The Sequential Intercept Mapping of
Reentry and Community Services
highlighting
Persons with Behavioral Health Challenges in
Hillsborough County Florida

Enhanced Community Collaborations Committee Report

June 2021

Image by John Hain from Pixabay

The Sequential Intercept Mapping of Reentry and Community Services for Persons with Behavioral Health Challenges in Hillsborough County Florida

SIM Reentry: Enhanced Community Collaborations Committee Report

Craig Powell, Chair *Marie Marino, Co-Chair*

June 2021

Table of Contents

Our Challenge

"… a long sought, but largely unrealized goal of many in community corrections – to engage the community in the reentry process" (Young, Taxman & Byrne, 2002).

I. Introduction

To begin, it is important to distinguish between reentry, reintegration, and rehabilitation. Reentry is used broadly to describe the process of persons returning to the community from jail or prison.[1] Reintegration is more specific and describes the process of persons connecting to the community through employment, stable housing, access to mental health and substance abuse treatment services, and involvement with community-based organizations after being released from jail or prison (Hunter et al., 2016; Travis, 2005). Rehabilitation, on the other hand, refers to the action, such as programs and/or services provided to justice involved individuals, intended to reduce criminal behavior, which would include education, soft-skills, and vocational training, psychological/behavioral interventions, and programs addressing addiction problems (Forsberg & Douglas, 2020). Recidivism statistics and research on factors related to recidivism support the notion that reentry without reintegration and rehabilitation leads to re-arrest (Esparza Flores, 2018; Hunter et al., 2016; Travis & Petersilia, 2001). According to the Florida Department of Correction's (FDC) latest quarterly recidivism report, almost two-thirds (62.7%) of persons who returned from state prisons were rearrested within three years after being released (FDC, 2020a).[2] In addition, research shows us that many former inmates return to the most distressed and underserved neighborhoods in the community that lack stable jobs, safe housing, access to mental health and substance abuse treatment services, as well as adequate public transportation (Fogel et al., 2021).

Another factor contributing to poor reentry outcomes is the disproportionate number of persons with mental illness who are incarcerated. For instance, studies have found rates of serious mental illness for persons in jails and prisons ranging between 6% and 31% compared to rates of 3% to 7% in the general population (Broner et al., 2004; Bronson, 2017; HHS, 2002; Hiday & Wales, 2003; More & Hiday, 2006; Steadman, et al., 2009; Teplin, 1990; Teplin et al., 1996). Rates of persons with co-occurring mental health and substance abuse disorders in jail and prison are similar, with rates ranging between 33% and 60% for persons in jail or prison compared to rates of 14% to 25% in the general population (Baillargeon, et al., 2010; Wilson et al., 2011).

[1] The criminal justice literature often refers to persons who are incarcerated or transitioning, or have transitioned, from jail or prison back into the community as *offenders, ex-offenders, or former offenders*. To avoid the dehumanizing and lingering negative effects of the label *offender* and to promote individual restoration as well as the status of citizenship and its associated social responsibilities, person-first language, such as *persons transitioning from jail* or *prison* or *persons involved in the criminal justice system*, is used throughout this report instead of *offender*.

[2] This rate is consistent with rates of recidivism over the years (Alper et al., 2018; Langan et al., 1992).

The disproportionate number of persons with mental illness in jail presents additional challenges for local communities and detention facilities. Studies have found persons with mental illness are less likely to post bail and often remain in jail longer than persons without mental illness (Metzner & Fellner, 2010; Wolff et. Al., 2007). Persons with mental illness also typically do not receive adequate mental health treatment, serve more time in segregation, and are more likely to experience victimization or exploitation while incarcerated than persons without mental illness (Ditton, 1999; McNeil & Binder, 2007; More & Hiday, 2006; Veysey et al., 1997).

Adding to the burden on local communities is the fact many persons with mental illness return to the most underserved neighborhoods in the community straining the already taxed systems of care and resources. This reality adds to the phenomena known as trans-institutionalization, where persons who cannot access needed mental health services and social supports end up being transferred back and forth between local crisis stabilization units (CSUs), jails, shelters, hospitals, and assisted living facilities/nursing homes (Fisher et al., 2006; Frank et al., 2003; Steadman et al., 1984; Teplin, 1983, 1984; Torrey, 2008). This pattern of being recycled through local institutions is perpetuated by a lack of dedicated resources that support collaboration among community providers and delivery of behavioral health services along the continuum of care.

Given the significant challenges of reentry, a comprehensive strategy that promotes provider collaboration and supports a recovery-oriented, evidenced-based continuum of services is needed. Such a strategy would begin at initial arrest and continue through release into the community, focusing on assessment with the primary goal being reintegration to reduce recidivism (Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015). Such a strategy would support cross-agency collaboration as well as data collection and sharing to improve service delivery through targeted services, program evaluation, and community strategic planning.

The vision articulated by the Enhanced Community Collaboration Committee (hereafter referred to as "Committee") would be the development of a comprehensive plan that seeks to mitigate the negative impact of thousands of adults returning from jail and prison to the most distressed and underserved neighborhoods and assists with transforming our acute system of care into an effective Recovery-Oriented System of Care (ROSC) that enhances public safety by focusing on the reduction of criminal recidivism and the creation of a more proactive, coordinated, and collaborative approach among community providers when addressing reentry. The following report was built from Committee membership (Exhibit A), stakeholder presentations during Committee meetings (Exhibit B), as well as consultation with subject matter experts.

A. Hillsborough County Sequential Intercept Mapping – Reentry

**Chief Judge Ronald Ficarrotta addressing Stakeholders at the Sequential Intercept Mapping Event, January 2019*

On January 10, 2019, Hillsborough County hosted a "Sequential Intercept Mapping" (SIM) workshop facilitated by University of South Florida (USF), Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center leads. Opening remarks by Chief Judge Ronald Ficarrotta and Public Defender Julianne Holt of the Thirteenth Judicial Circuit underscored the importance of the mapping process in establishing an action plan. In attendance were 69 participants representing behavioral health and criminal justice stakeholders including advocacy groups, corrections, the courts, human service organizations, law enforcement, and treatment providers.[3]

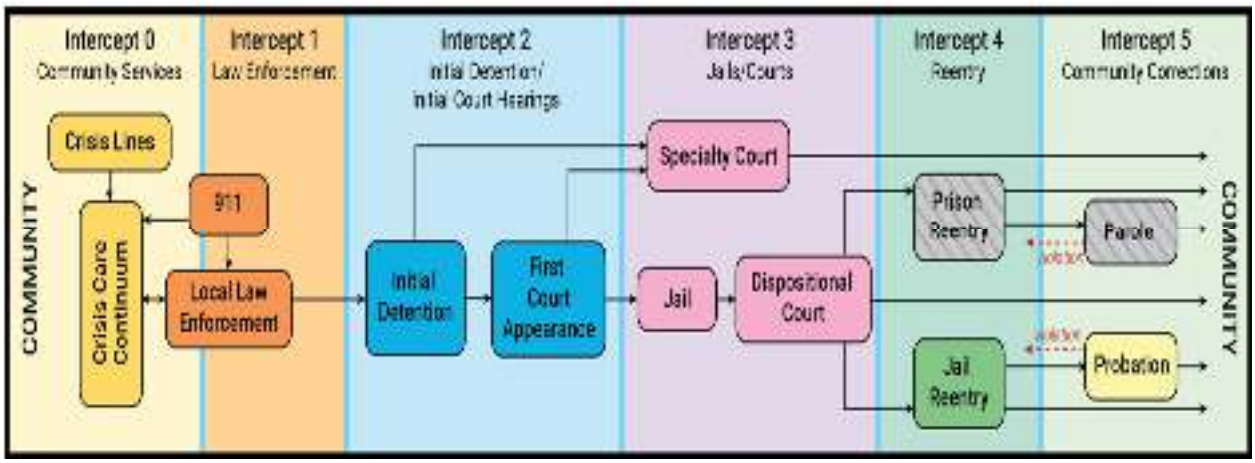
The SIM workshop focused on Intercept 5 of the SIM model, reentry, and community supervision/services (Figure 1). The focus of the workshop was to identify resources, gaps in services, and diversion opportunities in the existing mental health system and to establish priorities for enhancing the Recovery-Oriented Systems of Care (ROSC) with a focus on adult individuals with substance use, mental health or co-occurring disorders transitioning from jail or prison to their prospective neighborhoods in Hillsborough County. Four ad hoc committees were formed to address each of the four priority areas and participants developed a strategic action plan with specific objectives and action steps to address each area.[4]

- Priority Area 1: Enhanced Community Collaboration;
- Priority Area 2: Supportive Housing (Transitional and Permanent);
- Priority Area 3: Residential Treatment (Co-occurring Disorders);
- Priority Area 4: Employment.

Figure 1. Sequential Intercept Model

[3] The *Sequential Intercept Mapping, Hillsborough County, January 10, 2019* report can be found at: https://www.usf.edu/cbcs/mhlp/tac/documents/mapping/sim-reports/hillsborough-reentry-2019.pdf.

[4] Committees were not established for priority areas 2 & 3.

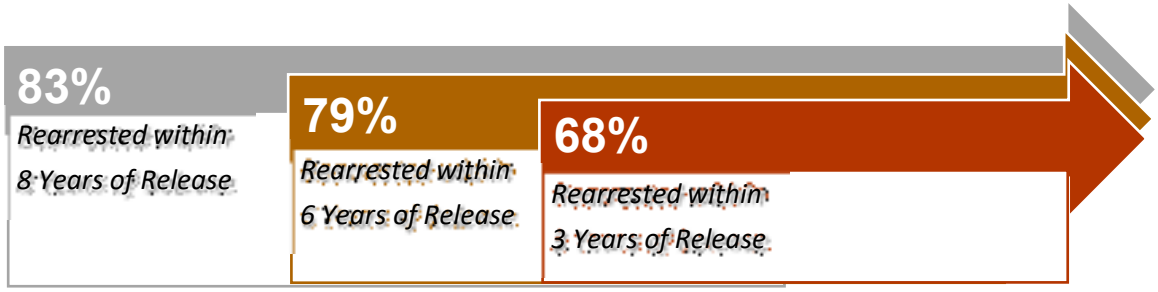


Retrieved from https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

II. Statement of the Problem

In 2017, state and federal prisons in the United States released 626,000 individuals from confinement (Bronson & Carson, 2019). Research has shown re-arrest rates of 68% within three years of release, 79% within six years of prison release, and 83% within eight years of prison release (Alper et al., 2018). See Figure 2 below. Durose et al. (2014) also found that 45.2% of those released were reconvicted of a new crime within three years and 55.4% were reconvicted within five years.

Figure 2. *2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014) (Alper et al., 2018)*



In 2020, the Florida Department of Corrections (FDC, 2020b) reported recidivism rates of approximately 61% for prisoners released between 2012 and 2016 after three years and a rate 24.7% for those returning to prison after the same time (FDC, 2020b). In 2016 the recidivism rate in Hillsborough County (defined as a return to prison for any reason within three years) for persons released from Florida prisons was 27% - slightly higher than the Florida average (FDC, 2020b). Inmates with violent convictions on their record, typically those assessed as high risk and a predictably higher overall rate of recidivism, made up 55.8% of the Florida prison population as of June 30, 2018 (FDC, 2020b). The Florida statewide recidivism rate for those with a violent primary offense from October 1, 2017 to March 31, 2018 was 27%; and, for Hillsborough, it was 31%, again higher than the overall Florida rate (FDC, 2020b). Furthermore, between 2014 and 2016 FDC released more inmates (6,462) to Hillsborough County than any other county in Florida, including Miami-Dade (4,901), Broward (6,023), and Palm Beach (3,313), which are the three most populous counties in the state. Less inmates were released to Pinellas (5,223) and Duvall (5,442) counties during the same time period as well (FDC, 2020b).

Hillsborough County has a strong contingent of case management, behavioral health, housing, educational training, vocational training, and employment service providers. However, these services

are often not readily accessible or integrated in a way to support a seamless continuum of care for individuals who want to succeed in the community but struggle to (re)gain social, economic, and political equity and inclusion. Additionally, inmates released back to Hillsborough County often return to neighborhoods high in poverty, including the 32 economically distressed communities, or *Qualified Opportunity Zones* as identified by the U.S. Department of the Treasury, which is second only to those returning to Miami-Dade County (Fogel et al., 2021). Census tracts in Hillsborough County with the highest rate of inmate releases have the highest percentage of residents living below the poverty line, higher levels of unemployment, the lowest per capita income, the lowest level of educational attainment, and highest percentage of single parent households (Fogel et al., 2021).

While the Florida Department of Corrections (FDC) has accurate data on the number of persons released to Hillsborough County each year, the Hillsborough County Sheriff's Office who operates the local jails does not publish release information on unique individuals. In addition, the Federal Bureau of Prisons (FBP) only reports on releases to Florida, not individual counties. The Committee was unable to obtain exact numbers on jail releases and Federal Bureau of Prisons (FBP) releases to Hillsborough County for this report. Table 1, which contains Florida Department of Corrections (FDC) data on releases to Hillsborough County, includes estimates of releases based on state level data of unique individuals being released in Florida. The Enhanced Community Collaboration Committee estimates 23,992 individuals were released from jail or prison to Hillsborough County in 2019.

Table 1. Estimated Total Releases from Jail and Prisons to Hillsborough County Using 2018/2019 data

***Florida State Prison Releases to Hillsborough County**	****Estimated Federal Bureau of Prisons Releases to Hillsborough County**	*****Estimated of Releases from Jail in Hillsborough County**	**Estimated Total Releases**
2,017	~186	~21,789	**~23,992**

**Based on 2018/2019 total. Source Florida Department of Corrections Statistics retrieved from http://www.dc.state.fl.us/pub/index.html*

***The Federal Bureau of Prisons (FBP) only provided the total number of prisoners returning to Florida in 2019 (N=2,728). The committee reached out to FBP regarding returns to Hillsborough County specifically and FBP responded the data was not available. Estimated returns to Hillsborough County are based on the percentage of Hillsborough County residents in Florida (6.8%). Sources Florida Criminal Justice Trends Presented at the Criminal Justice Estimating Conference retrieved from http://edr.state.fl.us/Content/* and FDC data retrieved from https://www.bop.gov/about/statistics/.

****Estimate calculated using estimates of total unique arrests in Florida (N=~350,000) based on the percentage of Hillsborough County residents in Florida (6.8%) subtracting number of commitments to Florida state prison in FY18/19 (N=1,825) and estimated commitments to Federal prisons (N=~186). Florida unique arrest estimates retrieved from https://www.prisonpolicy.org/blog/2019/09/18/state-jail-bookings/.*

III. Responses to the Problem

A. Risk-Needs-Responsivity (RNR)

RNR & Reentry

The Risk, Needs, Responsivity (RNR) model is an evidence-based criminal justice strategy to reduce recidivism (Andrews & Bonta, 2010). RNR is widely used in the criminal justice system for persons with and without mental illness and as a framework for effective reentry planning. *Risk*, *Needs* and *Responsivity* refer to the three main principles of RNR, which are described in Figure 3. Persons at high-

risk for re-arrest are prioritized to maximize the effectiveness of scarce community resources and because research shows the provision of intensive services to low-risk individuals increases their risk for re-arrest (Andrews & Bonta, 2010). Criminogenic needs are targeted with interventions because they are the greatest *dynamic* (changeable) risk factors for recidivism. Responsivity factors, on the other hand, are addressed because they are essential for improving a person's ability to respond to interventions that reduce recidivism. Targeting the responsivity factor of major depression, for example, would help a person better engage in a criminal thinking intervention that targets the criminogenic need of pro-criminal attitude. Altogether, RNR is an effective strategy for reentry because RNR targets many areas needed for successful reintegration, such as job training and employment, criminal behaviors. substance abuse, and mental health symptoms.

Figure 3. Principles of Risk-Need-Responsivity (RNR)

B. State & Community Responses to the Problem

Florida

The Office of Programs and Re-Entry (OPR) is the branch of the Florida Department of Corrections (FDC) charged with developing inmate programs to prepare persons for release into the community (FDC, n.d.-a). The OPR incorporates evidence-based strategies based on the Risk-Needs-Responsivity (RNR) model to assist FDC with meeting recidivism goals. OPR is dived into four sections: (1) the Bureau of Program Development, (2) the Bureau of Education, (3) the Bureau of Substance Use Treatment, and (4) Chaplaincy services (FDC, n.d.-a).

To improve the delivery of correctional services and meet reentry goals, the FDC Bureau of Program Development (BPD) created the Corrections Integrated Needs Assessment System (CINAS).[5] CINAS is a proprietary data system that collects criminal justice and risk/needs information on inmates and generates an offender profile based on the data (FDC, n.d.-b). [6] There are two versions the CINAS data system, CINAS and CINAS Lite. CINAS Lite was designed to be used by criminal justice and behavioral health agencies to streamline the process of reentry and improve the effectiveness of service delivery (FDC, n.d.-b). FDC indicates CINAS Lite training has been conducted in Leon County (FDC, 2020).

In addition to FDC initiatives, Governor Ron DeSantis recognized the importance of reentry with the creation of the *Florida Foundation for Correctional Excellence* (FLGOV, 2020). The purpose of this

[5] The Committee discussed CINAS under its previous name "Spectrum."
[6] As a proprietary system, CINAS does not include any psychometric data or peer review research on the validity and reliability of its assessment of risk factors and criminogenic needs. The system also has not been widely distributed through the state and there is limited or no data sharing available for community behavioral health providers in Hillsborough County.

foundation is to increase investment in reentry programs by bringing together public and private organizations. According to Governor Desantis' website, the goal of the newly established foundation is to "publicize needs, seek resources and donations and encourage philanthropic giving" in order to increase "investment in workforce trainings and reentry programs" (FLGOV, 2020). This announcement was made in February of 2020 and the impact of this foundation on reentry in Hillsborough County is yet to be determined.

Hillsborough County

Hillsborough County has been at the forefront of jail diversion initiatives in Florida and has actively fostered collaboration among community stakeholders to implement evidence-based programming and improve access to treatment for persons with behavioral health needs involved in the criminal justice and acute care systems. Working with the Department of Children and Families (DCF), Central Florida Behavioral Health Network (CFBHN) and Gracepoint, Inc. (formerly Mental Health Care, Inc.), Hillsborough County implemented one of the first mobile crisis response teams in Florida. Mobile crisis teams function as a pre-booking diversion program by providing mental health assessment and referral services to law enforcement officers in the field to assist with decision-making and to prevent the unnecessary arrest of persons with mental illness. Hillsborough County was also one of the first counties in Florida to implement a Crisis Intervention Team (CIT) program. CIT is a pre-booking diversion program that trains law enforcement officers on how to identify symptoms of mental illness, de-escalate presenting crisis and engage persons exhibiting symptoms of mental illness. Hillsborough County was also one of the first counties to implement a post-booking jail diversion program in Florida. Working with Gracepoint, Inc., and the Court, Hillsborough County implemented processes in preliminary presentation (first appearance) court that enabled judges to divert persons with low-level misdemeanor charges exhibiting symptoms of mental illness from county jail to Gracepoint,Inc., for mental health assessment and treatment.

Hillsborough County has since expanded these programs and added new pre-booking diversion programs and forensic case management and intensive case management programs to assist persons with behavioral health needs. These assist both with jail diversion and reentry. As part of the overall strategic plan, Hillsborough County has led the effort to ensure these forensic programs are evidence-based, working closely with community stakeholders and providers communicating this priority.

To assist with a coordinated implementation of evidence-based programing in 2016, the Hillsborough County Criminal Justice and Grants Management Office and Court Administration worked with Roger Peters, PhD at USF to investigate risk/needs instruments and present on the assessment of risk for behavioral health providers and specialty courts working with individuals in the criminal justice settings. Based on a review of the psychometric properties of the LS/CMI as compared to other widely used risk/needs tools, Dr. Peters found the LS/CMI to be a reliable risk/needs assessment instrument that can be effectively used by behavioral health providers for treatment planning purposes.[7] Since the presentation in 2016, the LS/CMI has been adopted by many of the behavioral health providers that work directly with problem-solving courts in Hillsborough County and county funded jail diversion programs.

While the LS/CMI is the most widely used risk/needs assessment instrument, not all agencies use a risk/needs assessment, and some use a different risk/needs assessment. The veterans treatment court in Hillsborough County, for instance, uses a risk/needs instrument developed specifically for veterans, while the Florida Department of Corrections (FDC) uses Corrections Integrated Needs Assessment

System (CINAS). Despite the widespread use of CINAS in the state correctional system, FDC does not allow community service providers to access the assessment data. As a result, behavioral health providers in Hillsborough County are not able to access the system and utilize needs data while working with persons returning from the state prison system. In addition, peer reviewed research on the validity and reliability of its assessment of risk factors and criminogenic needs is not available to determine its effectiveness and use with specific populations.

Altogether, Hillsborough County has a strong contingent of case management, behavioral health, housing, educational training, vocational training, and employment services that are available to persons being released form the jail or prison into the community. As part of this effort, the Hillsborough County Public Safety Coordinating Council is supporting steps to improve collaboration among community stakeholders. One such effort is the Coordify data-sharing software application. The purpose of the software is to facilitate interagency collaboration and assist behavioral health providers to develop case management plans using real-time data shared between criminal justice and social service agencies. This system was developed by Naphcare, Inc., the contracted medical and mental health provider for the Hillsborough County jails.[8] Such a system would support the continuum of care for persons with behavioral health needs being released from jail into the community and would support the Committee goals for reentry.

IV. Recovery-Oriented System of Care (ROSC) & Reentry

As mentioned previously, the focus of the January 2019 SIM meeting and workshop was to identify resources, gaps in services, and diversion opportunities in the existing mental health system and to establish priorities for enhancing the Recovery-Oriented Systems of Care (ROSC) with a focus on persons with behavioral health needs transitioning from jail or prison into the community.

To this end, the Committee discussed a vision for reentry in Hillsborough County and agreed that recommendations for reentry would mitigate the negative impact of thousands of adults returning from jail and prison to the most distressed and underserved communities in the county and assist the community in transforming the acute system of care into an effective ROSC that enhances public safety by creating a more proactive, coordinated, and collaborative approach to individual care.

A Recovery-Oriented System of Care (ROSC) can be defined as framework of effective community-based services organized into a coordinated network that supports a continuum of care and builds on meaningful partnerships made with individuals and their families in the context of the local community. ROSC emphasizes person-centered supports and services that are designed to change and adapt to meet the person's served needs and builds on the strengths and resilience of individuals, their families, and the community (SAMHSA, 2012).

Florida continues to promote the development of ROSC across the state as well. In 2016, the Florida Department of Children and Families (DCF) set the goal of working toward a ROSC across the state and partnered with various stakeholders holding a series of summits to flesh-out a shared vision of ROSC. Over 800 participants attended these summits including behavioral health providers, county officials, criminal justice providers, and peers and their family (FLGOV, 2017).

Committee discussions regarding reentry centered on transforming our ROSC by building upon existing community structures and working toward the goal of a comprehensive universal system that supports

[8] A brief description of Coordify can be found on the Naphcare website under technology solutions https://www.naphcare.com/services#technology-solutions

interagency collaboration. Given the emphasis on *recovery* and its importance in reentry, the focus of any reentry plan should be consistent with SAMHSA's guiding principles of recovery and include the 17 essential elements of a recovery-oriented-system found in SAMHSA 's recommendations for operationalizing recovery-oriented systems, which can be found on SAMSHA's website.[9]

V. Priority Area 1: Enhanced Community Collaboration

A. Committee Charge

Each committee was charged with gathering information from relevant social service and criminal justice agencies to: a) better understand the current available level of services being delivered to various segments of the criminal justice involved residents of Hillsborough County, and b) make recommendations for our integrated Recovery-Oriented System of Care (ROSC) community stakeholders to address gaps and needs in services and supports, implement positive change and increase recovery capital for a successful transition and sustainable life in the community and establish appropriate and measurable goals to meet the anticipated or unmet need. The Committee was tasked with six objectives (Figure 4).[10]

Figure 4. Priority Area 1 Action Plan

Priority Area 1: Enhanced Community Collaboration and Follow-Up				
	Objective	Action Step	Who	When
1.1	Data collection and information sharing (housing and employment)	• To explore the feasibility of a data workgroup or data collaborative • To research the Pinellas County Data Collaborative • To identify gaps in the existing data systems • To identify the number of individuals on county probation who have a serious mental illness	• Craig Powell (PowerNet of Tampa) • Julie Poole (The End Recidivism Project Extreme) • Shelley Pauls (The End Recidivism Project Extreme) • Carol Blalon (Central Florida Behavioral Health Network) • Marie Marino (Public Defender's Office) • Dr. Bethany Mitchell (NaphCare) • Angie Smith (Court Administration) • Gary White (Hillsborough County Anti-Drug Alliance)	6-12 months
1.2	Exposure to evidence based practices (cognitive behavioral intervention)	• To review the research on evidence-based and best practice models		6-12 months
1.3	Implementation of a universal release form	• To review Central Florida Behavioral Health Network's universal release form template		6-12 months
1.4	Explore the feasibility of implementing a common assessment tool across agencies and community providers	• To review current assessment tools being utilized by providers		6-12 months
1.5	Explore transportation options for the CIMHSA target population	• To conduct an inventory of existing transportation services in Hillsborough County (i.e. Sunshine Line and faith-based)		6-12 months
1.6	Utilize peer support specialists	• To determine which community providers have experience with hiring peer support specialists		6-12 months

[9] The guiding principles of recovery as articulated by SAMHSA can be found at https://www.samhsa.gov/sites/default/files/expert-panel-05222012.pdf.

[10] There was limited involvement from community behavioral health providers. The Committee recommends obtaining additional feedback from community providers regarding all recommendations made and to incorporate such feedback and deemed appropriate in the implementation Committee recommendations.

B. Committee Objectives & Recommendations

1.1 Data Collection and Information Sharing

Action Step(s): 1) To explore the feasibility of a data workgroup or data collaborative; 2) to research the Pinellas County Data Collaborative; 3) to identify the gaps in existing data systems; 4) to identify the number of individuals on county probation who have a serious mental illness.

Current Status. There are many governmental and non-profit agencies in Hillsborough County that provide various services to adults in Hillsborough County with substance use, mental health, or co-occurring disorders. Each agency collects person level data for their internal use based on programmatic needs. In a relatively few project specific cases, these agencies may share data with local collaborators to serve clients, satisfy contractual requirements, and meet government mandates, such as those required by the divisions of state and federal governmental including the Office of Economic and Demographic Research (the research arm of the Florida State Legislature), the Florida Department of Law Enforcement, and the US Department of Justice. In addition, the State Attorney and Public Defender rely on clinical data and behavioral health assessments to effectively divert eligible defendants with substance use, mental health, and co-occurring problems from arrest, incarceration, prosecution, and further advancement in the criminal justice system.

Problem Solving Courts (PSC) in Hillsborough County, such as the Mental Health Court, Veterans Court, and Drug Court, collect and share person-level data on defendants, as do many community agencies. This is possible because defendants must sign a Release(s) of Information to be accepted into the PSC. This data is critical to the operation of the PSC and assists with the effective provision of behavioral health services. To support and advance PSCs, court administration is required to collect and enter data on PSCs into state-system for monitoring purposes. In addition, community providers in Hillsborough County working directly with local PSCs to share clinical data with the court, including information on individual treatment progress. Most persons involved with the criminal justice system who have substance use, mental health, and co-occurring problems, however, are not being served by PSCs because the person is not eligible for the PSC. This may be because of the type of charge (many PSCs do not include violent charges), prior felony convictions, the person's refusal to participate in the PSC (voluntary participation is mandatory), or the person not admitting they have a behavioral health need or problem.

In terms of data sharing, the UNITY Information Network (UNITY) is the only data sharing system being used in Hillsborough County that allows providers to access person-level data to assist with linkages to community resources.[11] As part of the Tampa Hillsborough Housing Initiative (THHI), UNITY focuses exclusively on assisting individuals and families experiencing homelessness with finding affordable housing. While a vital community data sharing system that assists providers in the Continuum of Care (CoC) effectively plan and manage community resources, UNITY in its current form does not share person-level behavioral health and criminal justice data that would assist providers with reentry and the transitioning of individuals from jail into the community.[12]

[11] The Hillsborough UNITY system, which is maintained by Tampa Hillsborough Housing Initiative (THHI), collects data on persons who are homeless in Hillsborough County. For recommendations regarding housing and continued work with THHI for persons transitioning from jail or prison into the community see part C of this section, *Considerations Involving Housing and Shared Resources & Additional Recommendations.*

[12] The Continuum of Care CoC is the planning body responsible for organizing and delivering services for individuals and families experiencing homeless.

Overall, in Hillsborough County there is not a standardized process for collecting or sharing person-level behavioral health data on persons involved in the criminal justice system. This lack of standardization limits the ability of agencies to collaborate and share important information to better serve clients in forensic case management or jail diversion programs, such as PSCs, the mental health pre-trial intervention (MHPTI) program, the Jail Diversion Program (JDP) and Early Jail Diversion (EJD) programs. For instance, not all agencies collecting risk/needs data use the same risk needs instrument. PSCs and treatment providers working with the PSCs in Hillsborough County use the LS/CMI, while the Florida Department of Corrections (FDC) uses CINAS. In addition to lacking standardization, there is not a centralized database or information system in place that can act as a central hub where data can be accessed and shared among agencies.

Not only is there not a centralized database or system where person-level data can be accessed, there is no centralized system containing data that can be aggregated to inform strategic planning, drawing from multiple forensic programs. Programmatic data would include aggregate data on persons with behavioral health needs and criminal justice involvement. The lack of a centralized database with aggregate data limits the ability to measure recidivism rates, program effectiveness, and outcomes, as well as the ability to identify gaps of services needed for persons transitioning from jails and prisons into the community. This, in turn, limits the ability of the community to strategically plan and address reentry needs.

As mentioned previously, the Hillsborough County Public Safety Coordinating Council has supported preliminary plans to pilot a data sharing software application named Coordify. This data sharing application can assist community providers to develop case management plans using real-time data shared between agencies that supports the continuum of care for persons released from jail into the community.

Best Practice. Because a community develops data-sharing systems based on the individual needs of their community, there is not a single model that is recommended as best practice. The Justice Center, however, recommends building databases that can talk to each other stating:

> Think about ways to build in data matching potential by ensuring that criminal justice and behavioral health datasets use a common unique identifier. Attention to harmonizing terminology and using national information-sharing data standards can help communities develop both simple and sophisticated data exchanges. Developing different permissions levels based on roles also helps ensure PHI is kept private (CSG Justice Center, 2019).

In 2010, the Justice Center identified Pima County, Arizona and Dutchess County, New York as two communities that developed processes to where behavioral health data can be shared with criminal justice agencies (CSG Justice Center, 2010).[13]

Recommendation.[14] Based on a series of discussions and presentations from community stakeholders that include governmental and non-profit agencies, the following recommendations are being made to address gaps and needs in services and supports:

[13] Hillsborough County Sheriff's Office currently shares jail arrest data with the regional DCF managing entity, Central Florida Behavioral Health Network (CFBHN), which is matched with CFBHN client data. This assists CFBHN with strategic planning to address the behavioral health needs of CFBHN clients in Hillsborough County.

[14] In terms of addressing *Action Step 2*, the Pinellas County Data Collaborative is set up where person-level data is submitted to USF from various agencies in Pinellas County and then matched based on reporting requirements and/or specific requests. Only aggregate findings are available to providers. This data collaborative is different than the data sharing collaboration this

1. Establish the expectation for criminal justice and reentry service providers to share de-identified client demographic, process, and outcome data for purposes of county-wide planning and mapping of resources;
2. Create a Universal Client Release of Information form to allow service providers to share client information to improve effectiveness, efficiency, and continuity of care;
3. Establish a centralized database, or data sharing system, such as Coordify or UNITY, to collect, analyze and report on appropriate and agreed upon data points received from criminal justice agencies and community service providers with appropriate participant permissions, legal considerations, and risk management.
4. Lastly, community stakeholders doing the work of reentry are recommended to become part of the Continuum of Care (CoC) and to obtain access to the UNITY system as an effective reentry resource.

1.2 Exposure to Evidence Based Practices (Cognitive Behavioral Interventions)

Action Step. To review the research on evidence-based practice and best practice models.

Current Status. Behavioral health agencies receiving funding from Hillsborough County and/or the DCF managing entity in Hillsborough County, Central Florida Behavioral Health Network (CFBHN), use evidence based cognitive behavioral interventions to address needs of clients with behavioral health needs. An evidence-based strategy for working with persons involved in the criminal justice system is described in detail in Objective 1.4, Use of a Validated RNR Assessment Tool. No information regarding evidence-based practices is available for non-profit agencies that do not receive funding through the Hillsborough County or CFBHN.

Best practice. According to SAMHSA's *Principles of Community-Based Behavioral Health Services for Justice-Involved Individuals: A Research-based Guide* (2019), the third principle of community-based behavioral health services for justice-involved individuals is that evidence-based and promising programs and behavioral health treatment services should be used to provide high quality clinical care for justice-involved individuals. SAMHSA writes:

> Evidence-based programs and practices for mental and substance use disorders should be used for all individuals, with adaptations specific to justice involvement when appropriate. Adaptations include practices that specifically address criminal thinking through cognitive-skills training focused on judgment and criminal behaviors. Treatment should be tailored to the individual and address motivation; problem solving; skill building to improve cognitive, social, emotional, and coping skills; and assist in building prosocial supports and activities. Where needed, integrated treatment for co-occurring mental illness and use disorders should be provided to ensure coordination and continuity of care. As with all clinical care, community providers should track treatment outcomes and adjust treatment as needed (SAMHSA, 2019, p. 10).

Recommendation. It is recommended that governmental and community-based service providers should access and train its staff on the most current information, evidenced-based programming and/or best practices related to their respective roles to provide the most effective services to criminal justice involved clients.

committee is recommending. In terms of addressing *Action Step 4,* the number of individuals on county probation who have a serious mental illness was not made available to this Committee.

1.3 Feasibility of a Universal Release Form

Action Step. Review of multi-agency releases of information forms used by Central Florida Behavioral Health Network (CFBHN) and Tampa-Hillsborough Homeless Initiative (THHI).

Current Status. A universal release of information template was developed in Hillsborough County by various agency partners. This template, however, does not include all providers and stakeholders at this time.

Best Practice. The Justice Center (2019) recommends that criminal justice and behavioral health agencies establish agreements to share information and indicates both HIPAA and 42 CFR Part 2 have provisions to create interagency agreements. Furthermore, SAMHSA's *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison* (2017), they recommend the development of mechanisms to share information from assessments and treatment programs across the various points in the criminal justice system.

Recommendation. Design or identify a universal release form that all stakeholders and service providers can use to share information which contributes to more effective and efficient client-specific information to aid in the delivery of criminogenic need-responsive services for the criminal justice population. It is critical that the utilization of this type of release contain specific data restrictions for release to partners and that only information authorized for release by a signed release of information is shared among providers and that persons authorizing the release of information are aware they may change their decision and not have their information released, and that time restrictions on the sharing of data are enforced.

1.4 Use of a Validated RNR Assessment Tool

Action Step. To review current assessment tools being used by providers.

Current Status. As mentioned previously, the Hillsborough County Criminal Justice and Grants Management and Court Administration worked with Roger Peters, PhD at USF in 2016 to investigate risk/needs instruments and present on risk/need assessments to the court with local behavioral health providers in attendance. In his report and presentation, Dr. Peters recommended the LS/CMI as the preferred risk/needs assessment instrument for providers developing case management plans for justice-involved individuals. Based on Dr. Peter's recommendation, Hillsborough County and Court Administration have taken the lead with promoting the LS/CMI and the LS/CMI has been adopted by many community agencies working directly with problem-solving courts and forensic case management and jail diversion programs funded by the county.

Best Practice. Risk/needs assessments are considered an evidence-based practice for assessing risk and risk factors for recidivism. (NCSC, 2014; NDCI, 2015). Such assessments are used by criminal justice and behavioral health programs to assist with case management planning to assist with recovery. Risk/needs assessments also inform correctional recommendations and court decisions concerning conditional release. These assessments assist with individualized treatment planning and consider a person's specific strengths, needs, abilities and preferences, and identify reintegration challenges. Moreover, risk/needs assessments provide a roadmap for criminal justice and behavioral health providers to assist persons transitioning from jail and prisons to the community and assist agencies with

utilizing scarce resources and providing services more effectively in meeting goals of reducing recidivism by targeting risk factors that lead to re-arrest.[15]

Recommendation. Based on principals of the RNR model that focus on serving individuals with the greatest risk for recidivism and targeting the greatest risk factors for re-arrest, this Committee recommends:

1. All community providers doing the work of reentry should maximize the use of a RNR tool for reentry purposes.
2. Community providers utilize a validated RNR tool.
3. The preferred assessment being funded and utilized in the court system is the LSCMI. To the extent possible, the LSCMI results would be shared with entities and service providers based on the authorization levels permitted by the client. If the entity doing reentry does not have the capacity to conduct a risk/needs assessment, the entity could refer the person to a service provider that has the capacity to conduct the LSCMI[16].

1.5 Transportation

Action Step. To conduct and inventory the existing transportation services in Hillsborough County (i.e., Sunshine Line and faith-based).

Current Status. Hillsborough County's surface area is 1,266 square miles with various urban and rural gaps in transportation resources. Although transportation is not the greatest limiting factor for persons transitioning from jails and prisons into the community, the lack of easily accessible transportation can be a significant barrier that hinders individuals from connecting to community resources.

Tampa, FL, considered the regional urban hub of Hillsborough County, was ranked 98 out of 100 with 100 being the worst in a survey combining the factors of accessibility, convenience, safety, and reliability and public transit resources (APTA, n.d.). The lack of accessible transportation is a significant issue facing many people reentering the community from jail or prison. A comprehensive discussion of such issues, however, is beyond the scope of this Committee.

Best Practice. The elimination of barriers to public transportation significantly improves re-entering citizens ability to access behavioral health services. According to the 2019 Hillsborough County Community Needs Assessment prepared for Hillsborough County Social Services, transportation affects all aspects of every-day life and access to transportation can cause or eliminate poverty (Hillsborough County, 2019). As such, the importance of transportation on reentry cannot be underestimated.

Recommendation. Despite the challenges faced in our community specifically for individuals reentering the community with few resources for transportation, there needs to be a multi-faceted approach to the challenge of eliminating transportation as a barrier to successfully meet the needs for sustainable community living reentry. Pre-planned arrangements are necessary for ensuring safe release as well as access to care are critical to bridging service needs. Given this challenge the following options exist but may be limited in availability, funding, and coordination. Transportation options for

[15] See Section II or this report and Risk-Needs-Responsivity (RNR) regarding the LS/CMI and its use as a risk/need assessment in criminal justice settings.

[16] Capacity includes a consideration of the financial costs of purchasing screening/assessment instruments and training staff to conduct screenings/assessments.

persons transitioning to the community from jail or prison are often best coordinated by behavioral health agencies as part of case management services. Such transportation options include:

- Public transportation;
- Family, friends and associates;
- A coordinated community effort among faith-based organizations;
- Mentors and peer specialists;
- Individual efforts including bicycles, scooters, taxicabs, etc.

1.6 Use of Peer Support Specialists

Action Step. To determine which community providers have experience with hiring peer specialist and to define the purpose and role or peers.

Current Status. Peer support has been underutilized in Hillsborough County as is the case in most communities throughout the United States. Peer run organizations such as Recovery Community Organizations (RCO) and Peer Ally, which is part of the National Alliance on Mental Illness (NAMI), lack sufficient funding to support peer efforts and training. For many paid peer support positions, peers are required to be trained and certified to be hired working in evidenced-based programs. Larger publicly funded behavioral health organizations in our community have adopted the integration of peer specialists to varying degrees.

To define the role and the purpose of the use of Recovery Peer Specialist's in community reentry, one must first understand the definition of recovery and why peer support specialists are an invaluable resource who can assist with communication across agencies in an effective Recovery–Oriented System of Care (ROSC). The SAMHSA definition of recovery states, "Recovery is a process of change whereby individuals improve their health and wellness, to live a self-directed life, and strive to reach their full potential" (SAMSHA, 2018). With this definition in mind, the peer role is to model recovery in their own life through the application of recovery knowledge and skills guided by recovery principles. Through this, the peer support specialists demonstrate how living a self-directed life fosters a sense of meaning and purpose as one grows beyond the potentially catastrophic effects caused by their behavioral health diagnosis. Some of the tasks of peers and peer support services include (Chapman et al., 2018).:

1. Assist in the development of strengths-based, individual, SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals.
2. Assist in the development of rehabilitation/recovery goals to get back to school and work.
3. Serve as a mentor & advocate for resolution of issues.
4. Assist in identifying and developing community support through encouragement of family communication, volunteering, and connection to faith- based communities.
5. Educate on ways to maintain wellness and recovery through lived experiences and exposure to evidence-based wellness supports and tools such as the Wellness Recovery Action Plan (WRAP).
6. Provide education on navigation of community supports and services and substance use and mental health recovery (Chapman et al., 2018).

Best Practice. Research indicates that Recovery Peer Support Specialists can provide an advantage to the criminal justice population in terms of advocacy, mentoring /coaching, education, and general support. According to Chapman et al. (2018), "The use of peer support in forensic settings is particularly promising as many incarcerated individuals also have mental illness or SUDs (substance use disorders) or both" (Chapman et al., 2018, p.272). Recovery Peer Support Services have been shown to

improve mental health outcomes and to reduce readmission of persons with multiple psychiatric hospitalizations (Chinman et al., 2014; Sledge et al., 2011). In addition, the Centers for Medicare and Medicaid Services (CMS) recognize peer support as an evidence-based practice that can be reimbursed attesting to the positive impact of these supports (Daniels et al., 2013).

Recommendation. The committee recommends peer support services as a strongly desired part of Recovery-Oriented System of Care (ROSC). Peer services can assist with bridging gaps in the service continuum and enhancing cross agency service coordination. In addition to discussing the importance of paid peer support specialist being included in array of services being provided by behavioral health agencies, the committee discussed the existence of informal peers acting independently as an additional and important support to persons re-entering the community from prison settings. The Committee recognizes peers in informal roles support persons transitioning to the community from jail or prison and that barriers exist for many peers with lived experience who also have criminal histories and may not be able to access incarceration settings to assist individuals with reentry.

The Committee recommends identifying and supporting the development of peer-run organizations who offer peer support services by Certified Recovery Peer Specialists who have been trained to provide recovery-oriented services. Central Florida Behavioral Health Network (CFBHN) has taken a primary role in supporting peer specialist training to meet the requirements for and certification in our region and is an integral partner supporting the expansion of this valuable initiative.

It is further recommended that behavioral health agencies and community stakeholders recognize the benefits of peer support and that they engage in the recruitment, training, and retention of peers as a reimbursable and value-added service for persons involved in the criminal justice system.

C. Considerations Involving Housing and Shared Resources & Additional Recommendations

Housing was not a direct objective of this Committee. However, lack of available, affordable, and stable housing is a primary barrier to successful reentry efforts and, as such, housing issues became essentially intertwined with multiple committee objectives. The "Data Collection and Information Sharing" and "Implementation of a Universal Release Form" objectives resulted in this Committee hosting a presentation by Tampa Hillsborough Housing Initiative (THHI) to learn about the potential for collaborating with their Continuum of Care (CoC) and utilization of the UNITY Information Network (UNITY) data system to maximize mutual efforts of housing and resourcing individuals involved in both the reentry and homeless systems.

THHI is the lead agency designated by the State of Florida for Hillsborough County's CoC to develop and provide innovative solutions for making homelessness rare, brief, and non-reoccurring. The CoC is the planning body responsible for organizing and delivering services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. Through inter-agency coordination and collaboration which utilizes metric-informed strategies and best practices, THHI maximizes effectiveness by confronting the challenges endemic to tackling homelessness. THHI does this by creating and maintaining strategic relationships with federal, state, local and provider entities. The CoC is not a closed group and additional community organizations can become a member of the CoC with appropriate agreements and protocols in place.

THHI utilizes the UNITY Information Network (UNITY), which is the Tampa/Hillsborough County Continuum of Care's Homeless Management Information System (HMIS). HMIS is a shared, secure data system used by CoC partners. UNITY is utilized to aid individuals and families that are homeless or at risk of becoming homeless and the database collects information about the people being served through the homeless system of care. Related to ongoing reentry efforts, the UNITY system can house a

universal release that would enable reentry providers who are part of the CoC to share mutually beneficial information and resources. There is also the opportunity for the UNITY system to be the home of a best practice risk/needs assessment instrument. At this time, there is no direct cost associated with accessing UNITY or utilizing it as the home to potentially access either of these documents.

It is widely recognized that persons reentering the community from incarceration are frequently the same persons being assisted by the CoC and being tracked in the UNITY database. Therefore, within existing resources, the Committee believes it is effective and efficient that relationships between those who undertake reentry efforts and THHI should be established to maximize collaboration, coordination of resources, and utilization of beneficial tools. Accordingly, the Committee recommends the following related to partnership:

1. Community stakeholders doing the work of reentry to become part of the CoC and to obtain access to the UNITY system;
2. A reentry steering housing committee be created, as part of THHI or independent of THHI, that directly links community reentry initiatives and THHI housing capabilities/resources related to reentry;
    i. The housing committee would collaborate with THHI to develop and sustain a coordinated entry position or focused effort within the THHI continuum of care that supports effective housing efforts targeted at the specialized issues of individuals reentering the community from incarceration or who have criminal records creating a barrier to obtaining housing;
    ii. The housing committee would collaborate with THHI, as part of its overall strategic plan, and develop a coordinated system of homeless service, which includes offender reentry, with input from community agencies, landlords, and individuals, such as peers for whom housing is being sought during the reentry process who have criminal records and can provide feedback and insight regarding barriers to obtaining housing for those transitioning from jails and prisons;
    iii. The committee consider using the UNITY system as an option to house a universal release and the common, mutually agreed risk screening tool and risk/needs assessment instrument which are being recommended by this committee pursuant to the committee objectives.

VI. Conclusion

The Committee thanks our community partners for their valuable input and commitment to enhancing the opportunities for our criminal justice involved citizens so they may live with stability and be able to contribute to our vibrant community that is dedicated to the wellness and safety of all citizens. It is our fervent desire that the recommendations included herein serve to provide a basis for continued improvement in service delivery and enhanced understanding of persons involved in the criminal justice system in need of our support.

Although funding and differing priorities pose a challenge to having all desired services to meet the behavioral health needs for justice-involved persons in our community or those returning to the community from jail or prison, enhanced awareness of the unmet need serves as a foundation for

action. The goals remain to educate and improve collaboration for a Recovery-Oriented System of Care acknowledge the significant needs of those with serious mental health and substance use disorders, and expand on the many ways we can positively impact and support the individuals in their recovery.

THE REST OF THIS PAGE INTENTIONALLY LEFT BLANK

Appendix A: Sequential Intercept Mapping Reentry Committee Membership

Craig Powell, Executive Coordinator, PowerNet of Tampa, Inc.

Marie Marino, Chief- Forensic Behavioral Health Unit, Circuit 13 Public Defender's Office

Angie Smith, Chief Deputy- Circuit 13 Court Programs

Julia Pauls, Managing Director, End Recidivism Project

Carol Eloian, Consumer and Family Affairs Director, Central Florida Behavioral Health Network

Alice Flowers, Circuit 13, Correctional Probation Senior Supervisor, FL Department of Corrections

Sherry Woody-Loud, Correctional Probation Senior Supervisor, FL Department of Corrections

Bethany Mitchell, M.D., Medical Director, Naphcare Inc. (Hillsborough County Sheriff's Office Health Services)

Daniel Ringhoff, PhD, LCSW, University of South Florida, and Behavioral Health Consulting & Counseling, LLC.

Robert Sweeney, Correctional Probation Supervisor, Florida Department of Corrections

Manny Guevara-Ruiz, Manager- Veteran's and Peers Initiatives, Crisis Center of Tampa Bay, Inc.

Deb McGinty, Criminal Justice Prevention and Grants Coordination Manager, Hillsborough County

Special Acknowledgements

Meeting Support Coordination: Eva Dyer, Project Manager, Hillsborough County Criminal Justice Unit

Editorial Contribution: Daniel Ringhoff, PhD, LCSW, Behavioral Health Consulting &Counseling, LLC

Appendix B: Presentations to the Committee

Presentations to the Committee (referenced in approved Committee minutes)

May 22, 2019:

- Ms. Carol Eloian spoke about the Universal Consent/Release form. Ms. Eloian also led the group through a discussion of arrest and recidivism statistics that are available from Central Florida Behavioral Health Network (CFBHN).
- Dr. Dan Ringhoff discussed the challenges of data collection. Dr. Ringhoff was invited to be a member of this committee and graciously accepted.
- Chief Deputy Court Administrator Angie Smith distributed a list of the 13th Judicial Circuit's Problem-Solving Courts Funding Sources and Contract Providers. The process and criteria for selecting providers for grants that have been awarded was reviewed. Reasons why providers drop out was also discussed.
- County Manager of Criminal Justice Grants Coordination Unit Deb McGinty reviewed mapping of County's Grant Programs, Grants, Requirements, Funding Sources and who they are managed by, along with who can refer, eligibility and capacity.

June 25, 2019:

- Dr. Ringhoff reviewed the eight criminogenic risk factors and needs and discussed which ones should be addressed first.
- Ms. Sherrie Woody-Loud did an overview of how Spectrum system works, both in and out of prison.[17]
- Mr. Manuel Guevara from the Crisis Center discussed available community resources and how to access them.

July 23, 2019:

- Dr. Ringhoff provided a presentation of "Hillsborough County Criminal Justice Data Sources" to educate members on available data sources related to jail and prison populations.

August 27, 2019:

- Mr. Robert Sweeney, Correctional Probation Supervisor, Circuit 13, Florida Department of Corrections, presented recidivism statistics and data requested by Chair to workgroup.
- Dr. Ringhoff discussed jail data he has collected.
- Ms. Eloian stated there is a CFBHN funded initiative- "Recovery Community Organization" built on individuals who are in recovery receiving grass roots funding to offer Peer led supports and services. A summit is scheduled.

December 3, 2019

- Dr. Ringhoff reviewed data contained in Annual HCSO report.

[17] Spectrum was renamed the Corrections Integrated Needs Assessment System (CINAS). This is referenced in the report in Section III part B.

January 28th, 2020

- Mr. Tony Parker (NOAH Community Outreach) shared that housing and employment are the biggest challenges they work with. Ready for Work has helped their residents and their model works. Housing is NOAH's primary focus, but they also have weekly classes for life skills.
- Mr. Robert Blount (Abe Brown Ministries) shared that Abe Brown Ministries has been around for 40 years. Housing, both transitional and permanent, is imperative. Mr. Blount recommended starting with a risk and needs assessment, and utilization of Motivational Interviewing.

February 25, 2020:

- Ashley Wynn from Tampa Hillsborough Homeless Initiative gave a PowerPoint presentation entitled, "Intersection of Incarceration and Homelessness: Reentry".
- Mr. Byron Harrison, Director of Information Systems for NaphCare, Inc. gave a PowerPoint presentation entitled "Sequential Intercept Mapping Workgroup" describing Coordify data management system.

June 23, 2020:

- Dr. Ringhoff shared his research findings on returning citizens.
- Ms. Deb McGinty introduced two guest speakers, Peer Support Specialists Mr. Jerome Alexander, and Ms. Janice Daniel. They discussed the mission and roles of Peer Support Specialists, as well as the certification and hiring process. Ms. McGinty provided a PowerPoint on Recovery Peer Support-Best Practices on behalf of Ms. Carol Eloian. Ms. McGinty highlighted essential responsibilities of Peer Specialists and how their role was differentiated from other direct service provider roles. Mr. Alexander and Ms. Daniel answered questions. Ms. Eloian coordinates region wide trainings and continuing education and support to Peer Specialists working with our behavioral health providers.

July 28th, 2020:

- Naphcare representatives Mr. Byron Harrison, Director of Information Systems, and Mr. Ken Davis, Vice President of Business Development, gave a brief synopsis on the purpose and capabilities of the COORDIFY system, and how it would potentially benefit Hillsborough County. A question-and-answer session followed. Stakeholder commitment, expectations and overall cost were addressed.
- Mr. Robert Sweeney introduced a guest speaker, Ms. Leslee Pippen, Assistant Warden at Polk Correction Institution. Ms. Pippen discussed the roles volunteers fill at her organization, as well as qualifications and requirements that must be met. A question-and-answer session followed.
- Co-Chairperson Marie Marino summarized what the subcommittee has been discussing regarding housing, including the Tampa Hillsborough Housing Initiative (THHI) Strategic 560 Plan and use of the UNITY database. Mr. Rob Parkinson discussed the role of the VI SPDAT to determine service eligibility, as well as the transitional housing component of the 1800 Orient Road Project.

References

Alper, M., Durose M. R., & Markman, J. (2018). Update on prisoner recidivism: A 9-year follow-up period (2005-2014). *Bureau of Justice Statistics*, May 23, 2018 NCJ 250975 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6266

Archara Consulting. (2017). Creating a recovery-oriented system of care in Florida. Retrieved February 21, 2021 from https://www.flgov.com/wp-content/uploads/childadvocacy/CreatingaRecovery-OrientedSystemofCareinFlorida-2017.pdf

Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*(1), 39–55. https://doi.org/10.1037/a0018362

Andrews, D. A., Bonta, J., & Wormith, J. S. (2010). *The Level of Service (LS) assessment of adults and older adolescents.* In R. K. Otto & K. S. Douglas (Eds.), *International perspectives on forensic mental health. Handbook of violence risk assessment* (p. 199–225). Routledge/Taylor & Francis Group.

Broner, N., Lattimore, P. K., Cowell, A. J., & Schlenger, W. E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study. *Behavioral Sciences & the Law,* 22(4), 519-541.

Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011-2012. *Bureau of Justice Statistics*, April 2019, NCJ 252156 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946

Bronson, J., & Carson, E.A. (2017). Prisoners in 2017. *Bureau of Justice Statistics*, June 22, 2017 NCJ 250612 https://www.bjs.gov/content/pub/pdf/p17.pdf

Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, 54(6), https://doi.org/10.1016/J.AMEPRE.2018.02.019

Chinman, M., Georg, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. Psychiatric Services, 65(4), 429-441

CSG Justice Center. (2010). *Information sharing, criminal justice – mental health collaborations: Working with HIPAA and other privacy laws.* Retrieved February 21, 2021 from https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_CJMH_Info_Sharing.pdf

CSG Justice Center. (2019). Sharing behavioral health information: *Tips and strategies for police-mental health collaborations*. Retrieved February 21, 2021 from https://csgjusticecenter.org/wp-content/uploads/2019/11/JC-Information-Sharing-for-Police-Mental-Health-Collaborations.pdf

Daniels, A. et al. (2013) Best practices: Level-of-care criteria for peer support services: A best-practice guide *Psychiatric Services* 64(12), 1190-1192. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300277

Ditton, P. M. (1999). Mental health treatment of inmates and probationers. Bureau of Justice Special Reports, U. S. Department of Justice, NCJ: 174463.

Durose, M. R., Cooper, A. D., & H. N., Snyder, (2014). Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 2010 – Update. *Bureau of Justice Statistics* April 22, 2014 NCJ 244205 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=4986

Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. Administration and Policy in Mental Health and Mental Health Services Research, 33, 544-557.

Forsberg, L., Douglas, T. What is Criminal Rehabilitation? *Criminal Law, Philosophy* (2020). https://doi.org/10.1007/s11572-020-09547-4.

Esparza Flores, Nayely (2018). Contributing factors to mass incarceration and recidivism. *Research Journal of Justice Studies and Forensic Science:* Vol. 6(4). https://scholarworks.sjsu.edu/themis/vol6/iss1/4

Florida Department of Corrections (FDC). (2020a, February 21). *Quarterly recidivism report as required For quarter July1, 2020 to September 30, 2020*. http://www.dc.state.fl.us/pub/recidivism/2020-2021/Quarterly%20Recidivism%20Report%202020-Q3.pdf

Florida Department of Corrections (FDC). (2020b, February 21). *Florida prison recidivism report: Releases from 2008 to 2018.* http://www.dc.state.fl.us/pub/recidivism/2020-2021/Quarterly%20Recidivism%20Report%202020-Q3.pdf

Florida Department of Corrections (FDC). (2020c) *FDC partners with Leon County Sheriff's Office to increase public safety 2018.* Retrieved February 21, 2021 from http://www.dc.state.fl.us/comm/press/main/08-06-Leon.html

Florida Department of Corrections (FDC). (2019). *Florida prison recidivism report: Releases from 2008 to 2017.* Retrieved February 21, 2021 from http://www.dc.state.fl.us/pub/recidivism/RecidivismReport2019.pdf

Florida Department of Corrections (FDC). (n.d.-a). *Offices of programs and reentry.* Retrieved February 21, 2021 from http://www.dc.state.fl.us/development/index.html

Florida Department of Corrections (FDC). (n.d.-b). *Bureau of program development.* Retrieved February. 21, 2021 from http://www.dc.state.fl.us/development/applied.html

Florida Governor's Office. (2017). *Governor Ron Desantis announces creation of the Florida foundation for correctional excellence.* Retrieved February 21, 2021 from https://www.flgov.com/2020/02/07/governor-ron-desantis-announces-creation-of-the-florida-foundation-for-correctional-excellence/

Fogel, S. J., Lersch, K. M., Ringhoff, D. H., & Grosholz, J. M. (2021). Returning citizens and point of entry: Is there a match? *Families in Society*. doi:10.1177/1044389420956436

Frank, R. G., Goldman, H. H., & Hogan, M. (2003). Medicaid and mental health: Be careful what you ask for. *Health Affairs*, *22*(1), 101-113

Hiday, V. A., & Wales, H. W. (2003). Civil commitment and arrests. Current Opinion in Psychiatry, 16(5), 575-580.

Hillsborough County. (2019). *Hillsborough county needs assessment*. Retrieved February 21, 2021 from https://www.hillsboroughcounty.org/library/hillsborough/media-center/documents/social-services/cna-report-2019.pdf

Hunter, B. A., Lanza, A. S., Lawlor, M., Dyson, W., & Gordon, D. M. (2016). A Strengths-Based Approach to Prisoner Reentry: The Fresh Start Prisoner Reentry Program. *International journal of offender therapy and comparative criminology*, *60*(11), 1298–1314. https://doi.org/10.1177/0306624X15576501

Langan, P. A., & Cunniff, M., Ph.D., (1992) Recidivism of felons on probation, 1986-89. *Bureau of Justice Statistics*, *National Association of Criminal Justice Planners* February 1, 1992 NCJ 134177 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=3994

McNeil, D.E., Binder, R. L., & Robinson, J.C. (2005). Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. *Psychiatric Services,* 56, 840-846.

More, M. E. & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. Law and Human Behavior, 30(6) 659-674.

Multi-Health Systems, Inc. (MHS). (2021, February 21). *Level of service/case management inventory.* https://storefront.mhs.com/collections/ls-cmi

National Drug Court Institute (NDCI). (2015). *Selecting and using risk and need assessments.* Retrieved February 21, 2021 from https://www.ndci.org/wp-content/uploads/Fact%20Sheet%20Risk%20Assessment.pdf

National Institute of Corrections (NIC). (2014) *Offender risk & needs assessment instruments: A primer for courts.* Retrieved February 21, 2021 from https://nicic.gov/offender-risk-needs-assessment-instruments-primer-courts

Policy Research Institute. (2021, February 21). *Sequential intercept model.* www.praic.com https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

Sledge, W., Lawless, M., Sells, D., Wieland, M., O'Connell, M., Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services,62:541-544)

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B. & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. Psychiatric Services, 60(6), 761-765.

Torrey, E. F. (2008). *The insanity offense*. New York: Norton.

Travis J. But they all come back: Facing the challenges of prisoner reentry. Washington, DC: Urban Institute Press; 2005. [Google Scholar]

Travis, J., & Petersilia, J. (2001). Reentry Reconsidered: A New Look at an Old Question. *Crime & Delinquency*, *47*(3), 291–313. https://doi.org/10.1177/0011128701047003001

U.S. Department of Health and Human Services. (2002). Results from the 2001 National Household Survey on Drug Abuse: summary of national findings, Vol, I NHSDA Series H-17, DHHS Publication No. SMA 01-3758. Rockville, MD: DHHS, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide.* HHS Publication No. SMA-19-5097. Rockville, MD: Office of Policy

Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide.* HHS Publication No. SMA-16-4998. Rockville, MD: Office of Policy

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). *Recovery support tools and resources.* Retrieved February 21, 2021 form https://www.samhsa.gov/brss-tacs/recovery-support-tools-resources