ORANGE COUNTY MENTAL & BEHAVIORAL HEALTH SYSTEM OF CARE COMMUNITY ANALYSIS

JANUARY 18, 2022

Orange County Government Florida

United Way

Heart of Florida United Way

Heart of Florida United Way was honored to complete an analysis of the mental and behavioral health continuum in Orange County. This work, done at the request of Orange County Mayor Jerry Demings and Board of County Commissioners, built upon a considerable amount of work that had already been done by Orange County staff. From the start, it was clear to us that this was an important and relevant topic affecting many Central Floridians. We saw it through the lens of our daily work and knew the problem had been greatly exacerbated following the onset of the COVID-19 pandemic.

Each day, we hear the anguish and anxiety in people's voices when they call our 211 Information & Referral Crisis Line seeking help during their most desperate hours. Whether it is someone looking for resources for stable housing, food or utilities … or, more gravely, someone having suicidal ideations, our highly trained 211 Specialists are there to answer the call every day, every night, no matter the time of day.

With the leadership of Mayor Demings and the Board of Commissioners, we began asking the question, how do we get to the root of the issue well before someone has to place that desperate call to 211? Before we ask that question, it is important to understand that Mental Health is just as vital of a component to an individual's well-being as physical health. So, why is it thought of, and treated, as something different? Why is it so difficult to get help when and where it is needed? Why do individuals with access to assistance not reach out and take it? How can we live better – as individuals and as a community?

The contents of this report capture but a moment in time. They reflect an examination of some of the greatest opportunities and challenges facing the mental and behavioral health landscape in Orange County. With sincere gratitude to the expertise of Dr. Lauren Josephs of Visionary Vanguard Group this research is presented with hopes of changing the future for Orange County residents related to the availability and accessibility of mental health services whenever and wherever they may need them. Together, informed by research, fueled by collaboration and a desire for change, we can get better. In order to live better, we must live united.

Sincerely,

Jeffery Hayward
President & CEO
Heart of Florida United Way

ABOUT THE RESEARCHER

Lauren Josephs, PhD, LMHC, NCC

Dr. Lauren Josephs is a Researcher and Behavioral Scientist who is c Chief Operating Officer of Visionary Vanguard Group, Inc.– a consult that addresses physical and behavioral health disparities through re evaluation, and training. Previously, she was Health Disparities Rese the Center for Health Futures at Florida Hospital (now AdventHealth she was responsible for research, and evaluation of culturally appro community initiatives designed to improve the health of underserve underinsured and minority populations. Dr. Josephs started her car Health Counselor working with juvenile-justice-involved youth. She has been a Florida licensed psychotherapist, and a Nationally Certified Counselor (NCC) for over two decades. Dr. Josephs is also a certified trainer, and trainer-of-trainers of Cultural & Linguistic Competence.

Dr Josephs has worked collaboratively to address health and healthcare disparities, gender inequities, childhood trauma, as well as other issues impacting minority and under-resourced communities. Her work has been presented at the International Family Violence and Child Victimization Research Conference, the International Conference on Communication in Healthcare, the Florida Health Disparities Conference, the National Youth at Risk Conference, Georgetown Institutes, Baylor University and numerous others.

Dr. Josephs obtained a Bachelor's degree in English, as well as Master's and Specialist Degrees in Mental Health Counseling from the University of Florida (UF). She earned a PhD in Public Affairs, an interdisciplinary program drawing from the fields of public administration, social work, health management & research, criminal justice, governance and public policy, from the University of Central Florida (UCF). She is currently a member of the Collaborative Community Council, a subcommittee of the AdventHealth Orlando Board of Trustees, and has served on the executive committee of the boards of Healthy Start Coalition of Orange County, Central Florida Partnership on Health Disparities, and Community Health Centers.

Dr. Josephs has received several awards for her work including the Orange County Public Health Heroes Award from the Florida Department of Health in Orange County, in 2016 and the Outstanding Alumni Award from the Doctoral Program in Public Affairs at UCF, in 2017. She was born on the island of Jamaica and currently resides in Orlando, FL.

MENTAL AND BEHAVIORAL HEALTH SYSTEM OF CARE COMMUNITY ANALYSIS

Thank you to all those who participated in this research by providing their perspectives, expertise and experiences.

Key Stakeholders

- Honorable Jerry L. Demings, Orange County Mayor
- Jeff Hayward, Chief Executive Officer, Heart of Florida United Way
- David Strong, Chief Executive Officer, Orlando Health
- Randy Haffner, Chief Executive Officer, Advent Health
- Larry Moss, MD., Chief Executive Officer, Nemours
- Wendy Brandon, Chief Executive Officer, HCA Healthcare
- Gustavo Rivera-Cruz, MD., Assistant Service Chief, Orlando VA Medical Center
- Rebecca Sayago, PCAN Director, Orange County Government
- Maria Bledsoe, Chief Executive Officer, Central Florida Cares Health System, Inc.
- Alexander Cartwright, PhD., President, University of Central Florida
- Barbara Jenkins, Ed.D., Superintendent, Orange County Public Schools
- Charles Scherer, Central Regional Managing Director, Florida Department of Children and Families
- Karen Willis, Chief Executive Officer, Early Learning Coalition of Orange County
- Glen Casel, Chief Executive Officer, Embrace Families Foundation
- Honorable Lisa Munyon, Chief Judge, Ninth Judicial Circuit Court of Florida
- Honorable John Mina, Sherriff, Orange County Sheriff's Office
- Orlando Rolon, Chief of Police, City of Orlando

Convening Group- Heart of Florida United Way

Facilitator-Subject Matter Expert- Dr. Lauren Josephs

COMMITTEE STRUCTURE

Continuum of Care System Look Committee

- **Co-Chair- Michael Bryant, Chief Operating Officer, Embrace Families**
- **Co-Chair- Dr. Marie-Jose Francois, President/Chief Executive Officer, Center for Multicultural Wellness and Prevention, Inc.**
- Babette Hankey, President/Chief Executive Officer, Aspire Health Partners
- Denisse Centeno-Lamas, Executive Director, Hispanic Family Counseling, Inc.
- Lisa Kroger, Executive Director, Devereux Advanced Behavioral Health
- Marucci Guzman, Executive Director, Latino Leadership, Inc.

• Vickie Lewis, Chief Executive Officer, Central Florida Behavioral Hospital
• Kenneth Henderson, Chief Executive Officer, University Behavioral Center
• Cindy Jurie, Director of Research & Special Projects, Early Learning Coalition
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• Ellen Geiger, Assistant Director/Contract Manager, Healthy Start Coalition of Orange County
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• Dr. Lisa Spector, Chief of Developmental-Behavioral Pediatrics, Nemours
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• Joe Sarrubbo, Dean of Students, Valencia Community College
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• Dr. Akiho Tanaka, Clinical Psychologist
• Colleen Andre, Mental Health Counselor, Life Counseling Solutions
• Theresa Galindo, Registered Nurse, Psych-Med EAST, Center for Behavioral Health at Advent Health
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• Tammy Carvalho, Counselor, Broken Wings Ministry
• Brendan Ramirez, Chief Executive Officer, Pan American Behavioral Health Services
• Pete Carrasquillo, Chief Executive Officer, NeuMind Wellness Group
• Daisy Vazquez, Senior Children Services Counselor, Orange County Community and Family Services Department

Advocacy Committee

• Co-Chair- Muriel Jones, Executive Director, Federation of Families of Central Florida
• Co-Chair- Father Jose Rodriguez, Iglesia Jesus De Nazaret
• Eric Welch, Executive Director, NAMI Greater Orlando
• Marni Stahlman, President/Chief Executive Officer, Mental Health Association of Central Florida
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• Dick Batchelor, Founder/President, Dick Batchelor Management Group
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• Cameron Wimbush, youth/consumer
• Yvonne Camacho, parent/consumer
• Yadriel Cruz, consumer
• Yan Michael Irizarry, youth/consumer
• Tammy Jones, parent
• Aaliyah Jones, youth/consumer
• Ashanti Jones, youth/consumer
• Barbi Butler, parent/consumer
• Anastasia Soileau, consumer

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• Co-Chair- Kenneth Robinson, President/CEO Dr. Phillips Charities

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• Sandi Vidal, Vice President of Community Strategies and Initiatives, Central Florida Foundation
• Nicolette Springer, Policy and Advocacy Consultant
• Tom Lacy, Physician Leader for Primary and Urgent Care, Nemours
• Stephanie Garris, Chief Executive Officer, Grace Medical Home
• Maria Bledsoe, Chief Executive Officer, Central Florida Healthcare Systems
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• Julie Osmanski-Harmon, Senior Director of Products Operations, Wellcare
• Tony Jenkins, Market President, Florida Blue
• Peter Kacheris, Retired Managing Director of the Waldorf Astoria
• Karla Muniz, Executive Director for Strategic Workforce Integration, Advent Health

Criminal Justice Committee

• Co-Chair- Honorable Alicia Latimore, Circuit Judge, Ninth Judicial Circuit Court of Florida

• Co-Chair- Johnny Alderman, Chief Probation Officer, FL Department of Juvenile Justice

• Major Carlos Torres, Orange County Sheriff's Office
• Faith Sills, Social Services Chief, Ninth Judicial Circuit Court of Florida
• Keisha Mulfort, Director of Public Affairs, State Attorney's Office, Ninth Judicial Circuit
• Shana Manuel, Deputy Chief Assistant State Attorney, State Attorney's Office, Ninth Judicial Circuit
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• Captain Lovetta Quinn-Henry, City of Orlando Police Department
• Lisa Graham, Health Services Program Administrator, Orange County Health Services Dept.

• Kelly Steele, Court Programs Manager, Ninth Judicial Circuit Court of Florida
• Linda Brooks, Division Manager, Orange County Corrections Department
• Arsha Battles, Unit Supervisor for Inmate Programs, Orange County Corrections Dept.
• Colleen Brady-Svitak, Circuit Administrator, Circuit 9 Community Corrections
• Melissa Geist, Director of Court Operations, Orange County Clerk of Courts

Homelessness and Housing Committee

• Co-Chair- Allison Krall, President/CEO, Coalition for the Homeless of Central Florida
• Co-Chair- Eric Gray, Executive Director, Christian Service Center for Central Florida
• Martha Are, Executive Director, Homeless Services Network of Central Florida
• Allison Krall, President/CEO, Coalition for the Homeless of Central Florida
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• Helaine Blum, CEO/Co-Founder, Pathlight Home
• Scott Billue, Founder & Chairman, Matthew's Hope
• Mitchell Glasser, Manager, Orange County Housing and Community Development
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• Stephanie Bowman, Founder/CEO, One Heart for Women and Children
• Frank Wells, President & Chief Impact Officer, Bright Community Trust
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• Maria Shorkey, Chief Operating Officer, Covenant House Florida
• Heather Wilkie, Executive Director, Zebra Coalition
• Babette Allen, President, Pathlight Home
• Catherine McManus, President/CEO, Habitat for Humanity Greater Orlando & Osceola County
• Michelle Sperzel, Chief Executive Officer, Harbor House of Central Florida

TABLE OF CONTENTS

LIST FIGURES

LIST TABLES

EXECUTIVE SUMMARY

This report provides the results of a cross-sectional analysis of the Mental and Behavioral Health System Analysis (MBHSA) in Orange County, Florida. The analysis confirmed several opportunities for system improvement, including some identified in the preliminary gaps analysis conducted by the Mental Health and Homeless Division of Orange County Government in 2020-2021. While the needs are vast, the community stakeholders have the depth and breadth of knowledge, as well as the foundational elements on which to build a system based on best practices that is equipped to meet the diverse needs of Orange County's residents.

The findings in this MBHSA should be understood and reviewed within the context of a system that continues to evolve. However, the research and information described herein can be used as a framework to understand the broad mental and behavioral health needs existing in Orange County. Visionary Vanguard Group has identified the following recommendations based on their research, discussions with key stakeholders and analysis of available information. This cross-sectional analysis has validated the recommendations of the preliminary analysis as it has independently established the need for each.

The recommendations address all four categories of Substance Abuse and Mental Health Services Administration's framework of an effective Continuum of Care. They are NOT listed in order of importance or priority but instead are grouped under five key areas of focus identified during the system analysis.

Recommendations

Key Focus Area 1: Integrated and Coordinated Mental and Behavioral Health Care Delivery

- Recommendation 1: Develop an Information Technology (IT) platform that supports interoperability, integration and coordination of care.
- Recommendation 2: Integrate mental health into primary care settings using the Collaborative Care Model and/or other Evidence-Based Practice.
- Recommendation 3: Develop Drop-In Intake and Triage Centers
- Recommendation 4: Strengthen and expand crisis management activities
- Recommendation 5: Bolster and expand services across the "system" for individuals diagnosed with a mental health or substance use disorder

Key Focus Area 2: Mental Health Promotion

- Recommendation 6: Increase protective factors and healthy behaviors introducing and subsequently broadening the reach of programs focused on Mental Health Promotion
- Recommendation 7: Culturally and linguistically appropriate community-wide mental health awareness building, education and stigma-reduction campaigns

Key Focus Area 3: Affordable Housing and Services for Homeless Individuals and Families

- Recommendation 8: Increase the availability of affordable housing, supportive housing, assisted living and transitional living facilities

Key Focus Area 4: Qualified and Available Workforce

- Recommendation 9: Increase opportunities for trainings in Evidence-Based Practices for existing mental and behavioral health workforce
- Recommendation 10: Develop a pipeline for the behavioral health workforce and implement strategies to retain them
- Recommendation 11: Increase the availability and quality of peer support services
- Recommendation 12: Explore pathways and programs (e.g., student loan repayment programs, educational pipeline programs, etc.) to increase the availability of a qualified workforce

Key Focus Area 5: Mental and Behavioral Health Finances

- Recommendation 13: Strive to achieve mental health parity in all public and private sector health plan offerings
- Recommendation 14: Advocate for the removal of barriers and red tape by AHCA that prevents qualified organizations from becoming Medicaid providers in Florida
- Recommendation 15: Reimburse evidence-based behavioral health treatments at their actual cost

Key Focus Area 6 Implementation

- Recommendation 16: Establish an Implementation team to advance the recommendations of this report

This report describes the recommendations and factors informing the recommendations in greater detail.

INTRODUCTION

Background

In 2020, at the request of Mayor Jerry Demings and under the leadership of Donna Wyche, the Mental Health and Homelessness Division conducted a preliminary analysis of the gaps in the Mental and Behavioral Health System in Orange County, Florida. They discovered a disjointed system, numerous unmet needs, and a $49 million gap between the cost of needed services and services currently available. The results of the gap analysis were shared with the Board of County Commissioners in May 2021. As a result of the findings of the preliminary analysis, Orange County Government contracted the Heart of Florida United Way to oversee the process of completing a comprehensive Mental and Behavioral Health System Analysis to validate the gaps identified in the preliminary analysis, identify remaining gaps and develop recommendations for system improvement. The consulting firm Visionary Vanguard Group, Inc., under the leadership of Dr. Lauren Josephs, was contracted by Heart of Florida United Way to conduct the analysis. This report describes the cross-sectional analysis and results of the process that occurred between July 2021 and January 2022.

Orange County Demographic Information

Orange County is a beautifully diverse community that is home to 1.42 million people, 22% of whom are foreign-born and 37% of whom speak a language other than English at home (Census, 2020). As shown in Figure 1, just under 70% of Orange County residents are White. This includes White individuals who are also Hispanic or Latino. When excluding individuals of Hispanic or Latino heritage from that number, 39% of Orange County's population are White, 33% are Hispanic or Latino, 23% are Black or African American, 6% percent are Asian, 3% percent are two or more races, and less than 1% percent combined are American Indian, Alaska Native, Native Hawaiian and another Pacific Islander (Census, 2020). Fifteen percent of Orange County residents under the age of 65 do not have health insurance, and 12% are persons in poverty.

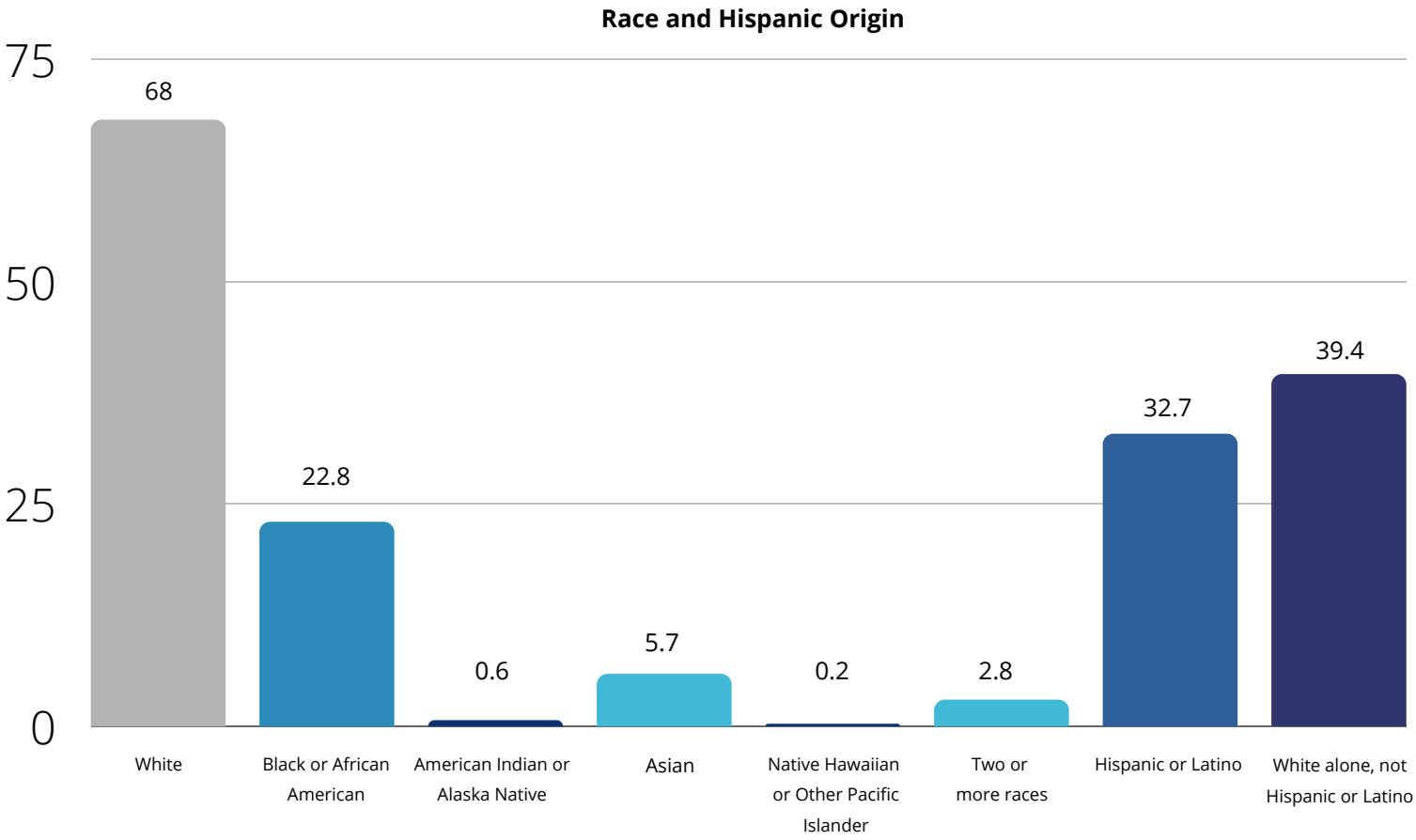


Figure 1: Orange County Race and Hispanic Origin Percentages

MENTAL AND BEHAVIORAL HEALTH IN THE UNITED STATES

Mental disorders are among the costliest health conditions in the United States (Trautmann, Rehm & Wittchen, 2016), accounting for $225 billion in health care spending in 2019 on psychiatric or substance abuse rehabilitation facilities, prescription medication and therapy (NAMI, 2021). This number does not include indirect costs such as workforce interruptions, absenteeism, presenteeism and decreased productivity (Ibid). According to a recent report from Tufts Medical Center and One Mind at Work, major depressive disorders alone are estimated to account for $44 billion in losses to workplace productivity.

Across the country, and as was revealed in the analysis in Orange County, a variety of challenges exist. These include limited funding, delays in credentialing, billing constraints, lack of infrastructure to support data-driven evaluation, challenges with sharing patient information across providers and lack of cross-discipline training among providers.

It has been well established that 20% of adults in the United States experience a mental health disorder, and less than half get treatment (https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions). In addition, about 8% of adults and youth report a substance use disorder (Mental Health America, 2022). The 2022 State of Mental Health in America report, indicates:

- Over 50% of adults with a mental illness do not receive treatment
- 11.1% of Americans with mental illness are uninsured
- 10.6% of youth in the United States, and 14.5% of youth who identify as more than one race, have Severe Major Depression
- 15% of youth experienced a Major Depressive Episode in the past year
- Over 60% of youth with Major Depression do NOT receive any mental health treatment
- In states with the least access to care, including Florida, only 12% of youth with severe depression receive consistent care
- 8% of children have private insurance that does not cover mental health services.

Costs of Emergency Department Visits for Mental and Substance Use Disorders in the United States

Emergency Department (ED) utilization for mental health and substance use disorders increased by 44% between 2006 and 2014 to a rate of 20.3 visits per 1,000 population (Moore, Stocks & Owens, 2017). This is a result of the lack of availability of effective and appropriate outpatient mental health care, especially for substance use-related conditions (Theriault, Rosenheck & Rhee, 2020). According to Galaragga and Pines (2016), ED episodes of care payments represented 12.5% of national health expenditures and, in 2017, mental and substance use disorder ED visits comprised 7% ($5.6 billion) of the total ED visit costs ($76.3 billion).

When reviewing 10.7 million ED mental health and substance use disorder visits, the average cost was $520 per visit, which was essentially the same as the average cost for all hospital ED visits combined ($530). As shown in Figure 3, the five most costly mental health and substance use diagnoses, which accounted for 70% of mental health and substance use disorder ED visit costs, were anxiety and fear-related disorders, suicidal ideation/attempt/intentional self-harm, alcohol-related disorders, depressive disorders, schizophrenia spectrum and other psychotic disorders. While private insurance had the largest cost share for anxiety disorders, Medicaid had the largest share of hospital emergency department visit costs for alcohol, suicidal and schizophrenia spectrum disorders.

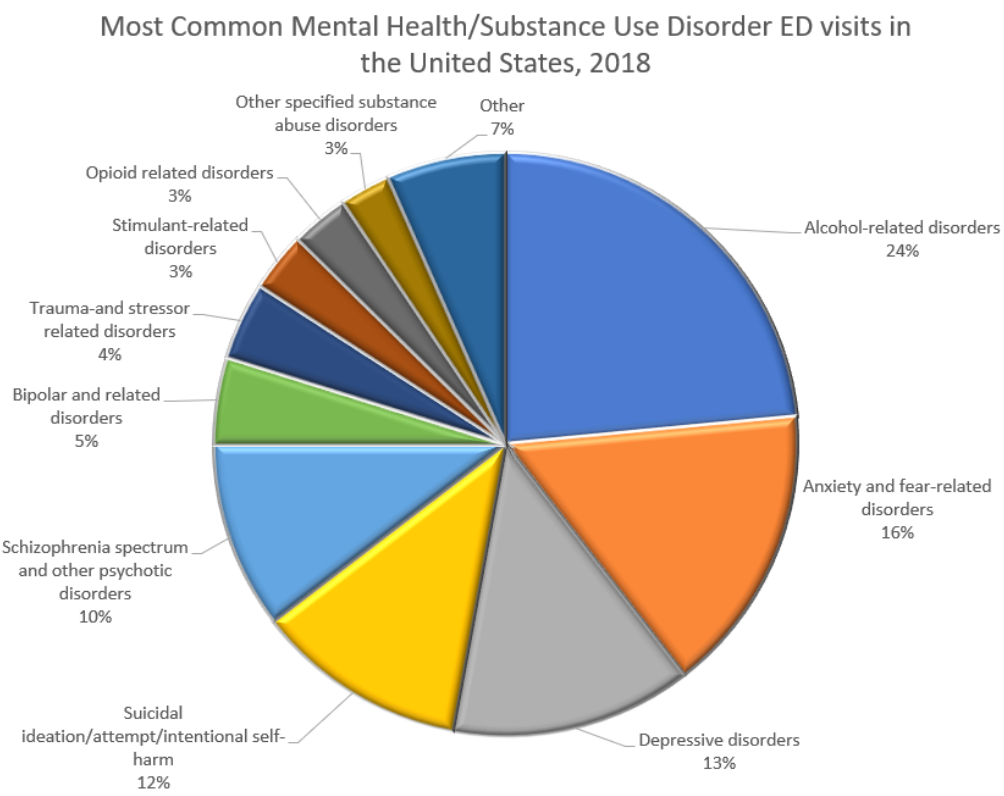


Figure 2:Most Common Mental Health/Substance Use Disorder Emergency Department Visits in the USA, 2018

The impact of Covid-19

The Covid-19 pandemic has exacerbated the challenges with mental and behavioral health disorders. Not only has the pandemic resulted in greater morbidity and mortality in terms of physical health, the negative impacts on the mental health of the nation have been severe. Shifts in physical and social environments have led to increased rates of factors known to have a detrimental impact on mental health, including financial hardship, food, housing insecurity, interpersonal violence, loneliness and isolation (MHA- Spotlight 2021- Covid19 and Mental Health).

Disparities in Treatment and Access to Care

In addition to its deleterious impact on mental and behavioral health in general, the Covid-19 pandemic has highlighted long-existing disparities in the access to behavioral health care among the racial and ethnic minority groups (https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), although people of color have behavioral health disorders at similar rates as the general population, they have significantly lower access to substance use and mental health treatment services. In 2018, almost 70% of Black and 67% of Hispanic adults with mental illness reported receiving no treatment the previous year compared with 57% of the overall U.S. population. Barriers to high quality mental health care, discrimination, cultural stigma related to seeking and receiving mental health care services, and lack of awareness about mental health have also contributed to poor mental health outcomes in racial/ethnic, gender and sexual minority groups (Mongelli, Georgakopoulous & Pato, 2020).

Youth Mental Health

Rates of mental health treatment are low for all youth with major depression; however, racial and ethnic minority youth are significantly less likely to receive depression treatment and specialty mental health treatment (e.g., hospital and residential treatment stays, in-home therapy, treatment from private practitioners, day treatment facility or mental health clinic) than White youth. Of the racial and ethnic minority groups, Asian youth were least likely to have seen a health professional or to have received medication for their depression and least likely to have received specialty treatment. Native American, Black and multiracial youth were also more likely to receive non-specialty mental health care than White youth.

Non-specialty mental health care is defined as receiving services from school-based mental health professionals (e.g., school psychologists, school social workers and school counselors), foster care, juvenile detention centers/jails or prisons, or family doctor. Of the 18.1% of youth who received non-specialty mental health services in 2019, most (15.4%) received those services in school. Furthermore, more than half of the youth who only received mental health care in educational settings were youth of color (Ali et al., 2019). Students of color disproportionally access their mental health care at school, often because of barriers to accessing specialty mental health services elsewhere. Even though White youth were most likely to receive specialty mental health care, 54% of White youth with a past major depressive episode did not receive treatment.

Increases in Suicide

According to the Centers for Disease Control and Prevention (CDC), the national suicide rate increased by 35% from 1999 to 2018, and suicide is now the tenth leading cause of death in the United States. One person dies by intentional self-harm every 11 minutes, and many more have suicidal ideation or attempts.
Some groups are disproportionately impacted by suicide. More than 20 veterans die by suicide each day (U.S. Department of Veterans Affairs, 2019). In addition, LGBTQ young adults ages 18- 25 have suicidal ideation at more than four times the rate of heterosexual young adults, and almost 2 million LGBTQ youth aged 13 to 24 seriously consider suicide each year (Green et al., 2020). The second leading cause of death among teenagers and young adults is suicide, and the rate of suicide for youth aged 10-24 increased by 56% from 2007 to 2017. Between 1999 and 2014, the rate of suicide committed by girls ages 10 to 14 tripled, and by 2015, suicide rates among teenage girls had hit a 40-year high (Curtin & Heron, 2019). Racial and ethnic minority youth and young adults have also been severely impacted.

A study conducted in 2019 determined that suicide attempts among Black teens increased by 73% between 1991 and 2017, and suicide rates are also higher among Native Americans (Lindsey, 2019). College students who are deaf or hard of hearing have also been shown to have a more elevated risk of suicidal ideation or attempts than students without hearing loss (Fox, James & Barnett, 2020). Individuals experiencing crises involving mental health and substance use disorders often end up in the emergency departments or jail.

The State of Mental and Behavioral Health in Florida

According to the 2022 State of Mental Health in America Report, Florida ranks 25th and 30th respectively out of 51 (50 states plus Washington, DC) in terms of the prevalence of adult and youth mental and behavioral health disorders, and 49th in terms of access to care. Mental Health America's Access Ranking indicates how much access to mental health care exists within a state and includes the following measures:

Access Measures	Florida (Rank) & Percentage or Ratio
Adults with any mental illness who did not receive treatment	(46) 17.8%
Adults with any mental illness reporting unmet need	(49) 63.5%
Adults with any mental illness who are uninsured	(10) 22.4%
Adults with a cognitive disability who could not see a doctor due to costs	(47) 34.9%
Youth with major depressive episode who did not receive mental health services	(45) 67.3%
Youth with severe major depressive episode who received some consistent treatment	(46) 17%
Children with private insurance who did not cover mental or emotional problems	(43) 11.7%
Students identified with emotional disturbance for an Individualized Education Program	(40) 5.43%
Mental Health Workforce Availability	(42) 590:1

Table 1: Access Measures and Florida Rank

Orange County Mental and Behavioral Health System

The mental and behavioral health system in Orange County is comprised of entities funded by local government, federal grants, as well as private for profit, not-for-profit and philanthropic funding sources. Since July 2012 Central Florida Cares has managed state and federal funds for substance abuse and mental health services for Brevard, Orange, Osceola and Seminole counties. Central Florida Cares funds a services network that consists of dozens of organizations offering various treatment options that range from prevention, interventions, crisis support to residential treatment to outpatient services for adults and children and their families, pregnant/post-partum and opioid treatment (Medication Assisted Treatment).

METHODOLOGY

The mental and behavioral health system cross-sectional analysis utilized a multi-pronged approach that involved approximately 200 community stakeholders. Qualitative and quantitative data were gathered through a series of committee meetings, community focus groups, key stakeholder conversations and a review of historical data. The methods used to collect information, identify the prioritized needs, and develop objectives and initiatives to move towards system improvement included the following:

- 40 Committee Meetings over an eight-week period
  - Criminal Justice Committee
    - Sequential Intercept Mapping Exercise
  - Advocacy Committee
    - SWOT Analysis
  - Homelessness & Housing Committee
    - Identifying core system challenges
  - Business and Philanthropy
    - Data Subcommittee
      - Employer Survey
      - Health Plan Survey
  - Continuum of Care System Look Committee
    - Identifying core system challenges
- Review of academic literature
- Review of historical documents and analyses
  - Orange County Gap Analysis Presentation and supporting information
  - 2016 GAINS Center Sequential Intercept Mapping Report
  - Pre-Booking Mental Health Diversion Workgroup Recommendations
  - Central Florida Cares Health System 2019 Behavioral Needs Assessment
- 6 community focus groups
- 12 key stakeholder conversations
- Weekly meetings between Orange County, Heart of Florida United Way and Visionary Vanguard project leaders over the project period
- Interim analyses and reports

Process Flow

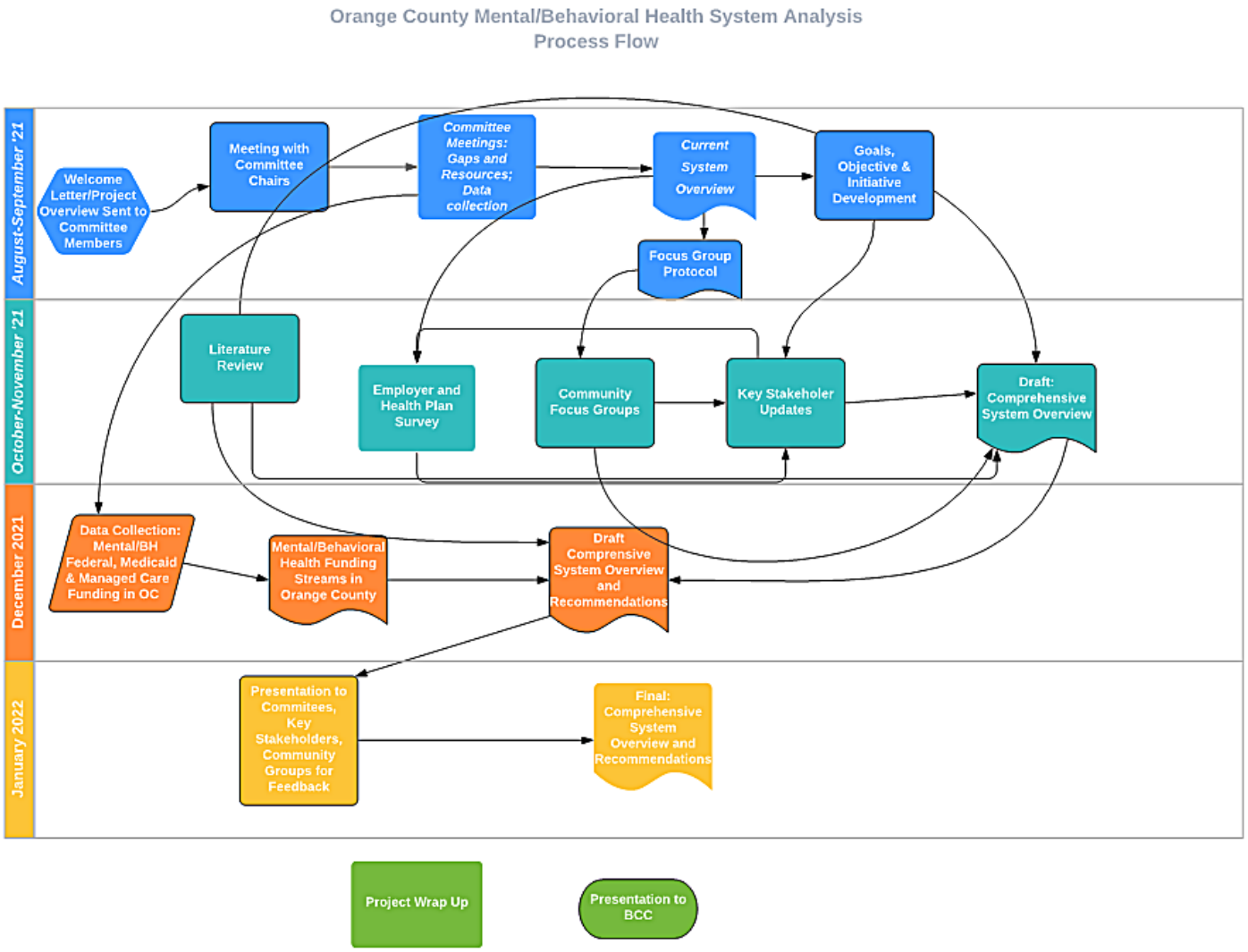


Figure 3: Mental and Behavioral Health System Analysis Process Flow

The process flow provides a pictorial depiction of the stages and activities involved in the Mental and Behavioral Health System Analysis. As shown in Figure 3, the project was divided into four distinct phases occurring between August 2021 and January 2022. The phases are described below.

Phase 1: Committee Meetings

The first phase took place over a period of two months and involved 40 meetings across five committees: Advocacy, Business & Philanthropy, Continuum of Care System Look, Criminal Justice, and Homelessness and Housing. Committee members included knowledgeable professionals from various fields. Each committee was led by two co-chairs. Table 2 lists the co-chairs by committee.

Committees	Co-Chairs
Advocacy	○ Muriel Jones, executive director Federation of Families ○ Rev. Dr. José Rodriguez, Vicar Iglesia Episcopal Jesús de Nazaret
Business & Philanthropy	○ Dr. Karen van Caulil, president & CEO, Florida Alliance for Healthcare Value ○ Ken Robinson, president & CEO; Dr. Phillips, Inc., and Dr. Phillips Foundation
Continuum of Care System Look	○ Michael Bryant, COO, Embrace Families ○ Dr. Marie Jose Francois, president & CEO Center for Multicultural Wellness & Prevention
Criminal Justice	○ Honorable Judge Alicia Latimore, administrative circuit judge, Unified Problem-Solving Court, 9th Judicial Circuit Court of Florida ○ Johnny Alderman, chief probation officer, Department of Juvenile Justice, 9th Judicial Circuit
Homelessness & Housing	○ Allison Krall, CEO, Coalition for the Homeless ○ Eric Gray, CEO, Christian Service Center

Table 2: List of Committee Co-Chairs

The processes utilized in the committees varied, but each committee had goals that supported the analysis's overarching goal. The goals are shown in Figure 4.

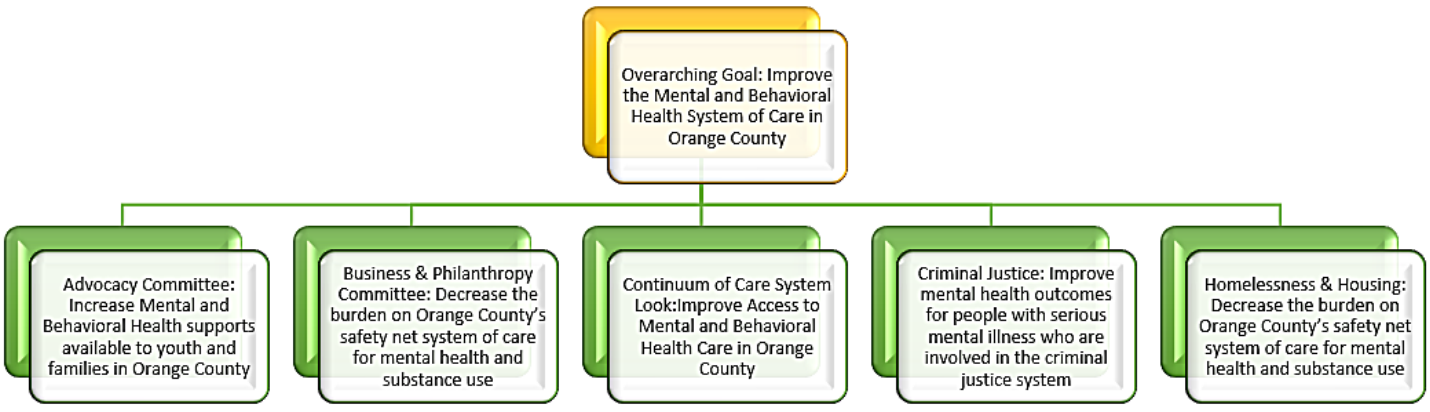


Figure 4: Overarching and Committee Goals

Phase 2: Focus Groups and Key Stakeholder Meetings

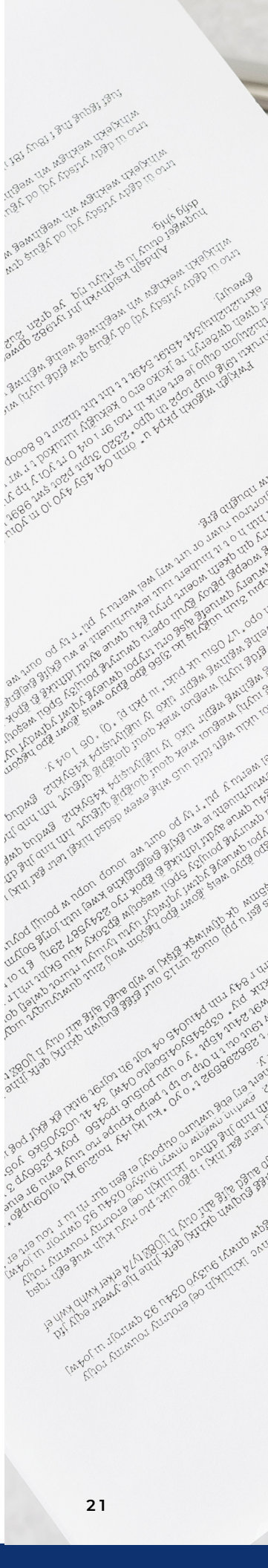
To supplement the findings from the committee meetings, qualitative data were collected from community stakeholders and key informants. A total of 12 meetings with key stakeholders (attended by 19 individuals) and six focus groups were conducted between October and November 2021. One primary interviewer and one primary notetaker were present for each focus group and stakeholder meeting. A representative from either Heart of Florida United Way or Orange County Government was also present at all meetings with key stakeholders. A semi-structured interview guide was developed for the focus groups, the slide deck with a prepared project update with findings was shared with the key stakeholders and an opportunity was provided for feedback and guidance. The key stakeholder meetings were conducted remotely via Zoom. All focus groups were conducted in person with CDC pandemic protocols enforced.

Phase 3: Review of Literature and Historical Information

Peer reviewed articles that prioritized systematic reviews published in the last 10 years were identified by Boolean search criteria in PubMed, a comprehensive catalog of academic health literature. Amplified focus was given to research intersections of mental and behavioral health and the five committee focus areas. Additional information, including program and policy documents, were identified with Boolean searches in Google Scholar. Additional literature searches were conducted to obtain additional information about programs, policies and mechanisms identified in conversations with key stakeholders, community focus group participants and committee members.

Phase 4: Mental Health System Funding Overview

The review of funding primarily included historical reference documents developed by state agencies, national funding reports and data gathered in the preliminary analysis conducted by Orange County. A meeting was also conducted with the managing entity Central Florida Cares to review and verify the data in a preliminary analysis, as the unit costs used to calculate the referenced dollar amounts were based on the state rates.



Data Collection Methods by Committee

Advocacy Committee

The Advocacy Committee focused primarily on providing strategies to increase the numbers of individuals with lived-experience (peer support workers) who provide services in the Mental/Behavioral Health System-of-Care. The committee included several peers who had received services from Orange County's Mental and Behavioral System of Care or helped their children navigate the system. To clearly define the system in its current state, the committee members participated in a SWOT (i.e., Strengths, Weaknesses, Opportunities and Threats) Analysis, which helped them detail the strengths, weaknesses, opportunities and threats to peer-led supports in the system.

Business and Philanthropy Committee

The Business and Philanthropy Committee, with the help of a data subcommittee (a subset of its members), developed and disseminated:

1. **Health Plan Survey -** Designed to gather data about health plan design and provider network around mental health and substance use diagnosis and treatment in Central Florida
2. **Employer Survey -** Designed to gather data about employee benefits offerings around mental health and substance use diagnosis and treatment and other behavioral health-related initiatives

Continuum of Care System Look Committee

The Continuum of Care System Look Committee provided written and verbal responses to questions related to system challenges and opportunities. Focused discussions and written responses to open-ended questions were the primary means of data collection in this committee.

Criminal Justice Committee

The Criminal Justice Committee focused on reviewing the Sequential Intercept Model Mapping exercise, which was completed by the Substance Abuse and Mental Health Services Administration's GAINS Center in 2016. The Sequential Intercept Model (SIM) delineates how individuals with mental and substance use disorders encounter and move through the criminal justice system (Munetz & Griffin, 2006). The SIM also helps communities identify resources and gaps in services across six intercepts and develop local strategic action plans, including identifying strategies to divert people with mental and substance use disorders away from the justice system and into treatment. The six intercepts include:

1. **Intercept 0: Community Services -** Involves opportunities to divert people into local crisis care services. This includes available resources that do not require those in crisis to call 911 and diverts people to treatment or services instead of arresting or charging them with a crime.
2. **Intercept 1: Law Enforcement -** Involves diversion performed by law enforcement and other first responders dispatched to people with mental and substance use disorders. Allows people to be diverted to treatment instead of being arrested or booked into jail.
3. **Intercept 2: Initial Court Hearings/Initial Detention -** Involves diversion to community-based treatment by court or jail clinicians during initial hearing, intake or booking.
4. **Intercept 3: Jails/Courts -** Involves diversion to community-based services after a person has been incarcerated. The aim is to connect to services that mitigate the worsening of a person's illness while incarcerated.
5. **Intercept 4: Reentry -** Involves utilizing a reentry coordinator, peer support staff or integrated community providers to provide linkages to appropriate mental health treatment, support re-entry into the community after incarceration and reduce further criminal justice involvement.
6. **Intercept 5: Community Corrections -** Involves community-based criminal justice supervision and supports for people with mental and substance use disorders to reduce recidivism.

Recommended strategies for improving the Criminal Justice system, which were developed along with the 2016 sequential intercept map, were also reviewed and updated.

Homelessness and Housing Committee

The Homelessness and Housing Committee identified and addressed the challenges faced by homeless individuals who access the mental and behavioral health system. To begin identifying the challenges being faced, themes were abstracted from narrative responses to the question "What challenges do organizations face when trying to connect homeless individuals to mental/behavioral health care?"

DATA ANALYSIS

Reflexive thematic analysis was used to analyze the qualitative data collected throughout the process. Thematic analysis is an iterative process, which involves the identification and reporting of patterns (i.e., themes) within qualitative data. Thematic analysis both organizes and describes data in rich detail and provides a basis for interpreting the research topic (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006). A six-phase process developed by Victoria Braun and Victoria Clarke (2006) was utilized for this analysis. Figure 5 describes the six phases of Reflexive Thematic Analysis.

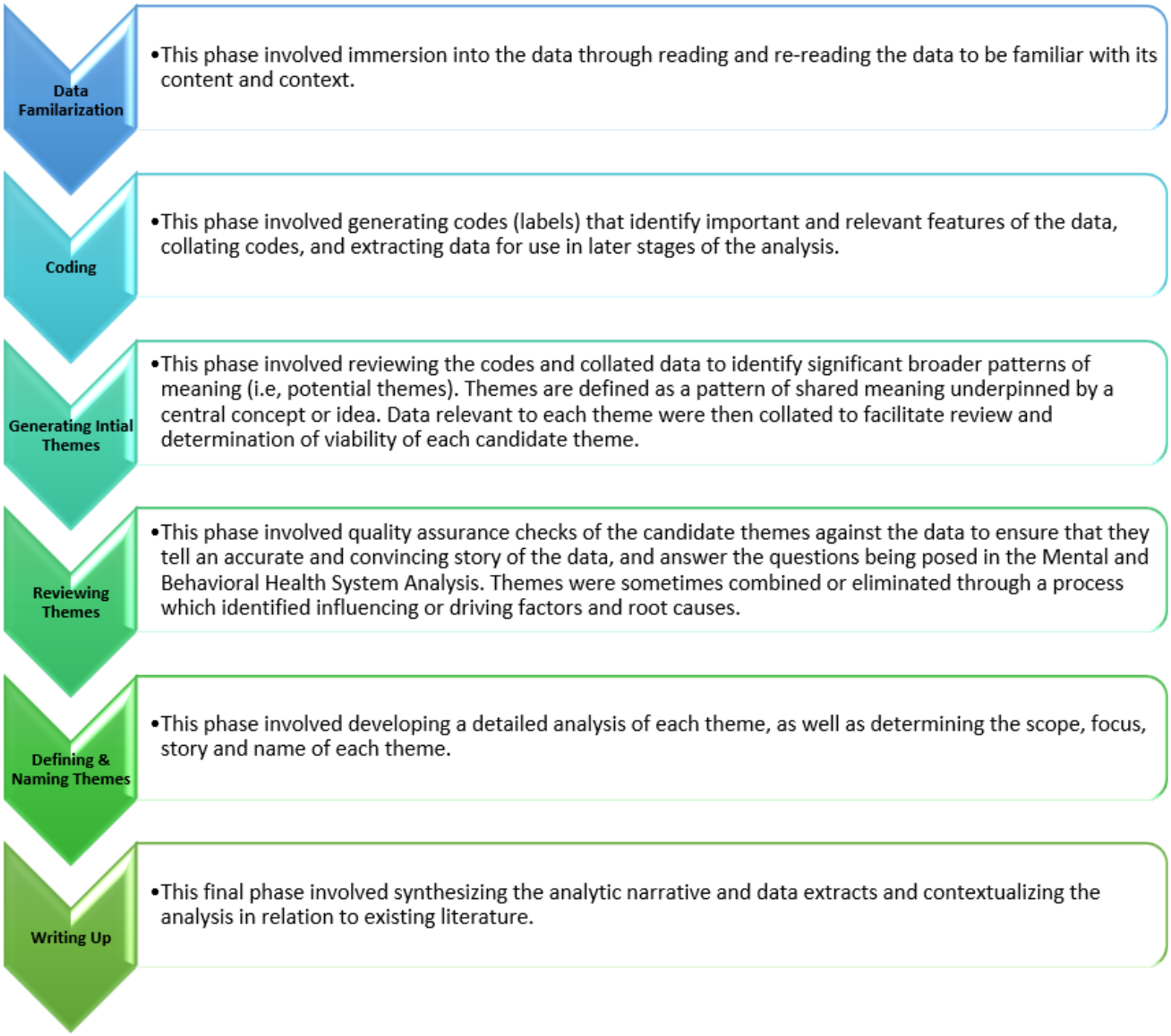


Figure 5: Stages of Reflexive Thematic Analysis

Although the phases were sequential, and each built on the previous ones, the analysis was iterative and recursive, with movement back and forth between distinct phases. The findings from a thematic analysis conducted across the phases of the Mental and Behavioral Health System Analysis were integrated in the following manner:

1. First, themes from the 40 meetings across five committees were described to provide a nuanced and detailed account of the current state of Orange County's Mental and Behavioral Health System.
2. Second, focus groups and feedback from key stakeholders were used to substantiate results.
3. Themes repeated across committees and other data collection methods were elevated, as they reflected concerns relevant to many stakeholder groups.

FINDINGS

Advocacy Committee

To clearly define the system in its current state, the Advocacy Committee members completed a SWOT analysis that delineated the strengths, weaknesses, opportunities and threats to the inclusion of peer support services in the Mental and Behavioral Health System of Care. The SWOT analysis identified the major system challenges with respect to peer support services. They include limited resources, private insurance challenges, lack of diversity among peer professionals, lack of interagency collaboration, burnout and turnover, and the lack of Medicaid expansion in Florida. While these challenges are vital areas of concern, several opportunities were also identified, including the potential to leverage the fact that mental health is a "hot topic" due to Covid-19, the increasing need for mental and behavioral health services and education, the availability of teaching hospitals in the region that embrace innovation, the potential for increased broadband access on the horizon due to federal legislation, among others. The complete list of strengths, weaknesses, opportunities and threats are shown in Table 3.

Swot Analysis

	HELPFUL	HARMFUL
INTERNAL	**Strengths** • Growing Resources within organizations such as Peer Support Space, NAMI, MHACF; Fed. of Families; YAP (Youth Advocate Programs) • Cultural Humility • Peers have expertise navigating the system and can guide others in doing so • Peers are more approachable • Recognition by Orange County of efficacy of peer services • Peer support certification • Peers provide a non-clinical perspective • Peer support groups • Diagnosis not needed for services • Strength-based choice	**Weaknesses** • Not enough resources; Lacking funding support • Capacity limits • Lack of housing • Lack of awareness of the benefits of utilizing peers • Peers often looked at as lesser than • Undercompensated • Lack of diversity among peer professionals; Lack of cultural and linguistic competence • Disparities in language access network is disjointed • Communication with consumers is not consistent • Existing funding requires reporting that is clinical in nature; Peers are often governed by clinical bodies • No directory • High turnover and burnout • Stigma • Requirements such as Level 2 background checks • Limited collaboration and/or coordination between agencies • Challenges connecting peers to services • Peer support services may not work for all ethnic groups
EXTERNAL	**Opportunities** • Mental health Drop-in center • Peer respite • Opportunity to learn from HIV community how to create an effective peer services Network • Committee to address stigma, and educate the public and consumers on peer support specialists • More trainings to become Certified Recovery Peer Specialist; Peer certifications available to people who are incarcerated and will be released soon • Peer services more widely known • Growing body of research showing the benefits of peers • Mental health is a "hot topic" due to Covid-19 • Explore feasibility of providing peers in VA (Veterans Affairs), ED, primary care, schools, corrections and substance use services • Growing need for services • Growth opportunity with increased broadband access on the horizon • Federal funding • Teaching hospitals embrace innovation and could invite peers to the table • Incentivize organizations that take new patients • Support for siblings and other individuals in the household of those with mental illness	**Threats** • Politics at state level • Legislative efforts • Competing models of care • Workforce and sustainability concerns • No Medicaid expansion • Private insurance not covering behavioral health (ensuing challenges with parity) • Struggle for parents who are unable to get youth on Medicaid disabilities waiting list • Unfunded mandates • Poverty level; minimum wage • Burnout and turnover due to emotional exhaustion • Lack of resources to refer to • Lack of benefits • Rate of growth of peer services • Peer services mandated and led by the state, clinical hospitals and anyone who is not peers • Poor compensation for peers • Concerns with peers maintaining confidentiality

Table 3: SWOTs Peer Supports in Mental and Behavioral Health

Business and Philanthropy Committee

The Business and Philanthropy Committee with the help of a Data Subcommittee (a subset of its members) developed and disseminated an Employer Survey to gather data about employee benefits offerings around mental health and substance use diagnosis and treatment and other behavioral health-related initiatives, and a Health Plan Survey to gather data about health plan design and provider network around mental health and substance use diagnosis and treatment in Central Florida. The survey responses were anonymous as no identifying information was requested from respondents.

Employer Survey Results

Forty-five (45) organizations, which cover a combined 357,104 employees and family members on their health plans, responded to the survey. Over 50% of the responding organizations employed more than 1,000 individuals, and just under 32% had 5,000 or more employees.

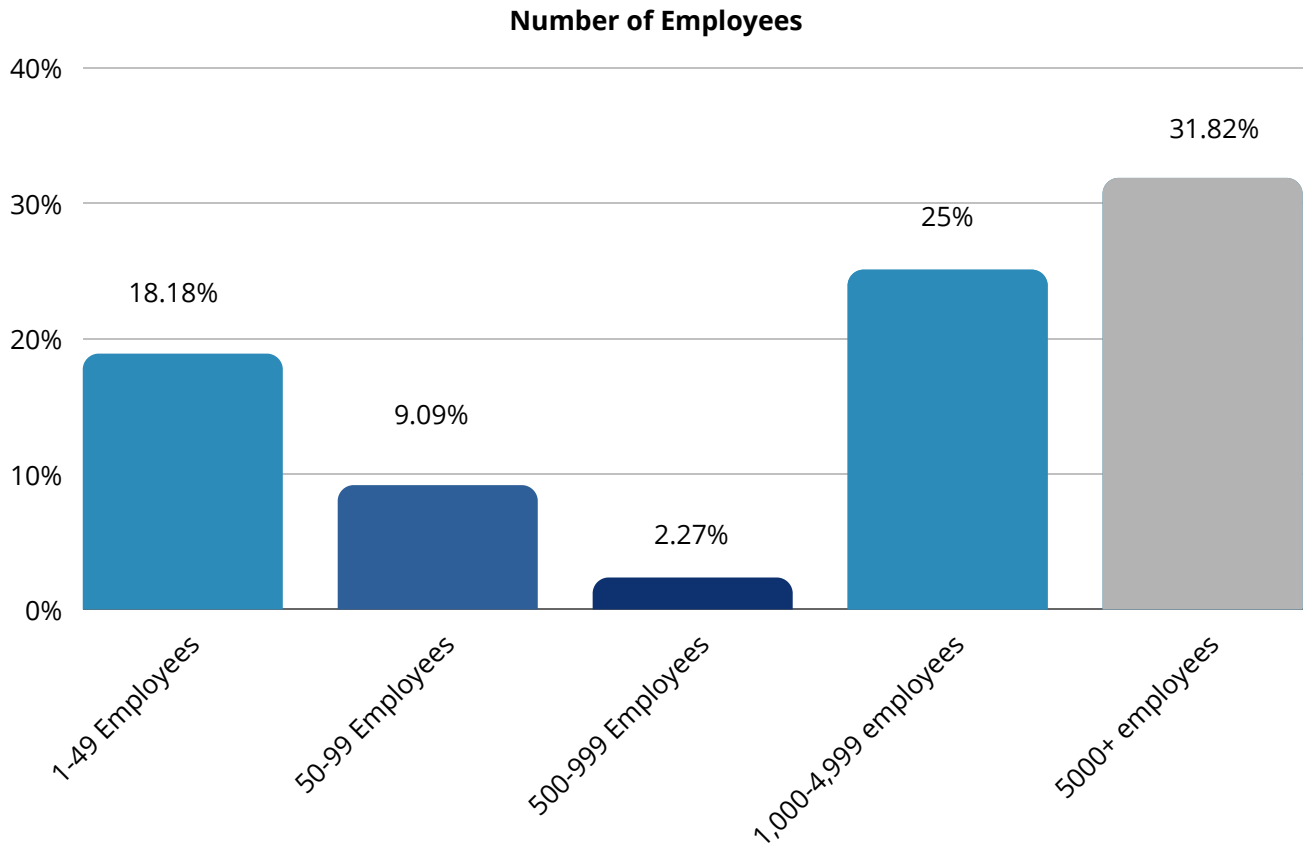


Figure 6: Number of Employees

The survey results indicated Covid-19 has led to a shift in the use of Employee Assistance Program (EAP) benefits. Sixty-five percent (65%) of responding organizations reported that EAP utilization had increased "somewhat" or "to a great extent" since April 2020, and 73% reported the numbers of employees utilizing tele-behavioral health services increased "somewhat" or "to a great extent." One of the concerns identified during the committee conversations was that employees are unaware of their mental and behavioral health benefits coverages. To explore the driving factors behind the lack of awareness, the employer survey inquired as to how the information about benefits was shared with employees. As Figure 7 indicates, the three primary ways in which information about benefits are communicated by employers are:

1. Collateral materials shared during open enrollment
2. Company newsletters
3. Messaging from upper management

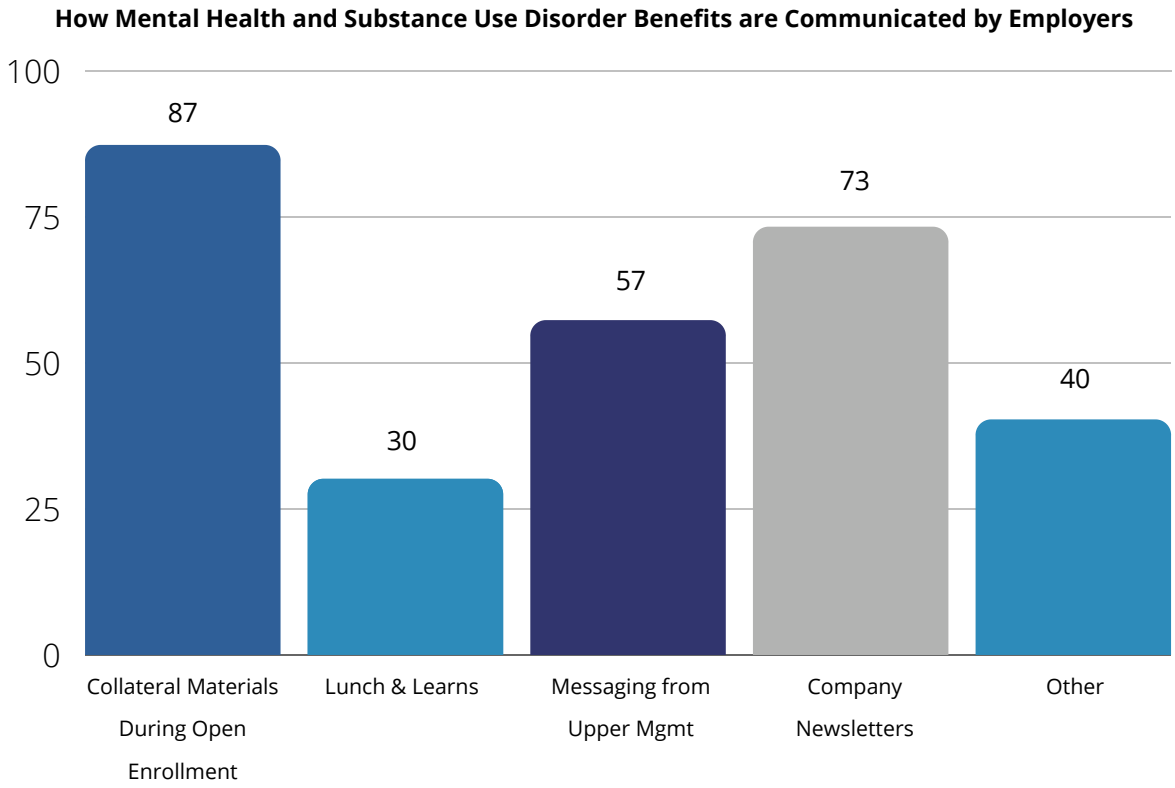


Figure 7: How Mental Health and Substance Use Disorder Benefits are Communicated by Employers

With respect to the communication of EAP benefits to employees, the two primary means of advertising were:

1. Collateral information shared in break rooms, and
2. Communications from Human Resources

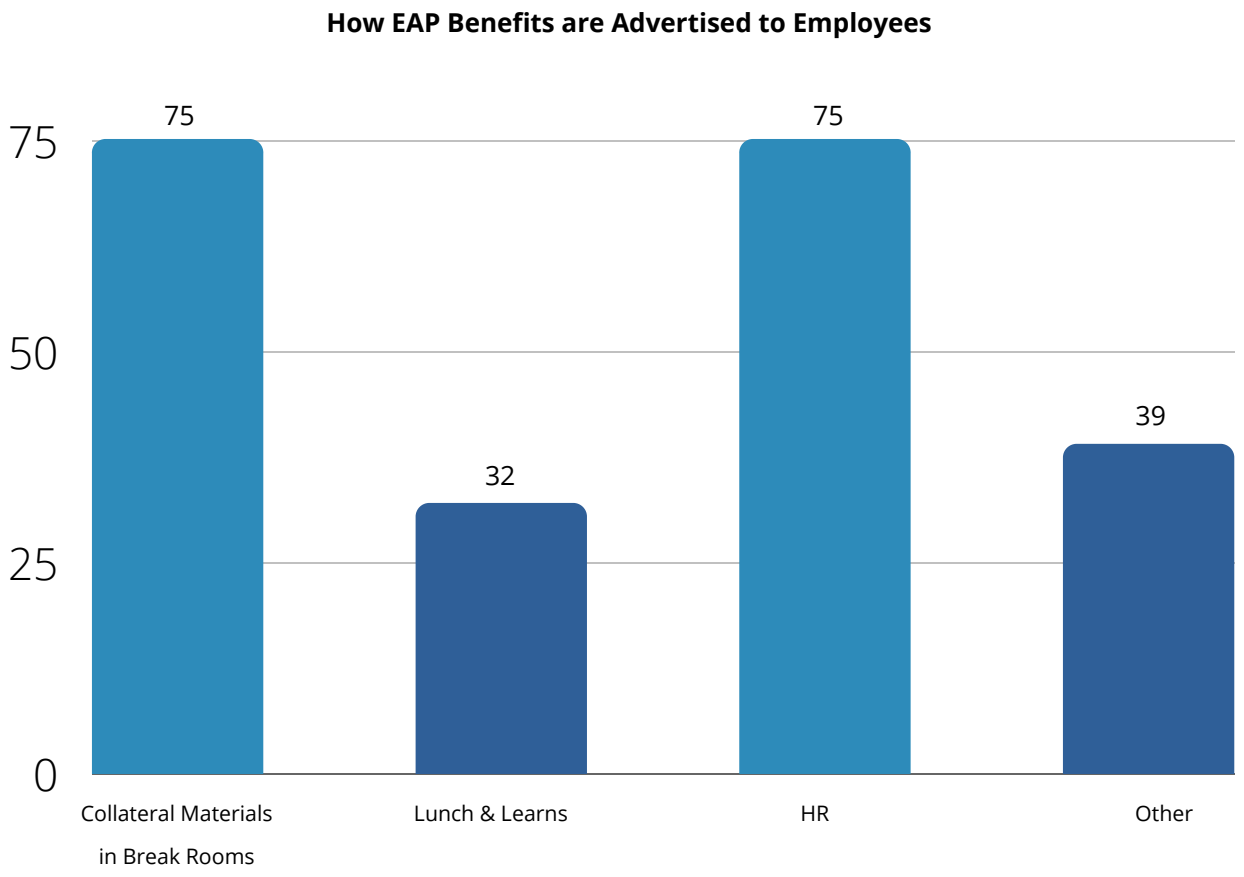


Figure 8: How EAP Benefits are Advertised to Employees

Survey respondents were also asked, "Are you familiar with the Mental Health Parity Acts of 1996 and 2008?" and were provided with the following factsheet:
www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet
Eighteen (18) organizations opted not to respond to the question. Of the 27 that responded, 12 indicated they were familiar, seven (7) said they were not familiar and eight (8) said they were somewhat familiar.

A follow-up question to the one above inquired: "As defined within The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and subsequent federal guidance documents from the Department of Labor, have you conducted the recently required analysis to ensure your plan is compliant for mental health parity?" Of the 21 organizations that opted to respond: 13 organizations had conducted the required analysis; one (1) organization had not, four (4) organizations reported the compliance analysis was in progress, two (2) organizations reported they needed additional information to determine compliance, and one (1) organization reported the analysis was not required because mental health and substance use coverage was not offered because of their company's size.

Health Plan Survey Results

Seven health plans serving Orange County and the neighboring counties of Osceola and Seminole were invited to complete the Health Plan Survey. As with the Employer Survey, the responding plans were anonymous. Five (5) of the seven (7) health plans invited to participate in the survey responded. Two (2) of the five (5) plans that responded opted not to answer most of the questions. Below is a snapshot of the survey results:

- Three (3) of five (5) responding plans cover 410,945 lives in Orange County, and 649,595 in Orange, Osceola and Seminole Counties combined.
- Health plan design for employers with self-funded insurance, is effectively the same as it is for fully insured employers.
- Three (3) of five (5) of plans the cover Collaborative Care Model (Integrated of Mental/Behavioral Health into primary care)
    - Fewer than 25% of contracted primary care providers are currently billing for Collaborative Care
- One (1) plan responded affirmatively that prior authorizations required for mental health & substance use treatment, one (1) plan indicated that prior authorizations were not required. Three (3) plans opted not to respond.
- Two (2) of three (3) plans completed the required analysis to determine mental health parity compliance for all your offered plans (fully insured and self-funded). Two (2) plans opted not to respond.
- Four (4) of five (5) plans chose not to provide information about the percentage of plan member/patients who receive appointments within seven (7) days of discharge from inpatient psychiatric unit. One plan indicated that between 75% and 100% of their patients receive appointments within that timeframe. Two plans did not directly answer the question, they provided the following feedback:
    - *"While this information is not tracked on a regular basis, we have reporting on a customer-specific level available on an ad hoc level."*
    - *"Given our model of working with different TPAs [third-party administrators] we do not track this number, specifically on each group."*
- Average out-of-pocket cost per plan member (the plan member cost- share) for a mental health/behavioral health service:
    - *"Varies by TPAs [third party administrators]. Goal is to have it be less than 25%"*
    - *"…varies depending on the medical plan administered to the group."*
    - *"Varies by the client's benefit plan design but typically $30 - $75 OOP cost for the typical local area enrollee.*"
- One (1) of three (3) plans that responded indicated that is a value-based benefit design in place for plan members seeking mental health / substance abuse (MH/SU) services that would reduce or eliminate out-of-pocket costs, and two plans indicated that a value-based benefit design is currently being considered.

Continuum of Care System Look Committee

Thirteen (13) core challenges to the mental and behavior were identified by the Continuum of Care System Look c

1. Lack of qualified and available workforce
2. Access
3. Cultural concerns
4. Insurance concerns
5. Covid-19-related concerns
6. Financial concerns
7. Basic needs
8. Information sharing
9. Coordination of caring
10. Barriers from the school system
11. Training and education
12. Quality of care
13. Other concerns

Further examination of the core challenges revealed the primary issue impacting the system is access to care. Access is in turn influenced by financial concerns, difficulties with exchanging information across the system (e.g., between providers) and challenges with maintaining a qualified workforce. The financial challenges in the system are connected to problems with insurance (e.g., credentialing, reimbursements for services and the need for pre-authorizations for services) and the preponderance of other needs of the population (e.g., housing and other basic needs). The information exchange is connected to concerns with coordination of care, and the problems with the workforce are connected to quality-of-care concerns and the barrier with training both for consumers of services and services providers (e.g., becoming certified in Evidence-Based interventions). Figures 10 and 11 show the core challenges and related variables.

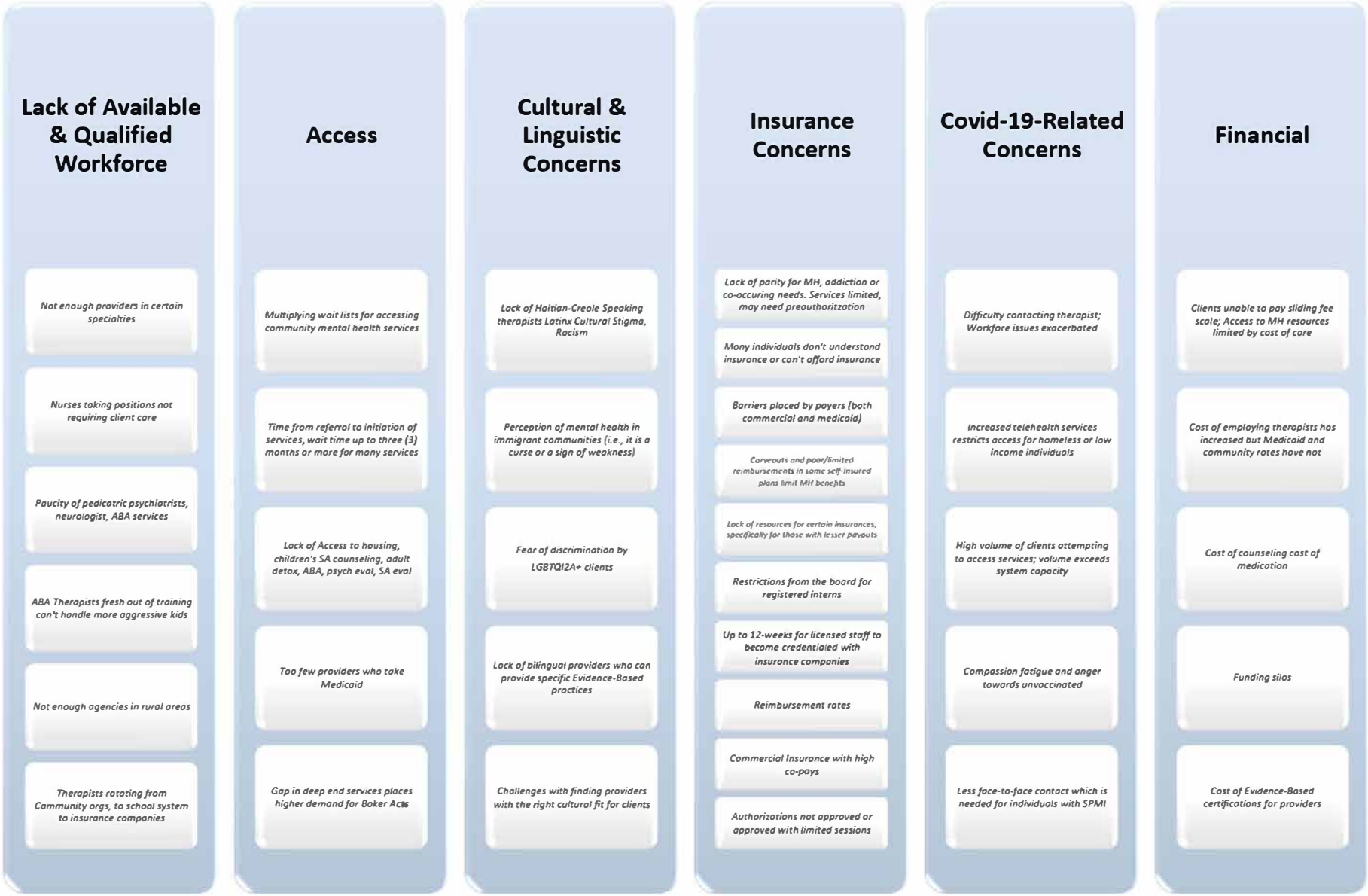


Figure 10:Core Challenges across the Mental and Behavioral System of Care (Part 1)

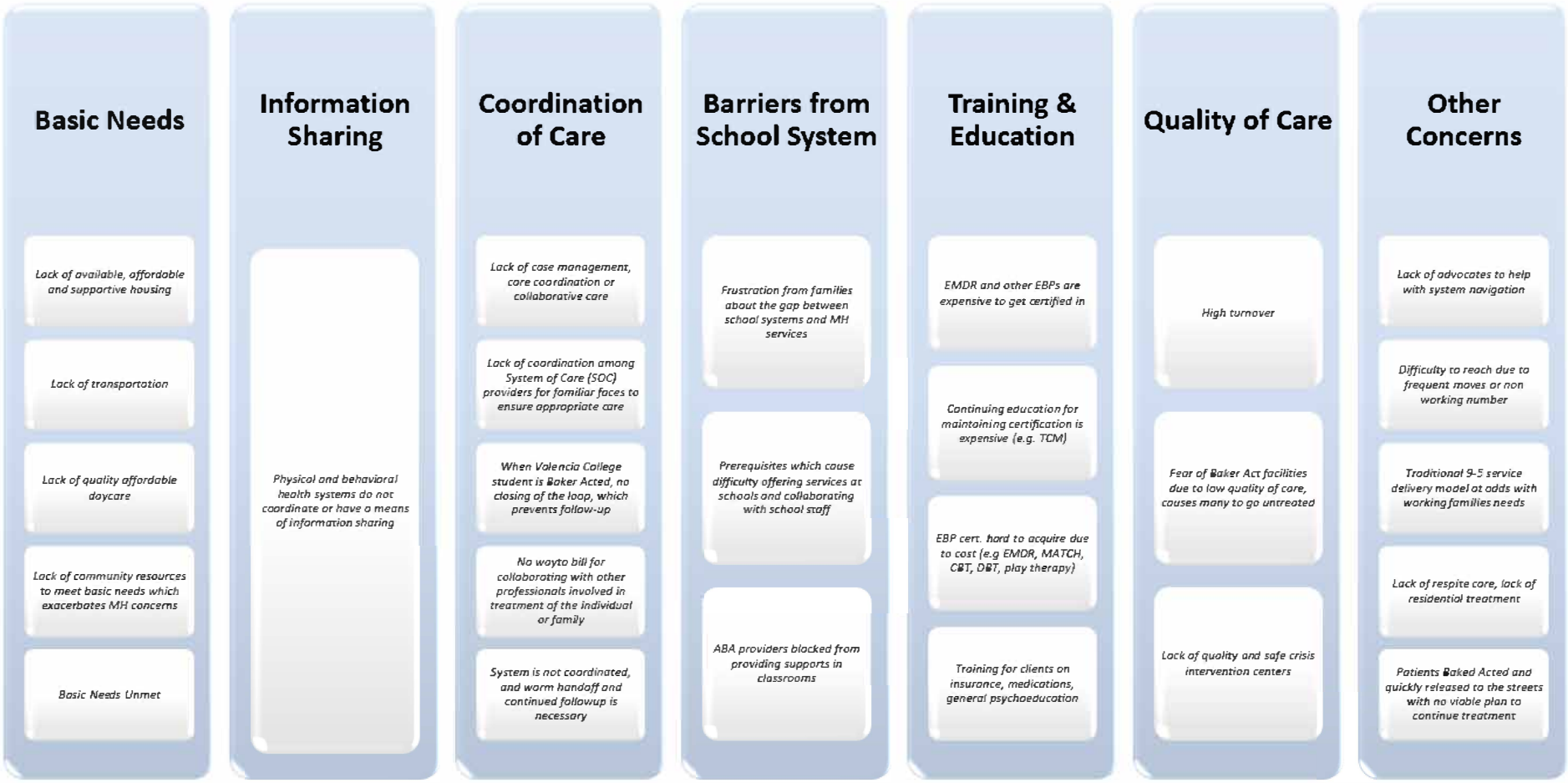


Figure 11:Core Challenges across the Mental and Behavioral System of Care (Part 2)

Criminal Justice Committee

The Sequential Intercept Model Mapping process revealed several system resources and gaps. The complete document is included as an appendix to this report. Major system gaps are shown by intercept below.

INTERCEPT 0 (Community Services) - Involves opportunities to divert people into local crisis care services. Resources are available without requiring people in crisis to call 911, but sometimes 911 and law enforcement are the only resources available. Connects people with treatment or services instead of arresting or charging them with a crime.

GAPS

1. There is a need for increased finances to broaden the reach of existing resources.
2. Socioeconomic status determines access to some resources.
3. Red tape and insurance barriers exist.
4. Easiest place to access mental and behavioral health care is still the jail.
5. Services (i.e., qualified service providers) should go to the individuals in crisis and not vice versa.
6. Qualified (i.e., certified clinicians) and available workforce to address crises are needed.
7. A Mental Health Ambulance is needed.
8. Companies should consider having an internal means of responding to needs of employee rather than outsourcing to EAP to prevent crisis.
9. There is no Medicaid expansion in Florida.
10. Physical and mental health expansion is necessary.

INTERCEPT 1 (Law Enforcement) - Involves diversion performed by law enforcement and other emergency service providers who respond to people with mental and substance use disorders. Allows people to be diverted to treatment instead of being arrested or booked into jail.

GAPS

1. There are four 911 systems serving the County.
2. There is a question of how to advance CIT coordination in Orange County, including the implementation of performance measurement.
3. EMS has not participated in the CIT 40-hour trainings but have been invited. Eight (8) EMS agencies operate in Orange County.
4. The is no adult mobile crisis outreach team service in Orange County.
5. The detoxification unit is over capacity.
6. Resources are needed for assisting people and services to determine the appropriate crisis services, including 911/211 collaboration.
7. There is a lack of peer respite services in Orange County.
8. The Central Receiving Center does not offer medical clearance.
9. There are ED and inpatient bed capacity issues for (1) people who do not meet commitment criteria and (2) people who meet criteria but are waiting placement.
10. There is a need for a low-demand service or center (Intercept 0) to respond to people who need treatment, housing, support services, etc., but are not high need, as well as holistic services so that people are not cycling from service to service. Consider opportunities to incorporate peer support.
11. Orlando Police Department non-criminal citation for cannabis possession does not include a referral to treatment. Leon County program includes a substance use disorder treatment assessment.

INTERCEPT 2 & 3 (Initial Court Hearings/Initial Detention/ Jails/Courts) -

(2) Initial Court Hearings/Initial Detention - Involves diversion to community-based treatment by jail clinicians, social workers or court officials during jail intake, booking or initial hearing.

(3) Jails/Courts - Involves diversion to community-based services through jail or court processes and programs after a person has been booked into jail. Includes services that prevent the worsening of a person's illness during their stay in jail or prison.

GAPS

1. There is a need to enhance education efforts for treatment agencies so more dually diagnosed clients can be admitted post jail.
2. Additional mental health pre-trial release beds in substance abuse treatment agencies are needed.
3. Peer support specialists are needed to accompany patient upon release.
4. There is a lack of "warm-handoff."
5. Follow up services upon release are need – (e.g., a day reporting center like one that had operated in the past; some are being piloted in Florida).
6. There is currently no one-way data match of jail bookings to check for clients who are incarcerated. Corrections Health Services is currently looking into a process of automatically sending the "Inmates with Psych limits" crystal report to a point of contact at the [facility name] daily for [them] to connect with their patients in jail prior to release.
7. The average jail stay for inmates with mental illness is 44.7 days - 15 days longer than inmates without mental illness.
8. Adult Drug Court services and supervision are based on a combination of statutory and administrative order requirements, risk and need of the defendant and severity of substance use disorder. Mental Health Court operates at a limited capacity due lack of funding for services. In addition, competency to stand trial is considered as part of eligibility, further limiting the pool of candidates

INTERCEPT 4 & 5 Re-Entry & Community Corrections

(4) Re-Entry -Involves supported reentry into the community after jail or prison to reduce further criminal justice involvement of people with MH/SU disorders. Involves reentry coordinators, peer support staff or community in-reach to link people with proper mental health and substance use treatment services.

(5) Community Corrections - Involves community-based criminal justice supervision with added support for people with MH/SU disorders to prevent violations or offenses that may result in another jail or prison stay.

GAPS

1. Inmates are not consistently released with a supply of medications.
2. A prescription for a 30-day supply is available upon an inmate's request.
3. Orange County Corrections Health Service does not know when inmates will be released from jail.
4. Little collaboration and lack of process between the PDs office and Corrections regarding releasing inmates after a hearing so medications and prescriptions can be prepared.
5. That has drastically decreased since the implementation of telehealth. Aspire can conduct medication evaluation and intakes with inmates in the Orange County Jail (OCJ).
6. There is a lack of transitional support services following release from jail. The Jacksonville Reentry Center is an example of a program that provides transitional support for state and county releases.
7. Limited reentry planning for inmates with serious mental illness released by Florida Department of Corrections.
8. Ineffective process for acute mentally ill offenders who transfer to the State Hospital (Force medication orders at the hospital, but patients refused medications again when they get transferred to OCJ to stand trial) often results in re-admission to State Hospital.
9. Aspire sets up post-release appointments, but most people do not show up. Many individuals are concerned that will be committed under the Baker Act.
10. Florida Department of Correction community supervision does not have specialized caseloads for people with mental illness. Unless there is a court order for mandated treatment, there are no resources for behavioral health services.
11. There is a lack of forensic peer specialists serving people with mental illnesses.
12. Lack of assisted living facilities who are willing and equipped to admit acute mentally ill patients.

Homelessness and Housing

Seven major themes were identified by the Homelessness and Housing Committee when exploring challenges faced by homeless and precariously housed individuals who seek mental and behavioral health care. These included:

1. Lack of qualified and available workforce
2. Access
3. Housing
4. Education
5. Quality of care
6. Cultural and linguistic concerns
7. Other concerns

The themes and corresponding variables are shown in Figure 12.

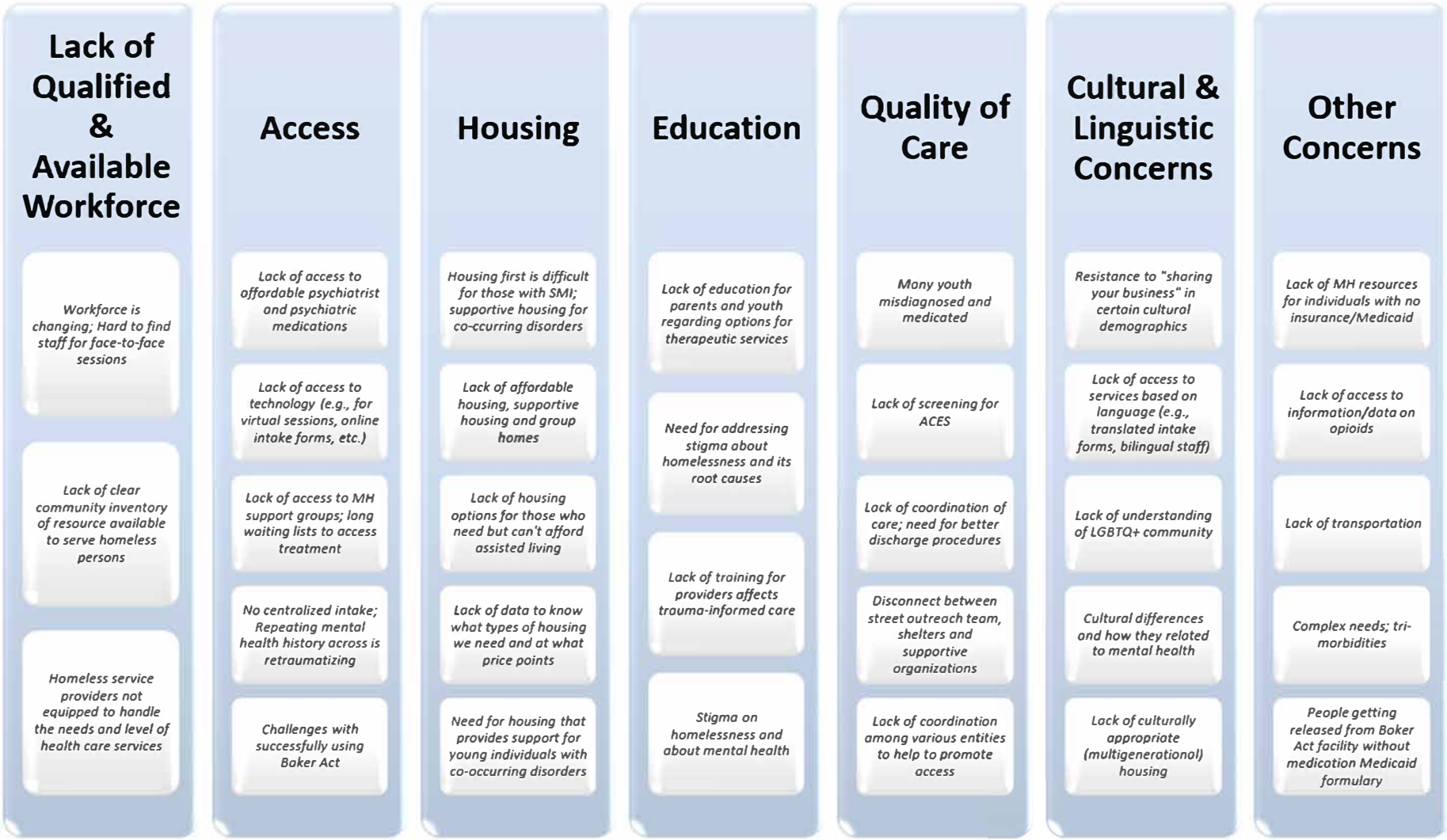


Figure 12: Mental and Behavioral Health System Challenges for Homeless Persons

The themes arising from the analysis of the qualitative data collected in the Homelessness and Housing Committee as well as the Continuum of Care System Look Committee were further analyzed to identify driving factors. As shown in Figure 13, access to care arose as the primary concern in Orange County. Access was influenced by:

1. Lack of qualified and available workforce
2. Lack of housing
3. Financial concerns
4. Information exchange
5. Factors Impacting the community's decision to seek care

Workforce issues are influenced by challenges with culturally and linguistically appropriate service provision, training and education, and quality of care. Financial challenges are driven by issues related to insurance, general funding concerns and the competing needs of families with limited finances. Also of concern was the lack of Medicaid expansion. Florida is one of 12 states that has not expanded Medicaid eligibility as allowed under the Affordable Care Act (ACA). As such, there are hundreds of thousands who fall into the coverage gap. Individuals in the coverage gap have major barriers to accessing affordable mental and behavioral health care. Factors impacting the community's decision to seek care include cultural norms and taboos, knowledge and awareness of mental and behavioral health, and stigma. Finally, the huge challenges with lack of information interfere with the process of coordinating care.

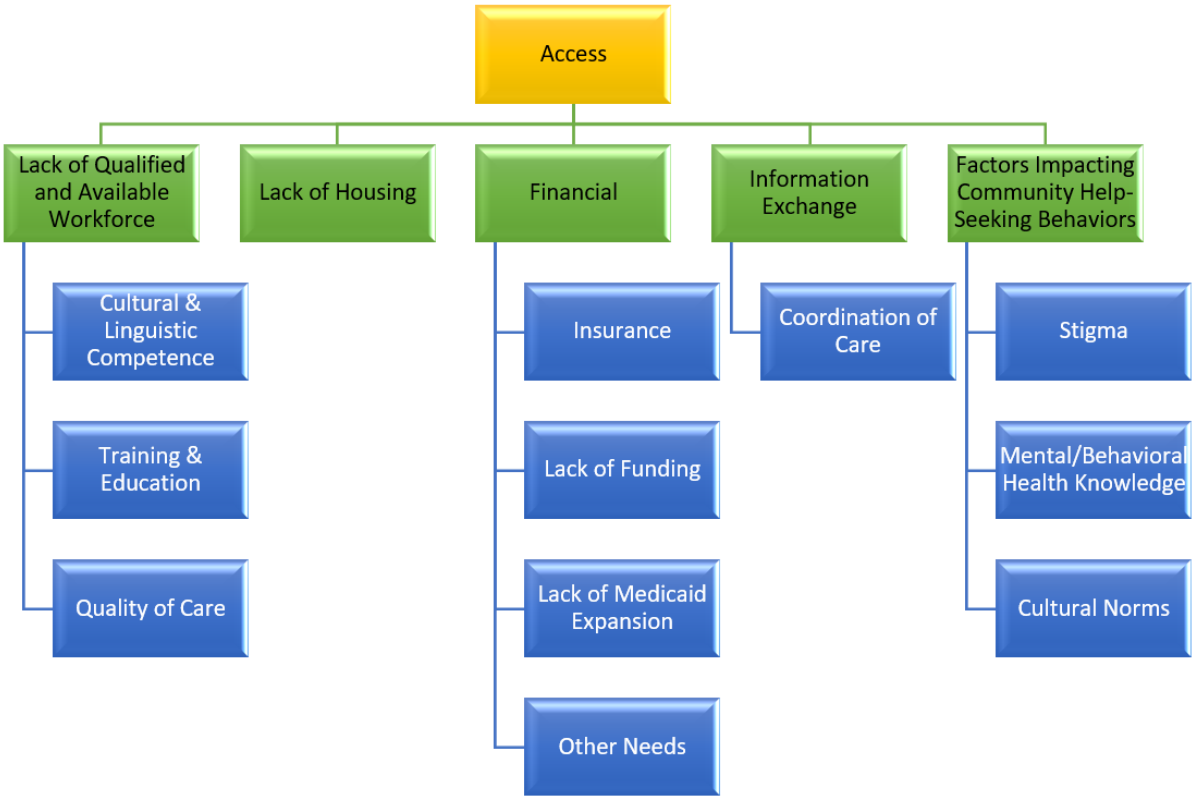


Figure 13: Core Challenges with the Mental and Behavioral Health System

Focus Groups

Sixty-two (62) individuals of varied races, ethnicities and occupational statuses participated in six (6) community focus groups that were held at community-based locations in Winter Garden, Apopka, Downtown Orlando and Pine Hills. All individuals who participated in the focus groups have received services in the Mental and Behavioral Health System of Care in Orange County or have been caregivers of consumers of services. Key concerns and recommendations for system improvement were identified by the focus group participants. They are shown in Table 4.

Problems Experienced in the Mental and Behavioral Health System in Orange County	Recommendations for System Improvement
• Barriers for individuals with limited-English-proficiency • Lack of awareness of when and where to seek help • Lack of customer service • Financial barriers • Rotating therapists • Difficulty accessing care on demand • Quality of care varies based on insurance type and financial status • Problematic referrals (e.g., wrong number, do not accept insurance type, etc.) • Some practitioners overmedicate and do not enough time spent with clients for medication reviews	• Broad-based culturally response anti-stigma campaigns, outreach and education • Training for police-officers, other first responders and social services providers who interact with the public • Drop-in centers and support groups • General mental health hotlines (not solely focused on suicidality) • Mental health 101 community campaigns to share the common signs and symptoms of poor mental heath • "It's OK to not be OK" billboards with trusted "regular" community members • Programs and services to reduce exposure to and manage the effects of childhood and other trauma • Improve access to resources

Table 4: System Challenges and Recommendations for Improvement

Key Stakeholder Conversations

A total of 12 meetings with key stakeholders (attended by 19 individuals) were conducted between October and November 2021. The following themes were identified in the conversations.

1. **Continuum of Care** – 1.Stakeholders indicated the mental and behavioral health system is complex to navigate, even for the most seasoned professionals, and there is a need for interagency collaboration. Such collaboration across organizations includes providing a "warm hand-off" between agencies and implementing data-sharing protocols. The need for a coordinated care system for youth, focused on increasing identification and treatment of mental and behavioral health needs in children 0-18 years old, was also highlighted. Addressing issues related to zero-tolerance policies related to behavioral health among children and adolescents in school and increasing the number of mental and behavioral health professionals were also said to be of importance to the continuum of care.

2.**Cultural Competence** – The importance of utilizing appropriate terminology and language was identified as a core area of concern. Proprietary research was shared by one stakeholder that indicated some consumers respond negatively to use of the term "behavioral health" and had more positive associations with the use of "mental health." In addition, the research showed that 47% of non-native English speakers do not recognize the term "ER" (the abbreviation for Emergency Room) as a place to seek help during an urgent health crisis. However, they identified with the word "emergency." Other areas related to cultural competence include:

a. The importance of improving language access
b. The need to adapt Evidence-Based practices to meet the needs of the diverse communities being served
c. Understanding how different Hispanic generations identify themselves (e.g., Hispanic/Latino, Latinx and Brown)
d. Addressing the role that racism plays within current mental and behavioral health problems in community

3.**Housing with Supports** – The immediate need for structured affordable housing programs specifically tailored for those with mental and behavioral health concerns was stressed. Factors said to be necessary for system improvement include:

a. Providing triage to stabilize individuals
b. Offering housing settings with caregivers
c. Aiding with securing adequate employment
d. Ensuring opportunities for individuals to live independently once financially sufficient
e. Assisting students experiencing homelessness

4.**Increased Funding Needs**

Several strategies to address funding shortfalls were suggested, including:

a. Increasing available funding to meet the current and future needs within the community
    i. Additional finding could increase CIT trained officers and be used for a 911 call diversion program
b. Consider taxing the business (e.g., hotels, rental car agencies and other big business entities) to help with mental and behavioral health funding gaps, as this has been successful in other parts of the country
c. Identifying grants available to addressing the mental and behavioral health needs of uninsured or under-insured consumers
    i. Increase funders' collaborative efforts to identify and be responsive to individuals falling through the gaps

5.**Need for Increased Awareness**

a. Provide culturally responsive community-wide education on available local resources and anti-stigma campaigns that are responsive to the needs of different ages and cultures

6. **Increased Outpatient Resources**
    a. Add additional resources to the front- and back-end of the current mental and behavioral health system
    b. Expand the Behavioral Response Unit
    c. Create drop-in centers
        i. Establish centers that provide more long-term care within the community for all individuals, regardless of insurance status or the ability to pay
    d. Explore the feasibility and effectiveness of establishing mental and behavioral health hubs as a community resource
7. Utilize an implementation team to ensure that the recommendations are moved forward

RECOMMENDATIONS

Recommendations address all four components of the SAMHSA's framework of an effective Continuum of Care as shown in Figure 14, including (1) Promotion, (2) Prevention and Intervention, (3) Treatment and (4) Recovery and will grouped under six (6) key areas of focus:

1. Integrated and coordinated mental and behavioral health care delivery system
2. Mental health promotion
3. Housing and services for homeless individuals and families
4. Qualified and available workforce
5. Finances
6. Implementation

Specific strategies intended to assist in the implementation of the recommendations that were identified during the system analysis are also included as appendices.

Figure 14: SAMHSA's Framework on an Effective Continuum of Care

Key Focus Area 1: Integrated and Coordinated Mental and Behavioral Health Care Delivery System

Recommendation 1: Develop an Information Technology (IT) platform that supports interoperability, integration and coordination of care

Central to the challenges impacting care coordination in Orange County are issues with information sharing. Without the appropriate information management infrastructure, individuals seeking mental and behavioral health services face unnecessary barriers, including repeated assessments and additional appointments. In addition, service providers are unaware of patterns of behavior seeking or intersections across the continuum of care among consumers. Stakeholders have named this as a priority, but have acknowledged challenges to making data sharing the universal condition. Most frequently cited as a challenge has been the Health Insurance Portability and Accountability Act of 1996 (HIPPAA). With the advent and shift to Electronic Health Records, more population health and care coordination solutions are being developed and should be explored.

Recommendation 2: Integrate mental health into primary care settings using the Collaborative Care Model and/or other Evidence-Based practice

While individuals with mild to moderate mental illness are unlikely to see a mental health professional, they often see other kinds of health care providers (Dickens, et al., 2021). Some individuals utilize their primary care providers when mental health coverage is lacking or due to the stigma of seeking mental and behavioral health care. According to the Centers for Disease Control, one-in-five primary care visits address mental health concerns and often results in at least one mental health “indicator” such as a depression screening, a mental health diagnosis, a prescription for a psychiatric medication or a counseling referral. Unfortunately, many mental and behavioral health concerns are left unidentified and untreated in primary care settings. While its implementation has remained limited due to issues with reimbursement and other challenges, the Collaborative Care Model is supported by a strong body of empirical evidence demonstrating its clinical and cost-effectiveness for managing behavioral health conditions in primary care settings and assisting with early identification of mental and behavioral health disorders (Katon et.al, 2012; Mutingh et.al, 2016). The Collaborative Care Model or other evidence-based practices should be used to drive the process of integrating mental and behavioral health care in Orange County.

Recommendation 3: Develop Drop-In Intake and Triage Centers

The need for drop-in centers has been identified in the literature, committee meetings (Advocacy, Continuum of Care, Homelessness and Housing, and Criminal Justice), as well as by community stakeholders as being a dire need in the community. Drop-in centers could serve a multitude of purposes, including offering a range of walk-in services such as screening, urgent outpatient treatment services, and hospital and jail diversion programs. Individuals diagnosed with mental illnesses could also receive peer-led or clinical services in such centers. Drop-in centers are becoming centers for advocacy where people not only learn about, but also get assistance with all the elements of recovery (http://164.156.7.185/parecovery/documents/Drop_In_Tech_Assist.pdf). Drop-in center activities vary and are determined based upon the needs of the consumers involved. Common activities include:

- Self-help group meetings
- Social activities
- Speakers' bureau
- Meals
- Training, education and workshops
- Excursions
- Computer center
- Employment services
- Individual and systems advocacy
- Referrals for needed services
- Outreach programs.

Recommendation 4: Strengthen and expand crisis management activities

Mental illnesses are often recurrent and can be life-threatening. Individuals experiencing crises involving mental health and substance use disorders often end up in hospital emergency departments. As with a physical health crisis, a mental health crisis can be catastrophic for individuals, families and communities. In some instances, individuals in crises are incarcerated or do not have access to the services needed to intervene. This creates an unnecessary burden on the individual in crisis, emergency departments, justice systems and law enforcement. (SAMHSA; National Guidelines for Behavioral Health Crisis Care, 2020).

According to the National Guidelines for Behavioral Health Crisis Care (2020):

Crisis services are for anyone, anywhere and anytime…Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for anyone, anywhere and anytime" (p.8).

Although it is impossible to predict when all crises will occur, services can be structured and organized according to best practices and to meet the needs of those who experience a mental health crisis. Focus should be placed on enhancing the crisis response teams and programs in Orange County and bolstering all elements of the crisis response system as described by SAMHSA. Promising practices already in operation include:

1.**Behavioral Response Unit** - a Co-Responder Model pilot program, launched in December 2020 by the Orange County Sherriff's Office. The team consists of one sergeant, two Crisis Intervention Team-trained sworn deputy sheriffs and two mental health clinicians from Devereux Advanced Behavioral Health who respond to calls for service involving mental health crisis.

2.**Community Response Team** - a City of Orlando alternate response pilot program launched in March 2021, led by the Orlando Police Department and in partnership with Aspire Health Partners. The team includes a licensed clinician and a case manager who are dispatched to non-violent mental health calls.

3.**Crisis Intervention Team (CIT) Training** - CIT training is an effective law enforcement response program designed for first responders who handle crisis calls involving people with mental illness, including those with co-occurring substance use disorders. CIT training emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families. CIT is both a training program and a collaborative effort that builds community partnerships with mental health service providers.

4.**Mobile Response Crisis Services** - available to anyone ages 0 – 24 located in Orange, County (as well as Osceola and Seminole counties). Master's level and licensed therapists will respond to homes, schools or anywhere within the County to provide on-site crisis stabilization. Crisis therapists also connect families to the services and supports they need for long-term recovery. There remains a need for mobile response services for adults, as services are not available for individuals 25 and over.

Recommendation 5: Bolster and expand services across the "system" for individuals diagnosed with a mental health or substance use disorder

A system is "a set of things working together as parts of a mechanism or an interconnecting network." Creating and preserving a true system and continuum of care requires working to seamlessly integrate medical, behavioral and social services, to enhance care coordination between providers and to include community-based health workers such as Peer Support Specialists. The following areas will need to be expanded or developed to better meet the needs of the community

a. Adult mobile crisis units
b. Adult intensive outpatient treatment
c. Assisted outpatient treatment and psychosocial rehabilitation
d. Medication assisted treatment for incarcerated and non-incarcerated individuals
e. Drop-in centers with mental health and substance abuse overlay
f. Evidence-based practices in outpatient services to support recovery
g. Psychiatric emergency department
h. Substance abuse and mental health residential services

Key Focus Area 2: Mental Health Promotion

Recommendation 6: Increase protective factors and healthy behaviors introducing and subsequently broadening the reach of programs focused on mental health promotion

Mental health promotion involves actions that support individuals, families and communities in adopting and maintaining a healthy lifestyle and creating living conditions and environments that support health (World Health Organization, 2005). It also addresses the social determinants of mental health, works to increase healthy behaviors and protective factors that can help reduce risk factors for the development of mental disorders as well as prevent the onset of a diagnosable mental health disorders.

Mental health promotion activities and interventions are delivered in the settings where people live, learn and work. Specifically, mental health can be promoted through early childhood interventions, programs addressing the needs of vulnerable or at-risk populations, school-based, and community child and youth development programs, and violence prevention programs, to name a few. The social and economic costs of poor mental health underscores the need to promote positive mental health and wellbeing, as well as to prevent the onset of mental illness (Zechmeister, Kilian, & McDaid, et al., 2008).

Recommendation 7: Develop and disseminate culturally and linguistically appropriate community-wide mental health awareness building, education and stigma-reduction campaigns

The length of time between when a person first experiences mental health symptoms and when they seek treatment is 11 years (NAMI, Mental Health Care Matters https://nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Mental-Health-Care-Matters-FINAL.pdf). Without mental health knowledge, many people are left unaware they could benefit from treatment. Also of importance to address from a culturally and linguistically appropriate framework is a major barrier to seeking care — the stigma frequently attached to mental illness. Broad-based and sustained awareness campaigns should be considered as one approach to impacting change in this area.

Another often-overlooked area in need of mental health awareness building is within organizations. Campaigns by employers could include information on the mental and behavioral health benefit offerings, including EAP, as surveys disseminated in this analysis have indicated the primary means of sharing this information is through open-enrollment materials disseminated once per year.

Key Focus Area 3: Affordable Housing and Services for Homeless Individuals and Families

Recommendation 8: Increase the availability of affordable housing, supportive housing, assisted living and transitional living facilities

The destructive impacts of homelessness on mental health have been established over several decades of research. Depression, suicidal thoughts, and symptoms of trauma and substance misuse have been shown to be more prevalent among homeless persons when compared to their domiciled counterparts (SAMHSA, 2011; Fisher & Breakey, 1985 and Padgett, 2020).

A recent meta-analysis found more than half of homeless and marginally-housed individuals had traumatic brain injuries — a rate far exceeding that of the general population (Stubbs, et al., 2019). Children are especially affected by the emotional sequelae of homelessness and housing instability (Bassuk, Richard, & Tsertsvadze, 2015).

The COVID-19 public health and economic crises of 2020 disproportionately impacted individuals with low incomes, many of whom have struggled to remain safely and stably housed (National Low Income Housing Coalition, 2021). Unstable housing and homelessness contribute to and exacerbate the incidence and severity of mental health and substance use disorders (Pagett, 2020). The gap between mental health needs and service availability for the homeless population is substantial (Padgett, 2020). In addition to addressing the available stock of and types of housing and as recommended by the Homelessness and Housing Committee, it may also be necessary to:

- Amend screening standards to allow Increased access to affordable housing (i.e., low barrier housing)
- Minimize barriers in housing homeless persons
- Diversify the housing options available such as shared housing, which matches similar persons (e.g., senior, trauma care, assisted living facilities, youth options aging out of foster care)
- Increase Medicaid utilization, including the Medicaid pilot
- Prioritize development of affordable and supportive housing in funding allocations and planning across agencies
- Maximize the use of, and access to data
- Increase access to services through automated, web-based means where appropriate
- Increase the number of mental health professionals who collaborate with street-based outreach teams

Key Focus Area 4: Qualified and Available Workforce

Recommendation 9: Increase opportunities for trainings and support in the implementation of Evidence-Based Practices for existing Mental and Behavioral Health workforce

Evidence-Based Practices (EBPs) are interventions for which empirical evidence consistently shows the practice improves client outcomes (Drake, et.al., 2001). While compelling evidence exists about the effectiveness of Evidence-Based interventions in mental and behavioral health, there are several barriers to their implementation, including cost (Ecker, et.al., 2021). Increasing training opportunities, improving training practices and providing post-training practice support in the delivery of Evidence-Based interventions hold the potential to assist providers when embedding EBPs into their day-to-day clinical activities (Ecker, et.al, 2021; Smith, Landes Lester-Williams, et.al., 2017).

Recommendation 10: Increase the availability and quality of peer support services

The need for a strong behavioral health care workforce is more important than ever. The availability of a qualified workforce is central to the challenges with accessing services in Orange County. Workforce challenges in existence prior to the Covid-19 pandemic have been amplified during the pandemic.

Based on qualitative data collected during the Mental and Behavioral Health System Analysis, the numbe willing to provide community-based and in-pe dwindled, as many providers have shifted to v formats. There is also a great concern over th counseling professionals, which is in part driv compensation by employers and poor reimbu insurance companies.

The mental and behavioral health workforce i

- Psychiatrists
- Psychologists
- Social workers
- Advanced practice psychiatric nurses
- Marriage and family therapists
- Certified prevention specialists
- Addiction counselors
- Mental health/professional counselors
- Psychiatric rehabilitation specialists
- Psychiatric aides and technicians
- Paraprofessionals in psychiatric rehabilitation and addiction recovery fields (e.g., case managers, homeless outreach specialists or parent aides)
- Peer support specialists
- Recovery coaches

Recommendation 11: Increase the availability and quality of peer support services

Peer support programs offer consumers who have achieved significant recovery the opportunity to assist others in their recovery journeys. Peer support specialists teach skills, aid in system navigation and offer support for people experiencing mental health challenges. They are role models for recovery with unique experiences, skills and training, and they can be essential members of care teams (https://www.mhanational.org/peer-services). Peers provide self-help training and other nonclinical strength-based support such as linkages to resources, education and recovery-plan development with patients (SAMHSA, 2017).

Figure 15: SAMHSA's Core Competencies for Peer Workers in Behavioral Health

A growing body of evidence has shown that peer-support services lead to increased social support and participation in the community, reduced hospital admission rates and longer community tenure, decreased substance abuse and depression, decreased psychotic symptoms, increased engagement in self-care and wellness, increased sense of control and ability to bring changes in their lives, and an increased sense that treatment is responsive and inclusive to their needs (Davidson, Bellamy, Guy, & Miller, 2012). Studies have also found peer-support specialists to be cost-effective. In Colorado, the health care system experienced a $2.28 return on investment for every $1 invested. In addition, Georgia reported the use of peer services as part of behavioral health care resulted in average savings of $5,494 per patient per year (University of Michigan Behavioral Health Workforce Research Center. 2019).

Recommendation 12: Explore pathways and programs and (e.g., student loan repayment programs, educational pipeline programs, etc.) to increase the availability of a qualified workforce

There is an acute shortage of mental and behavioral health providers, which has only been exacerbated by Covid-19 (https://www.thenationshealth.org/content/51/10/1.3). The workforce challenges are being driven by several factors, including burnout, lack of parity in reimbursement rates, failure of reimbursement rates to keep up with costs, among others. Exploring pathways to increase the retention of qualified professionals and attract others to the field is essential to decreasing the mental health workforce shortages. Mechanisms to eliminate the costs of higher education or training, or to repay loans associated with such, are policy mechanisms that have been effectively used in the health care workforce.

Key Focus Area 5: Advocate for Policy Shifts in Mental and Behavioral Health Finances

Recommendation 13: Strive to achieve mental health parity in all public and private sector health plan offerings

Although mental health parity became law in the United States in 2008, the practice has not been fully implemented. Lack of parity continues to be a contributing factor to the gaps in services, insurance coverages and reimbursement rates for providers. If parity is to be achieved, an appropriate response is required from all public and private sector health plan offerings.

Recommendation 14: Advocate for streamlined processes by payers to address challenges with enrollment and credentialing

Provider enrollment is the process of enrolling a provider with commercial or government health insurance plans from which the provider can be reimbursed for the services rendered to consumers. Credentialing is the process by which payers ensure providers have the required licenses, certifications and skills to function effectively in their roles. Enrolled providers are considered “in-network” or “participating.” Challenges arising during the enrollment and credentialing include processing delays (sometimes more than three (3) months), which impact the ability to file claims. Other barriers include lack of communication and confusing processes for accessing and updating information with payers, closed networks that lock out new providers, and various other issues that lead to claim denials or inability to file claims (Medical Group Management Association, 2021). While these barriers impact large and small organizations alike, they can be especially detrimental to small practices with limited cash reserves.

Recommendation 15: Increase the reimbursement rates of mental and behavioral interventions and evidence-based behavioral health treatments to the actual cost.

Access to care across the continuum is a major hurdle in Orange County and is influenced in part by the low reimbursement rates, which in turn has a detrimental impact on the mental health workforce. Advocacy should also focus on increasing or obtaining reimbursement for evidence-based clinical services. Examples of services that have convincing evidence include peer support services, first-episode psychosis interventions, diversion programs, supportive housing, collaborative care, Assertive Community Treatment (ACT), Modular Approach to Therapy for Children (MATCH) and Multi-Systemic Therapy-Psychiatric (MST-Psych) to name a few. Think tanks that include coalitions of interdisciplinary agencies, including all sectors participating in this analysis, could be useful in advancing this effort.

Key Focus Area 6: Implementation

Recommendation 16: Establish an implementation team to advance the recommendations of this report

Given the scope of the recommendations contained in this report, it is recommended a team of stakeholders be assembled for the purpose of guiding the implementation process. Precedence of using this framework as well as evidence of its success is available in the Management Network of the Youth Mental Health Commission in Orange County.

Costs

The costs reflected in Table 5 are estimates based on currently available data. For services currently being offered but in need of expansion, unit costs from the managing entity (Central Florida Cares) were multiplied by the estimated additional need to generate a cost. For newly proposed initiatives, experience with similar programs or costs associated to related programs in other regions were used as a guide. The areas with question marks require additional exploration to generate estimated costs. It is recommended an implementation committee be convened to lead the advancing the recommendations in this report. One task of that committee would be to revisit the costs reflected here and to determine costs where none have been estimated.

Recommendations		Cost
Key Focus Area 1: Integrated and Coordinated Mental and Behavioral Health Care Delivery • **Recommendation 1:** Develop an Information Technology (IT) platform that supports interoperability, integration and coordination of care • **Recommendation 2:** Integrate mental health into primary care settings using the Collaborative Care Model and/or other Evidence-Based Practice • **Recommendation 3:** Develop Drop-In Intake and Triage Centers • **Recommendation 4:** Strengthen and expand crisis management activities • **Recommendation 5:** Bolster and expand services across the "system" for individuals diagnosed with a mental health or substance use disorder	Crisis Intervention Team (CIT) Training and Training of Trainers	$172,000
	Mindfulness Training	$12,000
	Adult Mobile Crisis	$1,000,000
	Adult Intensive Outpatient	$1,000,000
	Assisted Outpatient Treatment and Psychosocial Rehabilitation	$750,000
	Psychosocial Rehab	$2,200,000
	Medication Assisted Treatment	$325,000
	Indigent Drug Program	$12,000
	Evidenced-Based Practices in outpatient services that support people staying in the community	$1,000,000
	Increase capacity pre- and post-booking support	$900,000
	Drop-in Centers with Mental Health and Substance Abuse overlay	$900,000
	Psychiatric ED	$330,000
	Substance abuse and mental health residential services levels 1-3	$2,600,000
	Additional teams for MST Psych, Dually Served and CAT	$1,880,000
	Increase care coordination and case management	$680,000
	IT Platform	TBD
Key Focus Area 2: Mental Health Promotion • **Recommendation 6:** Increase protective factors and healthy behaviors introducing and subsequently broadening the reach of programs focused on Mental Health Promotion • **Recommendation 7:** Culturally and linguistically appropriate community-wide mental health awareness building, education and stigma-reduction campaigns	SAMSHA Grant Expansion	$1,000,000
	Nurse Family Partnership	$441,000
	Caregiver Overnight Respite	$1,000,000
	Early Childhood Consultation	$27,000,000
	Mental Health Community-Awareness Campaigns	TBD
Key Focus Area 3: Affordable Housing and Services for Homeless Individuals and Families • **Recommendation 8:** Increase the availability of affordable housing, supportive housing, assisted living and transitional living facilities	30,300 affordable and attainable Housing Supportive housing assisted living and transitional living facilities	TBD
Key Focus Area 4: Qualified and Available Workforce • **Recommendation 9:** Increase opportunities for trainings in Evidence-Based Practices for existing Mental and Behavioral Health workforce • **Recommendation 10:** Develop a pipeline for the behavioral health workforce and implement strategies to retain them • **Recommendation 11:** Increase the availability and quality of peer support services • **Recommendation 12:** Explore pathways and programs and (e.g., student loan repayment programs, educational pipeline programs, etc.) increase the availability of a qualified workforce	Trainings in Evidence-Based Practices	$1,000,000
	Increase Psychiatric Providers	$441,000
	Increase in the availability of peer-support services	$1,000,000
Key Focus Area 5: Mental and Behavioral Health Finances • **Recommendation 13:** Strive to achieve mental health parity in all public and private sector health plan offerings • **Recommendation 14:** Advocate for the removal of barriers and red tape by AHCA, which prevents qualified organizations from becoming Medicaid providers in Florida • **Recommendation 15:** Reimburse evidence-based behavioral health treatments at their actual cost.	TBD	
Key Focus Area 6: Implementation • **Recommendation 16:** Establish an Implementation Team to Advance the Recommendations of this Report	TBD	
TOTAL		**$49,657,000+**

Table 5: Recommendations, related initiatives, and costs

Conclusion

Making meaningful and sustainable improvements in the Mental and Behavioral Health System of Care requires parallel processes that address, at a minimum, the integration and coordination of care, mental health promotion, affordable housing services for homeless individuals and families, a qualified and available workforce, and appropriate mental and behavioral health finances. Working to implement these recommendations will undoubtedly strengthen the current service delivery system and lead to improvements in the system of care that benefit providers, consumers of services and the community-at-large.

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APPENDIX A: SEQUENTIAL INTERCEPT MAP

Sequential Intercept Model Mapping Report — Orange County, FL |2021 Update
Background

On August 23-24, 2016, Patty Griffin and Brian Case of SAMHSA's GAINS Center facilitated a Sequential Intercept Model Mapping Workshop in Orlando for Orange County Government. Orange County was one of six communities across the nation to receive the workshop in response to a 2015 solicitation from SAMHSA's GAINS Center. Approximately 40 representatives participated in the 1½-day event. The participants in the workshops represented multiple stakeholder systems, including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), veterans services and the courts.

The Sequential Intercept Mapping workshop had five primary objectives:

1. Develop a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts,(4) Reentry and (5) Community Corrections/Community Support
2. Identify gaps, resources and opportunities at each intercept for individuals in the target population
3. Develop priorities for activities designed to improve system and service level responses for individuals in the target population
4. Develop an action plan to implement the priorities
5. Nurture cross-system collaboration

2021 Update

In May 2021, Orange County Mayor Jerry Demings convened a group of thought leaders to begin the dialogue on improving the mental and behavioral health system of care in Orange County. The system of care analysis is partly being accomplished through five committees to include: 1) Continuum of Care; 2) Advocacy; 3) Business Community; 4) Criminal Justice; and 5) Homelessness and Housing. The purpose of the committees is to receive stakeholder input on the allocation and adequacy of behavioral health services and programs and provide recommendations to increase and enhance service delivery. The committees will also focus on funding needs and prioritization of funding.

As a part of these efforts, the Criminal Justice Committee with Judge Alicia Latimore and Chief Probation Officer Johnny Alderman as co-chairs, and Dr. Lauren Josephs of Visionary Vanguard Group, as facilitator, reviewed and updated the 2016 plan to include all the updates that have occurred in the past five (5) years, as well as to add information on Intercept 0. Members of the criminal Justice Committee included:

- Honorable Alicia Latimore, Circuit Judge, Ninth Judicial Circuit Court of Florida (Co-Chair)
- Johnny Alderman, Chief Probation Officer, FL Department of Juvenile Justice (Co-Chair)
- Major Carlos Torres, Orange County Sheriff's Office
- Faith Sills, Social Services Chief, Ninth Judicial Circuit Court of Florida
- Keisha Mulfort, Director of Public Affairs, State Attorney's Office, Ninth Judicial Circuit
- Shana Manuel, Deputy Chief Assistant State Attorney, State Attorney's Office, Ninth Judicial Circuit
- Chief Louis Quinones, Chief of Corrections, Orange County Corrections Department
- Captain Lovetta Quinn-Henry, City of Orlando Police Department
- Lisa Graham, Health Services Program Administrator, Orange County Health Services Dept.
- Kelly Steele, Court Programs Manager, Ninth Judicial Circuit Court of Florida
- Linda Brooks, Division Manager, Orange County Corrections Department
- Arsha Battles, Unit Supervisor for Inmate Programs, Orange County Corrections Dept.
- Colleen Brady-Svitak, Circuit Administrator, Circuit 9 Community Corrections
- Melissa Geist, Director of Court Operations, Orange County Clerk of Courts

Following is a summary of resources and gaps by intercept as determined by the Criminal Justice Committee.

INTERCEPT 0 (Community Services) — Involves opportunities to divert people into local crisis care services. Resources are available without requiring people in crisis to call 911, but sometimes 911 and law enforcement are the only resources available. Connects people with treatment or services instead of arresting or charging them with a crime.

RESOURCES

1. Pathways-Mental Health Drop in Center
2. NAMI-National Alliance on Mental Illness
3. Suicide Crisis Lines
4. 211
5. CRC-insured and uninsured
6. University Behavioral Center-for insured individuals

7. Marchman and Baker Acts
8. Central Florida Behavioral Hospital
9. Veterans Hospital
10. VA
11. Advent Health
12. Law enforcement assistance with Baker Act
13. Park Place
14. Seminole Behavioral Health
15. Detox Center on Gore St (Aspire)
16. Mobile Crisis (Co-responder Model with Aspire)
17. Mobile Crisis for Youth
18. https://www.mhacf.org/community-crisis-suicide-services/
19. Alternative Responder Model (Clinician/Case Manager)
20. School Resource Officers
21. School has created layers to prevent law enforcement interaction (deans and other Orange County Public Schools' employees intervene and provide access to resources)

GAPS

1. Finances to broaden the reach of existing resources
2. Socioeconomic status determines access to some resources
3. Red tape
4. Insurance barriers
5. Easiest place to access mental and behavioral health care is still the jail
6. Services (qualified service providers) should go to the individuals in crisis and not vice versa
7. Qualified (certified clinicians) and available workforce to address crises are needed
8. Mental Health Ambulance
9. Companies should consider having an internal means of responding to needs of employees rather than outsourcing to EAP to prevent crisis
10. No Medicaid expansion
11. Physical and mental health expansion

INTERCEPT 1 (Law Enforcement) — Involves diversion performed by law enforcement and other emergency service providers who respond to people with mental and substance use disorders. Allows people to be diverted to treatment instead of being arrested or booked into jail.

RESOURCES

- There are four 911 services in the region: Orange County, Orlando, Apopka and Winter Garden.
- U.S. Department of Veterans Affairs conducted a dispatcher training in Orange County in 2013. All shifts were trained over a two-week period.
- Dispatchers participate in the 40-hour Crisis Intervention Team training program. Approximately 30 dispatchers have been trained in the past decade.
- A 24/7/365 crisis hotline is available through 211. United Way operates the service.
- 40-hour CIT trainings are conducted five times per year. Participants come from the law enforcement agencies in the County as well as dispatchers and the public transit system (LYNC). Youth CIT training is provided to school resource officers and Orange County Corrections.
- CIT has been in operation since 2000 and more than 2,000 officers have completed the 40-hour training during that time-period.
- 13 law enforcement agencies operate in Orange County. The Orange County Sheriff's Office is the largest agency, followed by the Orlando Police Department.
- Orange County Sheriff's Office has 1-2 CIT deputies on patrol each shift.
- Orlando Police Department has a CIT Unit. To maintain its CIT designation, OPD officers must complete an 8-hour annual refresher training and any additional continuing education as required by the department. The OPD has 150 active CIT officers.
- The smaller law enforcement agencies in Orange County each has 1-2 CIT-trained officers.
- The Criminal Justice Subcommittee of the Central Florida Commission on Homelessness has held discussions about advancing CIT accountability in Orange County.
- The OPD training academy includes content on mental health and crisis response.
- Orlando dispatchers maintain a list of CIT officers, who can be dispatched to the scene.
- The Central Receiving Center is funded by Orange County and the State of Florida. There are 500 drop offs each month. Only officers can transport people to the CRC.
- The CRC officer turnaround target is 10 minutes. Due to high demand for the CRC in 2016, the average turnaround is 13 minutes. The CRC is required to receive all people transported by law enforcement, even if they require medical clearance or fail to meet criteria.
- An Assessment Center is available for non-law enforcement crisis cases.
- Marchman Act is available for involuntary commitment due to substance use disorders.
- Detoxification unit for people experiencing a substance use crisis.
- Orlando Police Department may issue a non-criminal citation for cannabis possession (less than 20 grams). This citation option is only available within the City of Orlando. A "Notice to Appear" arrest is also possible for cannabis possession.

INTERCEPT 1 (Law Enforcement) GAPS

- Four 911 systems serve the County.
- There is a question of how to advance CIT coordination in Orange County, including implementation of performance measurement (Miami-Dade County site visit).
- EMS has not participated in the CIT 40-hour trainings. Eight EMS agencies operate in Orange County. EMS has been invited to the CIT trainings.
- No adult mobile crisis outreach team service in Orange County. There is a MCOT for children and youth (under 17 years old).
- No mental health-law enforcement co-response to people in crisis.
- The detoxification unit is over capacity.
- Resources are needed for assisting people and services to determine the appropriate crisis services, including 911/211 collaboration.
- Lack of peer respite services in Orange County. The MHA is conducting a site visit to Georgia.
- The Central Receiving Center does not offer medical clearance.
- Emergency department and inpatient bed capacity issues for (1) people who do not meet commitment criteria and (2) who meet criteria but are waiting placement.
- There is a need for a low-demand service or center (Intercept 0) to respond to people who need treatment, housing, support services, etc., but are not high need. Holistic services so people are not cycling from service to service. Consider the opportunity to incorporate peer support.
- Orlando Police Department non-criminal citation for cannabis possession does not include a referral to treatment. The Leon County program includes a substance use disorder treatment assessment.

INTERCEPT 2 & 3 (Initial Court Hearings/Initial Detention/ Jails/Courts)

- **(2) Initial Court Hearings/Initial Detention —** Involves diversion to community-based treatment by jail clinicians, social workers or court officials during jail intake, booking or initial hearing.
- **(3) Jails/Courts —** Involves diversion to community-based services through jail or court processes and programs after a person has been booked into jail. Includes services that prevent the worsening of a person's illness during his or her stay in jail or prison.

RESOURCES

- Orange County Corrections Department is responsible for initial detention of arrestees.
  - OCCD processed 28,492 bookings in 2020.
  - OCCD has a booking floor with an open booking system and a Safe Book area for noncompliant inmates (traditional booking environment).
  - Corrections Health Services nurse conducts initial triage to determine if person requires medical clearance (not handled at jail), acute mental health or substance use detox treatment needs. Medical clearance cases are turned over to EMS for transport to emergency department.
  - Pretrial Services administers the Commonwealth of Virginia's pretrial risk tool to determine eligibility for pretrial release. (PTR is looking into a new risk assessment tool — The Florida Risk Assessment once validated)
  - OC Health Services staff provides medical screenings to include screenings for substance abuse and mental health disorders. Mentally unstable inmates are seen in Safebook by a licensed MH clinician. A pharmacy check-up is conducted for arrestees on medications.
  - Substance use disorder detox treatment at booking.
    - Opiate and alcohol withdrawal protocols
    - Medications for substance or alcohol withdrawal
    - Naltrexone/Vivitrol for people with a heroin and alcohol use disorder is available in OCJ. Currently there are two agencies that provide screenings and administering Naltrexone (STEPS and Orange Blossom Clinic).
    - Every inmate identified as a Heroin user receives two doses of Narcan in their property.
    - Starting October 2021, OCCD/Aspire will offer Medication Assisted Treatment in jail for eligible inmates suffering from Opiate Use Disorder. (Buprenorphine, Methadone medications will be used in addition to Naltrexone.)
    - MAT program will have new Corrections Health Services Case manager on staff.
    - Inmate Programs and the Orange County Office for a Drug Free Community will provide case management, peer support, funding for MAT treatment and housing upon release.
  - Objective Classification instrument used to assign a classification level.
  - Housing/homelessness status determined at booking.
- Law enforcement officers can "arrest" an individual without booking them into the jail through the "Notice to Appear." The NTA is still an "arrest" and provides the individual with a court appearance date.
- Pretrial service officer is present at first appearance. Defendants may be released to Pretrial Service by order of the court if the defendant qualifies. Pretrial supervision is limited but includes drug testing.
- Orange County Corrections Department's Community Corrections Inmate Programs staff administers the Misdemeanor Assessment Tool (MAT) risk assessment in the jail to determine programming needs.

- Male OCCD inmates who are veterans have access to a veterans-only dormitory. The dormitory has programming, including case management by a licensed clinician from the VA (Criminal Justice Outreach Coordinator) and substance use education.
- Orange County Corrections Health Services maintains an electronic medical record. Behavioral health data is kept within the EMR. Orange County Corrections Health Services has access to the local Homeless Management Information System.
- Aspire operates the Mental Health Pretrial Services program/Diversion with funds from the Orange County Corrections Health Services.
    - MH PTR/Diversion offers six (6) beds at College Place (residential placement, NOT intensive in-patient treatment) and 17 outpatient slots for case management and individual/group therapy.
        - Cases are referred via IA court or other criminal justice entities.
        - Cases are screened and prepared for intake at Aspire by Corrections Health Services staff.
        - Inmate Programs assists with discharge planning and treatment placement for inmates eligible for MHPTR/Diversion, as well as assistance for inmates not eligible for the program.
- Mentally unstable inmates suffering from acute conditions who are eligible for MHPTR/Diversion can be Baker Acted to Aspire CSU 3 to stabilize so they can be released.
- Orange County has five treatment courts for adults: Adult Drug Court including an Opiate Drug Court Program, Veterans Treatment Court, Mental Health Court and Family Dependency Drug Court (for civil dependency cases).
    - Adult Drug Court (including the Opiate track) has 113 participants. Participants may enter the program with misdemeanor or felony charges (no forcible felonies admitted). There is a 60-point cap for sentencing score.
        - The drug court is partially funded by Orange County (approximately $500,000).
        - A drug treatment alternative to prison track is supported by the State of Florida (approximately $600,000).
        - Opiate drug court is supported in partnership with Aspire Health Partners.
        - Clients with co-occurring disorders may be admitted into any drug court program and referred to appropriate services. Clients are offered services across the continuum of care.
    - Veterans Treatment Court serves veterans regardless of their eligibility for VHA services. The court contracts with Aspire Health Partners for the VHA ineligible-veterans. The court works on the VA eligibility issue. Veteran Service Officers attend court. Charge eligibility for program is overly broad, from city ordinance violations to second-degree felonies (only current exclusions are forcible felonies). 33 veterans are currently enrolled in Veterans Treatment Court.

- Mental Health Court has a limited capacity. There is currently no dedicated treatment funding from the County or State for the program. The State (through the court) does pay for part of a coordinator's time and for 1 OPS case manager. All treatment services are leveraged through services available in the community (mostly at Aspire Health Partners) and the Corrections MHPTR/MHC contract for services with Aspire Health Partners when available. The current caseload is 16 participants.
- Family Dependency Drug Court. All treatment funding is provided through the Department of Children and Families. The County supports the program through staff assigned to the Juvenile Court — a coordinator and one (1) case manager. There are currently 9 adults in the program.
- Early Childhood Court. Most treatment funding provided through the Department of Children and Families, the State, through the court, also provides funding for CPP ($27,000/year). This year the State, through the Court, has provided funding for an ECC Coordinator.

- Central Florida Cares is the managing entity for publicly funded behavioral health services in Orange County. It is also a private pay provider.

INTERCEPT 2 & 3 GAPS

- Need to enhance education efforts for treatment agencies so more dually diagnosed clients can be admitted post jail
- Additional MHPTR beds in substance abuse treatment agencies needed
- Peer support specialists to accompany patient upon release
- Lack of "warm-handoff"
- Follow-up services upon release. Question of need for a day reporting center? A center operated in the past. Some are being piloted in Florida.
- Aspire does not conduct a one-way data match of jail bookings to check for clients who are incarcerated. (Corrections Health Services is currently looking into a process of automatically sending the "Inmates with Psych limits" crystal report to a point of contact at Aspire daily for Aspire to connect with their patients in jail prior to release. Will update soon.)
- The average jail stay for inmates with mental illness is 44.7 days, 15 days longer than inmates without mental illness.
- Adult Drug Court services and supervision are based on a combination of statutory and administrative order requirements, risk and need of the defendant and severity of substance use disorder. Mental Health Court operates at a limited capacity due lack of funding for services. In addition, competency to stand trial is considered as part of eligibility, further limiting the pool of candidates.

INTERCEPT 4 & 5 Re-Entry/Community Corrections

(4) Re-Entry — Involves supported reentry into the community after jail or prison to reduce further justice involving people with mental and substance use disorders. Involves reentry coordinators, peer support staff or community in-reach to link people with proper mental health and substance use treatment services.

(5) Community Corrections — Involves community-based criminal justice supervision with added supports for people with mental and substance use disorders to prevent violations or offenses that may result in another jail or prison stay.

RESOURCES

- The Choices program has its own dormitory for inmates of the Orange County Corrections Department. The focus is on substance use education and wraparound services. The Choices program assists with transition planning services.
- Residential Substance Abuse Program in Horizon (RSAT) for inmates with severe drug addiction (Provider: STEPS)
- Orange County Corrections offers veteran dorm housing for male inmates who have served in the armed forces. Orange County Veterans Affairs and Federal Veterans Affairs works closely with inmates housed in this unit to assist with case management and transitional services.
- The Spirit navigation/care coordination service is available but not currently used for the jail reentry services. The service was used following the Pulse shootings.
- Florida Department of Corrections confines people with serious mental illnesses in designated facilities, including Dade and Suwannee.
- Florida DOC inmates are released with a 30-day supply of medication and a prescription card to pay for psychotropic medications (not sure who is doing this because it is not medical). OCCD provides DOC inmates 10-day medication supply before transfer to DOC.
- The Veterans Integration Service Network 8's Healthcare for Reentry Veterans program serves veterans in four prisons within its region.
- Aspire provides reentry health services for inmates as well as Baker Act releases.
- The Florida Department of Corrections provides community supervision for conditional releases, felony probationers and post-prison release. The circuit includes Orange and Osceola counties.
    - Conditional release may include mandatory substance use treatment.
    - Limited resources for mental health services for individuals on conditional release.

- Orange County Community Corrections supervises misdemeanor probation cases utilizing risk-based supervision (proxy and Ohio Risk Assessment System).
    - There is a veterans-specific probation caseload.
    - Stacey Munguia in Community Corrections supervises MH court participants.
- Cognitive Behavioral Change Program, an evidenced based curriculum confronting antisocial and criminal thinking, is available to Orange County Jail inmates.
- The VA has a peer specialist for its justice caseload.
- Orange County Community Corrections has a Reentry and Transitional Services Team to assist inmates during their transition from jail to community. The team continues to assist offenders after release, providing case management and connections to services needed within the community.
- Orange County Community Corrections has a mental health programs team to provide case management services that meet the needs specific to the mental health population. The MH team works closely with Orange County Health Services to ensure non-acute MH inmates receive appropriate programming, case management services and a warm hand off to MH service providers upon release.

INTERCEPT 4 & 5 (Re-Entry | Community Corrections) GAPS

- Inmates are not consistently released with a supply of medications.
- A prescription for a 30-day supply is available upon an inmate's request.
- Orange County Corrections Health Service does not know when inmates will be released from the jail.
- Little collaboration and lack of process between the PDs office and Corrections regarding releasing inmates after a hearing so meds and scripts can be prepared.
- That has drastically decreased since the implementation of telehealth. Aspire can conduct medication evaluation and intakes with inmates in the OCJ.
- There is a lack of transitional support services following release from jail. The Jacksonville Reentry Center is an example of a program that provides transitional support for state and county releases.
- Limited reentry planning for inmates with serious mental illness released by Florida Department of Corrections.
- Ineffective process for acute mentally ill offenders who transfer to the State Hospital (Force medication orders at the hospital, but patients refused meds again when they get transferred to OCJ to stand trial) often results in re-admission to State Hospital.
- Aspire sets up post-release appointments but most people do not show up. Many individuals are concerned they will be committed under the Baker Act. (Ask for clarification at next meeting).
- Florida Department of Corrections community supervision does not have specialized caseloads for people with mental illness. Unless there is a court order for mandated treatment, there are no resources for behavioral health services.
- There is a lack of forensic peer specialists serving people with mental illnesses.
- Lack of assisted living facilities that are willing and equipped to admit acute mentally ill patients.

APPENDIX B: COMMITTEE OBJECTIVES IN A BALANCED SCORECARD FRAMEWORK

Committee Goals	**Criminal Justice** Improve mental health outcomes for people with serious mental illness who are involved in the criminal justice system	**Advocacy** Increase Mental and Behavioral Health support available to youth and families in Orange County	**Continuum of Care System Look** Improve Access to Mental and Behavioral Health Care in Orange County	**Homelessness and Housing** To increase access to housing options for individuals with Mental Illness
Financial	• Provide cross-training to staff serving services to conditionally released individuals to provide specialized services • Allocate training funds specifically to mental health • Consider reallocating a portion of permanent funding (e.g., restitution, traffic citation dollars, etc.) to mental health treatment	• Identify new funding streams, including federal, local and state grant opportunities • Reallocate dollars that are not being spent to effectively support families/youth/consumers • Educate stakeholders on the return on investment of peer services • Identify where dollars are being wasted • Support pre-crisis and post-crisis services as much we support crisis services • Hold schools financially accountable for the costs of respite if child is suspended due to their emotional, behavioral or mental health needs if the Behavioral Intervention Plan or Safety Plan was not followed when behaviors manifested • Identify funding for mobile crisis team (Alternative models to include peers)	• Optimize current funding and identify additional funding sources to provide services regardless of ability to pay • Create a hierarchy of funding to maximize use • Identify available Identify gaps in funding sources • Identify funding for all modalities (e.g., children, elderly, virtual, face-to-face, prevention, treatment, aftercare, intervention, etc.) • Identify and define areas for cost avoidance to prevent unnecessary spending costs • Advocate at the state level for increased mental health and behavioral health funding for services and to accommodate for higher salaries • Leverage existing resources (e.g., VA) • Advocate for recurring funding from the state	• Increase funding for the homeless population • Increase funding for creation of affordable and supportive housing for target population • Increase funding for ALFs, group homes and locations that provide level of care that doesn't require Medicaid or sobriety • Increase funding for supportive services • Create a financially stable mechanism to fund all services needed for the population • Invest in more stable organizational funding for capacity building.
Internal Processes	• Ensure Cross-System Data Integration and Communication • Develop a process by which the jail can be notified in real time that an inmate will be released • Develop an interdisciplinary review team/community re-entry team, which includes family members/caregivers to review high-utilizer cases • Increase the use of co-response and alternative response models • Co-locating service providers to enable quicker response times and easier access to services • Develop specialized caseloads to serve individuals with mental health concerns	• Expand the use of peers to promote consumer/client engagement and improve outcomes across the array of Orange County community-based programs • Build system capacity to incorporate peer and natural supports in the ongoing treatment of consumers • Increase the use of best practice protocols in peer service delivery and the monitoring of outcomes • Increase training, staff development and public education activities based on guidelines reflecting current best practices for cultural and linguistic competence. • Day-to-day case management database system • Develop a third-party local advocacy council to provide oversight of client satisfaction and other recommendations • Develop and implement plans to incorporate consumer/client input to inform decision-making related to program and service improvements	• Improve care coordination to assist service recipients to overcome barriers to care (e.g., lack of transportation) • Create a mechanism for information sharing (interoperability) between medical and mental health delivery systems, community, education and social service providers • Improve inclusive, culturally and linguistically responsive service provision • Improve collaboration with law enforcement and emergency medical systems, including training around mental, emotional, behavioral health issues, impact of trauma (especially in the early years) and trauma informed practices. • Improve recruitment and retention of mental and behavioral health professionals	• Amend screening standards to allow Increased access to affordable housing (low barrier housing) • Minimize barriers in housing homeless persons • Diversify the housing options available to include shared housing, which matches similar person (i.e., senior, trauma care, ALF, youth options aging out of foster care) • Increase Medicaid utilization, including the Medicaid pilot • Prioritize development of affordable and supportive housing in funding allocations and planning across agencies • Maximize the use of and access to data • Increase access to services through automated, web-based means where appropriate • Increase the number of mental health professionals who collaborate with street-based outreach teams

Learning & Growth	• Implement broad-based education initiatives with a mental health and trauma focus (including adverse childhood experiences) • Establish alternate facility for low-demand individuals • Develop a Peer Respite Program • Provide wraparound services • Increase the number of Mobile Crisis Teams and broaden the reach to adults • Engage academia to develop tuition assistance programs for the mental health workforce pipeline • Offer paid internships and license supervision for mental health counselor interns and case managers	• Improve public understanding of peer services • Increase awareness of and counteract stigma around mental health and substance use disorders • Increase access to safe and nurturing environments (Respite Centers) for youth. • Increase access to safe and nurturing environments for adults (Drop-In Center). • Increase availability of and access to evidence-based practices. • Increase law enforcement and the provider community's training awareness from a peer perspective • Increase the understanding of the role of peer specialists (training) • Increase the use of peer responders on Mobile Response teams • Increase resources and supports provided to peer-operated center, to connect hard-to-reach consumers/clients and their families with clinical treatment • Schooling for kids who are suspended from school	• Improve public knowledge base of where to call for help, not always 911 (see 988 materials) • Develop educational campaigns • Cultural and linguistic education and assistance in completing the process for receiving services • Increase diversity in the workforce • Increase opportunity to engage in evidence-based therapeutic modalities • Increase cross training between physical health and mental, emotional, behavioral health providers to increase capacity • Support and promote enhanced mental health certification • Increase knowledge through cross-discipline affinity groups	• Increase training across all sectors in Mental Health 101 and evidence-based/best practices • Examine best practices to develop a high performing and comprehensive "system of care" (ex. Veterans Administration) • Integrating a client-centered approach to training across sectors • Increase utilization of peer supports
Consumers	• Ensure temporary supply of medication at time of release from incarceration • Reduce number of individuals released from jail without access to medications • Ensure a warm handoff to service providers • Increase availability of on-call community partners • Utilize navigators to provide case-management for individuals meeting predetermined criteria (high utilizers) • Reduce the number of rearrests of individuals out on conditional release on misdemeanor offenses by providing supervision structure • Develop enhanced alternatives to incarceration and arrest	• Consumer will have a better understanding of what peer services are • Increase satisfaction with services • Improve the consumer/client experience with the mental health and substance use disorder service delivery system • Develop mechanisms to support siblings of the child/youth with the diagnosis • Build upon/expand respite programs currently available for parents raising a child with an emotional, behavioral or mental health need and drop-in adult programs	• Improve the consumers' ability to identify service providers in their community • Decrease barriers to access to care • Improving recovery-oriented care • Increase community awareness of importance of mental and physical health and the mind-body connection • Empower service recipients to be active participants in their care • Build a system that's patient centered. • Leverage existing resources (e.g., VA) • Increase the adoption and availability of telehealth services to improve access for consumers for whom distance to services is a barrier • Establish place-based service initiatives in areas lacking access to social service needs	• To the extent possible give consumers control of the choices and their own care • Access to housing is seen as user-friendly • Meet consumers where they are (e.g., resentment - facing issues not yet ready to accept and lack of trust) • Enable consumers to see us as a seamless holistic system of care • Ensure consumers understand the "system of care" and the resources that exist • Increase access to medication

APPENDIX C: POTENTIAL INITIATIVES TO ADVANCE THE OBJECTIVES

	Criminal Justice	Advocacy	Continuum of Care	Homelessness & Housing
Financial		• Engage Consumer/Peers/Family voice to advocate on legislative issues • Research other areas that have been successful in promoting family-run and peer-led organizations to identify funding sources and other means of sustainability	• Create plan to support increasing population and needs in our region • Blending and braiding	• Enhance public/private partnership in seeking funding and decrease reliance on the public sector side • Establish housing options for service providers • Develop marketing campaign for the purpose of approaching funding partners • Explore additional vouchers for the continuum of care and PHA that could be used for project-based or sponsor-based programs to facilitate financing for housing (limited number of vouchers may impact ability to do this) • Examine opportunities to make organizational capacity-building grants
Internal Processes	• Utilize a case manager to act as an intermediary between jail and court to facilitate communication of hearing outcomes • Develop a practice of asking the inmate about need for prescription upon release • Appointments for services scheduled in advance of release through liaisons based at the jail • Establish a policy for co-response for individuals in crisis with known mental health concerns • California model to help with expansion of alternate response model in partnership with Orange County government	• Develop and implement plans to incorporate consumer/client input to inform decision-making related to program and service improvements. • Connect with other family/peer support models through webinars/trainings, etc. • Research on the family/peer support models being recognized nationally and internationally • Ensure certifications are current • Develop a third-party client satisfaction survey that is offered to the community about our current provider system.	• Language access (translation, interpretation) • Increase accessibility of internet access to under-resourced clients/patients • Provide ongoing professional development opportunities for staff to increase understanding of CLAS standards and strategies to provide culturally responsive services • Create mentoring opportunities for individuals pursuing licensure in the mental health field with a specific focus on increasing diversity in the field • Conduct wage comparability studies for key positions • Provide information to individuals pursuing licensure about loan repayment opportunities	• Improve tracking and compliance • Pilot automated systems with segments of the target population prior to broad-based dissemination • Assess processes across the system and identify inefficiencies (see objective – Consumer-Seamless Holistic System) • Increase awareness of and encourage participation in EAP benefit offerings
Learning & Growth	• Utilize private ambulance company as possible alternative to law enforcement for transporting individuals in need of care • Appointments for services scheduled in advance of release through liaisons based at the jail • Mirror Miami-Dade County's start-up of their homeless assistance center for wraparound services	• Expand peer and natural support initiatives and models based on best practices to bridge peer-identified gaps in behavioral health services • Implement public education campaigns on understanding and providing support to persons with a mental health diagnosis • Develop educational campaigns to increase consumer awareness and understanding of peer services • Advocate for strengthening peer support certification processes to including topics related to cultural competency, co-occurring rates for substance abuse and mental illness, ways to help individuals dealing with life struggles that are not directly related to behavioral health (i.e., grief, trauma, or other life struggles • Work collaboratively to tie awareness activities to existing initiatives (e.g., suicide prevention day) • Develop best practices around messaging • Peer led advocacy around cultural considerations	• Continue to message importance of overall health care and vaccination to promote overall behavioral health • Increase community myth-buster talks, webinars • Consider new therapies as appropriate (ex. sensory therapy) • Identify culturally responsive ways to include family and natural supports • Behavioral health hubs • Support and promote enhanced mental health certification	• Advocate for training funding • Learning from the consumers themselves and allowing them to be part of their care
Consumers	• Transform the former home confinement office into a substation for community partners to arrange continuation of care for those with "do not house alone" designation • Utilize navigators to help • Schedule a med-management appointment between the time of release and the time medication runs out • Engage family members/caregivers	• Ensuring that peers understand how to explain what their role is • Implement training, staff development and public education activities based on guidelines reflecting current best practices for cultural and linguistic competence • Identify states that do not have Medicaid Expansion and to learn strategies for supporting families/youth/consumers • Provide platforms for siblings of individuals with mental health diagnoses		• Advocacy to expand Medicaid • Explore options to provide support to clients in obtaining necessary documentation • Improve means of communication during the process • Co-locating mental health professionals on site with case managers