to identify and establish a healthy home.

Goal: Develop a healthy home environment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will develop a healthy home environment. Person served states: "I am going to do whatever it takes to keep a healthy home and complete my case plan to get my children back"

Objective: Housing
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to obtain adequate housing

Objective: Food
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will identify any nutritional needs for self and/or family unit.

Objective: Clothing
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will identify any clothing needs for self and/or family unit.

Objective: Transportation
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Need for transportation services will be assessed and arranged as appropriate by assigned staff person.

Objective: Financial necessities
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Need for financial assistance will be assessed and appropriately linked to resources by assigned staff person.

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Medical care
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks the ability to recognize medical issues or the need for medical care.

Goal: Obtain/maintain healthcare
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will acquire/maintain necessary medical care. Person served states:

Objective: Medical services
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to establish primary medical care services, including prenatal care (if pregnant).

Objective: Insurance
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to apply for eligible medical insurance and other appropriate medical assistance.

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Vocational and educational needs
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks the ability to engage in needed education and/or employment.

Goal: Vocational or educational issues
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will engage and/or maintain necessary education and/or employment. Person served states:

Objective: Schooling
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to complete testing/assessment for educational placement.

Objective: Enter educational program
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to enter appropriate level of education.

Objective: Obtain employment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to engage in employment-seeking process

Objective: Employment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to maintain existing employment

Objective: Disability benefits
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to complete disability application process.

Objective: SOAR Benefits
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will assist Person Served in obtaining income and income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and SSI/SSDI through the SOAR Process.

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Substance abuse
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks the ability to begin necessary treatment services

Goal: Enter into recommended treatment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will comply with substance abuse treatment. Person served states:
f

Objective: Substance abuse
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**

Description: Person served will be responsible to engage in recommended substance abuse treatment within _0__ days

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Mental Health
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks the ability to begin necessary treatment services

Goal: Enter into recommended treatment
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will comply with mental health treatment. Person served states:

Objective: Mental health
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to engage in recommended mental health treatment within _10__ days

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Support Systems
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served lacks support systems needed to maintain a recovery lifestyle.

Goal: Healthy Support System
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person Served will develop a healthy support system. Person served states:

Objective: Support system
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Person served will be responsible to develop a healthy support system

Intervention: Recovery Support
Start Date: 4/15/2020 **Target Date:** 4/15/2021 **End Date:**
Description: Staff will provide necessary recovery support to Person Served.

Problem/Skill Deficit: Transition Plan from Helping Hands to Roots for Services
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: A transition from Helping Hands to Roots is necessary for the P/S to receive housing and/or benefit services.

Goal: Transitioning Person Served to Roots
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Helping Hands will refer Person Served to Roots which will provide Person Served with housing and/or benefits services. Person Served states:

Objective: Housing
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will work with Housing Specialist to receive assistance in obtaining stable housing.

Intervention: Case Management
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Case manager will contact Person Served at least __4__ times per month.

Problem/Skill Deficit: Not residing in a stable housing environment-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served needs assistance in identifying and obtaining stable housing.

Goal: To live in a stable housing environment-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will identify and establish stable housing. Person Served states:

Objective: Create a housing budget-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will set a realistic budget that will factor in other recurring expenses in addition to housing.

Objective: Begin housing search-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will begin to seek housing within their budget.

Objective: Utilities-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will find out the cost of having utilities connected and any outstanding balances from old utility accounts under their name.

Intervention: Case management-ROOTS
Start Date: 8/6/2020 **Target Date:** 8/6/2021 **End Date:**
Description: Person Served will meet with ROOTS Case Manager at least _2___ time(s) per month to search for housing and conduct lead follow-ups.

Attachment #5

APPENDIX A
CRIMINAL JUSTICE, MENTAL HEALTH & SUBSTANCE ABUSE REINVESTMENT GRANT PLANNING COUNCIL

PLEASE PRINT

Brian Hass
STATE ATTORNEY OR DESIGNEE

Pamela Hoffman, Rex Dimmig, Patrick Long
PUBLIC DEFENDER OR DESIGNEE

Judge Michelle Pincket
CIRCUIT COURT JUDGE

Judge Susan Barber
COUNTY COURT JUDGE

Hans Lehman, LPD & Larry Holden,DPD
POLICE CHIEF OR DESIGNEE

Major Kim Marcum, PCSO
SHERIFF OR DESIGNEE

Pat Deshommes, DOC
STATE PROBATION CIRCUIT ADMINISTRATOR

Nick Sudzina
LOCAL COURT ADMINISTRATOR

Bill Braswell
COUNTY COMMISSION CHAIR

Michelle Thurner
COUNTY DIRECTOR OF PROBATION

Robert Rihn, CEO, Tri-County Human Services
LOCAL SUBSTANCE ABUSE TREATMENT DIRECTOR

Candace Barnes, COO, Peace River Center
COMMUNITY MENTAL HEALTH AGENCY DIRECTOR

Mary Butler
DCF - SUBSTANCE ABUSE PROGRAM OFFICE REPRESENATIVE

Andrea Anderson
PRIMARY CONSUMER OF MENTAL HEALTH SERVICES

Denise Harrison
PRIMARY CONSUMER OF SUBSTANCE ABUSE SERVICES

Fran Maron
PRIMARY CONSUMER OF COMMUNITY-BASED TREATMENT FAMILY MEMBER

Laura Lee Gwinn, Executive Director, HCPC
AREA HOMELESS PROGRAM REPRENSTATIVE

Chief Michael Allen, PCSO
DIRECTOR OF DENTENTION FACILITY

N/A
DJJ – CHIEF OF PROBATION OFFICER

Attachment #6

POLK VISION LEAD
LEARN ENGAGE ALIGN DEVELOP

Behavioral Health Strategic Plan Development & Sequential Intercept Mapping

Stage 2: Gap Analysis and Needs Assessment

Published: December 2020

Consultant:

crescendo

Contents

Introduction

Project Goal

The ultimate goal of the project is to improve the quality of life of Polk County residents by addressing the behavioral health needs in the community. To accomplish this goal, several components need to be simultaneously achieved.

- Develop a comprehensive behavioral health strategic plan, and behavioral health system access and process mapping.
- Identify systems and resources that are valued and working well; help determine how they may work together more efficiently.
- Identify and prioritize system gaps and community needs.
- Engage a broad set of stakeholders; build consensus around results and actions.
- Use resources more efficiently – focus on a finite set of objectives, establish a timeline for results, and "work with the willing" to achieve results.

Engagement of Diverse Community Sectors

A core focus of the project – especially Stage 2 – was to engage a highly inclusive and diverse set of community stakeholders in order to guide project activities and to inform project results. The Leadership Group was (and remains) highly involved on a weekly basis to provide guidance, project insight, linkage to existing materials, problem-solving ideas, and other support. The community groups engaged in the Stage 2 activities were highly diverse and spanned the County in terms of location, demographics, health and lifestyle issues, social determinants, and many other categories. Generally, Stage 2 activities connected with higher-risk community groups, service providers, and an expanse of other Polk County residents and community members.

Polk Vision leadership and the highly diverse set of community stakeholders were engaged throughout each project stage. Stage 2 involvement provided a solid basis to achieve Stage 2 goals and – based on the Stage 1 research foundation – prepare for Stage 3 activities to identify pathways designed to positively impact community behavioral health. For an overview of each of the three stages, refer to the section "Review of the Three Project Stages" below.

Project leaders and categories of "Stage 2 Research" community group members include the following:

Project Leadership Group Members	Community Groups included in Stage 2 Research	
• Kim Long, Polk Vision • Holly Vida, Central Florida Health Care • Alice Nuttall, Lakeland Regional Health • Joy Johnson, Polk County Board of County Commissioners • Andrea Clontz, Polk County Board of County Commissioners • Joy Jackson, MD, Florida Department of Health – Polk County • Cathy Hatch, Polk County Board of County Commissioners • Vicky Santamaria, AdventHealth • Stephanie Arguello, AdventHealth • Sarah Hawkins, AdventHealth • Lisa Bell, BayCare • Christy Olsen, Polk County Public Schools • Gwinnell Jarvis, Polk County Sheriff's Office • Luis Rivas, Central Florida Behavioral Health Network • Kirsten Sheehan, Polk Vision	• Criminal justice system • Educators • Business leaders • Community members who have direct experience in the behavioral health system • People experiencing homelessness • Victims of intimate partner violence • Disadvantaged youth • Seniors facing social isolation • Seniors with low income • Behavioral healthcare providers • Medical care providers • Community service agency leaders	• Public health officials • Public safety • Elected officials • High school students • Young adults • Foster children • Parents in recovery from substance use disorder or other behavioral health issues • LGBTQ community members • LGBTQ family and support network members • Peace River Center's Sheriff Outreach program • Continuing education experts and people knowledgeable about Adverse Childhood Experiences (ACEs)

Review of the Three Project Stages

All work plan activities for this project were developed to address Polk Vision's preferences and needs. Importantly, though, some research activities were slightly modified based on new information learned throughout the process. For example, substantially more stakeholder interviews were conducted than originally planned due to the tremendous insight and depth of knowledge shared by early project participants. As such, the project has successfully engaged a diverse set of key stakeholders.

The goal of the project methodology is to seamlessly address each of three research stages in the scope of work. The stages include:

Stage 1: Resource Mapping and Process Flow

Goal: To create a statistical and map-based profile of Polk County. Deliverables included an inventory of existing behavioral health service sites and a profile of each.

Stage 2: Gap Analysis and Needs Assessment

Goal: To generate a comprehensive analysis of the Polk County behavioral health environment and generate an in-depth Needs Assessment and Gap Analysis.

Stage 3: Implementing Strategies that Strengthen Communities

Goal: To create strategies to positively impact community behavioral health.

Objective of the Stage 2 Gap Analysis and Needs Assessment

As noted in the table above, the goal of Stage 2 research was to generate a comprehensive analysis of the Polk County behavioral health environment and generate an in-depth Needs Assessment and Gap Analysis. Stage 2 engaged a great breadth of stakeholders and identified a broad-based list of community needs. Activities were designed to help improve community behavioral health by engaging a broad-based set of community members and identifying helpful resources, access to care challenges, service gaps, and highly granular or unique needs based on various factors (e.g., demographics, location, lifestyle). The research conducted in Stage 2 had the additional benefit of building collaboration with individuals and community groups interested in future initiatives designed to improve behavioral health throughout the County.

Stage 2 Approach

The Stage 2 project approach is constructed on a foundation of solid, validated data and insight from a broad spectrum of providers and community members. Research activities provided in-depth analysis of system-level strengths, resources, needs, and service gaps (as well as identification of particularly high-risk communities). Results are intended to provide the basis for Stage 3 activities and – ultimately – ongoing collaboration among community members to improve behavioral health and the quality of life for Polk County residents.

The Stage 2 report includes results from a large number of qualitative research activities (e.g., stakeholder interviews, focus group discussions, casual intercepts), quantitative work (e.g., surveys, data analytics), and community engagement activities. Crescendo was able to engage hard-to-reach audiences (as noted above). The Stage 2 research activities are listed below and then results follow.

- Stage 1 Report Highlights – e.g., a summary of the network of Polk County service providers, a data-based description of higher-risk community groups and subpopulations, and links to helpful interactive maps (beginning on Page 5).
- Results of Qualitative and Quantitative Research Strategies (beginning on Page 9). In-depth analysis of qualitative research results from stakeholder interviews, focus group discussions, review of extant materials, and other research activities.
    - Conducting approximately 60 in-depth one-on-on interviews with stakeholders and community members to gain deep understanding of behavioral health issues and operations.
    - Convening 14 group discussions to expand understanding of system strengths and opportunities for improvement; learn from the interactions among group discussion participants.
    - Conducting an in-depth, quantitative analysis of a multi-lingual community survey. The survey was designed and administered to show community-based perceptions of the magnitude of need for specific services. This includes stratification of the results based on demographic factors, location (e.g., urban, suburban, and rural areas; or, distance from Lakeland), and other factors.
    - Conducting "access audit" calls to gain practical insight regarding access to care and other community-facing operational issues.
    - Review of the Digital and Social Media analysis of urgent or emergent issues.
- Summary of Needs From Stage 1 and Stage 2 Research (beginning on Page 52). Analysis of the Stage 1 results and the Stage 2 research led to the emergence of a breadth of needs and service gaps that were segmented into four core "themes" or "strategic objectives." Each of the four includes several more granular components (Action Areas) that show high-need opportunities, the community affected, support for the results, and illustrative quotations from community members.

The four higher-level themes include the following:

  - Increasing access to care
  - Reducing stigma
  - Increasing services for higher-risk groups
  - Breaking down silos

- Summary of system intervention and access points such as patient flows and barriers to care, access / system entry points, patient flow illustrations, and others (beginning on Page 57).
- Direction for Needs Prioritization and Stage 3 activities (beginning on Page 59).
- Appendices, citations, and other project materials.

The following section presents key findings from the research sections noted above. Note that the Stage 3 report will provide more granular details regarding implementation strategies that will help strengthen the community.

Stage 1 Report Highlights

Stage 1 Resource Inventory and Mapping of Existing Services

The Stage 1 Report provided a set of four maps that show the Polk County based behavioral health (including substance use disorder) care facilities. The maps present information by Type of Service, Setting, Population Served, and the Availability of Telehealth Services. Each map also includes a hyperlink which allows readers to access the online, interactive map and view contact information and other data about each site. The four maps are included in the Appendix of this report and are listed and hyperlinked below.

- Type of Service Provided
  For interactive map, see: https://arcg.is/1SfqnH1
- Setting (Inpatient, Outpatient, Residential, or Others)
  For interactive map, see: https://arcg.is/045X9
- Population Served
  For interactive map, see: https://arcg.is/iPHy4
- Availability of Telehealth Services
  For interactive map, see: https://arcg.is/j5bO1

Stage 1 Report Key Themes and Issues in Behavioral Health (Stakeholders)

As noted above, the primary objective of Stage 1 stakeholder interviews was to learn about currently available resources, services that are working well, and to gain initial insight regarding service gaps, and ways to better meet community needs. The stakeholders were very forthcoming in their ability and willingness to participate, and their insights helped to inform Stage 2. Some of their observations are noted below.

Capacity and Access to Care Remain Major Challenges

- Most stakeholders agree that demand for behavioral health, including substance use disorder services, outweigh the supply of providers.
- The perceived concentration of providers around the Greater Lakeland area (and subsequently fewer providers elsewhere in the County) creates a barrier to care for those living outside of Lakeland. The large geographic area of Polk County contributes to the difficulty of receiving care.
- A significant amount of red tape makes it challenging for people who need care to receive it in a timely manner.
- Interviewees stated that a lack of awareness of available financial support results in some individuals not seeking needed (and available) care.
- There is not good awareness of the first steps required to seek care. Awareness of a "central telephone number" or "no wrong door" policy appears to lacking.

"It's hard to know where to start to get help."

Inter-system Connectivity is Seen as a Major Opportunity

Stakeholders express a strong willingness to "break down silos" yet do not share a unified strategy to do so. For example, several Stage 1 interviewees indicate they want to affect positive change – especially since March 2020. There is a strong desire and belief that, as one stakeholder said,

> ***"Because of what we have all experienced since March [i.e., COVID-19 impact], we now more than ever believe that we all need to work together to save lives and truly improve the health and wellness of our community – ONE community!"***

- Stage 1 interviewees note that improving response to, and care for, individuals struggling with behavioral health issues requires collaboration across service sites and supporting agencies (including public safety and healthcare). Many state that "now more than ever," there is an opportunity to modify regulations, protocols and other system-level issues to improve the ability to share helpful information and optimize service efficiencies.
- For example, the criminal justice system plays a major role in addressing behavioral health and substance use issues. There is a strong [almost urgent] sentiment among several stakeholders that communication and information sharing among the current public health and public safety systems needs to be a high priority activity.
- Many feel it would be beneficial to relocate 2-1-1 services back to Polk County.

Treatment Demand is Increasing – Driving Telehealth and Other Service Line Changes

Providers are responding to increased behavioral health demand in an environment of more restrictive access to care (e.g., limited in-person hours, masking requirements, and others) by making service line changes; however, several barriers to care remain or may even be increasing.

- The COVID-19 pandemic has increased anxiety and depression, and the true impact of the pandemic is not yet known. Some expect suicide rates nationally and locally to increase as much as 32% over the next two years.
- Since many people have chosen to forego outpatient, partial hospitalization, or other care over the past nine months, the acuity level of those seeking inpatient care has increased dramatically.
- Telehealth, while not perfect for every situation, has helped to improve the access to services, but many providers indicated they will discontinue use of telehealth once the pandemic ends.

> ***"We previously had to allot a lot of time for travel between homes, but they [care providers] could increase case load due to telehealth. We worked through the wait list - people could get service in a week which is amazing."***

- Behavioral health and substance abuse issues are not mutually exclusive - many individuals suffer from both, and as such need to be treated for both simultaneously. The comorbidity of substance use disorders with other behavioral health conditions is very high; stakeholders said that efforts to address the issues must be coordinated and inclusive.

> ***"I spoke with about 35 people seeking some type of care for a substance use disorder problem this week. I'd say that nearly all had some additional form of behavioral health issue."***

- Stigma is perceived as greatly restricting people's willingness to seek care for behavioral health issues (especially substance use disorder and schizophrenia-related issues). Stakeholders suggest that stigma is prominent in the general population, as well as some additional challenges due to cultural, religious, and income-related issues.

Many Stage 1 Stakeholders Feel that it is Important to Capitalize on School Resources

Stakeholders indicate that schools (i.e., school-age children) are high need areas, and they have the ability to provide information and resources that can uniquely reach generations of families, catch problems early, and help potentially avoid future ACEs.

- Social media is a driver, and kids tend to frequently post on social media channels about drinking and drugs, which seem more accepted now. The increasing legalization of marijuana is a concern, as is the culture in schools of idolizing certain personalities.
- The COVID-19 pandemic has challenged communications with students, so more issues are likely to be discovered when students return to school.

Stage 1 Behavioral Health Data Highlights

The behavioral health climate in Polk County is characterized by substance use and behavioral health incidence rates similar to the Florida average. However, averages can often mask high-need pockets or communities within a county. Stage 2 research will provide further, in-depth analysis of these core issues. The following tables provide a high-level snapshot of the substance use and behavioral health incidence landscape in Polk County. Some of the key issues to particularly note include, but are not limited to, the following:

- Behavioral health capacity (e.g., inpatient beds) is well below the Florida average, as well as U.S. goals.
- There is a high concentration of providers in the Lakeland area, yet low numbers of providers in other parts of the County – even when adjusting for population concentration areas.
- While many general incidence rates for behavioral health (excluding substance use disorder) and for substance misuse, as noted above, are similar to state and U.S. averages, some trends such as suicide attempts and completed suicides underscore the need for additional focus.
- Approximately one in seven (about 15%) of Polk County residents indicate that they struggle with depression and/or are otherwise at risk for behavioral health challenges. Given the current (and growing) population, the percentage translates to approximately 100,000 people.
- Youth represent one of the particularly high-risk groups – especially females and youth (all genders) of a mixed-race heritage.
- The relatively high level of people with high Adverse Childhood Experiences (ACEs) scores (i.e., four or more ACEs as children) suggest ongoing opportunities to help support people who are working to address childhood trauma or abuse.

Many other data-supported observations are reflected in the following data tables. In the data section, review of the bold-face comments on most pages will cumulatively support the "story" suggested by the data. Stage 2 activities will provide greater detail to the issues suggested by the data and mapping in this Stage 1 report. Note also that secondary data and service use data will be added to the report throughout the project in order to compile the most up-to-date analysis and strategic plan strategies possible

Results of Stage 2 Qualitative and Quantitative Research Strategies

Qualitative Stakeholder Interviews and Focus Group Discussions

During Stage 2, qualitative stakeholder interviews and focus group discussions were held with a variety of representatives across the community. The almost 60 one-on-one interviews provided the opportunity to have in-depth discussions about behavioral health and substance misuse service-related issues with local community stakeholders. In many instances, interviewees provided granular insight regarding behavioral health services and access needs.

Composition

Initially, Polk Vision leadership shared the names of individuals whose experience and opinions should be heard for this research study. These conversations led to subsequent conversations with others who had relevant stories to share. Inclusive outreach targeted communities that historically tend to be frequent users of both behavioral health and substance misuse services, including individuals experiencing homelessness, the recovery community, domestic violence victims, and many others. Also included were groups that traditionally do not proactively reach out for services, including first responders, the business community, and public school personnel.

Over 190 individuals across Polk County were invited to participate in the Stage 2 interviews and almost 60 subsequently confirmed and were interviewed across the following segments:

- Polk Vision Behavioral Health Team
- Health care service providers
- Judicial system representatives
- Law enforcement representatives
- Social service and community organization leaders
- Faith-based leaders
- Childcare workers
- LGBTQ community members
- School social workers
- Elected officials

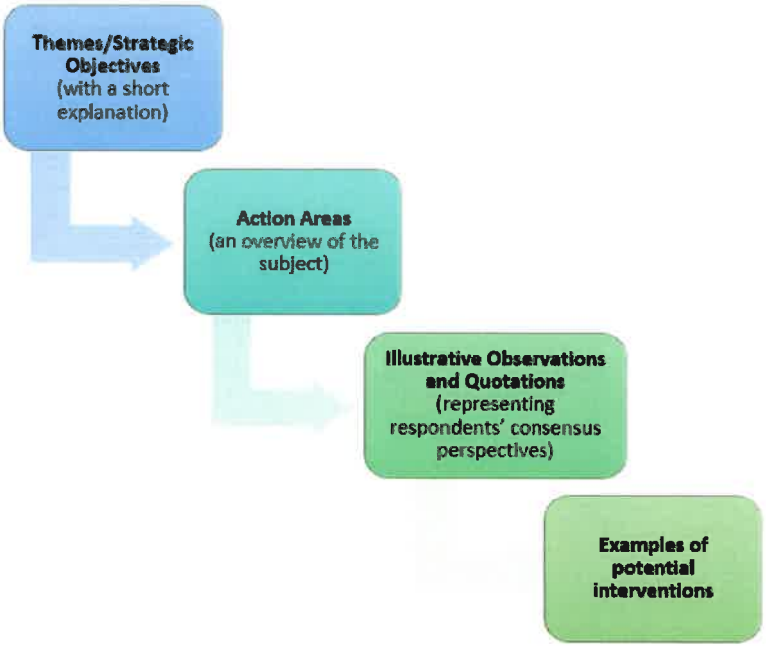
Virtual focus groups were also promoted and convened to provide further insight into the behavioral health and substance misuse-related needs of Polk County. Participants provided their perceptions about area services in addition to broader community needs. Fourteen focus group discussions were completed with approximately 130 total participants. The discussions included the following groups:

- People experiencing homelessness
- At-risk children
- At-risk young adults
- At-risk adults with children
- Workers who care for at-risk families
- Polk Vision Quality of Life members
- Recovery community
- School social workers
- Chamber and employer representatives
- Open forum public groups (four) which encompassed a broad range of community and healthcare leaders

Qualitative Discussions Needs Summary

Structure of the Following Section

Each of Themes/Strategic Objectives are identified below with a short explanation. Action Areas include an overview of the subject, de-identified interview observations in quotations which are representative of respondents' consensus perspectives[1] and examples of potential interventions. **Note that examples of potential interventions are only select suggestions based on Staged 2 research and do not encompass a full set of possible initiatives; they are only examples offered by research participants designed to help inspire further review and discussion in Stage 3 activities.**



The qualitative individual interviews combined with the group discussions resulted in a consensus of several top areas of need that can be described as **Themes/Strategic Objectives**. The Themes/Strategic Objectives and more granular Action Areas identified by qualitative research include:

- Building capacity and increasing access to care
  - Capacity and availability
  - Awareness of services and community education
  - Transportation and other logistics
  - Motivation and process of care
  - Improve system efficiency
  - Insurance and financial concerns

[1] Both interviews and focus groups occurred in the midst of the COVID-19 pandemic. Nearly every person compared and contrasted their experiences both before and during the pandemic; not surprisingly, what they experienced prior to March 2020 had no semblance to the then-current situation. Most if not all indicated a feeling of uncertainty of life and available healthcare services once the pandemic ended, although they all answered the questions as best as they could in the moment.

- Reducing stigma
    - Activities to address self-stigma, community stigma, and institutional stigma such as the following.
        - Enhanced public awareness and education
        - Suicide prevention activities, enhancing behavioral health wellness, and early intervention
- Increasing services for higher-risk groups
    - People experiencing homelessness
    - At-risk youth
    - First responders
    - Individuals of lower socioeconomic status
    - Senior citizens
    - Migrants
    - People of color
    - People who identify as LGBTQ
    - Incarcerated individuals
- Breaking down silos
    - Increasing focus on public safety and jail-related issues, including community transitions
    - Collaboration and communications

The potential interventions will be detailed in the Stage 3 Report.

Theme/Strategic Objective 1: Increasing Access to Care

National Strategy for Quality Improvement in Health Care (National Quality Strategy, or NQS)[2] sees access as the first step in obtaining high-quality care: To receive quality care, people must first be able to gain entry into the health care system.

The NQS uses the framework of the National Healthcare Quality and Disparities Report (QDR) to track Achieving Healthy People/Healthy Communities. **Measures of access to care** tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

For community members, the word "access" also refers to multiple aspects of receiving care. For the purposes of this report, access has been broken down into several "action areas":

- Capacity and availability
- Awareness of services and community education
- Transportation and other logistics
- Motivation and process of care
- Improve system efficiency
- Insurance and financial concerns

Throughout the conversations both in one-on-one interviews and focus groups, all of the above facets of access are areas of concern, and each are broken down below.

Action Area: Capacity and Availability

The research suggests that more providers at all levels of care are needed, including outpatient behavioral health counselors, psychiatrists, psychologists, case managers, social workers, therapists, and others.

Capacity issues[3] are particularly acute in parts of Polk County away from Lakeland. One particular subspecialty specifically mentioned included child and adolescent psychiatrists, psychologists, and therapists, which dovetails with the reported importance of addressing behavioral health issues as early as possible to reduce the incidences of behavioral health and substance misuse in adulthood.

To a person, participants indicated that the lack of behavioral health providers (e.g., counselors, case managers, peer specialists, and others) is widespread throughout the county. The lack of providers has a domino effect such that inadequate numbers of providers leads to long wait times for initial visits, long

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2 See: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr16/overview.html

[3] Note: Available system "capacity" include the number of providers (e.g., doctors, counselors, and other direct care providers) but more specifically, those currently in practice and accepting patients. Capacity is also refined by the availability of convenient hours of operation and available appointment times. Not that both issues are also addressed as part of this study with an Access Audit. The results are included later in the report.

wait times for follow-up visits and medication management services, and a more highly acute patient population – often requiring more services.

In addition, respondents also frequently indicated that the distribution of available providers heavily favors the larger cities in the county, including Lakeland and Winter Haven, and to a lesser extent Bartow. Residents of the outlying rural areas -- such as in the northeast along the "Ridge" and the southern area – have a more difficult time accessing geographically convenient providers.

The following are representative of respondents' consensus observations.

- "Case managers need fewer people to care for, and more understanding of the time it takes to develop [relationships]."
- "First appointment for most people is a month away – this is a challenge."
- "There's a lack of capacity, especially for children. There is a pronounced lack of services for kids and a long wait time, sometimes 6-8 weeks."
- "Treatment centers are very costly even for middle to upper class income [levels]."
- "People can wait 3-6 months for a follow-up appointment after a Baker Act."
- "Not enough substance abuse programs or rehab. A lot of faith-based programs, but whole spectrum of treatment isn't necessarily offered."
- "When it comes to regular counseling, it's once a month. People need it once a week."

Examples of Potential Interventions for Stage 3

- Decentralize counseling services across Polk County, rather than focusing services in Lakeland. Outlying, more rural areas feel a need for more mental health and substance use disorder counselors, outreach services to high-risk seniors (e.g., for social isolation, suicide prevention, and medication management), psychiatrists (especially child psychiatrists), Medication Assisted Treatment (MAT) programs, Recovery Resource Centers including residential care with embedded counseling support, and Peer Support Specialists (also noted below).
- Increase the number of certified community health workers by partnering with training sites such as Peace River, Tri-County Human Services, Southeastern University, and others.
- Expand Crisis Intervention Training (CIT) to a wider range of first responders and care providers.
- Greatly expand mobile crisis care service capacity, including first responder support, domestic violence and threat response, school-based interventions, and others. Expand other mobile care service capacity counseling services, suicide prevention, social isolation, screening, school-based services, and others.

Action Area: Awareness of Services and Community Education

In many communities, awareness of services and the "first number to call" present significant challenges.

Nationally, as many as 60% of people who need behavioral health services do not receive care.[4] Among those not receiving care, a lack of awareness of where to get services is among the most common barriers.[5]

Awareness of services and community education help community members know that a particular health-related issue may require treatment or additional insight from a third-party. This would include knowledge of where to get treatment or additional insight from a third-party, if needed. Many research participants stated that individuals who need help throughout the community don't know where to start, including those who may work in healthcare. Individuals frequently stated that Polk County needs one central location that can provide up-to-date resources for a variety of needs, specifically behavioral health and substance use services.

In order to make a centralized system useful to the broad community, interviewees and others stressed the need to communicate in a location and using a media commonly used by community members who may be in need. Commonly suggested channels include public libraries, public transit hubs, churches, shelters, hospital Emergency Departments, and primary care offices, social service provider agencies, and others.

Others feel that schools can be a hub of trusted information and care for youth. By creating awareness of mental wellness and providing programming to decrease stigma, students benefit, but they can also bring the knowledge back to their families, encourage early intervention, and reduce the prevalence of the cyclical nature of the by-products of the diseases.

- "Sometimes you're so close to the problem, you don't know where to begin and become paralyzed. Awareness and navigation are issues, even for people with means and knowledge. Most people don't know where to start."
- "We need to engage the entire community, community leaders, faith leaders, etc."
- "A regular liaison between healthcare provider and community groups – it can't be one and done, rather it has to be constant."
- "2-1-1 isn't as good as it used to be because people don't update it. It moved to Orlando."

Examples of Potential Interventions for Stage 3

- Identify and fund an organization that can interact with a broad spectrum of Polk County providers and populate a database of resources and associated key information needed by users – community members, providers, funders, and others.
- Expand Trauma Informed Care training to first responders and others co-located at intervention points (i.e., places at which new behavioral health patients may first seek information or care).
- Adopt a Public Resource Platform such as Enhanced 211, Polk FORWARD©, or FindHelp.org

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[4] Rowan, K., McAlpine, D. D., & Blewett, L. A. (2013). Access and cost barriers to mental health care, by insurance status, 1999-2010. *Health affairs (Project Hope), 32*(10), 1723–1730. https://doi.org/10.1377/hlthaff.2013.0133

[5] Sussman, David. Available at http://davidsusman.com/2015/06/11/8-reasons-why-people-dont-get-mental-health-treatment/

Action Area: Transportation and Other Logistics

Measuring over 2,000 square miles, much of which is rural, the expanse of the Polk County area can make it difficult for residents – especially those without personal vehicles – to conveniently travel to obtain the care they need.

Logistics frequently refer to a patient's ability to attain required services, including transportation, financial capability, home support, continuity of care, and other issues. Many respondents indicated that they needed travel unreasonably long distances to receive care or found it very difficult to schedule doctor's appointments around bus schedules. It was reported that use of limited public transportation (especially in more rural parts of the county) this could mean that someone can spend almost an entire day traveling to, attending, and traveling from an appointment, with much of the time being spent waiting for the bus or other transportation. This is also the case with individuals required to access the judicial system.

Both availability and affordability of housing were addressed, and many cited the need for more places for certain populations, such as people experiencing homelessness who also suffer from substance misuse, and victims of domestic violence.

A large percentage of those interviewed indicated that financial barriers are commonplace.

- "Transportation is a huge issue. We don't have a good bus system."
- "Sometimes people have to choose between a halfway house and employment."
- "In Fort Mead or Frostproof or Lake Wales or other rural communities, families don't have gas money to get to providers."
- "A few more urban spots that have transportation, but Frostproof, Avon Park, Eloise have to rely on Medicaid transportation but it's not always convenient. Someone may have an 11 am appointment but they get picked up at 8am, so it's all day."
- "Transportation used to be an issue, then they funded behavioral health centers with transportation money so they're Ubering people now."

Examples of Potential Interventions for Stage 3

- Expand public transportation capacity – especially in non-Lakeland portions of the County.
- Expand use of ride sharing resources such as Uber and Lyft.

Action Area: Motivation and Process of Care

Use of care coordination has the ability to provide motivation and support for people receiving behavioral health care – improving quality of care outcomes while simultaneously reducing the overall system cost of care and enhancing patient satisfaction.[6]

The process of care can include care navigators, community health workers, care coordinators, social workers, and others who are sometimes helpful – especially with higher-risk patients – when trying to manage care for community members in need of services.

Typically, those suffering from dual diagnosis – both behavioral health and substance misuse – require urgent or ongoing care. The research showed that community members value case managers, care coordinators, peer recovery support specialists, navigators, and similar roles, and they indicate that there is a greater need for this capability. These providers support enhanced continuity of care which (according to a recently released study of Opioid Use Disorder patients in Florida) can help address major service gaps among those who are identified as having behavioral health issues yet do not receive needed assistance. See the appendices for the "Cascade of Care" example.

For many who suffer from behavioral health or substance misuse, the act of asking for help is a monumental challenge to overcome. Individuals shared that motivation – whether it's the desire not to return to jail, to see one's children again, or otherwise – has to come from within. And when they do reach out for help and learn that there's a 4-6 week wait to see a provider; the motivation dies and it's easier to return to their old habits.

- "More peer supports, and more peer support programs, are needed. They're undervalued and under paid and there are too few positions. It takes a lot of work to become one. Hard to navigate certification process."
- "Create opportunities for wholistic case management to reduce acuity, and start early."
- "Applicant pools are limited, due to depth of experience or interest. Polk sits between two larger areas in the state and people don't want to leave Tampa or Orlando. People take advantage of tuition waiver then leave."

Examples of Potential Interventions for Stage 3

- Expand proactive outreach services to high-risk seniors who are likely to suffer from social isolation and reduced support or motivation to seek care for behavioral health and chronic condition care.
- Provide opportunities and reduce barriers for individuals who have personal experience with behavioral health or substance misuse services to return to school and earn gainful employment.

[6] Institute for Healthcare Improvement. Available at https://www.milbank.org/wp-content/files/documents/featured-articles/pdf/Milbank_Quarterly_Vol-93_No-_2_Pursuing_the_Triple_Aim_The_First_7_Years.pdf

Action Area: Improve System Efficiency

Respondents indicate that there is an opportunity to improve system efficiency by having an integrated, longer-term approach to service provision.

Research participants discussed system-level issues in two categories: (1) crisis or short-term needs; and (2) longer-term or chronic needs. Crisis or short-term needs benefit from immediate access to critical patient and situational information and care. Participants indicate that siloed operations among health systems, public safety, and other entities (though instituted to secure patient privacy – which all agree is important) can reduce ability of providers and first responders to have access to timely, helpful information.

Longer-term or chronic needs require coordination between and among service providers. Participants say that a centralized organization or other type of entity that could better coordinate system level activities would be helpful. For example, they say that in many cases, grants temporarily assist certain populations, but when the grant money runs out, programs end, and the patients are left without services. Additional coordination of care between organizations would help alleviate some of these issues. Others shared that excessive administrative burdens, duplicative / redundant paperwork, and other specific grant requirements are time-absorbing and consume limit resources that could otherwise be used to enhance patient care. Additional comments are included in the "Breaking Down Silos" theme narrative below.

- "We need a centralized grant management system that shortcuts a lot of the administrative work required of us [i.e., grant recipients]. Believe me, I would much rather spend an additional 20% of the grant money on direct care than on admin!"
- "The region needs a recovery community center – one centralized location, one phone number that can provide peer support, a robust longer-term care network, and a clearing house for services. Having 'trusted resources' takes a long time, as it requires a longer timeline for patients – especially mental health and SUD patients – to build trust. A more efficient system can be built by linking services."
- "Getting the initial intake is a big challenge. If you need to be seen by a psychiatrist, you'll need to be patient – and not in crisis! Many times, the doctor is overbooked, so it takes time."
- "PCPs are not fully educated on behavioral health issues and DO NOT have access to Care Coordination services."
- "Managing entity structure seems very finance-driven, rather than outcomes-driven because of working with managed care."
- "Many different organizations share the same patients; all have different processes, and the systems don't talk with each other. There are a lot of demands on patients, made even worse when they're in the criminal justice system. It seems that many organizations don't see the situation from the patient's perspective. Many others do, but they are limited in their ability to tear down silos. Also, in many places, there is a

culture of protectionism due to variety of limited financing (County health plans, grants, Medicaid). I understand that some aspects of the system-level, finance-related thing is unavoidable, but I think that something as simple as a grants management or coordination system would help."

- "Look at the County health plan and make sure it aligns with the goals of the population. Are they financing the right care to get to the desired outcomes?"
- "Some patients can't get the drugs they're on when they're in the jail, so they take other medication. Consistency of all the best practices models is hard to maintain."

Examples of Potential Interventions for Stage 3

- Adopt a Grant Management system that can (1) help coordinate access to care, (2) manage grant applications and track performance, (3) alert potential grantees of prospective funding streams.
- Streamline mental health admissions paperwork; currently, it is more highly protected (as is sexual health).
- Co-locate counseling services in hospital emergency departments.
- Co-locate care coordination services throughout Polk County, either telephonically or in-person.
- Build behavioral health system efficiency by strengthening awareness among medical and behavioral health providers regarding system resources and referral network.

Action Area: Insurance and Financial Concerns

Finances and/or the perceived cost of care is the most commonly identified reason why people with behavioral health needs do not seek services.[7]

The cost of services or lack of insurance were frequently cited as inhibiting access to care. Many interviewees commented that the number of individuals and families in lower socioeconomic classes either don't have insurance or the financial means to receive behavioral health care or services to address substance misuse. Regardless of income bracket, many research participants indicated that behavioral health care can be very expensive – especially if the care requires time away from work (i.e., a loss of income).[8] They indicate that financial impact and care alternatives can be overwhelming when entering the behavioral healthcare system. Clear sources of insurance and other support would positively impact the financial literacy aspect of care.

- "Funders are very specific in who they give money to and for what, and in these cases they succeed. When you don't meet criteria for a specialize program and you're thrown in with the general population, treatment fails."
- "So many decisions are driven on Medicaid and funders that you get lost in the money and don't see the people."
- "Private practitioners and agencies don't speak the same language – funding is different, billing and coding are different. Private practices can't afford to treat patients with Medicare and Medicaid because they need someone with different billing expertise; software is different, and it takes more time. Billing practices drive what practitioners do."
- "Getting care without insurance is impossible or else it's $700-800/month."
- "Talk about cost with awareness – impression is that behavioral health care isn't affordable."

Examples of Potential Interventions for Stage 3

- Expand Community Health Worker certification and training. Certification requires a high level of knowledge about local care and support resources, including financial resources.
- Develop a single source of financial literacy and supporting information for people considering behavioral health care. A printable and/or online resource available at all intervention points, combined with case management (where needed) may be able to help address initial finance-related concerns.
- Expand cost-reduced or free crisis services.
- Indirectly, economic development and job training activities will tend to improve behavioral health financial concerns by improving community-based financial security – correlated with lower demand for behavioral health care.

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[7] Sussman, David. Available at http://davidsusman.com/2015/06/11/8-reasons-why-people-dont-get-mental-health-treatment/

[8] Note: "One study found that individuals with depression and anxiety were three times more likely to be in debt. Other studies have even found a link between debt and suicide." Available at https://www.inc.com/amy-morin/7-reasons-mental-health-issues-financial-issues-tend-to-go-hand-in-hand-and-it-has-nothing-to-do-with-cost-of-treatment.html

Theme / Strategic Objective 2: Reducing Stigma

Stigma reduces people's willingness to get care and can suboptimize the impact of care. People with behavioral health challenges and facing the prospect of care often feel fear, anger, prejudice, and even exclusion based on perceptions or stigma.

There are three broad categories of stigma. First, "self-stigma" includes the individual's preconceived notions about "mental health patients" or self-image issues. A second type of stigma involves "community stigma," or attitudes and actions of people who interact or respond to the individual needing care – care givers, family members, employers, teachers, public safety leaders, and others. Third, "institutional stigma" is more systemic, involving policies of government and private organizations that intentionally or unintentionally limit opportunities for people with mental illness.[9] This can include health insurers.

Stigma in any form, as well as the response of providers, teachers, family members or others serving as the first point of contact for individuals with needs, can encourage or discourage the access to care and its ability to help people seeking care.

Some of the impacts of stigma include the following:[10]

- Reduced social support and treatment seeking.
- Reduced investment in behavioral health care services and lower funding for treatment facilities.
- Lower health insurance reimbursement rates.
- Negative image of mental illness and the associated impact on employment, housing issues, social opportunities, and other important components of a healthy lifestyle.
- Higher incidence of suicide and more acute behavioral health problems.
- Greater system cost of care.
- Reduced performance in school (children) and at work (adults) due to untreated needs.

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[9] According to the American Psychiatric Association (APA), researchers identify different types of stigma:
- Public stigma involves the negative or discriminatory attitudes that others have about mental illness.
- Self-stigma refers to the negative attitudes, including internalized shame, that people with mental illness have about their own condition.
- Institutional stigma, is more systemic, involving policies of government and private organizations that intentionally or unintentionally limit opportunities for people with mental illness. Examples include lower funding for mental illness research or fewer mental health services relative to other health care. Available at https://www.psychiatry.org/patients-families/stigma-and-discrimination

[10] da Silva, Antônio Geraldo and Baldaçara, Leonardo and Cavalcante, Daniel A. and Fasanella, Nicoli Abrão and Palha, Antônio Pacheco}, "The Impact of Mental Illness Stigma on Psychiatric Emergencies," Frontiers in Psychiatry, Vol. 11, 2020. Available at https://www.frontiersin.org/article/10.3389/fpsyt.2020.00573

There is broad recognition that stigma-related challenges exist in Polk County. Regarding Stage 2 research, the subject of stigma came up in nearly all interviews and focus group discussions, and many indicated that county-wide efforts to reduce stigma would be a key to improving the overall health of the community. While reducing stigma is quite a broad category, for the purposes of this report, we narrowed it down to two action areas that to some degree, encompass the three types of stigma noted above:

- Enhanced public awareness
- Suicide prevention activities, enhancing behavioral health wellness, and early intervention

To truly make long-term, impactful change, all aspects of stigma must be identified, and a strategic plan created that encompasses each of the types of stigma. This issue will be more fully addressed in the Stage 3 Report.

Action Area: Enhanced Public Awareness

Replacing public images of behavioral health (including SUD) stereotypes (e.g., the myth that the mentally ill are dangerous) with educational measures that provide true information helps slowly change public perceptions and stigma.

Educational strategies include public service announcements, books, brochures, films, videos, websites, podcasts, virtual reality, and other audiovisual resources.[11]

This Action Area ties into the need for additional awareness and community education discussed earlier, but whereas that referred to the need to educate individuals where to receive services, this focuses more on providing more accurate information to community members (including patients) about behavioral health impact and access to care. Specifically, as one respondent said, "Give people permission to ask for help, and let them know what is and isn't a 'normal' feeling; let people in need know that they are not alone or 'weak' if they'd like some help."

Some respondents indicated that individuals will not admit to having a problem because they fear of losing their child, or their job. Respondents indicated that system-level stigma negatively impacts willingness to receive care. In some reported cases, these concerns are said to be warranted.

Many used the word "trust" when discussing strategies to reduce stigma, as people trust others who look like them, talk like them, come from similar backgrounds or have shared experiences.

- "Bring a voice and face of recovery to community to break down stigma."
- "Stigma is still out there. It's a black community thing, people have pride in general."
- "Some families for economic reasons have embraced it - families can get money if kids have a diagnosis. Others try to hide it, and this doesn't help in long term."

Examples of Potential Interventions for Stage 3

- Work with providers and other community leaders to develop a set of Public Service Announcements (PSAs) to create storytelling and testimonials to help break stigma and build the concept of trusted resources.

[11] Ibid.

- Engage individuals from a variety of cultural backgrounds, countries of origin or nationalities, sexual preferences or gender affiliations, socioeconomic classes, professions, and others to share their stories of hardship and how they overcame their challenges.
- Create more AA, ALATEEN, and NA meetings and support groups.
- Work with churches and other cultural leaders to break culturally based stigma.
- See Downtown Streets Team note elsewhere in this report.

Action Area: Suicide Prevention Activities, Enhancing Behavioral Health Wellness, and Early Intervention

The majority of the respondents indicated that early intervention and teaching behavioral health wellness are key to preventing or reducing the severity of future behavioral health and substance misuse, including but not limited to suicide and anxiety.

This applies to both children and adults who have suffered a tragedy at some point in their lives, including those who have experienced one or more ACEs, or Adverse Childhood Experiences. The Centers for Disease Control and Prevention (CDC) states that "ACEs have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity."[12] The CDC continues to define ACEs as potentially traumatic events that occur in childhood (0-17 years), including:

- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Having a family member attempt or die by suicide
- Substance misuse
- Mental health problems
- Instability due to parental separation or household members being in jail or prison

ACEs are also linked to chronic health problems, mental illness, and substance misuse in adulthood, and can negatively impact education and job opportunities. In fact, about 61% of adults in one national survey had experienced at least one type of ACE, and nearly 1 in 6 reported that they had experienced four or more types of ACEs.[13]

The National Association of Mental Illness (NAMI) shared that 90% of those who commit suicide had an underlying mental health condition,[14] highlighting the importance of addressing and treating the root causes of mental illness as early as possible. And as a reminder, in the Stage 1 Report research was shared that indicated suicide was one of the leading causes of death in the area and that rates are higher in Polk County (18.7) than the state average (16.9).

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[12] https://www.cdc.gov/violenceprevention/aces/index.html

[13] https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

[14] https://www.nami.org/getattachment/Extranet/NAMI-State-Organization-and-NAMI-Affiliate-Leaders/Awareness/AKA/Mental-Health-Fact-Sheets/AKA-NAMI-Young-suicide.pdf

Experts interviewed shared that while research shows the importance of identifying and addressing ACEs in members of the community, the ACEs paradigm is still not as widely utilized as it should be by providers, which is an educational opportunity for mental health professionals, school social workers, and others.

- "Inequality Florida - working with this advocacy organization to learn best how to support LGBTQ students because they're more at risk for suicide, anxiety, etc."
- "In every school, a mandatory social and emotional skills curriculum (K-12) should be done, same as requirements to teach other subjects. Many curriculums currently exist, but the tendency is to focus on academics in schools - interpersonal skills are responsibility of parents."
- "Have supports for early childhood, for mental health starting as early as possible. If we had trained professionals so many problems could be alleviated. Community wide educational program to teach parents and others about how these issues develop. How to hold parents and community members accountable that today's actions affect tomorrow."

Examples of Potential Interventions for Stage 3

- Increase awareness of the National Suicide Prevention Lifeline 800-273-8255, or "chat" feature (https://suicidepreventionlifeline.org/chat/)
- Expand Mental Health First Aid training - schools, public safety, and other first responders.
- Expand training and certification of Peer Specialists.
- Review materials related to Zero Suicides and adopt helpful strategies.[15]
- Expand Crisis Intervention Training (CIT) to a wider range of first responders and care providers.
- Improve awareness of, and access to, crisis lines and other current programs; expand awareness of "No Wrong Door" initiatives.
- Develop strategies to identify and refer suicidal adolescents and young adults for mental health care, and collect data to evaluate the results. Also, develop strategies to address suicide risk factors – interventions promoting self-esteem and teaching stress management (e.g., general suicide education and peer support programs); develop support networks for high-risk adolescents and young adults (peer support programs); and provide crisis counseling (crisis centers, hotlines, and interventions to minimize contagion in the context of suicide clusters).[16] Other specific suggestions include the following:
    - Ensure that suicide prevention programs are linked as closely as possible with professional mental health resources in the community.
    - Provide prevention strategies that honor cultural issues and access to care challenges.
- Expand awareness of ACEs to providers and educate the community about the importance of addressing these issues.

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[15] Note: Zero Suicide Institute, "The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care." Information available at https://zerosuicide.edc.org/

[16] U.S. Centers for Disease Control and Prevention. Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/00031525.htm

Theme / Strategic Objective 3: Increasing Services for Higher-risk Groups

Several community sub-groups are at a higher risk of behavioral health issues due to life stressors and/or access to care issues. While no one in any community is immune to behavioral health or substance misuse challenges, certain populations tend to be more susceptible or have a harder time accessing care.

According to the American Psychiatric Association, "Racial/ethnic, gender, and sexual minorities often suffer from poor mental health outcomes due to multiple factors including inaccessibility of high quality mental health care services, cultural stigma surrounding mental health care, discrimination, and overall lack of awareness about mental health."[17]

Based on the research conducted for this project, we identified the following community groups deemed at higher risk:

- People experiencing homelessness
- At-risk youth
- First responders
- Individuals of lower socioeconomic status
- Senior citizens
- Migrants
- People of color
- People who identify as LGBTQ
- Incarcerated individuals

Note that vulnerable populations cut across all of the communities listed above.[18]

A deep dive on some of the more vulnerable populations in Polk County is included below. One item to note is that a group specifically addressing individuals with co-occurring disorders is not included, primarily due to the prevalence of co-occurring disorders. Nearly all participants indicated that this is the norm, rather than the exception, so this lens or assumption should be used to address all efforts moving forward.

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[17] American Psychiatric Association. Available at https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

[18] Vulnerable populations include the economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless, the HIV/AIDS community (HIV), and people with chronic health conditions. It may also include rural residents, who often encounter barriers to accessing healthcare services. Groups at higher-risk for attempted suicide (e.g., males over age 45, Native Americans, youth, trauma survivors, veterans, LGBTQ (especially individuals identifying as transgender), people in financial or relationship crisis). Source: AJMC. Available at https://www.ajmc.com/view/nov06-2390ps348-s352

Action Area: People Experiencing Homelessness

Nationally, nearly half (45%) of people experiencing homelessness suffer from a mental health challenge; approximately 25% exhibit symptoms of a Serious Mental Illness (SMI),[19] compared to only six percent among the general population.[20] Given the size of the homeless population in Polk County, this is a significant subpopulation needing focused support.[21]

Among the myriad challenges of people experiencing homelessness, addressing and maintaining adequate healthcare – including behavioral health needs – is only one of many experienced on a daily basis.

- "Patient's families aren't trained and don't know how to take care of their loved ones, so the patient gets kicked out of the house and they end up homeless."
- "Getting people a home, into therapy is next to impossible. It's hard to track someone who is homeless. Make it easier to complete the paperwork - bring it to them using iPads, etc. in the field."
- "People feel indifferent to homeless, project superiority and that makes a patient's situation that much worse. They get runaround and feel like no one really cares. Some caregivers and police seem to accelerate the crisis situation and intimidate rather than decelerate and understand."
- "Harder for homeless to have paperwork. Harder to find documents, and the intake visit is harder for the homeless. People don't have domicile paperwork that you can only have from the social services department."
- "More recovery houses for mental health and substance abuse with people who can help them get medications, and teach people how to become more independent."
- "More shelters or places for people to get off the street, even during the day, and also at night."
- "Many homeless have a history of sexual abuse or assault, and substance use disorder. Such a high percentage of the men who came into the office were sexually abused by fathers, uncles, or while in jail. Healthcare needs to deal with the trauma and urgency of the situation, and not put them in a place where people don't understand homelessness – it's not one size fits all."

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[19] National Institute of Mental Health, Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

[20] Mental Illness Policy group. Available at https://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html; National Homeless Coalition. Available at https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

[21] Homeless Coalition of Polk County. Note: The most recent Point-In-Time survey of individuals and families experiencing homelessness shows 563 people (including children) homeless in Polk County. Available at http://www.polkhomeless.org/images/data/PIT/FL-503%20HDX%20PIT%202020%20-%20TOTAL.pdf

Examples of Potential Interventions for Stage 3

- Engage in and build toward Zero Functionally Homeless goals[22].
- Review stigma fighting and service opportunities such as Downtown Streets (https://streetsteam.org/index).
- Increase case management capacity for the homeless since many do not want to see a counselor.
- Homeless shelter allowance (e.g., room options) for transgender individuals.
- Expand shelters for homeless youth.

Action Area: At-Risk Youth

Polk County's youngest residents not only tend to be among the most vulnerable, but they also tend to be the group that respondents offered the most amount of hope and opportunity to affect change for future generations.

This includes children who live in traditional homes, as well as those with special needs including autism, foster children, and others. Investing in caring for children now should provide incalculable benefits for both individuals and the community in the years to come, and should at some point alleviate the burden on the healthcare system.

- "School grades ("test and punish") has caused a lot of mental health problems, because they don't have time to focus on social development due to teaching to the test."
- "Autism spectrum kids when their behavior kids starts escalating, families start struggling and kids get Baker Acted not due to mental health but rather autism spectrum. Agency for Persons with Disabilities wait list for kids is 6,700 kids long and 20,000 adults. If these families can't get services there, then the kids start cycling in Baker Acts. sometimes kids need 20-30 mental admissions but they're not getting the right treatment."
- "Any child removed from a home should not have to ask for a referral for therapy; it should be automatic, but there are waiting lists. Telehealth isn't as good as face to face, especially for younger kids."
- "If an adoptive kid has issues, it's on the adoptive parents. Like with a child with fetal alcohol syndrome. The child has a biological predisposition for certain issues, yet the adoptive parents can't be proactive."
- "Start early; in order to have 'normal' adults then we need to start with children."
- "If we spent as much time and money on mental health, social/emotional aspects as we did putting up gates, active shooter drills, panic buttons in each classroom, then we wouldn't have

[22] Note: "The Built for Zero is a movement to end homelessness across your entire community, leaving no one behind. Teams focus on chronic and veteran homelessness to learn what it takes to get to zero. Then, they scale their success to find homes for everyone." Information available at https://community.solutions/functional-zero/

this reactionary response. Prevention is key, not paperwork. Need teachers, guidance counselors, social workers working as a team."

- "Youth recovery services are needed."
- "School psychologists are too busy doing the testing – need two, one for testing and one for guiding portion. Emotional and social and behavioral issues are key. If kids don't feel safe, they won't learn."

Examples of Potential Interventions for Stage 3

- Establish mentoring and access to care programs to provide case workers / mentors for disadvantaged youth (e.g., "JUMP" programs, https://ojjdp.ojp.gov; or others).
- Expand telehealth counseling services for youth e.g., TeenCounseling.com, Synergyetherapy.com, telehealth services offered through Lakeland Regional Hospital, BayCare, and others.
- Expand school-based support to help kids with developmental disabilities.
- Update Baker Act procedures and protocols to address youth-specific situations (in coordination with Public Safety, schools, and others.
- Review policies that limit services for children with autism.
- Add mental health career paths to the school curricula.
- Expand UthMpact and StandUP Polk Coalitions (www.uthmpact.org/about-us).

Action Area: First Responders

While traditionally not a population that comes to mind to require special services, the needs of first responders have gained additional attention during the COVID-19 pandemic, exacerbated by the social "Defund the Police" movement occurring across the country.

Putting one's life at risk has always been "part of the job," yet the mental health needs of those serving as police, firefighters, EMS, and others needs additional care from those that they serve. [23]

- "Tons of obstacles to overcome – fear of retribution, fear of being diagnosed with PTSD and getting fired, confidentiality."
- "They don't seek treatment early, so when they do it's overwhelming."
- "Education is #1 to breaking the stigmas."
- "Military vets are told twice not to speak up – once in the military and then again in their first responder role. They're not told directly, but it's part of the culture."
- "It's hard for females in a male-dominated workforce."

Examples of Potential Interventions for Stage 3

[23] Note: Some school social workers are strongly discouraged from seeking behavioral health care since there is a perceived risk that they may lose their license or that their job may be endangered.

- Work with county and individual city police departments, fire departments, and other first responder groups to create or expand trauma and other support groups. Create the equivalent of Peer Support Specialists for first responders.
- Expand or replicate the LRH "VIP" program at other facilities, in which first responders, hospital staff and others in high profile groups in need of care can receive discreet access to E.D. and behavioral health services to maintain confidentiality.
- Increase the number of first responders across all agencies participating in UCF's REACT Training (https://ucfrestores.com/training/peer-support/react-training-program).

Action Area: Individuals of Lower Socioeconomic Status

People with lower incomes who may find themselves unemployed or underemployed may have a lack of financial means to provide healthcare or insurance to themselves or their families, tend to face tremendous risk. In addition, national reports have shown that many people suffer from poverty due to a health crisis.[24]

JAMA Psychiatry published a report sharing the results of a longitudinal study examining the relationship between income, mental disorders, and suicide attempts. The results show that the presence of certain mental disorders was associated with lower levels of income. The study showed that participants with household income of less than $20,000 per year were at increased risk of incident mood disorders in comparison with those with income of $70,000 or more per year. The study concluded that "Low levels of household income are associated with several lifetime mental disorders and suicide attempts, and a reduction in household income is associated with increased risk of mental disorders."[25]

The COVID-19 pandemic has resulted in a large number of people experiencing reduced income, as well as increased mental health and substance misuse needs. KFF conducted a study entitled, "The Implications of COVID-19 for Mental Health and Substance Use," and they reported that, "Research shows that job loss is associated with increased depression, anxiety, distress, and low self-esteem and may lead to higher rates of substance use disorder and suicide. Recent polling data shows that more than half of the people who lost income or employment reported negative mental health impacts from worry or stress over coronavirus …."[26]

- "For people without insurance, there aren't enough options and people get lost in system."
- "Easier way to get affordable medication."
- "Everyone should have health insurance."

Examples of Potential Interventions for Stage 3

- Streamline processes to make it easier for people to qualify for free or reduced cost healthcare and medications.
- Improve promotion of free or reduced-cost healthcare.

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[24] https://link.springer.com/article/10.1007/s11606-019-05002-w
[25] JAMA Psychiatry. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/211213
[26] KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/#:~:text=Recent%20polling%20data%20shows%20that,compared%20to%20higher%20income%20people.

Action Area: Senior Citizens

Some of our communities' most at risk include senior citizens, who more than many others tend to experience difficult life circumstances on a regular basis including isolation, increased acuity of health needs, loss of friends and family due to advancing age or illness, and others; and due to these circumstances, they face unique hardships and barriers to accessing care.

The CDC published information indicating that approximately 20% of people age 55 years or older experience some type of mental health concern, and the most common include anxiety, severe cognitive impairment, and mood disorders including depression or bipolar disorder.[27]

COVID-19 has increased the isolation of everyone, but for seniors the affects tend to be exacerbated for many reasons including increased risk due to COVID, being unfamiliar with technology (i.e., Zoom) that may provide valuable human connections, and cognitive impairment. And some retired members of the community who continue to be productive citizens have been unable to volunteer their time due to higher risk of COVID, decreasing the quality of their lives and those who they serve.

- "Polk has a significant senior population, with the pandemic depression is worse for this group. Memory care units aren't affordable, and families have to make difficult decisions. There are empty beds at local memory care units because they're very expensive. Family has to band together or put the patient in skilled nursing facility if they can afford it."
- "Senior isolation – seniors feel that these years especially during COVID have been stolen from them."
- "For the elderly population, isolation, dementia care, and medication management are some of the biggest challenges facing our community."
- "Homeless with dementia are most at risk. Jail isn't built to take care of the elderly and it's not where they belong; it makes things worse. Once you're mobile, you can't be in an area where you're mentally compromised. They're expected to take care of themselves, but they can't."

Examples of Potential Interventions for Stage 3

- Develop outreach programs to provide companionship and support to senior citizens, such as Project VITAL sponsored by the Alzheimer's Association and Florida's Department of Elder Affairs, which provides tablets to nursing homes and senior care facilities.
- Create and/or distribute communications specifically addressing this group's needs and concerns.
- Improve care coordination for elderly with dementia or other cognitive impairment.

[27] CDC. https://www.cdc.gov/aging/pdf/mental_health.pdf

Action Area: Migrants

Migrants, those who work in the farming or agricultural industry, or others with unknown immigration status face unique hardships and barriers to accessing care.

Migrant workers often have precarious employment conditions and are more likely to be exposed to workplace hazards and other challenges that may heighten stress levels and increase the need for behavioral health support. Not only may they have the cultural issues due to stigma that affect many communities and the lack of understanding how processes operate in this country, they also may face language barriers and the risk of deportation for themselves, their family, or their friends. As a result, they can be among the hardest to reach either proactively or reactively, yet many indicated that the indigent healthcare funds have helped a large number of people. Therefore, awareness of services, culturally appropriate access to care, and the challenges associated with stigma are among the barriers to care for migrants.

- "Migrant issues include confidentiality and language needs, and not knowing the system. The first door is unknown!"
- "Cultural barriers are a big deal for migrant workers, immigrants including the Creole population. All are super reluctant to engage in ANY behavioral services."
- "Patients don't trust the government. They're very worried about immigration."
- "Migrant population in fear because many parents aren't legal and don't want to report anything to anyone that might keep an able-bodied student from working in fields. Language barriers – kids whose parents don't speak English have to skip school to take parent to doctor."

Examples of Potential Interventions for Stage 3

- Expand indigent healthcare funds.
- Research the possibility of training leaders in Peer Support Program.
- Incorporate cultural sensitivity training for Care Coordinators, Community Health Workers, and others having the ability to motivate migrants to get needed care.
- Increase communications targeted at this community.

Action Area: People of Color

Even though Blacks / African Americans and Hispanics are more likely to be in income groups that may be heavier users of behavioral health services, they, in actuality, receive less mental health care, suggesting that cultural or other factors present barriers and reduce access to care.[28]

Lower income levels are highly correlated with the need for behavioral health services in the general population. In Polk County, ethnic minority groups have notably lower median household income levels than whites. However, according to some interviewed, cultural barriers – culturally-based stigma, language issues, and others – in Black / African American and Hispanic communities discourage seeking care for behavioral health issues.

Respondents suggest a number of contributing factors and associated impacts. Noting the general capacity challenges facing the county, some respondents stated that there is a particularly large gap of providers (e.g., counselors) who are people of color and/or possess the language skills needed to effectively care for people who are members of a racial minority group. In addition, people of color living in more rural sections of Polk County face compounded challenges related to transportation and being able to access care. Some research respondent underscored the importance of addressing the needs of lower incomes households (in general) and racial and ethnic minority communities (specifically) since there may be opportunities to break cycles of generational poverty.

- "In many brown and black communities, mental health counseling is viewed as bad."
- "Stigma and pride are more so with black community due to the historical aspect, since many still are affected by the impact of 'Jim Crow' and segregation. In my view, minimal work has been done on how to deal with this issue and pursue real healing. How do you get to heal if you're constantly traumatized, especially if men or women are in abusive relationships?

  There is also a lack of trust of government agencies; many community members feel that they've been traumatized and at times ignored – this is very real to them. The Tuskegee experiment is only 49 years old, and so many other things have happened since then and other traumas. You can't ignore the mental health cost – you may have a breakdown, or it [the impact of system racism and the related behavioral health impact] might hit your child?"
- "People that we serve often get a ride here. Many of my clients [people of color and otherwise] travel 20 to 30 miles, and they don't have a car! Once they get here, we do our best to build a trusted relationship with them. If there are cultural issues, we always try to connect each client with someone [a counselor] who has a similar experience – culturally, racially, and otherwise. It works pretty well!"

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[28] Using 2015 outpatient mental health services was most common for adults reporting two or more races (8.8%), white adults (7.8%), and American Indian or Alaska Native adults (7.7%), followed by black (4.7%), Hispanic (3.8%), and Asian (2.5%) adults. Source: National Institute of Mental Health (NIH). Available at https://www.nimh.nih.gov/news/science-news/2015/a-new-look-at-racial-ethnic-differences-in-mental-health-service-use-among-adults.shtml#:~:text=Using%20outpatient%20mental%20health%20services,and%20Asian%20(2.5%25)%20adults.

Examples of Potential Interventions for Stage 3

- Find trusted leaders in Black and Brown communities to improve communications and trust.
- Encourage students to further education and find employment in behavioral health fields.
- Recruit providers who can culturally connect with people of color clients.
- Develop culturally-sensitive stigma reduction strategies (noted elsewhere in this report).
- Create and/or expand mentorship programs and Peer Support Programs.

Action Area: People Who Identify as LGBTQ

One group that tends to be marginalized in communities across the United States, the LGBTQ population, was particularly interesting due to the fact that many participants tended not to have much information about them.

About 4.5% of adults in the US identify as LGB[29], and this group faces an environment that puts them at risk for mental health problems[30].

- "People aren't as open about this and they don't push. Danger for transgender people, shelters assign people on gender assigned at birth, but no trans woman is going to stay at men's shelter, for example. LGBTQ youth kicked out of homes and don't have anywhere to go but they can't shelter them because of their age, and parents need to give permission for the youth shelters."
- "LGBTQ population is tough. Pride Polk County helps younger population especially with higher rates of suicide. Polk is rural and faith-based, so many kids don't feel comfortable coming out."
- "Gay Straight Alliances are helpful at the high school level, and this may be a good model to use for mental health."

Examples of Potential Interventions for Stage 3

- Expand Gay Straight Alliances at local schools (https://gsanetwork.org/what-is-a-gsa).
- Promote employers who hire based on sexual orientation or LGBTQ status.
- Build social activities into home room at schools to help build a more accepting culture.

[29] https://news.gallup.com/poll/259571/americans-greatly-overestimate-gay-population.aspx
[30] https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/lgbtq

Action Area: Incarcerated Individuals

Jail inmates are more than five times more likely to experience mental health problems than the general public.[31]

Many incarcerated individuals struggle with behavioral health or substance misuse, and frequently both. Some law enforcement personnel indicate that they can readily identify which inmates are in need of behavioral health services.

Additionally, many law enforcement personnel are also intimately connected and knowledgeable about the communities they serve and are often aware of individuals needing – but not getting – behavioral health care. One person reported that, when needed, they arrest these individuals specifically so they can receive help for their illness, as they may fall into one or more of the high-risk groups covered above who have a hard time accessing care.

While here we briefly cover the needs of individuals currently facing incarceration, the topic is covered in more detail below.

- "Many prisoners were abused, and you need to treat the root problem."
- "Barriers to success of people when they get out of jail include accountability, transportation, and cost. They need enough resources to touch them while they're in and when they get out."
- "Adverse Childhood Experiences (ACEs)[32] are played out in real life in front of me every day."

Examples of Potential Interventions for Stage 3

- Expand counseling services for incarcerated populations through telehealth options and/or additional contracts with local providers.
- Establish stronger MAT programs.
- Expand the Helping Hands program.
- Strengthen community partnerships to help people upon release.
- Ensure consistency of medications during incarceration, if applicable.
- Mandate drug and mental health counseling when individuals are incarcerated.

[31] Bureau of Justice Statistics. Available at https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946
[32] Adverse Childhood Experiences research. Available at https://www.cdc.gov/violenceprevention/aces/index.html

Theme / Strategic Objective 4: Breaking Down Silos

All other research "themes" and related behavioral health (including SUD) needs and service gaps can be positively impacted by effectively breaking down communication and operational silos.

Throughout the qualitative research, the air of collegiality permeated conversations, yet many participants feel that silos still exist – negatively impacting the quality of care and the efficiency with which care is provided. Respondents suggest that competing financial interests and laws that hamper the ability to share patients' protected healthcare information are among the contributing factors.

Another point of conversation within the theme of Breaking Down Silos is the belief that the criminal justice system plays an important role in both addressing and treating behavioral health and substance misuse. In fact, some stated that the criminal justice system may be one of the largest suppliers of mental health services in Polk County. Some interviewed feel that this is a consequence of a fractured healthcare system, and opine that by breaking down silos, improving communications among providers, and improving communications between providers and the various public safety entities, the number of people in jail or prison experiencing behavioral health and substance misuse would decrease. They suggest that breaking down silos would help ensure that people who need help can find the right type of care, rather than being criminalized, generating extreme societal benefit.

There is evidence that initiatives are already growing to address this issue in Polk County. One example is behavioral health providers holding office hours at primary care facilities (i.e., co-location of providers). Another example is mental health counselors being available to 9-1-1 personnel both telephonically and for in-person mobile crisis care, as previously noted. Both illustrate creative problem-solving initiatives among community organizations. To quote one participant, "Polk County seems ahead of the curve for working together and problem solving." Several research participants also strongly suggested that expansion of mobile crisis care services across community-wide organizations could further help break down silos.

Silos impact the continuity of care, as noted. A recent Florida-based study of opioid use disorder (OUD) patients shows that 72% of people identified with OUD never receive medication to address the issues; people who do not continue with a six month medication treatment regimen are five time more likely to die from OUD-related events.[33] Research participants indicate that breakdown silos and having additional supports in place will greatly improve outcomes. See "Cascade of Care" appendix.

For this report, we narrowed the action areas for this theme to:

- Increasing focus on public safety and jail-related issues, including community transitions
- Collaboration and communications

Both are covered in detail below.

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[33] Johnson, K., Hills, H., Ma, J., Brown, C. H., & McGovern, M. (2020). Treatment for opioid use disorder in the Florida Medicaid population: Using a cascade of care model to evaluate quality. The American Journal of Drug and Alcohol Abuse, [Epub ahead of print]. doi: 10.1080/00952990.2020.1824236

Action Area: Increasing Focus on Public Safety and Jail-related Issues, Including Community Transitions

As previously noted, jails and prisons care for a large share of Polk County residents experiencing behavioral health and substance misuse.

Challenging the ability of inmates to receive care, is that their time incarcerated is relatively short – too short to fully receive all of the needed care. Respondents also indicate that the recidivism in the jail population results in – at best – disrupted continuity of care between jail-based providers and community-based providers. This approach does not effectively meet the needs of the individual or the community as a whole. So, while the following provides some data points for consideration and suggestions collected from the research, true change needs to occur at the system level.

- "The county has a great problem-solving court. Engaging with re-entry people is needed. Going through problem solving court program is 18 months, but when they graduate, they need more help."
- "ROI is to invest with kids, but this isn't the discussion that occurs. All organizations look at their issues only."
- "Identify people who have reached out for help in many ways before the Sheriff's Office or police arrive at the scene."
- "We want to avoid the school shooting that happened at Marjory Stoneman Douglas."
- "We have the school silo, mental health silo, etc. The silos are killing us."

Examples of Potential Interventions for Stage 3

- Strengthen links between pre-release coordinators and community-based behavioral health (including substance use disorder) service providers.
- Pre-release, schedule initial community-based appointments to be conducted within 72 hours of release.
- Enhance pre-release planning activities by working with the incarcerated person, his or her family and support network to create a success plan.
- Expand job placement and housing support for inmates to be released.
- Create a concerted advocacy effort to change legislation.

Action Area: Collaboration and Communications

Perhaps one of the greatest opportunities for Polk County is to truly improve collaboration among providers.

Collaboration in this context, as related by qualitative research participants, involves the following topic areas:

- ***Client or Patient Information.*** Sharing of information about behavioral health clients / patients in a way that maximizes the efficiency of care, reduces client / patients burden and improves access to care, leads to better quality care and outcomes, and, of course, protects client / patient privacy.
- ***Multiple Provider Information.*** Coordinating services to provide enhanced continuity of care for clients or patients receiving services from multiple providers.
- ***System-level Coordination.*** Participants note that services are not always equitably administered across Polk County – some areas get few if any services while others receive a higher relative concentration of services. System-level coordination is suggested as a way to better attract and allocate scarce resources while improving access to care.

Collaboration in one or more of the topic areas above was identified by nearly all qualitative research participants. The goal of increasing the efficiency by which clients / patients receive care is often considered an immense challenge. However, some research participants articulately noted that a select number of core changes that involve a few of the larger providers could make a significant impact. Their associated point was, as one person said, "We can't boil the ocean, but with a little effort, we can make a positive change to how we work together and – more importantly – our patients' health."

Multiple conversations included suggestions about improving collaboration and communications. A few of the select topics included as coordinating client / patient protocols among continuity of care professionals, systems and technology connectivity, and more.

- "Improve communications between hospital, doctor and other facilities. And – don't forget about the [Public] Health Departments!"
- "Communication among agencies is vital – hard with HIPAA and other laws and restrictions. Several platforms are available to share info, but one universal system would be helpful, even if only for referrals to send patients for larger agencies. No time to manage all of the various platforms."
- "It comes down to data sharing and knowing who has a mental health or substance abuse history. Cops don't want to shoot."
- "Organizations need the same EHR to improve communications and break down silos."
- "Play devil's advocate and look at why things are the way they are, why things/processes should be changed, ask the hard questions and don't assume the way things have been done are the right way."

Examples of Potential Interventions for Stage 3

- Create one central resource for behavioral health and substance misuse services, and ensure it is kept up to date. Improve communications among agencies, including a possible listserv.
- Incentivize collaboration among community-based organizations (CBOs), health systems, and – importantly – Public Health agencies.
- Consider integrated strategies addressing social determinants of health for individuals with behavioral health needs.
- Fund partnerships focused on reducing stigma and educating community members on Mental Health First Aid, offering family support and counseling, and building crisis stabilization resources.
- Support development of "learning collaboratives" for therapists and providers, or a way to bring private practitioners together for learning, networking, etc.
- Consider a pilot project such as the following:
    - Get informed consent from people who have been Baker Acted and stabilized, so that the public safety agencies have their name and pre-defined information shared if/when they get in trouble again. Only limited people would have access to this information, and define parameters, such as in life or death situations.
- Review the processes of transitions of care and improve hand-offs between agencies.

Community Survey Analysis

Methodology and Survey Instrument Development

The survey results supplement other primary research activities and provide an empirical perspective on key project issues. Specifically, the confidential survey helped to further inform community members' perspectives and opinions about behavioral health needs, currently available resources, services that should be added or modified, and ways to help people get the care they need.

The survey was disseminated using online and paper questionnaires, and it was offered in three languages (Spanish, Creole, and English). The questionnaire included closed-ended, need-specific evaluation questions; open-ended questions; and demographic questions. Research suggests that individuals sharing many of the demographic characteristics of the target population may provide socially desirable responses, and thus compromise the validity of the items. Special care was exercised to minimize the amount of this non-sampling error by careful assessment of design effects (e.g., question order, question wording, response alternatives).

Invitations to participate were provided to the community through e-mails from area agencies and the Polk Vision project partners. Affiliated and non-affiliated community partners disseminated the survey through a wide variety of channels, including websites, social media, and emails.

Outreach was conducted throughout Polk County. A total of approximately 300 individuals completed the survey. The survey was open for approximately five weeks to maximize community involvement and analysis of results.

Survey Respondent Demographics

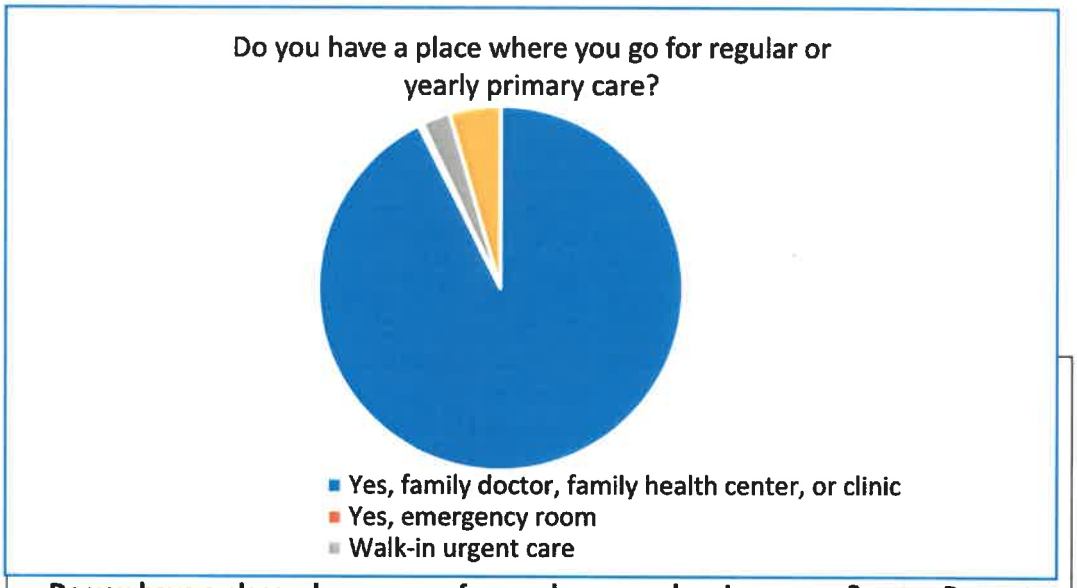
Of the approximately 300 individuals who completed the survey, survey respondents were most likely to identify as:

- Female (84.3%)
- Middle age (45 to 64 years old) – (57.6%)
- White / Caucasian (72.2%) or African American / Black (10.1%)
- With at least one college degree (84.1%); and
- Nearly one fifth of survey respondents make less than $50,000 a year (18.3%)

For a full demographic breakdown of the survey respondents, please see the Appendix.

Please note that as of the drafting of the Stage 2 Report, the community survey is still in the field; the purpose is to provide as many opportunities as possible for community members to share their insights. **When the survey is closed (January 2021), tables, charts, and (where needed) summary observations will be updated.**

Most survey respondents have a family doctor, health center, or clinic where they receive primary care. The link with the Primary Care Physician (PCP) is important because approximately one third of primary care patients receive some form of behavioral health care (e.g., medication management, assessment and screening, and others) from the PCP.[34] In total approximately 19% of adults experience mental illness – approximately half of whom do not receive any treatment. For those who do, many (approximately half) receive care for common psychiatric disorders from their PCP.



Do you have a place where you go for regular or yearly primary care?	Percent
Yes, family doctor, family health center, or clinic	92.6%
Yes, emergency room	0.4%
Walk-in urgent care	2.5%
No	4.5%
Total	100.0%

[34] Abed Faghri, N. M., Boisvert, C. M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): enhancing the assessment and treatment of psychiatric conditions. *Mental health in family medicine*, *7*(1), 17–25.

There is broad agreement that capacity – adequate numbers of providers – is lacking in Polk County for a variety of behavioral health conditions including substance use disorder. Respondents were asked to evaluate prevention, inpatient, outpatient, transitional services, and other social assistance. For nearly all, 90% or more of respondents indicated that there is a need for more providers.

How would you describe the number of doctors, therapists, or places to get help?		
Providers	**Just the right number of places to get help and doctors or therapists**	**More places to get help and doctors and therapists needed**
Prevention and education services	8.6%	90.6%
Aftercare services and care after leaving the hospital, recovery center, or other place to get help	10.5%	88.7%
Outpatient help for general mental health	4.7%	95.3%
Outpatient help for drug or alcohol use	6.1%	93.9%
Inpatient mental health services (other than drug or alcohol)	12.1%	87.9%
Inpatient help for people who need help with stopping drugs or alcohol use	5.4%	93.8%
Social and related community help	7.7%	91.6%
Transitional services for kids and teenagers such as intensive outpatient and transitional housing	1.4%	97.1%
Integrated care for people who need help for both mental health and drug or alcohol use	2.9%	95.6%

Substance Use Disorder (SUD), particularly use of methamphetamines and opioids (including fentanyl), as well as mental health services for people in jail, are seen as being among the highest-need / capacity gap areas. Approximately 60% to 70% of community members also indicate that a breadth of mental services and developmental issues vex the area.

How much more help is needed to fix the below mental health or drug or alcohol problems facing your community, friends, or family? Percent Saying "Some" or "A Lot More"

Issue	Some More	A Lot More	Total
Use of methamphetamine	22.1%	72.1%	94.1%
Use of opiates or prescription pain relievers	22.5%	71.0%	93.5%
Mental health needs for people in jail	17.5%	70.8%	88.3%
Trauma related conditions	25.3%	65.8%	91.1%
School-related mental health concerns	25.8%	62.9%	88.7%
Bipolar Disorders	27.0%	62.8%	89.9%
Integrated care, or including all doctors and others who keep people healthy	23.3%	62.7%	86.0%
Autism spectrum needs	25.7%	61.4%	87.1%
Problems that last a long time and have an effect on daily life, like Down Syndrome or learning differences, or when you have trouble understanding what is said to you, what you read, or paying attention in school	25.2%	61.2%	86.3%
Anxiety Disorders	29.3%	61.0%	90.2%
Depression	28.7%	60.4%	89.0%
Senior care, including Alzheimer's Disease and dementia	26.1%	58.7%	84.8%
Use of alcohol	31.6%	58.1%	89.7%
Schizophrenia	32.8%	56.9%	89.8%
Other general mood disorders	35.1%	53.4%	88.5%
Eating concerns, such as anorexia or bulimia	33.8%	51.1%	85.0%
Use of marijuana	31.0%	47.6%	78.6%
Attention Deficit / Hyperactivity Disorder (ADHD)	33.6%	43.2%	76.7%

- **For obvious reasons, issues related to the COVID-19 pandemic have been dominating public awareness. However, as supported by survey results and noted in the qualitative research, use of opioids** and methamphetamines (which were among leading pre-COVID health concerns) did not diminish. Therefore, even though not as commonly noted in public health coverage, the SUD issues remain.
- Even though issues such as use of marijuana, eating disorders, and ADHD are lower on the ranked list of issues above, more than three in four respondents indicate that more help is needed to address the issues.

People experiencing homelessness and others facing long-term money problems (overlapping groups) are considered to be the most at-risk segments of the community. Single people (men or women), pregnant women, and people new to the area are perceived as being as lower risk, relatively speaking.

Different groups in a community need different services. Which community groups need additional assistance?	
Community Group	**More help needed**
People who are homelessness	90%
People facing longer term money problems	86%
Veterans	84%
Children	84%
People with temporary money problems	83%
Families	82%
People in jail	80%
People whose first language may not be English	77%
Gay, lesbian, bi-sexual, transgender people	73%
Single women	71%
Pregnant women, or those who recently had a baby	71%
Single men	65%
People new to the area	58%

- Most respondents (90%) say that people experiencing homelessness require more assistance than they currently receive.
- Veterans groups and children are noted as requiring more help than they currently receive by approximately five of six respondents.

Survey respondents agree that there is a significant barrier to care to entering the behavioral healthcare system. Leading up to and making that "first call" (i.e., finding a provider and knowing whom to call) is considered to be the most challenging aspect of initial care. Once a provider is contacted, activities around having the initial appointment – wait times for appointments, the intake process, and actually making an appointment – can be challenging, but less so that earlier required steps.

For someone needing first time help for mental health or drug or alcohol needs, how easy are the following to do?			
Activity	**Hard**	**Very hard**	**Total**
Finding a doctor or therapist	57%	30%	86%
Knowing where or who to call first	56%	30%	85%
Receiving integrated care (drug or alcohol addiction services, mental health, physical or medical care)	51%	32%	84%
Receiving care coordination services (for example, scheduling care among different doctors or therapists)	51%	29%	80%
Waiting for a first appointment	45%	33%	78%
Waiting to see a doctor or therapist for follow-up appointments	49%	18%	67%
Going through the intake process	49%	17%	66%
Making an appointment	46%	15%	60%

- About six of seven respondents (about 86%) indicate that finding a provider and knowing whom to call is a "hard" or "very hard" task for people first entering the behavioral health system.
- Relatively more easily accomplished tasks such as making an appointment are considered hard to very hard by 60% or respondents. Research comments suggest for people struggling with behavioral health issues, these less-challenging tasks can still be very difficult.
- Overall, the survey notes that about half of respondents (47%) indicate that there is no easily accessible resource available to people seeking behavioral health and SUD services for the first time.

Issues accompanying homelessness or related issues dominate list of ranked community issues. Housing, social services, and healthcare for people experiencing homelessness are seen as requiring much more focus.

Which of the following community and health-related issues do you feel need more focus or could get better?		
Issue	**Somewhat More Focus Needed**	**Much More Focus Needed**
Affordable housing	13%	82%
Social services (other than healthcare) for homeless people	21%	76%
Healthcare services for homeless people	21%	75%
Access to preferred housing -- location, size of home, access to help, meets my mobility needs, etc.	27%	68%
Affordable healthcare services for people or families with low income	28%	67%
Services to help people learn about, and enroll in, programs that help people pay for healthcare	31%	65%
Transportation services for people needing to go to doctor's appointments or the hospital	37%	58%
Primary healthcare services (such as a family doctor or other provider of regular care)	43%	50%

- More than three of four respondents indicate that "much more" support is needed to address housing issues and issues faced by people experiencing homelessness.
- There are also perceived needs for additional access to care issues such as transportation (especially outside of the Lakeland metro area), financial literacy, and other issues.

Counseling for children struggling with mental health issues is seen as a major community health need. The results are consistent with those from other survey questions that asked about "school-based mental health concerns" or "... community groups need[ing] additional assistance?"

Which of the following community and health-related problems do you feel need more focus or help?

Issue	Somewhat More Focus Needed	Much More Focus Needed
Counseling services for mental health issues such as depression, anxiety, and others for teens / children	17%	80%
Case workers or "navigators" for people who have mental health or drug or alcohol problems; people who can help patients understand the system, make appointments, etc.	21%	77%
Drug and alcohol treatment and rehabilitation services	26%	72%
Emergency mental health services	27%	69%
Counseling services for mental health issues like depression, anxiety, and others for adults	31%	66%
Drug and alcohol education, prevention, and services that help people early	34%	62%
Programs to help people stop smoking	45%	33%

- Case workers or navigators are seen as a much needed resource to help people manage many of the behavioral health system challenges noted above.
- Counseling for more common mental health issues such as depression and anxiety in children is a highly rated need.

The COVID-19 pandemic has had a significant impact on the perceived need for behavioral health services in Polk County. Most survey respondents (91% or more) agree that COVID-19 has had a significant impact on residents' behavioral health and the need for SUD care.

Because of the COVID-19 pandemic, is there more, less, or about the same amount of need for mental health and drug or alcohol help for people?	
Issue	**More help needed due to COVID-19 pandemic**
Mental health help	94%
Drug or alcohol help	91%

- The COVID-19 pandemic highlights current and emerging barriers to behavioral health and SUD care.[35] The pandemic and the associated economic impact create new access to care issues for new patients, as well as acerbate challenges for people already receiving care. The recent (August 2020) Kaiser Family Foundation (KFF) survey showed that more than half (53%) of adults indicate that their mental health has been negatively impacted due to worry and stress due to COVID-19 – much higher than in March when only 32% indicated so. Some of the specific impacts include difficulty sleeping (36% of adults) or eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic medical conditions (12%), due to worry and stress.
- Other behavioral health issues noted as the pandemic ends 2020 include social isolation (especially among older people and the disabled)[36], stress and anxiety from actual or potential job loss, related issues of intimate partner violence and child abuse / neglect, suicide, and poor mental health due to burnout among front-line workers. Those with behavioral health issues and/or SUD pre-pandemic, and those newly affected, will likely require mental health and substance use services.

[35] Kaiser Family Foundation; "The Implications of COVID-19 for Mental Health and Substance Use," Nirmita Panchal, Rabah Kamal, Kendal Orgera Follow @ KendalOrgera on Twitter, Cynthia Cox Follow @cynthiaccox on Twitter, Rachel Garfield Follow @RachelLGarfield on Twitter, Liz Hamel Follow @lizhamel on Twitter, Cailey Muñana, and Priya Chidambaram. Available at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[36] Ibid. "A broad body of research links social isolation and loneliness to poor mental health, and data from late March shows that significantly higher shares of people who were sheltering in place (47%) reported negative mental health effects resulting from worry or stress related to coronavirus than among those not sheltering-in-place (37%). In particular, isolation and loneliness during the pandemic may present specific mental health risks for households with adolescents and for older adults. The share of older adults (ages 65 and up) reporting negative mental health impacts has increased since March. Polling data shows that women with children under the age of 18 are more likely to report major negative mental health impacts than their male counterparts."

Behavioral Health Access to Care Audit Analysis

Objective and Description

As noted, the NQS sees access as the first step in obtaining high-quality care: To receive quality care, first Americans must first gain entry into the health care system. The purpose of the access audit calls was to evaluate community access to care, provider responsiveness, and other customer service measures. The Polk Vision Access Audit involved making test phone calls to behavioral health service sites with the intent of identifying the following:

- Ability of the site to accept new patients.
- Expected wait time to have an initial appointment.
- Experience of the facility to refer the caller elsewhere when the desired services are not provided.
- How staff asks questions to define prospective client needs and other information prior to making an appointment (e.g., insurance coverage, appropriate levels of service, other access to care issues).
- Other customer service characteristics.

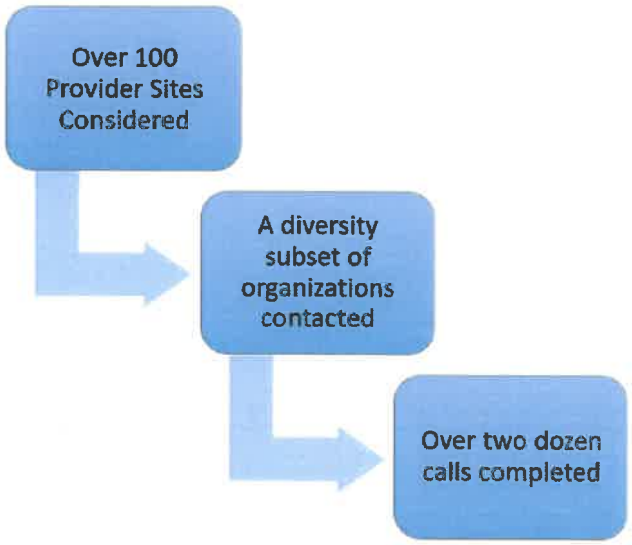
The Profile here summarizes calls made to select behavioral health and substance abuse service providers in order to better understand the degree to which services are readily available and to identify barriers that may challenge the system's ability to provide easy access for people in need. The following research summary highlights key results.

Access Audit Methodology

The audit involved making mock calls to service sites with the intent of identifying the ability of the site to accept new patients, the expected wait time to have an initial appointment, and other customer service and access characteristics. The results provide insight to access gaps, improvement strategies, and service variations based on insurance status.

The research included multiple calls to 20 behavioral health service sites in Polk County. The sites included were randomly selected from a list of County service providers – with the exception that organizations often mentioned during the stakeholder interview research phase were explicitly incorporated.

Most service sites were "shopped" (i.e., called on the telephone) by Crescendo "shoppers" seeking to schedule an appointment and to learn about other factors that potentially impact consumer access to services.[37] Calls were made at different times



[37] Crescendo's "shoppers" contacted service sites from the point of view of having a relative new to the area and seeking information regarding access to care.

throughout the day; most sites received multiple calls. The list of information gleaned during the calls includes those listed below.

- Basic customer service measures (e.g., number of rings before staff answered the phone, level of friendliness and helpfulness to the caller, level of professionalism in how staff assists the caller, and others; and variations in these measures based on the caller's insurance status).
- Wait time for an appointment and initial access
- Insurance status impact on access to care

The results help identify service access gaps, improvement strategies, and service variations based on insurance status. The appendices contain a descriptive profile of organizations included in the Access Audit.

Access Audit Results

The access audit calls revealed several key barriers that may limit an individual's ability to access behavioral health and substance use care when needed in the community. The purpose of the audit is to identify general access to care issues in the Polk County area – not to profile any particular site. The broad issues noted are used to help guide, validate, or improve service site-level practices that impact individual's ability to receive care.

The average wait time for an initial screening appointment is less than one week, yet counseling appointments are typically approximately two weeks at most sites. Appointments for medication management may require a wait time of more than three weeks.

Additionally, about half of phone calls were sent directly to voice mail. In those circumstances, patients must rely on the provider to a) return their call in a timely manner and b) call when the patient has the ability to answer the phone and freely hold a conversation about his or her health issues – which, for many, can be challenging. However, when engaged, live attendants were very empathetic and caring. In several cases, organizations were staffed by individuals who had previously received care for issues being addressed by their organization; those individuals were particularly effective in engaging the caller Other key summary points include the following:

- Walk-ins were noted as being available by one organization to identify patients in crisis, and as a way to schedule follow up visits after intake.
- In cases where a conversation was conducted, new patients were typically asked to come in and pick up initial material (or due to the pandemic, receive them via email or download information from a website), then be seen at a later date.
- The initial wait time for services is one week or sooner for an initial screening but about two weeks for a counseling appointment after the screening. However, patients in crisis can often be seen within one week.
- The wait time for psychiatry services is two to four weeks – longer in some cases. Medication management needs are particularly acute for pediatric services.
- In conversation, people freely referred callers to other providers, even if outside their own organizations. However, in many cases, organizations were unable to identify a publicly available source, database, online search tool, or directory of area service providers.

- A large selection of insurances seemed to be widely accepted.
- None of the calls connected asked about the current status of patient or if he or she was in crisis. Doing so may help callers and organizations make more timely decisions about the most appropriate care and required services.
- When speaking with live attendants, callers were usually quickly engaged by empathetic, caring individuals at the service organizations. Organizations providing residential or other longer-term care were particularly engaging; often being staffed by Peer Specialists or other who previously had experiences receiving care from the facility at which they now work.
- If a prospective patient did not have insurance, there was not a clear response, but it was implied that the provider and/or facility would help patients with reimbursement paperwork.
- Approximately half of the 25 calls were answered by an individual; the remaining calls were sent to voicemail messages or other form of automated attendant.

Access Audit Summary

The goal of access audit calls is to gain a better understanding of the pathways and processes available to community members seeking assistance.

Polk County service providers included in the Access Audit were typically highly empathic and provided clear information about the initial process of care. However, since many calls went to voicemail or an automated attendant, it implies that the initial outreach to learn about available services faces some process-based challenges.

A common refrain from key stakeholders and focus group participants (noted elsewhere in this report) centered on the importance of facilitating easy access to care – especially for those entering the healthcare system for the first time or seeking initial care for an urgent situation. In the interviews and focus groups, it was reported that the first "experience of care" when seek help for behavioral health issues (including substance use disorders) is critically important. Many suggested that patients were more likely give up efforts to receive services if the first call or outreach does not provide an immediate next step.

In summary, the Access Audit shows that initial contact with a live person is very important and, in many cases, delayed due to the use of automated attendants or similar features. However, once connected with live respondents, callers receive helpful information. Access to counseling and medication management services is often not readily available while initial screenings are usually handled quickly.

Digital and Social Media Analysis

The Digital and Social Media Analysis provides an opportunity to identify urgent or emerging issues in the behavioral health landscape. As background, over four billion people across the globe use the internet with approximately 3.2 billion using social media in 2018.[38] The internet and social media have become powerful channels to share information at home and around the world. Google continues to be the top search engine with 70% of all search market share.

With an abundance of information at an individual's fingertips, one in three Americans have searched online to figure out a medical or behavioral health condition.[39] Of those who seek information online, 46% of the individuals sought attention from their medical provider. Reviewing online search interest can help identify the most common, emerging, and surging healthcare-related issues in the local community.

Approach:

Crescendo deployed data analysis and reporting techniques based on digital communications resources using Google Analytics and Trend Analysis to review key search terms related to behavioral health and substance use in the Polk County region from January 1, 2018 to December 20, 2020. Due to how Google collects and analyzes trend data, it provides information and search pattern insight for users with select geographic regions. In this data analysis, the Tampa-St. Petersburg geographic region was used as it was inclusive of Polk County. However, it is important to note that due to the geography, the data may be skewed because of the highly populated cities of Tampa and St. Petersburg. The Orlando market was also reviewed since Polk County lies between the two metro areas. The following analysis includes data from only the Tampa and St. Petersburg area since there was little relative variation between Orlando and Tampa and St. Petersburg on most scales.

Goal:

To better understand community members' interest in behavioral health and substance use disorder topics by identifying the most common, emerging, and/or surging mental health and substance use disorder issues included in publicly available online discussions.

[38] We Are Social. *Digital in 2018: World's Internet User Pass the 4 Billion Mark*. https://wearesocial.com/blog/2018/01/global-digital-report-2018

[39] Pew Research Center. Health Online 2013. http://www.pewinternet.org/2013/01/15/health-online-2013/

About Google Trends

Google Trends is a search trends feature from Google that shows how frequently a given search term is entered into Google's search engine relative to the site's total search volume over a given time period.

Google uses a relative score to measure the index of search activity. The maximum value, or peak popularity, is 100. For example, if maximum number of searches for the term "Mental health" occurred in mid-February 2020, the value for that week is 100. If the following week had half as many searches, the charted value would be 50. In neither case is the actual number of searches revealed by Google. However, the tool can be used to identify peaks, trends, and spikes in interest in various behavioral health topics. A score of 0 means there was not enough data for the term.

The following charts depict the search interest for mental health issues in the Polk County region (i.e., the Tampa and St. Petersburg search area) from January 2018 to present. Though not available for charting, Google Trends provides ranks by city (including Lakeland) for some select terms.

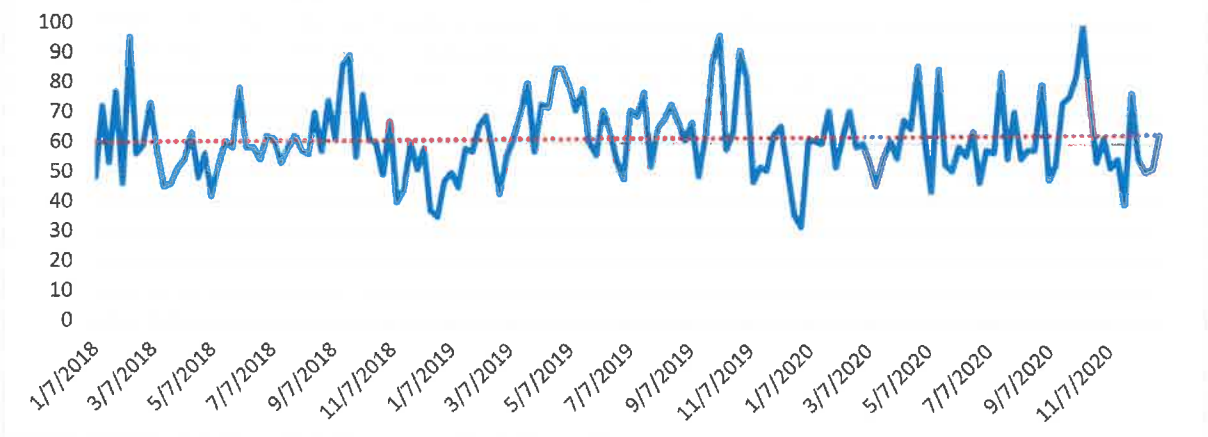
In summary, the Digital and Social Media Analysis identified three core issues.

- Interest in mental health issues is elevated since the pandemic but not extraordinarily so.
- "Sadness" and "depression" are subtle but growing parts of community interest. Lakeland is a leading city in the region for people experiencing or interested in the topic of sadness. This supports the general increase in the need for behavioral health services noted elsewhere in this report.
- Although mental health-related issues are common search terms among area residents, more are interested in general health (e.g., COVID-related, chronic disease, and other broader health and wellness) terms.

Mental Health Search Interest Overview

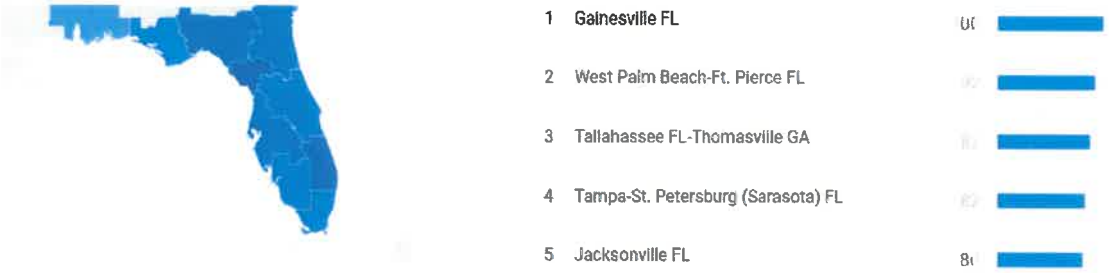
As the pandemic began and lockdowns were initiated in March 2020, there was an increase in mental health issues. The biggest spike of interest occurred in October 2020. Since then, interest in mental health has remained similar to pre-COVID levels.

Google Search Interest Over Time for Mental Health



- **When comparing search interest for "health" and "mental health," interest in mental health is substantially less than interest in more general health categories.** As expected, interest in broader, COVID-related health terms peaked in March and April 2020, as lockdowns took place and other health topics gained general focus.
- **Lakeland residents have a greater than average interest in behavioral health issues.** Google Trends ranks cities by their interest in search terms. For the search term "health," Lakeland ranked 38 out of 50 in the geographic region while it ranked 14th for "mental health" indicating that more people in Lakeland and Polk County are searching Google for mental health issues.

Google Search Interest Over Time for "Mental Health" by Geographic Region



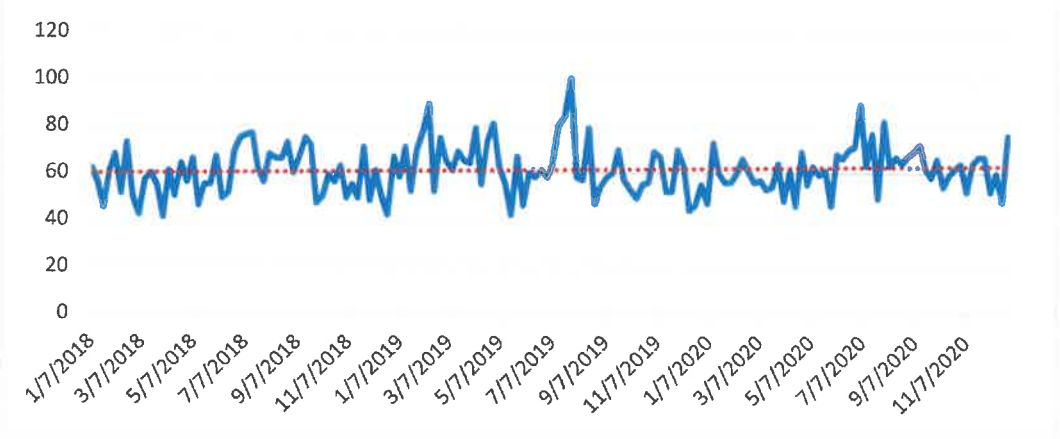
- **Throughout the state (including the Polk County area), access to care and issues related to awareness of services are leading topics.** Top search terms for that state include "Florida mental health," "mental health services," "what is mental health," "mental health near me," and "mental health counselor." The top rising search terms – i.e., the ones being sought out at a rapid, increasing rate – include "mental health facility near me" and similar terms.
- **Mental health search interest is highest in the Gainesville region followed by West Palm Beach.** The Tampa-St. Petersburg area is ranked 4 out of the 10 metro areas defined by Google. When looking at Florida by cities, Gainesville is ranked number one.

Mental Health Disorders Google Search Interest

Greater public anxiety is reflected in the June / July time frame. Approximately 35% of U.S. adults have reported they have gone online to learn about medical condition they or someone else might have.[40] While search interest for mental health has remained fairly stable, search interest for some mental health disorders (e.g., depression) in the area has increased since 2018. Search interest for lifestyle behaviors, such as marijuana use and child abuse, has decreased.

[40] Pew Research Center. Health Online 2013. http://www.pewinternet.org/2013/01/15/health-online-2013/

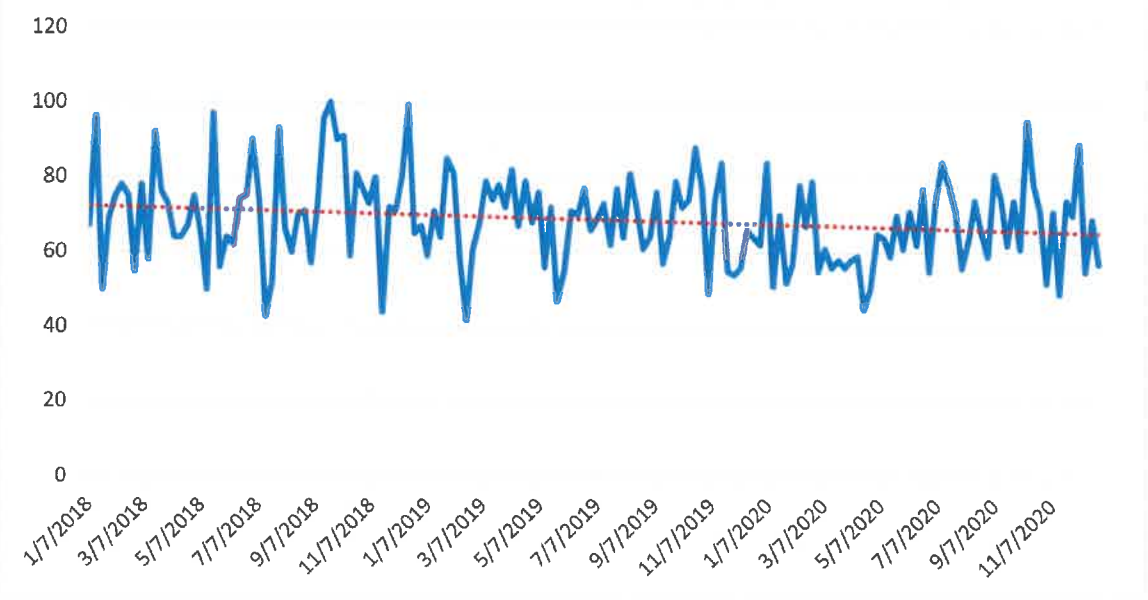
Google Search Terms Related to Anxiety, 2018-2020



- From January 2018 through December 2020, searches for anxiety (emotional disorders) increased about 2% since 2018.
- Top search terms include anxiety, depression, anxiety symptoms, and anxiety medication. Terms showing the most rapid increase among area residents focus on medicines or nutrients to help ease the effects of anxiety, e.g., "ketamines for anxiety," "CBD oil for anxiety," and others.

Google Search Terms Related to Depression, 2018-2020

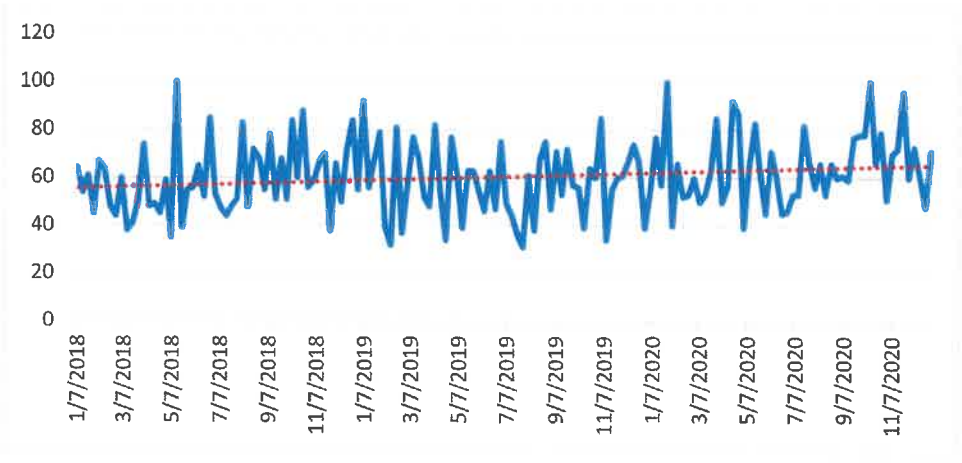
There is a general increase in depression and depression-related topics since early March 2020.



- From January 2018 through December 2020, search interest for major depressive disorder has decreased about 11%.
- Of the 21 cities in the geographic region that Google collects information from, Winter Haven is ranked number four and Lakeland is ranked 12. Gainesville is ranked number one.

- **Interestingly, one of the top search terms is "coronavirus depression" and "how to help someone depressed," which likely indicates that people are recognizing that someone needs help during the pandemic.** Other top search terms include "depression," "depressed," "anxiety," "depression and anxiety," and "what is depression."
- "Sadness" also shows a general increase since early March 2020. See below.

Google Search Interest for "Sadness," 2018-2020

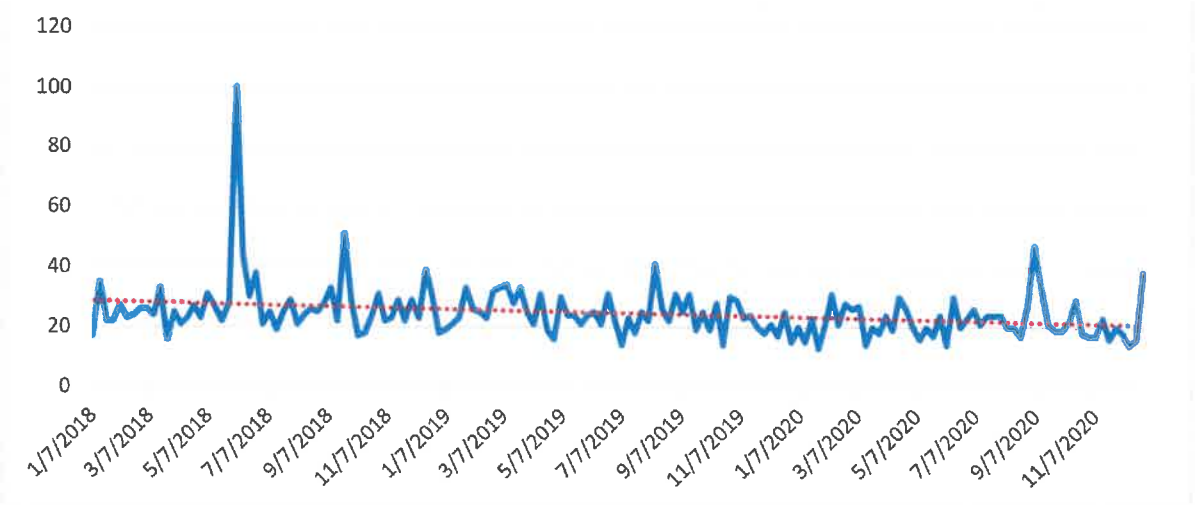


- From January 2018 through December 2020, searches for sadness increased approximately 14% since 2018.
- Sadness is a symptom of depression but is also an emotional feeling. During the COVID-19 pandemic, more people may be feeling sad and are looking for ways to express their feelings.
- **Lakeland ranked number one of the seven cities identified by Google in this geographic region for the search term sadness.**

Suicide

Suicide is the third leading cause of death for American adults. Since 1999, the suicide rate in most states, including Florida, has increased approximately 30%.[41] As awareness for suicide increases in the general public, more people are searching for information on suicide prevention and the suicide hotline.

Google Search Interest for "Suicide," 2018-2020



- Google search interest for "suicide" decreased approximately 33% from 2018 to 2020. Top search terms include suicide, murder suicide, suicide hotline, and suicide prevention.
- There is a spike around June 2018 in search interest for "suicide" due to the high profile suicides of Anthony Bourdain and Kate Spade.

Summary

The digital analysis of Google search interest trends in the Polk County area reveals some positive correlations between mental health disorder Google searches and diagnoses. The correlation between Google search interest for anxiety, depression, and suicide and mental health issues in Polk County may indicate two things: 1) awareness has increased and more individuals are searching for symptoms and prevention information, and 2) mental health stigma may be preventing individuals from seeking treatment and information from their medical providers and are thus turning to the internet for information. For example, top search terms for suicide include "suicide hotline" and "suicide prevention" indicating individuals are interested in learning more information on how to prevent suicide.

[41] Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., Ivey-Stephenson, A. Z, & Crosby, A. E. (2018). Vital Signs: Trends in suicide rates — United States, 1999-2016 and circumstances contributing to suicide — 27 states, 2015. Morbidity and Mortality Weekly Report, 67(22), 617-624. Retrieved from https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6722a1-H.pdf. Accessed December 2018

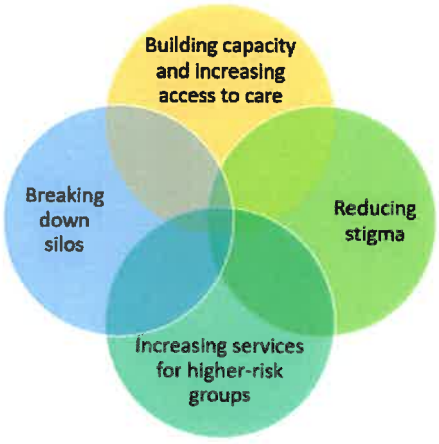
Summary of Needs From Stage 1 and Stage 2 Research

Stage 1 and Stage 2 project activities established a solid foundation of data and validated research. Additional qualitative and quantitative research engaged a broad spectrum of Polk County community members including those with personal experience receiving or providing care, as well as other representatives of at-risk groups. "Harder to reach" community groups taking part in the research include (but are not limited to) disadvantaged youth, lower income parents recovering from SUD and/or other behavioral health issues, LGBTQ community members, migrant workers, Hispanic community members and others whose primary language is not English, people experiencing homelessness, individuals living with seen or unseen disabilities, and others.

Research also included in-depth conversations with public health leaders, public safety leaders, direct care providers, first responders, Community Based Organization (CBO) affiliates, school officials, business representatives, many general community members, and others.

Based on the broad-based research, four, non-discreet, system-level needs were identified:

- Building capacity and increasing access to care
- Reducing stigma
- Increasing services for higher-risk groups
- Breaking down silos



More importantly, the research identified several specific community groups in which needs are particularly acute. Operations and future activities that positively impact the system-level needs noted above will help meet the needs of all community members. However, when identifying priorities for future strategies, it will be helpful to focus on activities that do one or more of the following:

- Increase support and care for the greatest number of community members in need
- Increase support and care for people with the most urgent needs
- Positively impact longer-term, cyclical (or "generational") behavioral health needs

Stage 3 of the project will further explore needs prioritization, develop strategies to address the needs, and create helpful tools or other mechanisms to measure progress.

The Stage 2 Qualitative Research Summary (above) provides a wealth of suggested activities that may be helpful in addressing Polk County behavioral health needs. This section provides more granular insight regarding specific opportunities and higher-need segments within each of the four system-level need categories. The following table provides a synopsis of the Stage 2 and Stage 1 research – showing system-level needs (that impact all community members) and lists of more detailed community segments who may be either at greater risk or may be a particular focus of strategies designed to address the system-level need. Again, note that all Polk County residents would benefit from actions that lead to system-level improvement (the first, or left-most, column on the next page), yet communities with elevated needs (i.e., those noted in the second column) are at particularly higher-risk, based on Stage 1 and Stage 2 research.

Stage 1 and Stage 2 Needs Summary Table

Stage 1 and Stage 2 Needs Summary Table	
System-level Needs	**Communities of Elevated Need or Requiring Particular Focus to Address Needs**
Building capacity and increasing access to care[42]	
	Communities of Elevated Need
	People in crisis and at-risk for self-harm – especially those in need or mobile crisis services
	Lower income households and/or educational attainment
	Migrant communities and others where English is not the primary language spoken in the home
	People living with a chronic medical and/or behavioral health condition
	People living with seen or unseen disabilities
	Rural households and other communities outside higher-capacity cities or towns
	Incarcerated individuals
	Residents who may benefit from telehealth-based care

[42] Includes service gaps such as Capacity and availability, Awareness of services and community education, Transportation and other logistics, Motivation and process of care, Improve system efficiency, and Insurance and financial concerns.

Stage 1 and Stage 2 Needs Summary Table

System-level Needs	Communities of Elevated Need or Requiring Particular Focus to Address Needs
Reducing Stigma[43]	
	Communities of Elevated Need
	Self-stigma and community stigma • People needing behavioral health care or information, especially those with SUD, schizophrenia, and psychoses • Youth • First responders • Direct care providers (including school counselors and others at intervention points)
	Groups Requiring Particular Focus to Help Address Needs
	Institutional stigma • Legislators and other elected officials • Public health officials • Education leaders • Business owners and other employers

[43] Including, but not limited to, enhanced public awareness and education, as well as suicide prevention, wellness, and early intervention activities.

Stage 1 and Stage 2 Needs Summary Table

System-level Needs	Communities of Elevated Need or Requiring Particular Focus to Address Needs
Increasing services for higher-risk groups	
	Communities of Elevated Need
	People experiencing homelessness
	At-risk youth • Females • Youth (all genders) of a mixed-race heritage • Others, as noted
	First responders
	Individuals of lowers socioeconomic status
	Senior citizens
	Migrants
	People of color
	People who identify as LGBTQ
	Incarcerated individuals

Stage 1 and Stage 2 Needs Summary Table

System-level Needs	Communities of Elevated Need or Requiring Particular Focus to Address Needs
Breaking down silos	
	Groups Requiring Particular Focus to Help Address Needs
	Public safety and individuals managing jail-related issues
	The breadth of community organizations involved in the behavioral health continuum of care, i.e., those who would benefit from enhanced collaboration and communications • Providers including public health and other Community Based Organizations (CBOs) • Public safety • Policy makers and people working in forensic intervention / access points • Schools • Employers and employer groups • Others

Intervention Sites and the Process of Care

System Framework

The following section describes behavioral health (including SUD) intervention points. The process of care described is intended to reflect the primary, system-level access points and processes faced by those seeking behavioral health care. Although there may be some unique instances not fitting into the model below, it shows the processes faced by the majority of people in need of behavioral health care in Polk County. Specifically, the purpose of the following section is three-fold:

- Illustrate the complexities of receiving care in Polk County
- Enumerate several key points at which people seek care for behavioral health issues and/or are identified as needing care
- Underscore the importance of collaborative work to break down silos and advance care to those in need.

The process of care is complicated, especially for behavioral health and substance misuse services. Multiple contact points or intervention sites in the community can exist for any individual seeking to get help. In addition, the process of care differs depending on the patient's insurance (or lack thereof) and the funder of the specific program or facility providing the care. To further exacerbate challenges, the pathway to receive care is not linear – one patient may touch multiple contact points or intervention points throughout his or her lifetime.

In yet another unique structure, the public safety or criminal justice system has distinct channels and processes (since a large percentage of people in the Polk County jail or prison system have or have had behavioral health or substance misuse concerns at some point in their lives).

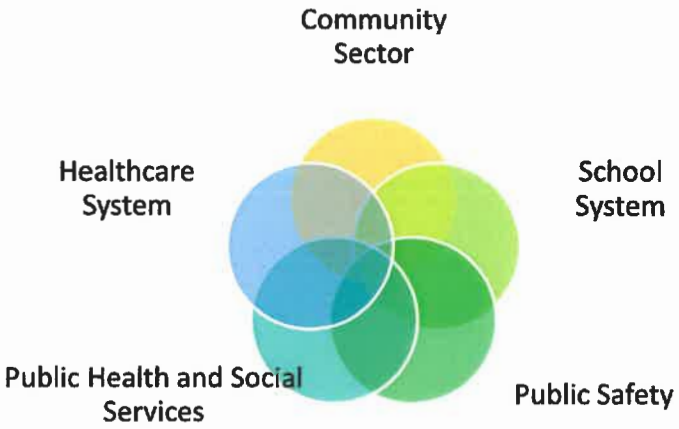
Patients face challenges when trying to get the right care at the right time in the right place. Access to care challenges remain – even after an initial experience in the behavioral health care system. Ongoing, or chronic, conditions pose ongoing challenges, as provider requirements changes, patient needs evolve, and process of care issues realign.

Stage 2 research was used to help illuminate the issues and serve as a basis to construct a simple to follow illustration of patient intervention points and channels to care sites. Specifically, it defined process of care components based on feedback from providers, general community members (including users of the behavioral health system), and other key stakeholders. The process of care components covered discussed in this section include the following:

- Environment Sectors: The broad categories or places within society with which people identify or where they live, work or play on a regular basis.
- Intervention Sites or Contact Points: People or places within the sectors that can identify or help inform someone who needs help with behavioral health or substance misuse issues.
- Care Sites: Facilities where people can receive behavioral health or substance misuse services.

The Five Environment Sectors

To start to think about improving this process (which will be covered in more detail in the Stage 3 Report), it's important to first review five initial environment sectors in which people live, work or play on a regular basis – ones at which they may also be identified as being in need of behavioral health care:



Each of these five environment sectors is comprised of several, more granular groups (i.e., "Intervention sites," or "contact points") in which someone may first turn for support for a behavioral health issue (or be identified as needing care). For example, within the School System sector, students (for instance) may seek help from teachers, coaches, guidance counselors, administrators, parents, or others.

Whether through a teacher, parent, coach, guidance counselor, or other (or intervention points in other sectors), care is provided by a similar set of care sites such as the following:

- Outpatient counselors or clinic
- Primary care physician
- Hospital emergency department
- Hospital inpatient care
- Hospital IOP or PHP care
- Baker Act referral sites
- Marchman Act referral sites
- Community support group or agency
- Residential or transitional care
- Others

An exception to the model is the Public Safety sector. Behavioral health care in the sector uses many of the same provider types, yet the channels to receive care differ.

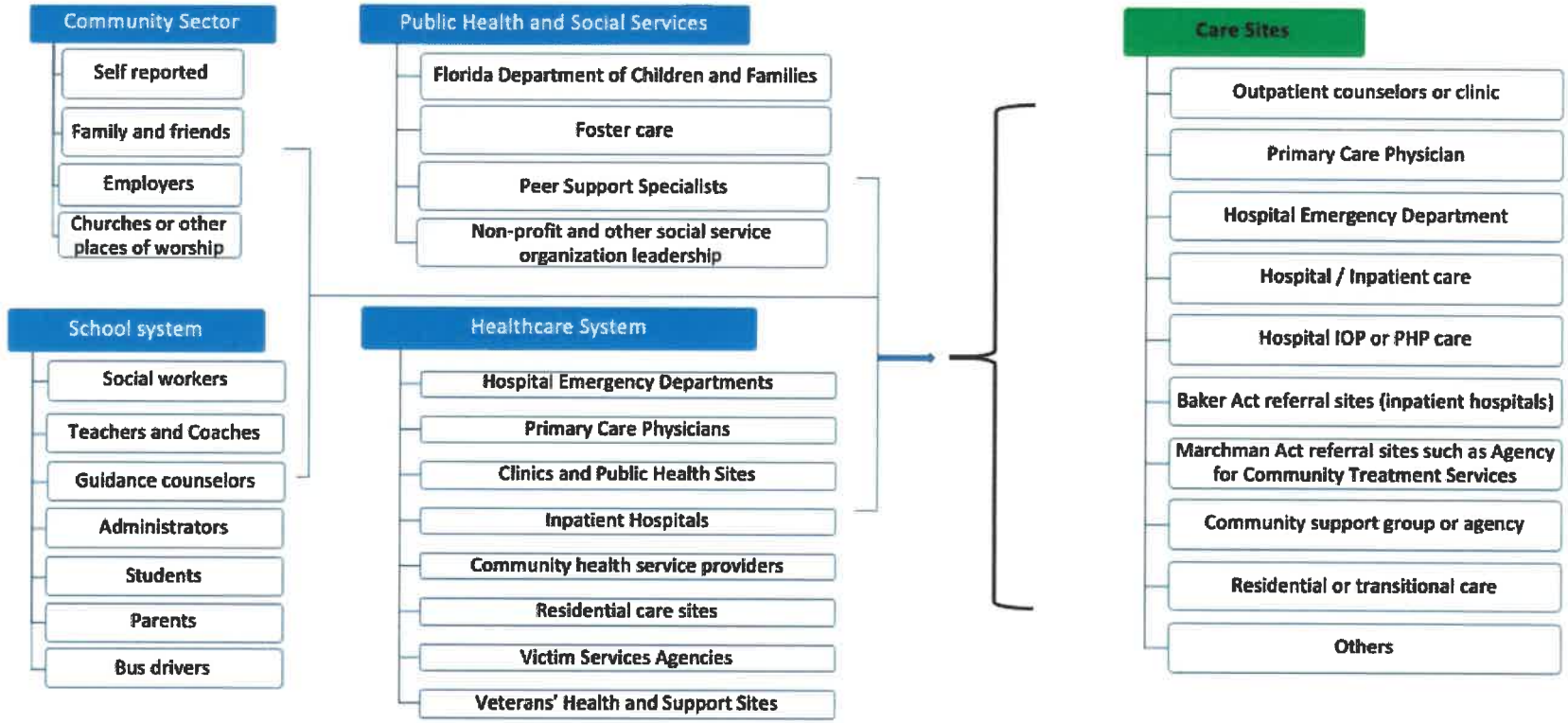
The appendices contain a more in-depth description of the environment sectors.

The graphics on the following two pages illustrate the environment sectors, intervention sites or contact points, and care sites.

System Illustrations

Four Similar Environment Sectors

In the illustration below, four environment sectors (i.e., Community Sector, School system, Public Health and Social Services, and Healthcare System) are shown with their respective lists of intervention sites, as identified in the Stage 1 and Stage 2 research. While each of the four sectors are distinct, yet they are presented together to illustrate that they typically channel patients to the same set of care sites. Note that Healthcare System intervention sites are shown in the Environment Sector, as well as among the Care Sites. The intent is to show that behavioral health and/or substance misuse patients are often identified through conventional healthcare channels (most commonly by Primary Care Physicians) and then receive care through the same entity or another provider on the list of Care Sites.

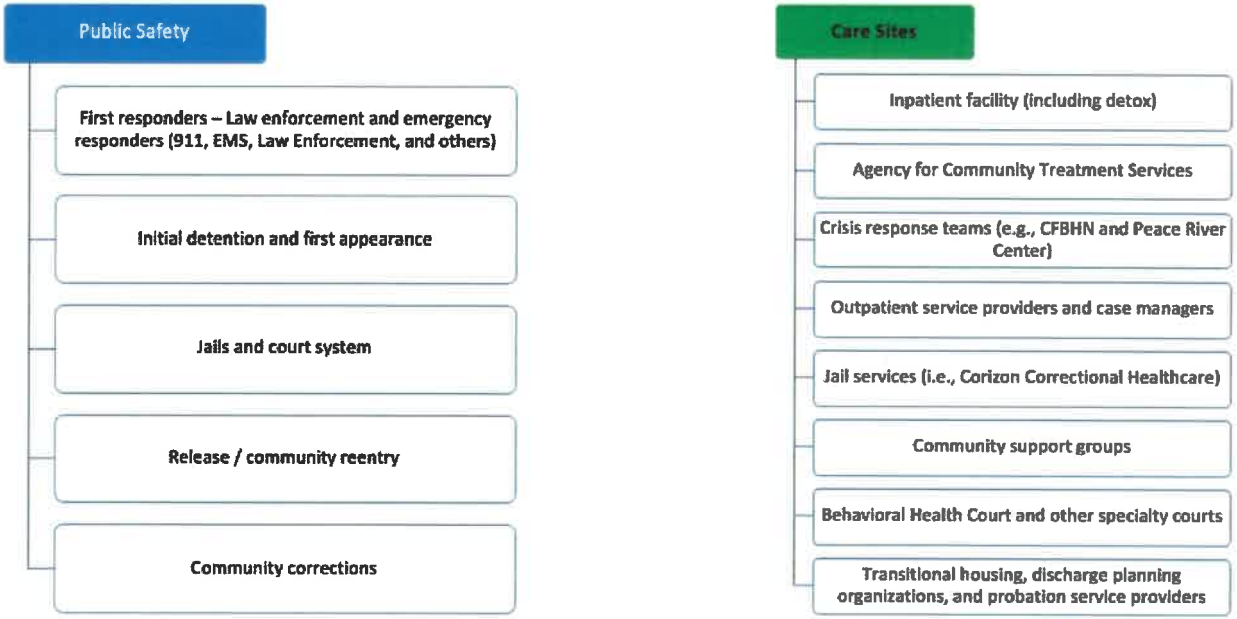


Public Safety Sector

Patients / inmates who receive behavioral health care within the criminal justice system – including jails, prisons, judicial proceedings, and courts, among others – face different experiences than others. The intervention sites differ, yet several of the ultimate sources of care are similar. However, the channels by which they receive care (and some of the care sites) are unique. If someone is identified as needing support within the public safety sector, it is likely that they will receive care at one of the below care sites:

- Inpatient facility, including detox
- Transitional housing, discharge planning organizations, and probation service providers
- Jail or prison health services
- Crisis response team onsite
- Outpatient service provider
- Community support group

The illustration to the right is based off of highly insightful research conducted in the Sequential Intercept Mapping project (and subsequent report) conducted by the University of South Florida.[44]



[44] The Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center Department of Mental Health Law and Policy Louis de la Parte Florida Mental Health Institute College of Behavioral & Community Sciences University of South Florida Available at https://www.usf.edu/cbcs/mhlp/tac/documents/mapping/sim-reports/polk-adult-2017.pdf

Intervention and Process of Care Trajectory

While the above is a simplified version of the behavioral healthcare system, it serves to illustrate the various touchpoints where an individual can be identified as having a behavioral health or substance misuse issue, or where they may receive care. The framework presented suggests support for the core themes and strategic objectives noted earlier in the Stage 2 report and provides a trajectory for the Stage 3 activities.

Throughout the research, some of the barriers to receiving care that participants frequently mentioned include the complicated intake process and the amount of paperwork (and the challenges of some of that paperwork for certain segments of the population, including those experiencing homelessness). This is therefore an opportunity for improvement. By mapping the multiple sectors, intervention sites or contact points, and care sites, Polk Vision can start to, for example, develop strategies to positively impact root causes of system of care gaps and behavioral health care needs. This will be further covered in the Stage 3 activities, subsequent report and ongoing project activities.

The following section provides additional guidance for Stage 3 activities.

Guidance for Stage 3 Implementation Strategies that Strengthen Communities, Capitalize on Strengths, and Address Prioritized Needs

The goal of Stage 3 is to create and implement strategies to positively impact community behavioral health. Stage 3 activities are based on the results of Stage 1 and Stage 2 research. Specifically, in Stage 3, Crescendo and Polk vision key stakeholders will work together to (1) prioritize the community needs, (2) identify strategies and partners required to address a select set of higher-priority needs and service gaps, and (3) establish mechanisms by which activities can be managed and progress measured (and strategies tweaked, if necessary).

The Stage 3 activities includes engaging key stakeholders, connecting with higher-need community groups, developing activities to address higher-need service gaps, and building or enhancing partnerships. Project tasks will include working with Polk Vision and other select stakeholders to establish ongoing initiatives that engage community members, service providers, and others throughout the County – urban, suburban, and rural areas.

Specific research activities include the following:

- **Needs Prioritization process.** During the Needs Prioritization Process, project leaders and stakeholders will quantitatively and qualitatively evaluate the breadth of needs identified in the Stage 1 and 2 research. Results will be categorized into three groups – "Highest priority, High priority, and Other Needs," "Red, Yellow, Green," or some other taxonomy, as determined to be most helpful to the community.
- **Secondary research** and review of Crescendo's in-house database of best-practices referencing effective programs that address prioritized needs identified in the Stage 2 Report.
- **Telephone or in-person interviews** with select leaders across the U.S. managing effective community programs.
- **Implementation Planning Matrix exercise**.
- **Community Dashboard**: Develop key measures, metrics, definitions, data sources, and periodicity that reflect progress on Strategic Action Plan goals.
- **"Learning Community"** of community service providers and others who will meet on a regular basis, report progress on assigned goals, collaboratively work on a focused set of activities.
- **Three community-wide "Visioning Groups"** in different parts of Polk County to build engaged community members (and service providers), if possible, based on COVID-19 and Public Health restrictions.

Stage 3 work will be designed to identify key activities needed to do the following:

- Build capacity and increase access to care
- Reduce stigma
- Increase services for higher-risk groups
- Break down silos

Appendices

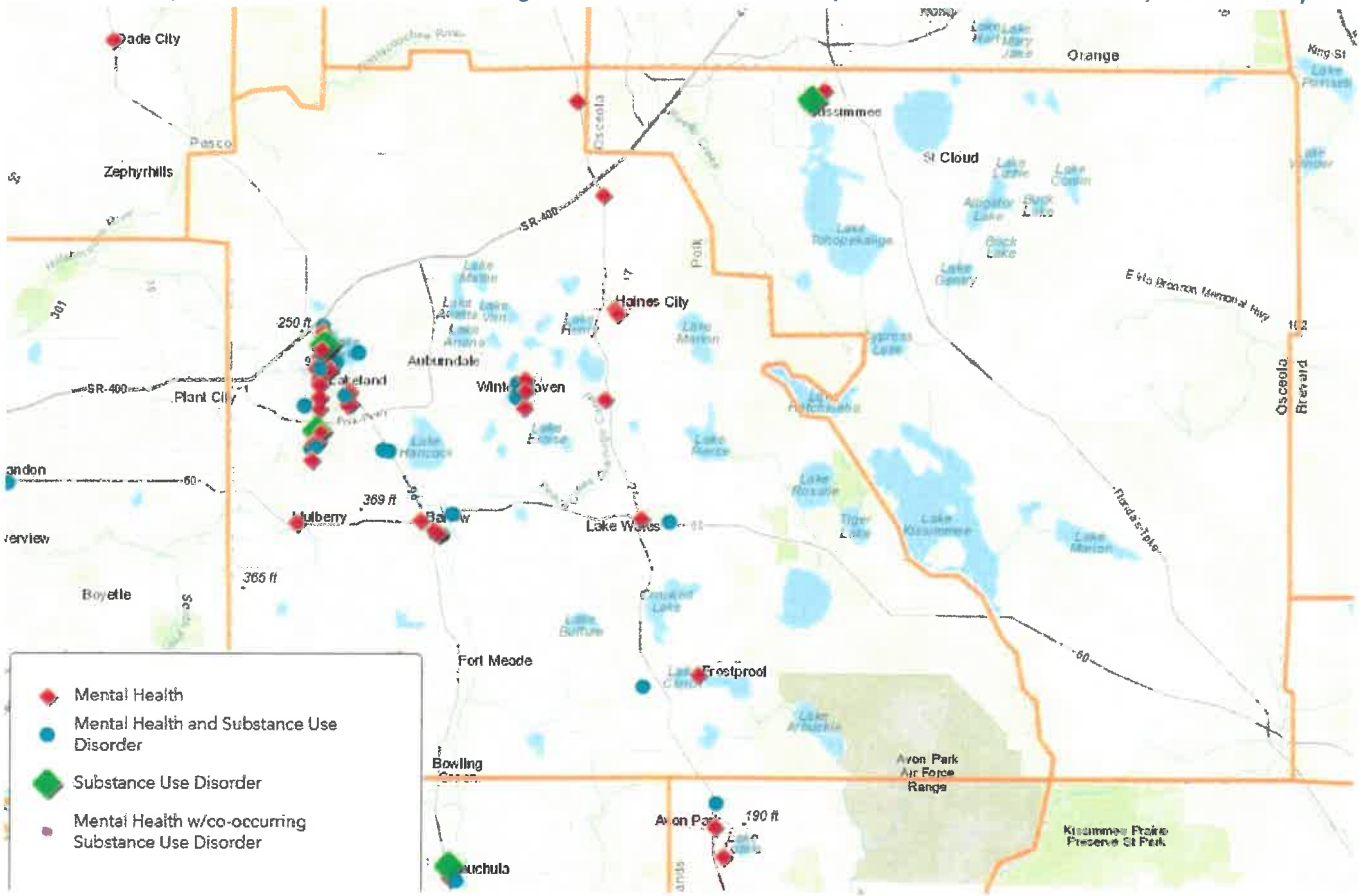
The appendices include the following items:

- **Appendix A: Stage 1 Report Interactive Maps and Resource Inventory and Mapping**
- **Appendix B: Access Audit Composition**
- **Appendix C: Community Survey Respondent Profile**
- **Appendix D: Description of Environment Sectors**
- **Appendix E: Continuity of Care, "Cascade" Example**

Appendix A: Stage 1 Report Interactive Maps and Resource Inventory and Mapping

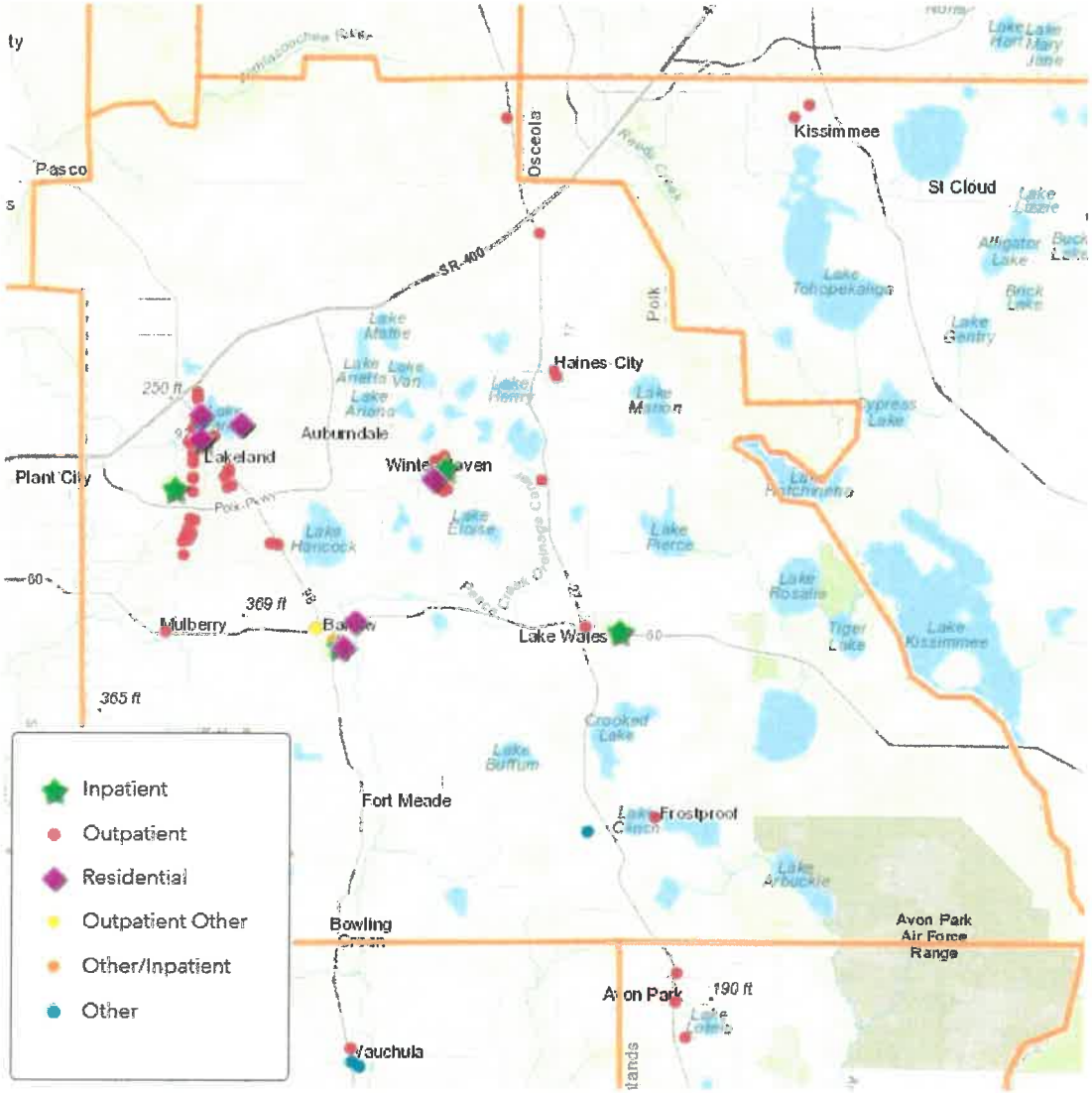
The following set of four maps shows the Polk County based behavioral health (including substance use disorder) care facilities. The maps present information by Type of Service, Setting, Population Served, and the Availability of Telehealth Services. Each map also includes a hyperlink at the bottom which allows readers to access the online, interactive map and view contact information and other data about each site.

Type of Service Provided (Behavioral Health, excluding Substance Use Disorder; Substance Use Disorder; and Others)



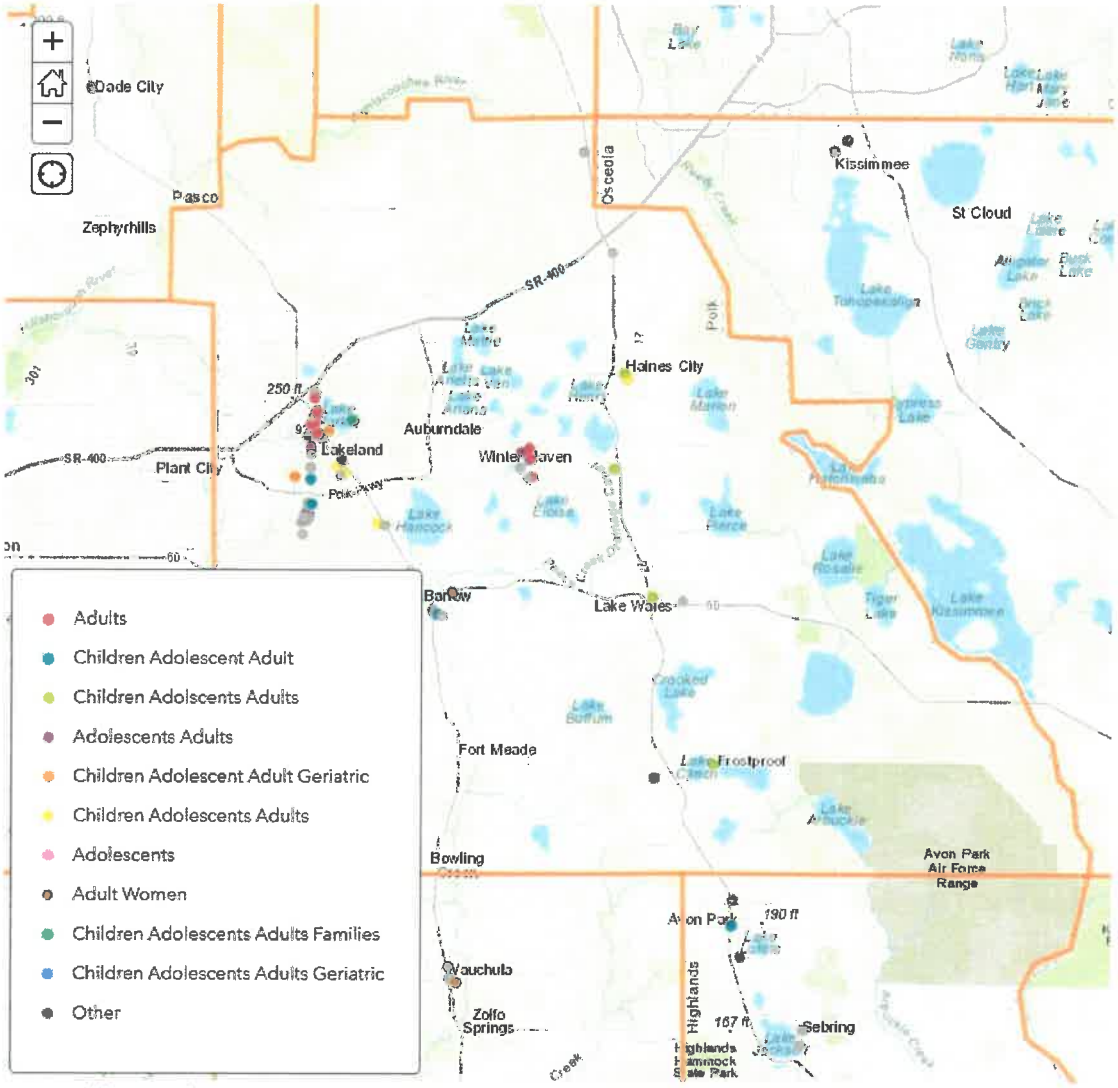
For interactive map, see: https://arcg.is/1SfqnH1

Setting (Inpatient, Outpatient, Residential, or Others)



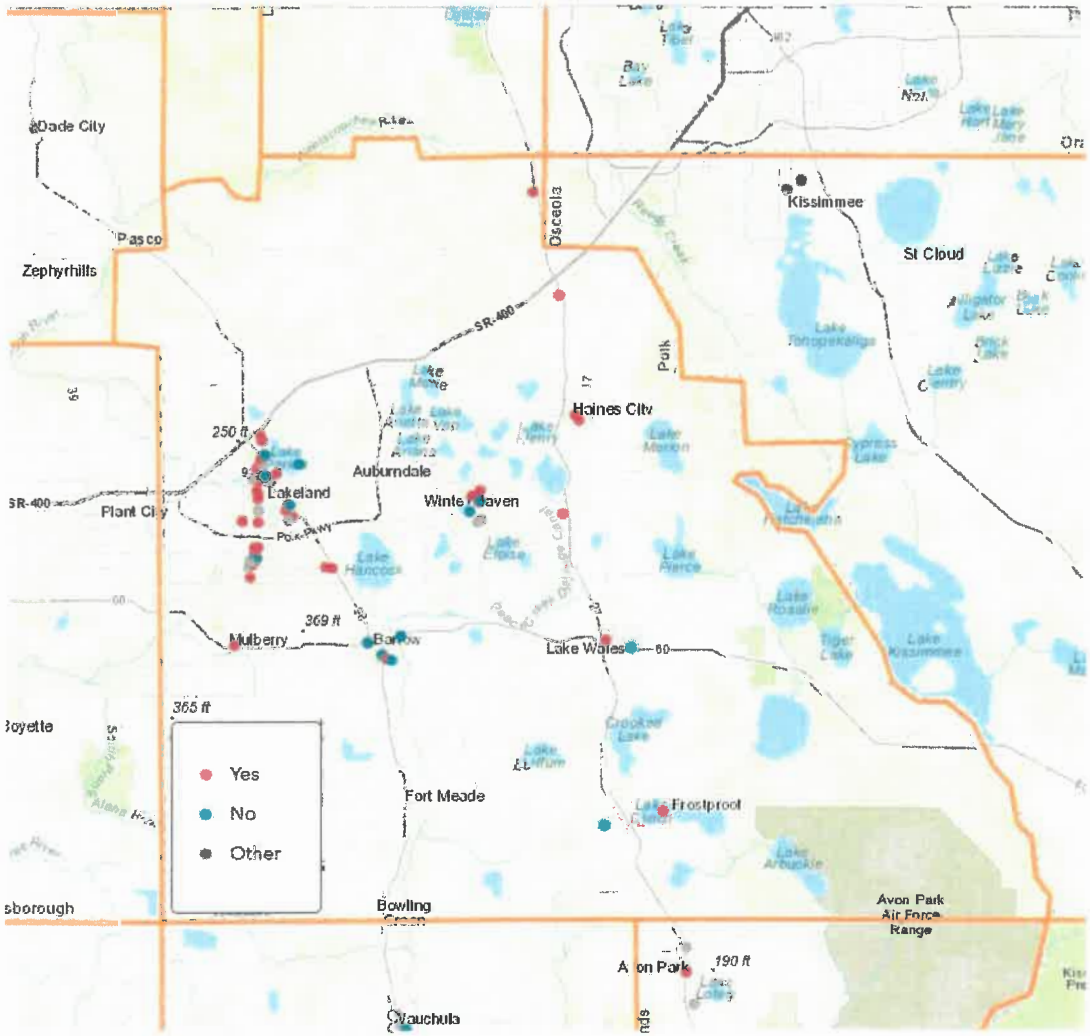
For interactive map, see: https://arcg.is/045X9

Population Served



For interactive map, see: https://arcg.is/iPHy4

Availability of Telehealth Services



For interactive map, see: https://arcg.is/f5bO1

Appendix B: Access Audit Composition

Access Audit calls were made to the following groups of service sites, by description:

Access Audit Call Distribution - Targets by Various Descriptors

Geography	***Count***
Lakeland	7
Winter Haven	2
Other	11
Focus	
Mental Health	11
Substance Abuse	5
Mental Health and Substance Abuse	4
Setting	
Inpatient	4
Outpatient	14
Residential	1
Other/Inpatient	1
Patient Type	
Adolescents	12
Children	10
Adults	17
Geriatric	6

Appendix C: Community Survey Respondent Profile

What is your race?	
Race or Ethnicity	**Percent of Respondents**
Black	10.1%
Asian	1.9%
Caucasian	72.2%
Hispanic	8.9%
Mixed Race	.6%
I don't want to share	7.6%
Other	.6%

Race or Ethnicity	Percent of Respondents
Male	15.7%
Female	84.3%
25 to 34	16.3%
35 to 44	18.3%
45 to 54	28.8%
55 to 64	28.8%
65 to 74	3.9%
75 or older	3.9%
Graduated high school	2.6%
Some college or vocational training	5.3%
Completed a 2-year college degree or a vocational training program	7.9%
Graduated college (4-year Bachelor Degree)	17.2%
Completed Graduate or Professional school (Masters, PhD, etc.)	66.9%
Less than $25,000	2.9%
$25,001 to $50,000	15.4%
$50,001 to $75,000	21.3%
$75,001 to $100,000	25.0%
More than $100,000	35.3%

Appendix D: Description of Environment Sectors

Community Sector

The Community Sector includes intervention points that anyone would generally come into contact with on a day-to-day basis. This includes family, friends, an employer, churches or other places of worship. This can also include individuals who realize that they need help and self-report to one of the care sites.

People in the community sector may not be behavioral health professionals, but they may be able to identify when someone they know or love simply isn't right. This provides a tremendous opportunity for general education about mental health issues and stigma reduction strategies.

School System

Schools – whether public or private – provide an excellent opportunity for many adults to identify and support students who may require special attention. Teachers, coaches, guidance counselors, administrators, other students, parents of classmates – even bus drivers – potentially spend more time with students than the families.

In addition, members of the school community may have more training than members of the community sector, and they tend to view the student through a more objective lens than the student's family, who may be unable or unwilling to identify a potential problem.

Public Health and Social Services

Many at-risk individuals experience circumstances which find them requiring public health support and social services, including foster care, other services through the Florida Department of Children and Families, peer support specialists, and other representatives of non-profit or social service organizations.

Individuals representing this sector tend to have some formal training relative to behavioral health, and possibly quite a bit of education depending on their role in the organization.

Healthcare System

The healthcare system is broad and includes hospital emergency departments; primary care physicians including pediatricians; clinics, public health sites, and community health service providers; inpatient hospitals; residential facilities; victim services agencies; veteran health sites; and others

People who engage with the healthcare system – including but not limited to those who receive regular primary care or other checkups, attend support groups, require emergent care – have the highest probability of coming into contact with someone who can help them and/or identify opportunities to provide behavioral health care services. Professionals who work within the healthcare system have advanced training to more accurately identify an individual who may require a behavioral health intervention or support.[45] They are also likely to be knowledgeable about channels to which they can refer patients in need.

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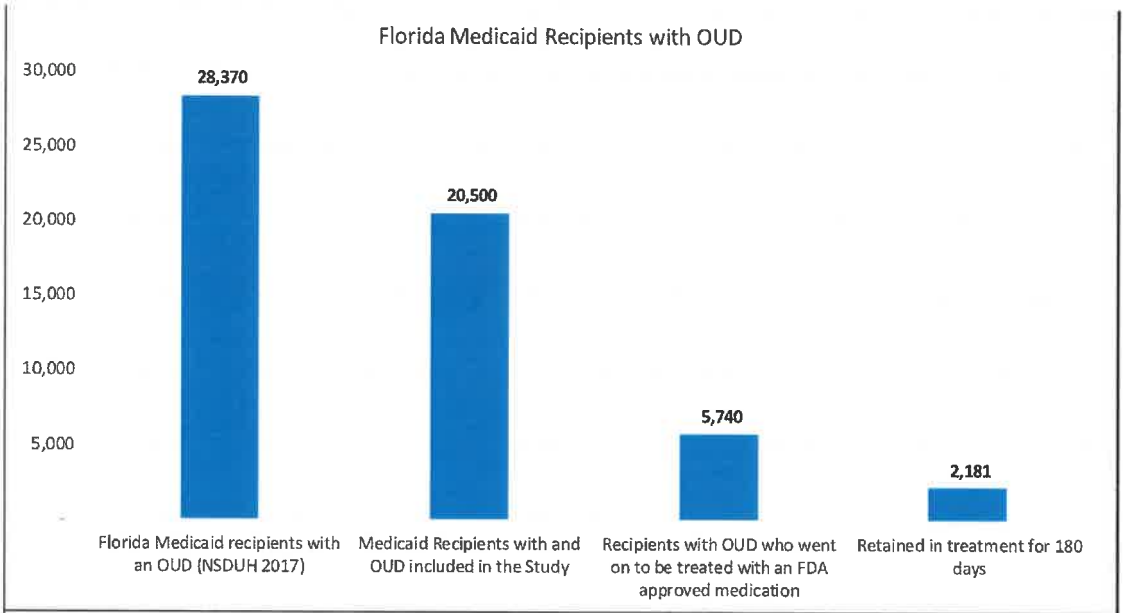
[45] Note: "Research indicates that in recent years the delivery of mental health services has changed significantly Increasing numbers of patients, especially depressed patients, are receiving psychiatric treatment from primary care physicians (PCPs), rather than from mental health specialists. In general, PCPs are more likely to provide psychiatric care rather than refer their patients to mental health specialists. Research has also shown that over a

Appendix E: Continuity of Care, "Cascade of Care" Example

A "cascade of care" is a structure often used to identify gaps continuity of care gaps. A recent Florida study published by the Recovery Research Institute of the Opioid Use Disorder (OUD) "cascade of care" shows that the people identified with an OUD often do not receive care. The biggest challenge identified in the research was that continuity of care and "hand-offs" failed to successfully link 72% of people identified with OUD to a provider of an FDA approved medication. Note, too, that the study found that individuals who stayed in treatment for 180 days were five time less likely to die from a OUD-related cause. The study also found that people over age 50 were significantly less likely to receive medication to address OUD issues. [46]

The research concludes saying that "all those that qualify should be offered medication to treat their OUD and have a system that permits at least a 180-day course of medication." Embedded in the research is the observation that the process of care, continuity of care, is a critical piece to effective outcomes.[47]



Cascade of Care Stage	Number of Individuals	Percent Loss from Previous Stage
Florida Medicaid recipients with an OUD (NSDUH 2017)	28,370	NA
Medicaid Recipients with and OUD included in the Study	20,500	28%
Recipients with OUD who went on to be treated with an FDA approved medication	5,740	72%
Retained in treatment for 180 days	2,181	62%

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ten-year period from 1987 to 1997, the percentage of patients who received psychiatric medication from PCPs increased from 37.3% to 74.5%.[6] These trends demonstrate that the role of the primary care physician has expanded such that PCPs are also becoming the primary psychiatric care physician (PPCP) for a considerable number of their patients."
Abed Faghri, N. M., Boisvert, C. M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): enhancing the assessment and treatment of psychiatric conditions. *Mental health in family medicine*, *7*(1), 17–25. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2925161/

[46] Johnson, K., Hills, H., Ma, J., Brown, C. H., & McGovern, M. (2020). Treatment for opioid use disorder in the Florida Medicaid population: Using a cascade of care model to evaluate quality. The American Journal of Drug and Alcohol Abuse, [Epub ahead of print]. doi: 10.1080/00952990.2020.1824236

[47] Ibid.

Attachment #7

Dear Sirs,

I am writing this letter to share with you my personal experience with the FICM program and Marybeth Moore.

3 years ago Marybeth came into my life while I was in the Polk County Jail for what seemed like the umpteenth time in a relatively short amount of time. I was in my life...a hopeless, homeless, criminal heroin junky. Nowhere to go and no one to turn to. My family wanted nothing to do with me. Rightfully so. How I got here is another story for another time. This story is one of hope and victory.

Marybeth came to see me and listened to me. Really listened! I was at a point where my only options were prison and/or death. (TRUTH). Imagine hearing for the first time in a VERY long time, "I can help you and I believe in you." Marybeth saved my life.

She understood that I needed, and even more importantly, wanted help. Legal problems, addiction, etc. She's a tireless miracle worker. She found a bed for me in an excellent, longtime treatment center (New Beginning Women). While in treatment I received help from FICM with so many other needs... personal things that made me start to feel human again. I came out of jail with nothing but the clothes on my back! Plus a counselor came to check on me every week. Amazing!

Now it was time for me to leave treatment. Now what? Back to the streets where nothing but failure awaited? Nope. Didn't happen. An apartment was found for me and expenses were taken care of until I found employment and could stand on my own. This also gave me time to work on my recovery outside of treatment. I attend and participate in a 12 step program EVERYDAY. Oh my gosh!!! I even have FICM and Marybeth to thank for my smile! They made it possible for me to have much needed dental work!

All of these things plus so much more, were what I needed to have a fighting chance to climb out of and leave the pit of hell my life had become. Without the FICM PROGRAM and Marybeth Moore I would not have become...dare I say it...a productive member of society.

I could write so much more; I could fill a book. Hey! Maybe I will do that someday. The possibilities for me now are endless. My gratitude is off the charts.

Thank you for your time.

Sincerely,
Mary Behrend

A partnership to expand access to appropriate mental health services through the Sheriff's Outreach Program

Scope of Work:

Peace River Center obtained one-time funding from CFBHN during this fiscal year to establish a Sheriff's Outreach Mobile Crisis Response Team (MCRT) in addition to our existing Mobile Crisis Response Team covering Polk, Hardee and Highlands Counties. The Polk County Sheriff's Outreach Program would fund Peace River Center to provide a MCRT physical presence in the Polk County Sheriff's dispatch and substations across Polk County. The Sheriff's Outreach program works closely with deputies in two critical areas: 1. To assist in crisis intervention of individuals with mental health and/or substance use disorder issues they may encounter in the community with a goal of diverting individuals from unnecessary jail bookings as well as emergency room, crisis stabilization unit, and hospital use and linkage to community-based alternative services; and, 2. To make direct contact with each individual the Sheriff's Office has enacted a Baker Act within ten (10) days of the individual being admitted to a receiving facility, prioritizing individuals who have been Baker Acted multiple times.

Placement of an MCRT Counselor in the Polk County Sheriff's Office locations during the initial deployment provides the opportunity for behavioral health calls to be diverted in a timely manner to PRC MCRT crisis counselors. Where appropriate, deputies and MCRT Counselors stationed in Sheriff Offices could also provide a partner approach on the behavioral health crisis call at the scene. MCRT Counselors would then follow-up post intervention to ensure linkage to appropriate services. The MCRT Counselor presence at the Sheriff's office locations will be scheduled on 12 hr. shifts, 7 days a week. Additional daytime and overnight coverage and calls will be handled through the existing Peace River community-based MCRT.

The community benefit of the Sheriff Outreach MCRT staff and sheriff's staff co-locating is the potential to divert arrests and de-escalate a behavioral health crisis, connecting individuals to appropriate community-based resources, alleviating further crises, and when necessary, facilitating the Baker Act process as needed. To increase and expand an appropriate response to a behavioral health crisis and considering the geographic size of Polk County this cross-system approach will benefit the community in a timely response to what is typically a time-consuming call for law enforcement.

PRC will be serving all ages of individuals who are in crisis or require follow up from a recent crisis situation. There will be no restrictions on access so that there are no barriers in terms of appropriate and equal access to care. There were 7,648 Baker Acts (BA) in Polk County with 22.75% associated with children for FY17/18 according the State Baker Act Annual Report (most recent published data). From FY11 to FY18 the total population of Polk County has grown by 9.89% while the growth in BA's for all ages has grown by approximately 109%. The number of Baker Acts associated with children (ages <18) has grown by approximately 139.5% (from 726 per year to 1,739 per year) with the adult population Baker Acts growing approximately 101.5% (from 2,932

per year to 5,909 per year). Involuntary examinations of individuals of all ages and specifically for minors have increased more rapidly than the population.

PRC is proposing integrating a web-based software to enable chat/text to increase access for Polk County citizens in crisis. This method would add immediate support in a manner that is increasingly a preferred communication method for younger generations. The need is immense and the Polk County community health assessments consistently identifies mental health and increased access to mental health crisis response services as the number one health concern and top response to this community need. Research and surveys cite privacy, accessibility, immediacy, and being less stressful as the motivation to preferring text/chat. Additionally, it is recognized that the increased frequent use and enormous reach of cell phones correlate that text and multimedia messaging are well suited for crisis interventions. A live, trained Mobile Crisis Counselor would receive the text and respond timely. The Crisis Counselor will help the chat/texter to move from a "hot moment" to a "cool calm" to stay safe and healthy using effective active listening, suggested referrals, and the ability to respond in-person - all with the addition of making contact through a text message, using Peace River's secure technology platform. In cases when a chat/texter may be in immediate danger of suicide or homicide, as determined by a risk assessment by the Crisis Response Team crisis counselor, our first step is to try to work with the chat/texter to form a safety plan. And, if the chat/texter is unable to plan for their own safety, the mobile crisis response team crisis counselor will "go mobile" as we reach out to the Sheriff's Office for a law enforcement response. Expanding access to mental health crisis support through text/chat will improve access during a crisis situation to a significant portion of the population and will benefit the entire community.

COVID-19 Impact and Increased Demand for Services –

Source: Kaiser Family Foundation, "The Implications of COVID-19 for Mental Health and Substance Use: (*https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/*), During the pandemic concerns about mental health and substance use have grown, including concerns about suicidal ideation. In January 2021, 41% of adults reported symptoms of anxiety and/or depressive disorder, a share that has been largely stable since spring 2020. In a survey from June 2020, 13% of adults reported new or increased substance use due to coronavirus-related stress, and 11% of adults reported thoughts of suicide in the past 30 days. Suicide rates have long been on the rise and may worsen due to the pandemic. Early 2020 data show that drug overdose deaths were particularly pronounced from March to May 2020, coinciding with the start of pandemic-related lockdowns. During the pandemic, about 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, up from one in ten adults who reported these symptoms from January to June 2019 .

History has shown that the mental health impact of disasters outlasts the physical impact, suggesting today's elevated mental health need will continue well beyond the coronavirus outbreak itself. For example, an analysis of the psychological toll on health care providers during outbreaks found that psychological distress can last up to three years after an outbreak. Due to the financial crisis accompanying the pandemic, there are also significant implications for mortality due to "deaths of despair." A May 2020 analysis projects that, based on the economic downturn and social isolation, additional deaths due to suicide and alcohol or drug misuse may occur by 2029.

If we work to put in place healthy community conditions and access to services, such as the proposed Sheriff's Outreach Program in concert with law enforcement, we can improve access to services, as well as mental health and well-being in Polk County while reducing costs and the burden on emergency departments, behavioral

health providers, law enforcement and the medical community, and reduce deaths of despair in our community.

Justification:

Calls involving a behavioral health crisis can be among the most complex and time-consuming for officers to resolve, redirecting them from addressing other public safety concerns and violent crime. The call can also draw intense public scrutiny and can be potentially dangerous for officers and people who have mental health needs. When these calls come into 911/ dispatch, the appropriate community based resources are often absent to make referrals, and more understanding is needed to relay accurate information to officers. The proposed cross-system approach of law enforcement and mental health collaborations builds on the success of mental health crisis training (Crisis Intervention Training) provided jointly by Peace River and the Sheriff's Office. The added benefit of expanding crisis support through a local text/chat feature will increase access to care and resources in a preferred format for the citizens of Polk County.

This project will expand community access to behavioral health services by facilitating increased collaboration between law enforcement and crisis counselors. The ability for PRC MCRT to be present and work alongside deputies during call dispatch will be the cornerstone for comprehensive, cross-system response to people who have mental health needs.

The goal is to reduce the number of initial and repeat Baker Acts and repeat arrests taking place and diverting and linking individuals to appropriate outpatient community-based resources and services, if the crisis situation can be successfully and safely de-escalated on-scene.

Based on current data, we are projecting the Sheriff's Outreach Program to respond to approximately 3,150 assessments and follows up with a fully staffed program operating a 12-hour shift 7 days a week.

The Sheriff's Outreach Model involves:

1. Embed crisis counselors in Polk Sheriff locations for a 12-hour shift 7 days a week. Additional daytime and overnight coverage and calls will be handled through the existing Peace River community-based MCRT.

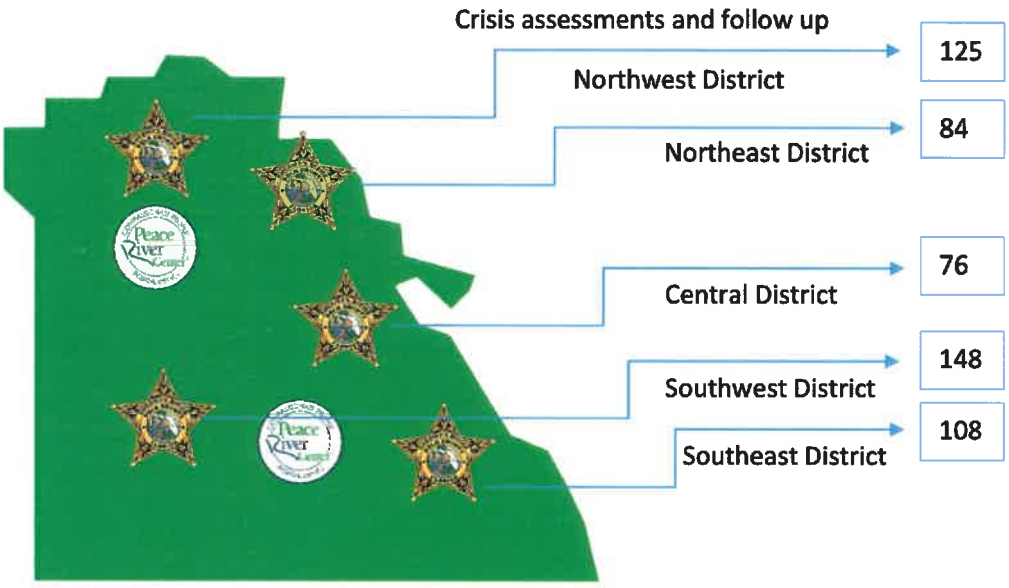
2. The Sheriff Outreach MCRT crisis counselors will join in or respond to crisis call questions received; check available Peace River data for prior behavioral health (mental health and substance use) history of callers; provide counsel to dispatch and responding deputies; dispatch other PRC community-based crisis counselors as necessary.

3. Dispatched crisis counselors will work with on-scene deputies to assess and de-escalate crisis situations; work with deputies to identify if community-based services can meet the individual's needs or if a Baker Act is warranted; link individuals to community-based services to divert/avoid a Baker Act, if determined to be appropriate;

4. Provide post crisis assessment follow up after contact for all mental health calls received by the Sheriff's Office; provide a 10-day follow up contact after discharge from an inpatient Baker Act stay within Polk County.

Sheriff's Outreach YTD (July 20- Feb 21)

541 Total Crisis Assessments and Follow up for Services



79% of callers were diverted from Baker Act and connected to community-based outpatient services

Measures of Success:

- A measure of success is a reduction of the percent of mental health related calls resulting in execution of a Baker Act, referred to as the Baker Act Rate.
- A reduction in jail bookings of individuals experiencing symptoms of mental illness during a law enforcement response
- An increase in connection/linkage to mental health resources
- A reduction in repeat Baker Act incidents for those engaged in services

ROI:

For every $1.00 spent on the Sheriff Outreach Program the ROI would be $7.83.

Cost avoidance = $6,655,572 Cost of program = $850,000

Sheriff's Outreach Program Budget	
Personnel	
Clinical Personnel – FTE's	12.42
Administrative Personnel – FTE's	1.00
Subtotal	13.42
Operational	
Salary and Benefits	$662,000.00
Staff Travel	$3,000.00
Conferences and Training	$2,000.00
Professional Fees	$18,000.00
Insurance	$10,000.00
Communications	$12,000.00
Rent/Lease	$1,000.00
Maintenance and Repair, Housekeeping	$10,000.00
Office Supplies	$19,000.00
IT Services, HIM and Registration	$28,000.00
General and Administrative	$85,000.00
Total Budget	$850,000.00

Budget Narrative:

Personnel	Personnel consist of the wages and benefits of the staff in the program. There are 12.42 Clinical FTE's and 1.00 Administrative FTE. Benefits are comprised of FICA & Medicare calculated at 7.65% of salaries, Health Insurance based on the number of FTE's in the department, Paid Time Off which is 10% of salaries, Retirement cost estimated at 3.0% of salaries, and an allocation of Life Insurance, Unemployment and Workers Compensation based on the number of FTE's in the department as a % of total FTE's in the agency.
Staff Travel	Staff Travel consists primarily of mileage reimbursement to staff at the rate of 50 cents per mile.
Conferences/Training	Conferences/Training consists of expected training costs for staff.
Professional Fees	Professional Fees is comprised of external audit fees which are allocated based on total FTE's, cost related to the Human Resource/Payroll system and pre-employment screening which are allocated based on total FTE's and software licensing fees based on the number of users.
Insurance	Professional Liability Insurance allocated based on the number of clinical FTE's in the department to the total number of clinical FTE's in the agency, and an allocation of Auto Insurance for vehicle usage.
Communications	Communications is comprised of phone system, cell phone and internet costs.
Rent/Leases	Rent/Leases includes the cost of the copy machines.
Maintenance and Repair	Maintenance and Repair includes equipment purchases including IT equipment and maintenance related to the vehicle assigned to the program.
Office Supplies	Office Supplies is comprised of office and computer supplies as well as program supplies used in treatment of the clients and fuel for vehicle usage. This line also includes the cost of the annual software license fee for the staff to be able to access the Sheriff's Office system ($6k) and the cost of the iCarol text/chat expansion ($9k).
IT Services, HIM and Registration	This section consists of an allocation of the IT Department costs, Health Information Management costs and Registration costs for support services to the program.
General & Administrative	General and Administrative costs are comprised of total expenses of the Administration, Human Resources, Accounting, Internal Transportation, Billing and Purchasing departments, allocated based on total expense of the program as a % of the total expenses of the agency excluding the expense of the departments being allocated. The G&A costs average 10%.