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Florida Commission on Mental Health & Substance Abuse Final Report

Florida Commission on Mental Health & Substance Abuse

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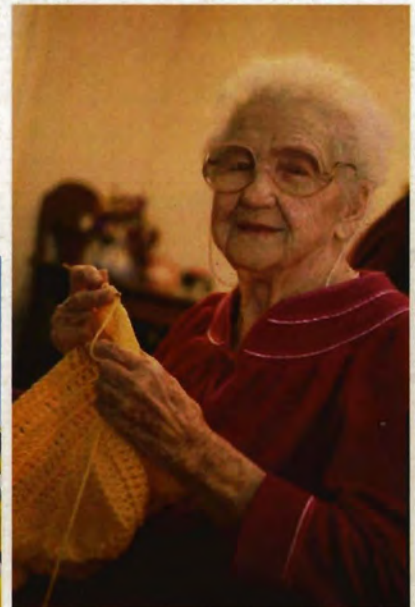
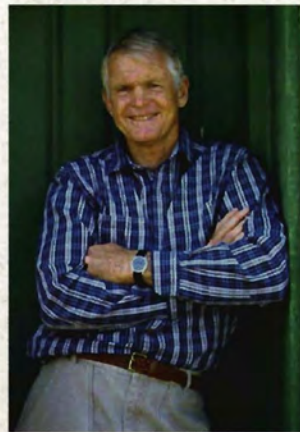
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Florida Commission On **Mental Health & Substance Abuse**



Final Report
January 2001

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Vision Statement

“All Floridians shall have access to a mental health and substance abuse system that works, with integrated treatment and prevention services that are affordable, client sensitive, high quality and outcomes focused, available within an unimpeded continuum of care.”

Acknowledgements

We acknowledge with appreciation the extensive efforts of the following Louis de la Florida Mental Health Institute colleagues in staffing and documenting Commission meetings and in developing and producing this report:

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January, 2001

The Honorable Jeb Bush
Governor of Florida

The Honorable John McKay
President of the Florida Senate

The Honorable Tom Feeney
Speaker of the Florida House of Representatives

Dear Governor Bush, President McKay, and Speaker Feeney:

The Florida Commission on Mental Health and Substance Abuse was created by the 1999 State Legislature to review and evaluate the state's mental health and substance abuse system and make recommendations for change. The Commission is made up of 23 diverse professionals from throughout Florida who have served voluntarily with commitment and integrity.

Several key themes emerged from our year-long meetings and research:

- Florida's services system for mental and addictive disorders is extremely complex and diffuse. A diverse network of service settings has evolved that comprises traditional programs concentrated in the Department of Children and Families' Mental Health and Substance Abuse Program Offices and a large number of other state and local programs.
- The state of the science in both mental health and substance abuse has also changed dramatically. Diagnosis and treatment for mental and addictive disorders have improved substantially.
- No one governmental entity is responsible for leading the overall system and for assuring that our practices parallel recent advances in science.

First, it is clear that Florida's services system for mental and addictive disorders has changed dramatically from its original concentration in the Department of Children and Families (DCF). The problems that were identified to us in public testimony are often found in settings outside those traditionally considered to be the public mental health and substance abuse (MHSA) system. Jails, prisons, juvenile justice facilities, primary health care settings, hospital emergency rooms, schools, child safety programs, income support programs, adult assisted living facilities, and nursing homes are among the settings in which MHSA problems present difficult challenges. We came to call this diffuse group of human service settings the combined or overall MHSA system to distinguish it from the traditional system located within DCF. We have come to understand that what happens (or fails to happen) in one service setting has an impact on other settings and on the system as a whole, not to mention the individuals served within it. Focusing only on the traditional DCF programs in our deliberations and recommendations, we realized, would miss these important interactions in the combined system and would simply not be sufficient to craft effective, long-term solutions.

We therefore chose to define the MHSA system broadly, embracing the full spectrum of settings that reflects the combined system. Our analysis indicated that only through this comprehensive perspective could we successfully address the chronic problems confronting our communities.

Second, we also realized that we live in extraordinary times, following 30 years of unprecedented scientific advancement in the treatment of mental and addictive disorders. Dramatic improvements have occurred in our ability to diagnose and treat these illnesses. We now have strong scientific evidence for the effectiveness of treatments as well as the impact of untreated illness on our communities. In order to build on this science base and realize its potential, however, we must improve our practices.

Third, perhaps the most important finding of this Commission is that no one entity is attending to the overall system, especially with regard to mental health policy. (Substance abuse is addressed in a structured system, as this report will explain). No entity of government provides the leadership needed across diverse treatment settings, differentiating the roles of agencies and articulating a strategy for the overall improvement of the system. No one is charged with integrating information about the performance of these wide-ranging settings. This absence of a single point of accountability has made governance of the system far more difficult than architects of the original public system anticipated.

We drew these conclusions following a year of extensive, systematic data collection. In our monthly meetings around the state, we heard from national, regional and community experts about our science and our practice. Perhaps most importantly, we heard testimony from hundreds of Floridians whose firsthand experiences in trying to access services galvanized our commitment to address these chronic problems. We learned that while there have been many successes and innovations in Florida, it is undeniable that many people with mental and addictive disorders receive less than optimal care – and sometimes no care at all.

To address these problems, the Commission formed three workgroups that concentrated on the needs of children, adults and older Floridians, and one workgroup charged with an in-depth analysis of available data and a critique of the current information management system. Finally, we formally interviewed representatives from all the state agencies and departments that, in addition to their primary missions, provide treatment for mental and addictive disorders.

Based on all of this input, we have crafted a set of findings and recommendations that will, if implemented, begin to fundamentally change Florida's approach to these problems. We have identified a strategy that will require statutory changes to accomplish two major objectives:

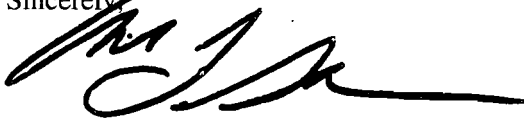
- First - Establish a statewide leadership entity similar to the Office of Drug Control Policy, but one that integrates mental health and substance abuse issues wherever they affect the health of our communities.
- Second - Redefine and clarify the role of traditional MHSA programs to provide greater specificity in targeting resources, greater leverage in establishing responsibility for persons most in need of care, and greater flexibility in contracting and purchasing services.

In our primary recommendations and in the four workgroup reports appended to this report, we have

developed a vision for the public's health related to mental and addictive disorders. At its December 15, 2000 meeting, the 18 Commission members present voted unanimously to adopt the Commission's report, including its findings and recommendations, in its entirety. One member Daniel Lestage, M.D., offered a dissenting opinion on three specific recommendations. His comments are appended to the end of this report.

The body of this report is a synthesis of the extensive work done by these workgroups and the full Commission. We urge you to read the four workgroup reports, as they contain specific findings and recommendations related to their areas of concentration. Finally, we urge you to carefully consider the Commission's overall recommendations and support them in the months ahead.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Shern', with a long horizontal flourish extending to the right.

David L. Shern, Ph.D.
Commission Chair

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**FLORIDA COMMISSION ON MENTAL HEALTH
AND SUBSTANCE ABUSE**

FINAL REPORT

Dissenting Opinion of Commissioner Daniel B. Lestage, MD, MPH

This statement is made in exception to specific recommendations outlined in the Draft Final Report acted upon by the Commission at its meeting held December 15, 2000.

The comments herein address the recommendation statements cited under Recommendation 8 and extend to like statements or recommendations that may be contained in the Final Report, including appended reports of the Commission's four (4) working committees.

The enacting legislation provided for twenty-three (23) Commissioners including a "representative of an insurer offering behavioral and physical health insurance benefits." As the health insurance industry member of the Commission, my views are intended to represent the interests of the some 5.2 million subscribers currently covered by health insurance and health plans in Florida.

RECOMMENDATION:

Floridians be assured timely access to state of the art pharmaceutical treatment including the use of standardized decision algorithm.

OPINION:

While this is a highly desirable goal, the statement clearly goes beyond the scope of the publicly funded system the Commission has been charged to address. It is not clear from the testimony and materials reviewed by the Commission that this issue was explored adequately to determine inadequacies in and specific recommendations for the pharmaceutical benefit in the public system. Furthermore, no exploration of this issue was made with regard to the private system.

RECOMMENDATION:

Financial barriers to the receipt of care should be removed through the provision of insurance benefits for mental, addictive and general health conditions that are at parity with general health benefits. No longer is it acceptable to discriminate against persons with MHSA disorders in terms of insurance coverage.

OPINION:

This statement raises questions of affordability, quality and cost in the privately funded system of care. There were no formal presentations or attempts at formal discovery in regards to the private insurance industry and its role in providing access to quality, affordable choices that include mental health and substance abuse services. While anecdotal comments were received by the Commission, there were no opportunities afforded to better understand the private sector's role, analyze its effectiveness or identify specific opportunities for improvements. This recommendation is particularly disconcerting in the absence of any proposed "Finding" in this regard. Further, the reference to discrimination is inflammatory, judgmental and without merit.

**FLORIDA COMMISSION ON MENTAL HEALTH
AND SUBSTANCE ABUSE**

FINAL REPORT

Dissenting Opinion of Commissioner Daniel B. Lestage, MD, MPH

RECOMMENDATION:

The Coordinating Council should promote policies to increase consumer choice. Specifically, the Commission recommends the following activity:

- ♦ Give consumers full choice of qualified, licensed providers for those services that require licensure.

OPINION:

Choice is an all important issue to consumers and must be respected and promoted. Notwithstanding, these statements are made without regard to the cost, quality, access equation. The Commission was not presented any data that the public system denies appropriate choices given the resource constraints under which it operates. The Commission neither studied nor was provided data to justify such a recommendation with regard to the private sector. This “any willing provider” statement is an insupportable recommendation that serves to discredit the otherwise well intentioned and constructive work of the Commission.

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Executive Summary

BACKGROUND

The Florida Commission on Mental Health and Substance Abuse was created in 1999 to conduct a systematic review of the state's mental health and substance abuse system. The Commission was asked to make recommendations in areas including planning, service strategies, funding, accountability, emergency behavioral health services, and the unique needs of older persons.

Twenty-three Commissioners from throughout Florida were appointed by the governor and the legislature to broadly represent the key constituencies in mental health and substance abuse. Four workgroups were formed to examine and report on special issues including: 1) information needs and technology; 2) children's; 3) adults'; and 4) older adults' mental health and substance abuse needs. Their extensive research and recommendations helped significantly to inform the Commission's work. The full reports of these workgroups are appended to the Commission's report.

DESCRIPTION OF THE STATE'S CURRENT MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM

Although the Department of Children and Families (DCF) has traditionally been considered the public mental health and substance abuse (MHSA) system, MHSA services are delivered in many settings outside of DCF. These settings include jails, prisons, juvenile justice facilities, primary health care facilities, hospital emergency rooms, schools, children's residential facilities, adult assisted living facilities, nursing homes and many others. The Commission therefore, chose to define Florida's MHSA system broadly. This diffuse group of human service settings is defined as the combined, or overall, MHSA system and the DCF programs are referred to as the traditional system. While it is clear that MHSA problems permeate all of our human service systems and underlie many of our most vexing social problems, our responses are fragmented. Better recognition and management of these problems holds great promise for improving the work of these human service programs and ultimately, the health and productivity of our communities.

COMMISSION FINDINGS

The Commission found that:

- The state of the science in both mental health and substance abuse has improved dramatically during the last 20 years. We now have proven techniques to successfully treat most mental and addictive disorders. With appropriate care, most people - even with the most severe disorders - can recover and become productive members of their community.

- Unfortunately, our practices significantly lag behind our knowledge, both in treatment and in service system design. The ways that we organize, finance and manage our system do not comport with our knowledge. We must improve the efficiency and effectiveness of the overall system.
- We have compelling reasons to better address these issues. Mental and addictive disorders are significant public health problems. According to the US Surgeon General, mental illness is the second leading cause of disability and premature death in the United States, following only cardiovascular disease.
- Due to failures in emergency care, local law enforcement systems are experiencing significant problems with persons with mental illnesses being arrested and jailed for minor offenses. The majority of persons in juvenile justice and corrections facilities have mental or addictive disorders. Our jails and prisons are now our largest mental hospitals.
- Financial and bureaucratic barriers, as well as continuing problems with stigma, all contribute to persons not receiving the care they need in order to avoid poor outcomes. Our communities suffer substantial expense and losses in human capital because of the shortcomings in our system.
- While we can document the significant costs associated with our current approaches to these complex problems, we have not organized an effective response at a statewide level. Many creative examples of local initiatives were presented to the Commission and represent important efforts. Similarly, specific state initiatives have been effective but none represents a system-wide strategy to these problems.
- The Commission found that the statutory basis for the publicly funded mental health system within DCF is in need of important revision to better reflect the current state of our science and the changing role of DCF services.
- The Commission also found that a new leadership function is required to better comprehend and manage the overall MHSA system. This leadership will rely on new information technologies and improved science to understand the interaction of the disparate parts of our MHSA system and to provide a forum within which all interested parties can craft a comprehensive strategy to improve the public's behavioral health.

COMMISSION RECOMMENDATIONS

T*o accomplish these ends the Commission of Mental Health and Substance Abuse recommends that:*

1. A statewide Coordinating Council for Mental Health and Substance Abuse be created in statute. Since MHSA problems affect all aspects of our human service system, the Council should be located in the Office of the Governor and be composed of leadership from across human service departments. This Council will be coordinated with the Office of Drug Control and charged with leadership of the overall system, including the production of a statewide strategy for mental health and substance abuse services.

2. The Coordinating Council provide and coordinate a wide range of prevention and education activities to inform the public of the signs and symptoms of MHSA disorders, that effective treatments are available and that early intervention into these problems can effectively reduce their negative impacts. The education activities ultimately will result in decreased stigma and discrimination for MHSA problems
3. The state statutes related to the traditional mental health and substance abuse system be updated to better conform to the realities of the contemporary service environment and knowledge base. The revised laws should better define the role and priorities of the DCF system and provide DCF with the management and purchasing tools needed to fulfill its missions. DCF should be charged with assuring an accountable system of MHSA services throughout the state by:
 - ♦ establishing local management entities and local advisory groups to organize and manage local service systems,
 - ♦ assuring single points of responsibility in each locality for persons with the most disabling illnesses,
 - ♦ removing bureaucratic barriers to the provision of integrated services to facilitate the well being and recovery of persons with the disabling illness,
 - ♦ disseminating state-of-the-art approaches for serving persons with MHSA disorders,
 - ♦ providing benchmarks to evaluate the adequacy of local system functioning, and
 - ♦ devising performance management systems that promote the use of effective treatment, support and rehabilitative technologies within local service contracts.
4. Adequate emergency response capacity must be uniformly available throughout Florida. In conjunction with local planning authorities, the DCF should develop and implement methods of estimating needed emergency capacity and assure that these services are available and accessible. The erosion in state funding for emergency services that has occurred during the last five years should be addressed through increased appropriations.
5. In order to recover, persons with disabling disorders require ongoing treatment, support and rehabilitative services that are age appropriate. The DCF, in conjunction with the local management entities, should establish criteria for identifying persons with ongoing need and implement a process to enroll these individuals in continuing care services. Once enrolled, single points of responsibility for their care should be established. Flexible purchasing mechanisms should be established within a strong accountability framework to assure that the broad range of service needs can be addressed efficiently.
6. The Commission identified a number of specific groups that are inadequately served by the current system due to limitations in our knowledge base, the complexity of their problems, their cultural context or their preferred methods of receiving services. Groups such as older Floridians, children in the dependency system, persons with both mental illnesses and substance abuse disorders, among others are specifically discussed. The Council should initiate special studies and demonstration programs to better understand their needs and ways to

efficiently meet those needs.

7. The Commission recommends that the Coordinating Council place particular emphasis on persons served in the law enforcement, corrections and court systems. Whenever possible, individuals should be diverted from incarceration into treatment and when incarcerated, they should receive effective treatment for their disorders.
8. Access to effective MHSA services underlies many of the problems that plague this system. The Commission recommends that DCF and the Coordinating Council continue to focus on the problems of access and choice. For example, Floridians should be assured access to state-of-the-art pharmaceutical treatments. They should also have access to insurance coverage for mental and addictive disorders on par with general health insurance benefits. In order to increase access, the Coordinating Council should ensure that the state pursue all available federal funding opportunities and promote policies and programs designed to increase consumer choice.
9. The Coordinating Council should promote the development of post secondary educational programs to provide state-of-the-art knowledge for Florida's professional and para-professional service providers that is responsive to the environments in which they will practice.

Chapter 1

History & Overview

INTRODUCTION

Florida's services system for mental and addictive disorders has changed dramatically in the last 50 years. Earlier in our state's history, individuals with serious mental illnesses (along with several other groups including persons with dementing illnesses) were treated primarily in large, publicly supported state mental hospitals. People with less serious illnesses were typically seen in the offices of private psychiatrists or, more likely, received no care for their mental illnesses. Florida's publicly funded mental health services operated under a state policy with clear boundaries between relatively few service providers. Compared to today's science, little was understood about the causes of mental disorders, and far fewer scientifically validated treatment options were available.

In 1971, Florida's mental health laws were substantially revised. Chapter 394 Florida Statute authorized the publicly funded mental health and substance abuse (MHSA) system, and the Baker Act was created.

With the development of newly effective psychotropic medications, as well as health insurance and income supports available through the social security system, many hospital patients were released into the community. Under federal sponsorship, community mental health centers proliferated, and specialty mental health services providers such as clinical psychologists, licensed mental health counselors, clinical social workers and others developed practices. Relatively few sources of mental health funding existed. These included general revenue (state taxes), Medicare, Medicaid and a predominantly fee-for-service private insurance system.

Florida's system has moved steadily toward change.

What had been a fairly simple service system became increasingly complex. A hybrid MHSA system evolved as a patchwork of mainly community-based settings comprising public and private sectors, general health and specialty mental health providers, as well as social services, housing, criminal justice and educational agencies. In addition to the traditional MHSA services provided under the auspices of Florida's Department of Children and Families (DCF) Mental Health and Substance Abuse Programs, a number of state agencies (including the Departments of Education, Corrections, Juvenile Justice, Health, and the Agency for Health Care Administration (AHCA)) now all provide or finance MHSA services. This is what we call the non-traditional, or non-DCF, MHSA service system. Law enforcement and the judicial system have emerged as prominent gatekeepers to the mental health and substance abuse treatment systems. In fact, MHSA services are currently provided in no fewer than 13 distinct service environments, including jails, prisons, juvenile detention centers, nursing homes, residential programs, emergency rooms and hospitals, crisis units and detoxification facilities, physicians' offices, schools, and assisted living facilities, as well as the individual's or family's home. (See *Figure 1.1*, page 2)

The resources and services that are provided through DCF's Mental Health and Substance Abuse Programs as well as the services that are financed by the Medicaid program in the Agency for Health Care Administration (AHCA), represent what has traditionally been identified as Florida's publicly funded mental health and substance abuse systems. However, there is growing recognition of the important roles that other providers play in the delivery of mental health and substance abuse services. As explained in the Preface and illustrated in *Figure 1.2*, DCF remains an important part of the publicly funded system, but is by no means the only provider of services. It is important to understand

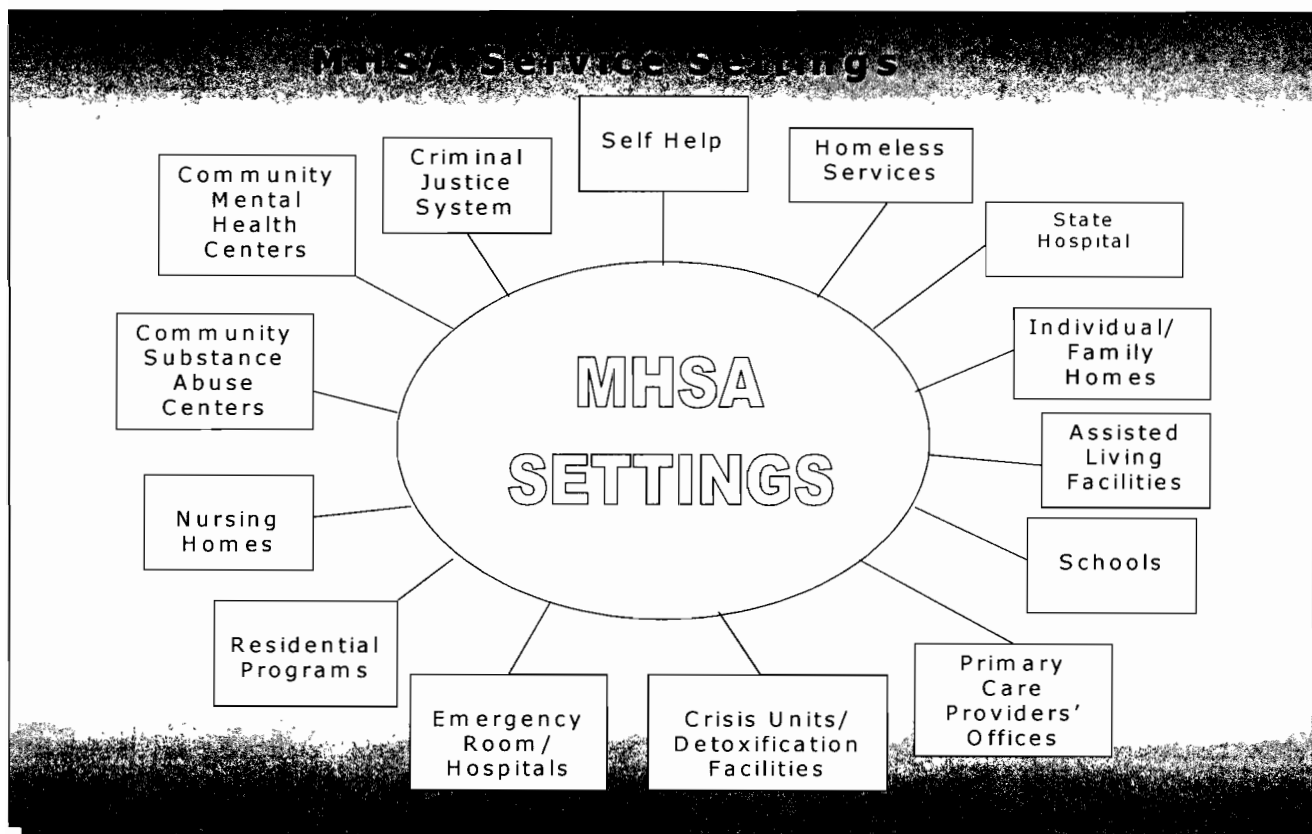


Figure 1.1

the roles of all service providers and the relationships among them and with their clients.

On the substance abuse side, 50 years ago, substance abuse and addictive disorders were regarded as character weaknesses rather than treatable medical conditions. Consequently, few treatment options existed. In response to a rapidly growing science base that began to recognize addictive disorders as medical illnesses that could be treated successfully, substance abuse treatment facilities and services have developed, become increasingly professional, and flourished in recent years.

Currently, it is estimated that nearly \$5 billion is spent annually in Florida on mental health and substance abuse services in the combined MHSA system. Services are financed through a variety of sources including state general revenue (i.e., taxes)

and trust funds, federal block grants and entitlement programs (including Medicaid), local governments, and special taxing districts.

It is now difficult to define the state MHSA system because, with an extensive diffusion of responsibility and roles, a blurring of service system boundaries has occurred. In contrast to the few, fairly centralized funding streams of the past, today Florida has at least 10 different funding streams involved in the provision of public mental health and substance abuse care, often within the same service sector. (Figure 1.2) As managed care has emerged as a financing strategy for both mental and addictive disorders, for-profit entities have emerged as major care providers.

In order to better understand the current environment within which mental health and substance services are provided, surveys were

conducted with the following state agencies:

- Department of Children and Families, (Mental Health, Substance Abuse, Developmental Services, Adult Services, Family Safety)
- Agency for Health Care Administration
- Department of Corrections
- Department of Education
- Department of Health
- Department of Elder Affairs
- Department of Labor
- Department of Juvenile Justice
- Office of Drug Control
- Florida Department of Law Enforcement

In addition, information was obtained from agency web site locations and from numerous agency documents. The following section reflects the outcomes of those efforts.

It should be noted that this list does not represent all the auspices under which mental health and substance abuse services are provided. For example, private insurance entities that reimburse primary care physicians and other specialists such as private psychiatrists and psychologists are not included in this description, but likely represent an important segment of the system.

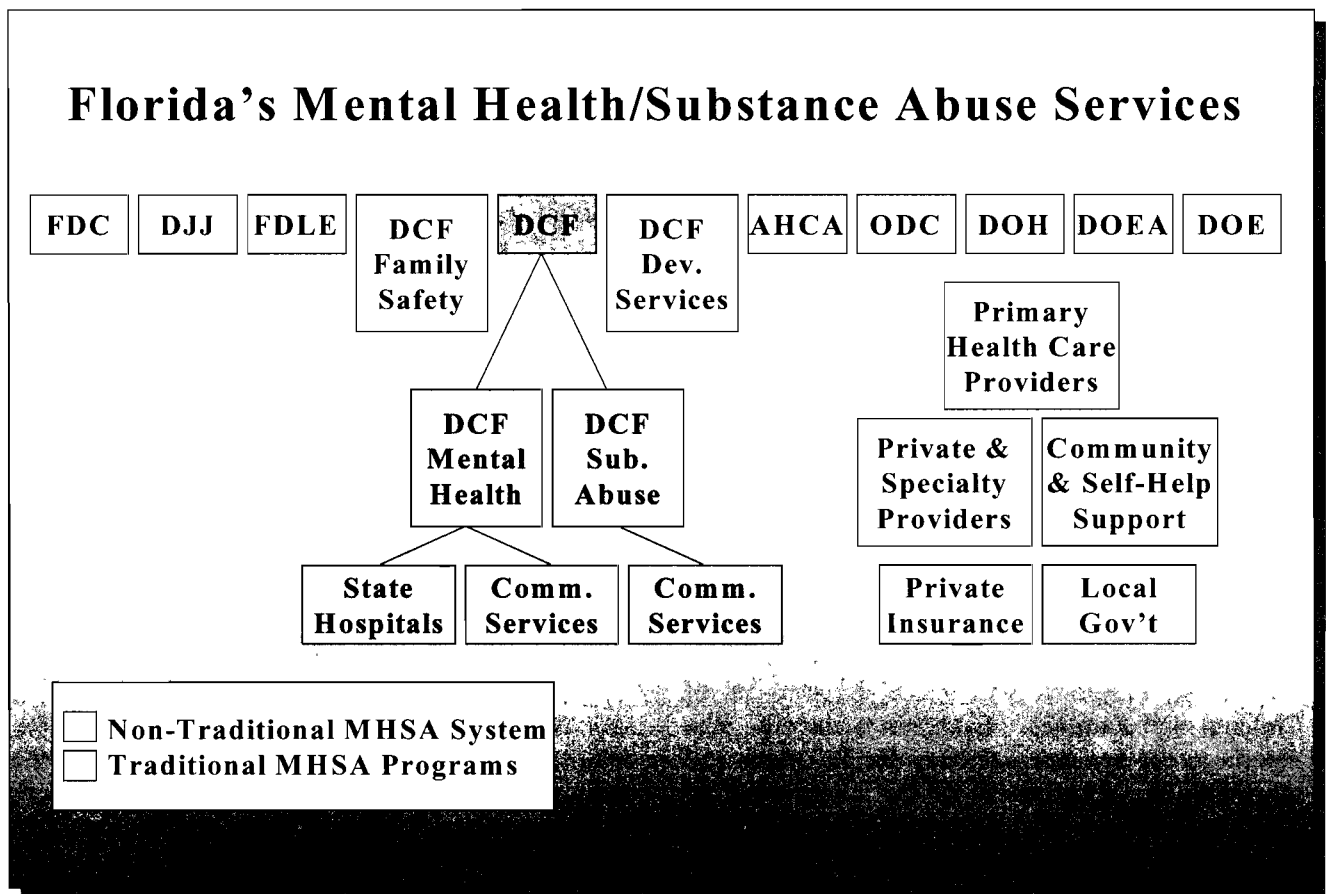


Figure 1.2

THE MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM OF SERVICES

DEPARTMENT OF CHILDREN AND FAMILIES (DCF) MENTAL HEALTH & SUBSTANCE ABUSE PROGRAM OFFICES

Chapter 394 Florida Statute (F.S.) is the primary authorizing legislation for the traditional publicly funded mental health system. It includes procedures for involuntary mental health treatment, the administration of the mental health system, the provision of children's mental health services, interstate compact, and the commitment of sexually violent predators. Chapter 915 F.S. authorizes mental health services for people with criminal charges (i.e., adults found not guilty by reason of insanity and adults found incompetent to proceed to trial).

Chapter 397 F.S. is the enabling legislation for Florida's publicly funded substance abuse system. Similar to the mental health legislation, Chapter 397 specifies the procedures for involuntary treatment and delineates client rights, defines children's substance abuse services, and establishes the Office of Drug Control and the Statewide Drug Policy Advisory Council.

System Structure and Planning

There are separate Mental Health and Substance Abuse Programs within the Department of Children and Families. Each has a director who reports to the assistant secretary for Programs and ultimately to the secretary of the Department of Children and Families. Currently, each of the 15 DCF districts has an administrative structure that is responsible for the management of the mental health and substance abuse programs in that district

(commonly referred to as ADM district offices) including planning, program development, contract negotiation, monitoring of providers, service monitoring, and drug abuse licensure. Each district office is uniquely structured, with some districts having additional programs included in their responsibilities (e.g., developmental disabilities).

District office staff report directly to their district administrators. In addition, the district administrators are responsible for state hospitals that are within their district's geographic boundaries.

All state agencies are statutorily (Chapter 216.013 F.S.) required to develop long-range program plans. Planning is also a federal requirement under the mental health and substance abuse block grants that Florida receives. A statewide Mental Health Planning Council including primary consumers, family members, and representatives from state agencies meets quarterly. The Council's role is to review and comment on the state's application for mental health block grant funds, to oversee the publicly funded mental health system, and advocate for mental health programs. Substance abuse is not an explicit part of their responsibilities.

A Strategic Plan for Florida's Mental Health Program For 1998-2002 was developed with the participation of a wide variety of stakeholders. Additional plans also were prepared for substance abuse and the mental health treatment facilities.

A few district program offices currently conduct district level planning. However, recent amendments to Chapter 394 F.S. require that district planning for MHSA be re-instituted statewide. A combined plan for mental health and substance abuse services is anticipated.

Because of the decentralized nature of DCF, the relative autonomy of district administrators, and the unique characteristics of each geographic area, there is little uniformity across the state with respect to how district offices are structured and managed or how the service delivery systems are configured. Currently, DCF is reorganizing to create seven

regions from the present 15 districts. It is also privatizing many of the services that were previously provided by DCF staff, especially in the area of child welfare. In an effort to create more involvement with the community, Community Alliances are being created that will serve as a “focal point of community ownership and oversight of the system of care.” This reorganization is being phased in and will represent significant changes for the department and its staff over the next few years.

Services

A broad range of mental health and substance abuse services is currently available in Florida in a variety of settings. Table 1.1 represents the services available in the mental health and substance abuse programs in DCF. As previously noted, however, the structure of the service delivery system varies considerably across the state.

Currently, DCF operates five civil hospitals, two forensic hospitals, and a forensic unit located within one of the civil hospitals. These seven state

hospitals use slightly less than half of the resources allocated to the mental health program within DCF. In addition, a growing number of treatment beds now serve forensic rather than civil patients.

People gain access to behavioral health services through a variety of gateways. A person who is experiencing a mental health crisis generally is taken to the nearest receiving facility (often a crisis stabilization unit or hospital with psychiatric services) for assessment. In non-emergency situations, individuals can be referred for services by formal caregivers, their families, or through self-referral. Their needs are assessed and appropriate services are scheduled when they are available.

Persons in need of emergency substance abuse services are usually taken to a non-secure detoxification unit unless they require medical supervision, in which case they are taken to a hospital emergency room. In non-emergencies, individuals may access services through referrals from the courts, other service agencies, their families, or by self-referral. Timely access is dependent upon availability of services.

DEPARTMENT OF CHILDREN AND FAMILIES

Mental Health Program Services	Substance Abuse Program Services
<ul style="list-style-type: none"> • Emergency stabilization, including inpatient treatment. • Residential care • Case management • Outpatient services • Community support services (including consumer run programs and medications through the Indigent Drug Program) • Assertive community treatment teams • Longer-term inpatient treatment (including state mental health treatment facilities) 	<ul style="list-style-type: none"> • Prevention • Substance abuse detoxification / addictions receiving facilities • Treatment and aftercare (day and night programs) • Outpatient treatment • Outpatient aftercare

Table 1.1

The Mental Health and Substance Abuse Programs have identified target populations that should be given priority consideration in the delivery of services. Table 1.2 identifies the target populations for both programs.

PROGRAM TARGET POPULATIONS

Mental Health	Substance Abuse
<ul style="list-style-type: none"> • Children <ul style="list-style-type: none"> - With serious emotional disturbances - With emotional disturbances - At risk for developing emotional disturbances - Incompetent to proceed to Juvenile Justice • Adults <ul style="list-style-type: none"> - Serious and persistent mental illnesses (SPMI) - Mental health crisis - Forensic involvement - Civil commitment - Forensic commitment • Older Adults 	<ul style="list-style-type: none"> • Children <ul style="list-style-type: none"> - With substance abuse problems - At risk for substance abuse problems • Adults <ul style="list-style-type: none"> - With substance abuse problems • Older Adults

Table 1.2

Financing and Contracting

Currently, there are no financial eligibility requirements for individuals to receive publicly financed services, except those financed by Medicaid. However, recent legislation requires an assessment of persons' ability to pay for their treatment. Contracted agencies are expected to collect fees when possible. Publicly funded, community-based mental health and substance abuse services are funded through a variety of sources including federal block grants, state general revenue, Medicaid Title XIX and Title XXI, local county government, and client fees. State and federal funds are appropriated by the state Legislature each year and are designated under specific categories of services. Table 1.3 identifies those categories for mental health and substance abuse.

Local county governments are required by 394.76 (9) (a), F.S. to participate in the funding of alcohol and mental health services. It is estimated that counties have provided slightly more than \$57 million as match to DCF contracts. There is no match requirement for drug abuse services, although some counties do provide resources for those services. The match requirement for most DCF funded programs is a 75-to-25 state to local ratio. There are some mental health and substance abuse state-funded programs that are exempt from local match requirements.

Funding for state hospitals has been derived from state general revenue and federal disproportionate share monies. State funds appropriated for disproportionate share programs were matched with federal funds through Medicaid. Recently Florida has experienced a

**DEPARTMENT OF CHILDREN AND FAMILIES
FUNDING CATEGORIES
MENTAL HEALTH AND SUBSTANCE ABUSE**

Children	Adults
<ul style="list-style-type: none"> • Children's mental health services • Therapeutic services for children • Purchase of therapeutic services for children • Purchased residential treatment services for emotionally disturbed children and youth • Children's Baker Act • Juveniles incompetent to proceed • Child / Adolescent substance abuse services 	<ul style="list-style-type: none"> • Adult community mental health services • Baker Act services • Indigent drug program • Sexually violent predator program • Continuity of care • Community substance abuse services • Mental health treatment facilities

Table 1.3

\$30 million reduction in disproportionate share funding for the state hospitals, necessitating the closure of one of the five civil institutions, G. Pierce Wood Memorial Hospital.

DCF is authorized to contract for the establishment

and operation of local mental health and substance abuse programs with hospitals, clinics, laboratories, institutions, or other appropriate service providers. The following chart identifies the primary contracting mechanisms used.

**DEPARTMENT OF CHILDREN AND FAMILIES
TYPES OF CONTRACTS**

- **Performance** - indicates the number of units of various services to be delivered to targeted priority populations with specified outcomes, including unit cost-based budgeting.
- **Purchase-of-service** - purchases specific goods and services for a particular individual (frequently used for services for children).
- **Rate Agreement** - specifies the services to be delivered at an agreed upon cost for a referred individual or individuals.

Table 1.4

Other Programs Within DCF

The Developmental Services, Family Safety, and Adult Services Programs within DCF do not directly provide mental health or substance abuse services for the individuals they serve. Individuals in need of such services are generally referred to Medicaid or general revenue funded mental health and substance abuse providers in the community.

However, for persons with developmental disabilities “specialized mental health services” are included within the program’s service directory as an allowable service. Medicaid (through the Medicaid Waiver) will reimburse community Medicaid providers for those services on a fee-for-service basis, at a negotiated rate. Substance abuse services are not included in the service directory.

For individuals served by the Family Safety Program, in those instances where Medicaid or the Mental Health or Substance Abuse Programs cannot fund or provide for the necessary services, the Family Safety Program can purchase services from “Family Preservation” funds for the purposes of keeping the family together. While there is no accounting of those services currently at the state level (thus the type and amount of services that they may have received is unclear), Family Safety does coordinate substance abuse and mental health referrals and evaluations at the district level with the local ADM Office.

The Adult Services and Developmental Disabilities Programs do not have designated staff responsible for oversight of MHSA services. In Family Safety, however, the Child Abuse Prevention staff has responsibility for overseeing the mental health and substance abuse services that are provided to their clients by mental health and substance abuse providers. These three programs look to the Mental Health and Substance Abuse Programs within DCF to conduct the planning for mental health and substance abuse services.

AGENCY FOR HEALTH CARE ADMINISTRATION / MEDICAID

Medicaid has emerged as a major source of funding for mental health services. The Florida Medicaid program, administered by the Agency for Health Care Administration (AHCA), is designed to provide medical services to people with low incomes. Medicaid is funded jointly by federal and state government, with counties contributing to the costs of hospitals and nursing home services. Medicaid is authorized under Chapter 409 F.S.

System Structure and Planning

The AHCA Medicaid program has a regional structure with 11 local offices. A local Medicaid field office manager who reports to the field office bureau in Tallahassee supervises each office. Because of the prescriptive nature of the program, local offices have little flexibility or autonomy.

At the central office level, there is a Long Term Care and Behavioral Health Care unit, within which there are staff designated to address Medicaid MHSA services (among others) within the Medicaid program. Also, the Hospital and Outpatient Services unit within the Division of Managed Care and Health Quality is responsible for licensing, registering and regulating hospitals, outpatient and health care service facilities including crisis stabilization units, short term residential treatment units and partial hospitalization programs. The agency also licenses assisted living facilities and nursing homes.

Medicaid has no formalized planning process that specifically addresses mental health and substance abuse services. There is a state Medicaid Plan that outlines Medicaid program benefits. Amendments to the state’s Medicaid Plan must be legislatively approved as well as approved by the federal Health Care Financing Administration (HCFA).

The staff of the Long Term Care and Behavioral Health unit also participate in planning activities of other state agencies, such as DCF/ Mental Health, Substance Abuse, Developmental Services and Family Safety Programs, the Drug Policy Advisory Council, and the Department of Health.

Services

A variety of mental health and substance abuse services are reimbursable under the state Medicaid plan. Table 1.5 identifies the reimbursable mental health and substance abuse services.

MEDICAID / AGENCY FOR HEALTH CARE ADMINISTRATION

Reimbursable Services

1. Community mental health services
 - Evaluation and testing
 - Treatment planning and review
 - Clinic visits and medical services
 - Services by a psychiatrist or psychiatric ARNP
 - Therapy (individual / group)
 - Rehabilitative services
 - Day treatment
2. Intensive therapeutic on-site services and home / community-based services are limited to recipients under the age of 21
3. Comprehensive behavioral health assessments (limited to under age 21)
4. Specialized therapeutic foster care (limited to under age 21)
5. Behavioral health overlay services in Department of Juvenile Justice residential facilities (limited to under age 21)
6. Community services are available to Medicaid enrollees with mental health or substance abuse diagnoses, except for targeted case management and services identified only for children, which have further requirements for eligibility
7. Inpatient services, prescription medications, laboratory services, and physician services (including behavior diagnoses)
8. Services for individuals over the age of 65 years who are in designated psychiatric geriatric units within state mental health hospitals
9. Targeted case management for children
10. Targeted case management for adults
11. Intensive team case management for adults

Table 1.5

Financing and Contracting

The Medicaid program is funded through federal (56%) and state (44%) participation (some Medicaid programs have a different federal matching level). Each year the state Medicaid authority estimates Medicaid expenditures for behavioral health services and the amount of state match required in order to earn the federal portion. The Legislature annually allocates Medicaid resources in specific budget categories.

Medicaid reimburses for behavioral health services through a variety of mechanisms. Table 1.6 summarizes these various strategies. Fee-for-service is a process by which providers bill Medicaid for eligible services provided to Medicaid recipients. To bill for community mental health services, providers must either have a contract or rate agreement with the district ADM office. Medicaid pays a fixed rate for the particular service that is provided.

Medicaid has also begun to implement managed care strategies, using prospective payments for behavioral health services. They obtained a 1915B waiver from HCFA that has allowed them to implement a capitated financing strategy in one area of the state (west central Florida) as a demonstration project that puts managed care entities at risk for the provision of mental health services for Medicaid recipients.

In the demonstration site (and soon to be expanded to other sites) Medicaid recipients who select Medicaid's MediPass program for the delivery of their health care services have their mental health needs provided through a prepaid mental health plan. Providers within that plan are paid a per member per month fee that is based on the age and eligibility category for the enrollees assigned to their plan. For that fee, providers are at risk for all the enrollee's mental health services, with the exception of medications that are still reimbursed on a fee-for-service basis. Substance abuse services will be added to the benefit structure in these plans as of January 1, 2001.

Medicaid recipients who enroll in a Medicaid HMO for their health services receive their mental health services through the provider networks selected by the HMOs. Those providers may be reimbursed for services by the HMOs or by their behavioral health organizations (BHOs) on either a fee-for-service basis or a sub-capitation payment. The sub-capitation payment is a negotiated amount between the provider and the HMO or BHO. Under the sub-capitation agreement, like the prepaid plan, the behavioral health provider is expected to provide all the services needed by the enrollee and is paid a flat fee per member per month. In contrast to MediPass, HMOs are at risk for the medications needed by their members.

The agency also has initiated another form of payment for health services (including behavioral

MEDICAID / AGENCY FOR HEALTH CARE ADMINISTRATION

- **Fee-for-Service** - providers bill Medicaid for eligible services provided to Medicaid recipients.
- **Capitated Financing** - places managed care entities at risk for the provision of mental health services of Medicaid recipients through a flat per member per month rate for enrollees.
- **Provider Service Network** - the network is paid a fee on a per member per month basis to manage the health services of those who enroll in the program. Managed services must be pre-authorized.

Table 1.6

health diagnoses). In Dade and Broward Counties, a provider service network called South Community Care Network has been formed. The network is paid a fee on a per member per month basis to manage the health services of those who are enrolled in the program. The amount of the fee is determined by the age and eligibility category of the Medicaid recipients. Providers in the network bill for their services on a fee-for-service basis, but managed services must be pre-authorized and the claims must be submitted to the managing organization before being submitted for reimbursement from Medicaid.

AHCA also has initiated statewide utilization management procedures aimed at containing or saving costs. These procedures require that inpatient (emergency and non-emergency) services be pre-authorized by the contractor for behavioral health care utilization management, First Health. Other services, including continued stay reviews, authorization for services for recipients with histories of high costs or service utilization, and retrospective on-site reviews are also conducted.

DEPARTMENT OF CORRECTIONS

System Structure and Planning

Other programs provide mental health and substance services for the people they serve even though it is not their primary mission. The Florida Department of Corrections (FDC) is one example.

Within FDC, an Office of Health Services is designated to oversee and plan for health services, including mental health services that are provided to people who are incarcerated in correctional institutions. The director of mental health is responsible for the mental health services of the department. Within some institutions, FDC psychologists directly provide mental health services. In other institutions, health services (including mental health) are provided by a contract provider in the facility.

The Bureau of Substance Abuse Programs within the Office of Program Services is responsible for the management and oversight of substance abuse services to incarcerated inmates and offenders on community supervision. Within FDC institutions, substance abuse services are either provided directly by FDC staff or by contract providers. For those offenders released from prison and placed on community supervision, substance abuse services are provided by contracted community-based providers.

While there is no formal departmental plan for substance abuse services as exists for mental health services, the Bureau of Substance Abuse Program Services participates in the planning activities of the Substance Abuse Program of DCF, the Florida Department of Law Enforcement and the Office of Drug Control.

Services

Within the Department of Corrections the following mental health services are provided either through departmental staff or through contracted providers:

- formal psychological evaluation
- crisis intervention
- individual and group therapy
- confinement assessment and monitoring
- case management services

The department operates six crisis stabilization units, five transitional care units, and one state psychiatric hospital. Designated facilities provide psychiatric assessment, prescribed pharmaceuticals, medication education, and inpatient services.

Substance abuse services are provided at 47 major institutions and work camps and 27 community correctional centers. Offenders under community supervision are provided residential substance abuse services in either secure or non-secure facilities. In addition, transitional housing is available for offenders who have completed a substance abuse

program in prison and may need a transitional or halfway house in the community. The department also contracts for outpatient and other substance abuse services for offenders on community supervision.

When individuals enter reception centers, their need for substance abuse services is assessed. Those who meet select criteria are mandated to participate in substance abuse services. They are sent directly to an institution with a substance abuse program for appropriate services or are placed on a waiting list pending programming availability. The following programs are offered:

- Tier I programs, consisting of 40 hours of psycho-education regarding substance abuse, is designed for inmates who have never received substance abuse treatment.
- Modality 1 programs consist of 4 to 6 months of intensive outpatient services.
- Modality 2 residential programs require 9 to 12 months of program participation in a therapeutic community.
- Specialized Modality 2, a therapeutic community program lasting 9 to 12 months is for inmates with co-occurring mental health and substance abuse disorders.
- Modality 3, offered primarily at work camps and work release centers, includes components focused on relapse prevention and community transition.

Financing and Contracting

Specific funding for substance abuse services within the Department of Corrections institutions is appropriated by the Legislature through general revenue, inmate welfare trust fund and special revenue contracted drug abuse services categories. This contract drug abuse category is used to contract with providers for the provision of substance abuse services within the institutions. FDC also receives federal grants. One type of grant serves inmates with substance abuse problems, and

the second type provides programming for those inmates who are dually diagnosed with both mental health and substance abuse disorders.

Funding for mental health services within the FDC comes through the Office of Health Services. There are two categories in which Health Services receives its budget from the Legislature, inmate health services and treatment for infectious diseases. Within the inmate health services category, psychotropic medications are a specific line item appropriated by the Legislature. The funding comes from general revenue. Requests for amendments to the appropriated categories must be submitted to the Bureau of Management and Policy within the Governor's Office.

The department contracts with individuals and/or with organizations for the provision of mental health and substance abuse services both within and outside the institutions. The nature of the contract is determined by the services being purchased.

DEPARTMENT OF EDUCATION

System Structure and Planning

The Department of Education (DOE) also provides mental health and substance abuse services. While its primary focus is student education, they provide services that are required through the Individual Education Plan (IEP) for each student with a disability.

Florida currently has an elected commissioner of education, but as a result of recent legislation, after 2002, the governor will appoint the commissioner. In addition to a large organizational structure at the state level, each county has an elected school board with either an elected or appointed superintendent who is responsible for the public school system within the county. Each superintendent and school board has considerable autonomy with respect to the management of their school district.

Within the current department, there are three primary areas with responsibility for mental health

or substance abuse services provided to students. The Bureau of Exceptional Education, through its statewide advisory board and 17 community-based SEDNET (Network for Severely Emotionally Disturbed Students) staff, identifies services needed by students with mental or emotional disorders. The goal of the SEDNETs is to provide a system to monitor and promote a comprehensive system of care that includes education, mental health treatment, and residential services for students with or at risk of emotional handicaps and/or severe emotional disturbances. In addition, the SEDNETs work to increase the effectiveness of existing services; facilitate continuous multi-agency planning, implementation, and evaluation of such services; identify gaps within the existing networks; and determine priorities for developing new services.

The DOE Bureau of Equity, Safety, and School Support is responsible for the Safe and Drug Free School program that provides funding for alcohol, tobacco, and other drug abuse prevention activities, as well as violence prevention activities through local schools. The DOE Bureau of Instructional Support and Community Services is responsible for student services, specifically the social workers, guidance counselors, psychologists, and nurses who provide services within the schools. School districts also contract for mental health and substance abuse services through local providers.

Services

Within the Department of Education, mental health and substance abuse services are delivered either through contract with outside providers or by staff employed by the school districts. School guidance counselors, social workers, psychologists, and nurses are involved in identifying and assessing students who may have special needs and developing individual plans to meet those needs. Psychologists conduct testing, provide crisis counseling, consult with teachers on interventions, and conduct staff training in mental health related areas. Social workers have the lead role in establishing home-school linkages. Specific

mental health and substance abuse services that may be needed are generally provided through contracts with providers in the community. Because school governance is so decentralized, little information is available regarding the specific types and volumes of services provided statewide.

Financing and Contracting

Funding for DOE mental health and substance abuse services is principally derived from state general revenue and federal sources. Student services has a few small federal grants and some private foundation funding. The Safe and Drug Free Schools program receives 80% of Florida's federal Safe and Drug-Free Schools and Communities Act allocation (which does not require state matching funds). This allocation varies each year based on federal appropriations. The governor receives the remaining 20% of Florida's allocation. In addition, the state Legislature provides the state Safe Schools Appropriation, which is "flow through" funding that goes directly to school districts. Proviso language dictates the categorical use of these funds; however, current proviso language neither encourages nor prohibits its use for substance abuse prevention and treatment. It is rare, however, for these funds to be used for such purposes. The majority of this \$75,350,000 allocation is used for security personnel and equipment. A minimum of \$30,000 of this state funding is allocated to each of the 67 counties, based upon the Florida Crime Index and percentage of total weighted enrollment.

The Exceptional Education program receives IDEA (Individuals with Disabilities Education Act) funding allocated by the federal government. Florida submits a state plan to the federal government each year. Once received, IDEA funds are allocated to the school districts, which then determine how the funding will be spent. Funding is provided based on the number and severity of the children with disabilities in each district. Each school district and individual schools have significant discretion as to how the funds are used at the local level. In addition, a small number of special projects are also funded by Exceptional

Education in the school districts (e.g., SEDNET, Transition to Independence, Project Hope and Project THINK).

Contracting for mental health and substance abuse services is done at the local level. The nature of the contract is determined by the services being purchased.

DEPARTMENT OF HEALTH

System Structure and Planning

Within the Department of Health (DOH), no specific staff is designated for behavioral health services. However, the Correctional Medical Authority (CMA) (organized as a result of litigation involving the health services provided in correctional facilities) monitors the mental health services provided by the Department of Corrections. The CMA has no responsibility for substance abuse services. In addition, the Department of Health is responsible for licensing of substance abuse and mental health professionals, including physicians, psychologists, social workers, and marriage and family therapists.

Each Florida county has a health department that is jointly administered by the Department of Health and county government. Each local health department has a significant amount of autonomy and flexibility in terms of the services that they offer and how they are provided. There are no planning activities specifically for mental health and substance abuse services within the Department of Health, although they may participate in the planning activities of the Mental Health and Substance Abuse Programs within DCF.

Services

The Department of Health also does not provide mental health or substance abuse services to the people they serve. They rely upon referrals to community providers for such services. A special

program for children called the Behavioral Specialty Care Network (303 treatment slots statewide) is funded by Title XXI to provide mental health and substance abuse services to children who are not Medicaid eligible but have significant need for mental health or substance abuse services. An agreement between the Department of Health and the Department of Children and Families assures that those children will receive services. Community mental health and substance abuse providers conduct the assessments and provide the treatment.

Financing and Contracting

The Department of Health does not receive any specific funding for the provision of mental health and substance abuse services.

DEPARTMENT OF JUVENILE JUSTICE

System Structure and Planning

The Department of Juvenile Justice (DJJ) currently does not have any designated staff for behavioral health services. However, the department is reorganizing and will have a medical unit that will be responsible for the mental health services and substance abuse services provided to the children and adolescents they serve. Planning for mental health and substance abuse services will be the responsibility of this unit once it is operational. Meanwhile, DJJ participates in the planning activities of other programs (e.g., Mental Health, Substance Abuse, and the Drug Policy Advisory Board). Currently, the Department of Juvenile Justice has a Mental Health and Substance Abuse Services Manual that provides guidelines for the delivery of services in DJJ secure detention centers, juvenile assessment centers, and residential commitment programs.

Services

The Department of Juvenile Justice contracts for the mental health and substance abuse services provided to the youths they serve. By law they are required to provide:

- mental health and substance abuse screening
- comprehensive mental health and substance abuse evaluations (when indicated through the screening process)
- access to mental health and substance abuse treatment
- specialized mental health treatment (e.g., sex offender therapy) when indicated
- suicide prevention
- emergency care services

These services are supposed to be available at all secure detention centers, juvenile assessment centers, and residential commitment programs at the low, moderate, high, and maximum risk levels. Youth who are given priority for intervention services include those who have serious emotional disturbance, mental illness, or substance abuse impairment and substantial functional limitations, or those who have emotional disturbance and meet additional diagnostic criteria. In department facilities, the superintendent or program director is responsible for ensuring that youths have access to and receive necessary and appropriate mental health and substance abuse services. Each departmental facility with an operating capacity of 100 or more youths is required to designate a single licensed mental health professional as a designated mental health authority responsible for coordinating mental health services in the facility. Mental health and substance abuse services provided to DJJ youths outside of state facilities are provided by contracted community providers.

All youth referred or delivered to the Department of Juvenile Justice are screened for substance abuse and mental health needs during the initial intake process. Further mental health screening is conducted upon admission to a secure detention

center, juvenile assignment center, or residential commitment program. Youths identified during screening or evaluation as having a mental disorder or acute emotional distress that may pose a safety/security risk must be brought to the attention of the superintendent or program director for follow up.

Financing and Contracting

The Department of Juvenile Justice estimates that between \$60 and \$70 million dollars is designated for mental health and substance abuse services. Approximately half of those funds are restricted by the Legislature, with the remaining half designated by the department out of its resources. Three major sources of funding for substance abuse services include the “Wheels Bill” funding (derived from taxation on rental cars), federal Department of Justice residential substance abuse treatment funds (which requires state matching funds), and the federal Violent Offender Truth in Sentencing law (which also requires state matching funds).

Similar to the Department of Corrections, DJJ also contracts with individuals and/or organizations for the provision of mental health and substance abuse services that are delivered inside DJJ facilities and to youth in the community. The nature of the contract is determined by the service being purchased.

DEPARTMENT OF ELDER AFFAIRS

System Structure and Planning

The Department of Elder Affairs (DOEA) also has no staff designated as responsible for behavioral health services to older adults, nor do they conduct planning for those purposes specifically. DOEA looks to the Department of Children and Families Mental Health and Substance Abuse Programs to plan for mental health and substance abuse services. DOEA also participates on the statewide Mental Health Planning Council.

General service planning is conducted at the local level through the 11 Area Agencies on Aging, funded through the Department. They are contracted to identify and advocate for the needs of persons age 60 and older as well as to fund and monitor programs.

Services

The Department of Elder Affairs does not directly provide mental health or substance abuse services to the people they serve. Individuals in need of such services are generally referred to mental health and substance abuse providers in the community. Consequently, the type and amount of services received is unclear.

Financing and Contracting

The Department of Elder Affairs is able to fund mental health counseling through the Community Care for the Elderly Program (supported through state general revenue), the Home and Community-Based Medicaid Waiver Program, and through the Alzheimer's Disease Initiative. Resources that serve older adults are primarily contracted through the Area Agencies on Aging, which make determinations about which services will be funded at the local level.

receives \$24 million in federal Byrne Grant funding annually for programs related to the criminal justice system. Of the 28 broad categories of programs, only two or three relate to substance abuse. However, almost 30% to 40% of the funding is used for substance abuse projects. These funds are made available to the Department of Corrections at the state level and to local city/county substance abuse planning boards. Funds are made available to counties based upon a formula that takes crime-related data into account. These federal funds have been gradually increasing over the past 10 years.

The other relatively new source of funding for substance abuse services is the \$2.9 million in federal Substance Abuse Treatment for State Prisoners funds that are received annually to provide drug treatment in state prisons or local county jails. Unfortunately, many local jails cannot meet the requirements of the funding which stipulate that populations receiving treatment be housed apart from the general jail population. These funds are allocated by FDLE through competitive bids.

While FDLE has no distinct staff designated as responsible for mental health or substance abuse services or plans that are specific to those services, FDLE staff participate in the planning activities of the Office of Drug Control and the Interagency Council on Substance Abuse Treatment. In addition, they require that project grantees develop program goals that are relevant and specific for the substance abuse projects funded.

OTHER STATE AGENCIES

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

The Florida Department of Law Enforcement (FDLE) does have a role in the provision of resources for substance abuse services within the criminal justice systems. Within this department, the Office of Criminal Justice Grants administers all federal and state grants that come to FDLE, two of which are related to substance abuse. FDLE

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY (AGENCY FOR WORKFORCE INNOVATION)

The Department of Labor and Employment Security does not actually fund any MHSA services. However, the 24 Workforce Development Boards (soon to be called Workforce Corporations) are funded throughout the state to plan and fund services needed to overcome barriers to Temporary

Assistance to Needy Families (TANF) clients' employment. While none of this funding is specifically targeted for mental health and substance abuse services, the Workforce Development Boards can refer persons to and pay for such services if their individual plan requires such services in order to obtain and retain employment.

While Work and Gain Economic Self-Sufficiency (WAGES), TANF, and Welfare to Work (WtW) funds are generally limited to persons who are categorically eligible for federal funding due to having dependent children, many persons who need mental health and substance abuse services do not have -- or no longer have -- dependent children in their care. However, \$135 million of federal Wagner-Peyser funds to Florida (administered through the Workforce Development Boards) are designated to serve single males with any type of job barrier, which could include mental health and substance abuse issues.

OFFICE OF DRUG CONTROL

The Office of Drug Control (ODC) was created to establish a process for long-range planning, information gathering, strategic decision-making, and funding for the purpose of limiting substance abuse. This office is responsible for coordinating drug control efforts and providing public information about substance abuse and available substance abuse programs and services. The director is appointed by the governor. The office acts as the governor's liaison with other state agencies, as well as the public and private sectors, on matters relating to substance abuse. It advises the governor and the Legislature on substance abuse trends in Florida, the status and funding of current substance abuse programs and services, and the status of the Office of Drug Control in developing and implementing the state drug control strategy. The Office of Drug Control reports to the governor but has no line authority over any agency or program. While the Office of Drug Control does not directly provide substance abuse services, it administers the U. S. Department of Education Drug Free Communities

Grant of approximately \$4 million for prevention services through the Florida Department of Law Enforcement as well as a yearly U. S. Department of Justice anti-alcohol prevention grant of \$366,000 for youth.

A statewide Drug Policy Advisory Council was established to conduct a comprehensive analysis of the substance abuse problem in Florida and to make recommendations to the governor and Legislature regarding the development and implementation of a state drug-control strategy. The Advisory Council is also charged with reviewing and making recommendations regarding the funding of substance abuse programs and services, consistent with the state drug control strategy. The Advisory Council reviews various substance abuse programs and recommends measures to determine program outcomes as well as to ensure that there is a coordinated, integrated, and multidisciplinary response to the substance abuse problem, including a multi-agency team approach to service delivery.

SUMMARY

As described in the introduction to this chapter, the overall mental health and substance abuse system in Florida is complex and diffuse. It comprises the provision of services across a wide range of settings, most of which have mental health and substance abuse concerns as a relatively minor aspect of their overall mission. The state system is characterized by a complex set of financial, organizational and regulatory relationships, with the boundaries between the differing state agencies causing a diffusion of responsibility for persons with mental and addictive disorders.

While they are not the focus of the current study, local governments and communities also provide many mental health and substance abuse services, often out of necessity. As will be discussed in the next chapter, local jails and law enforcement personnel must address the mental health and substance abuse problems of the communities that they serve. Local churches, informal self-help and

mutual support groups, shelters and missions, nursing homes, assisted living facilities, and families and friends complete a mosaic of settings and resources that help address the mental health and substance abuse problems that exist in communities all over Florida. Finally, businesses are becoming increasingly aware of and responsive to the needs of their employees who have mental and addictive disorders, both because of their self interest in assuring the health of their workforce and in response to national legislation such as the Americans with Disabilities Act.

The image that emerges from our analysis is one in which mental and addictive disorders permeate all aspects of our community life and most of our public institutions. As we will describe in the next chapter, our ability to effectively recognize and respond to behavioral health problems across this multiplicity of settings is a matter of critical importance for the health and productivity of our state.

Chapter 2

Findings

INTRODUCTION

Florida's services system for mental and addictive disorders has undergone significant and far-reaching changes. During the past 30 years, a diverse collection of MHSA programs has evolved outside the boundaries of the traditional DCF system. These service settings range far beyond what was originally conceived by legislators. In addition to the Department of Children and Families, MHSA services are now delivered by other departments and agencies of state and local government in an array of settings including health, education, child welfare, corrections and juvenile justice (see Figure 1.2, page 3). Although service delivery was not part of their original missions, each of these departments is now, in fact, in the business of providing MHSA services.

Increasingly, we believe that if they cannot successfully address MHSA problems, these agencies will be unable to achieve their primary objectives effectively. However, these additional responsibilities can strain existing resources and compromise the ability of these departments to meet their essential obligations to the populations they serve.

"We need to structure our mental health systems to better respond to individuals' actual needs, creating mechanisms for multiple systems to work together."

**Martin Cohen, President and CEO,
Metro West Community
Healthcare Foundation,
Framingham, MA.**

Additionally, all components of this combined system interact in ways that are not fully understood. They share an ecology of sorts in that the actions of each one separately - and all collectively - influence the others. In other words, problems and failures in one part of the system inevitably have an impact on other parts of the system. For example, when clients' mental health or substance abuse treatment needs are not met in the traditional DCF system, they may end up in jail, a setting ill-equipped to treat such problems. Or when individuals cannot access services through primary care providers, mental illnesses or addictive disorders may worsen, necessitating admission to a state treatment facility in an already overburdened traditional system.

KEY FINDINGS

The Commission's research and the testimony we heard throughout the last year highlight several important points:

- Parts of the traditional MHSA system's enabling legislation are out of date and out of step with the combined system that has evolved. Though incremental steps have been taken to update the legislation, the statute is nonetheless inadequate to address the diverse nature of existing services. The legislation must be modified to reflect the service settings, providers and clients in Florida's current system.
- The current combined system is complex, fragmented, uncoordinated and often ineffective. Multiple programs, numerous and often conflicting funding streams, and bureaucratic barriers frustrate access for many Floridians needing care.
- We must do a better job of understanding the combined system, capitalizing on the strengths of its components and the commitment and

expertise of the professionals who work within it. It is critical that we differentiate the roles of all the players in the system and establish clear priorities for both the specialized DCF system and other providers outside the traditional system. We must better delineate the roles of agencies, helping orchestrate their interaction and establishing clear points of responsibility, particularly for the most vulnerable Floridians.

- The non-DCF mental health system lacks a clear overall strategy and identified leadership. (This is not true of substance abuse). No one is attending to the workings and ongoing development of this diverse collection of mental health treatment venues.
- The data needed to make important treatment and funding decisions are either unavailable or cannot be integrated to the degree necessary to understand the full impact of the current system. While great progress has been achieved in assessing performance in the DCF programs during the last five years, we still cannot reliably estimate the magnitude of unmet need for mental health and substance abuse services, evaluate the relative value of individual treatment programs alone or in combination, and systematically monitor accountability for treatment outcomes across the combined system.
- Although a substantial amount of money is spent throughout the combined system, additional resources - and a better system for allocating them - are needed in many core areas. We must be sure that available money is spent wisely and is allocated based on need, optimal performance and outcomes.

The purpose of the remainder of this chapter is to identify Commission findings regarding major strengths, problems and crisis areas; specify implications for components of the combined system; and point to reasons for optimism as well as foundations for planning and positive change.

“Honest, comprehensive and quality reform will require a commitment by the Legislature, the administration, and the public to fully fund what is truly needed...Helping individuals with psychiatric disabilities is a statewide challenge, not a localized crisis. While implementation of any system should be flexible enough to accommodate local idiosyncrasies, the system itself must be the product of state policy, planning, funding, technical assistance and monitoring.”

**Brent Taylor, Director of Policy
Advocacy Center for Persons
with Disabilities, Inc.**

IDENTIFIED PROBLEMS

PREVALENCE AND UNMET NEED

Mental and addictive disorders constitute significant problems in Florida.

PREVALENCE

Mental illness is the second leading cause of disability and premature mortality in the United States and other established market economies (behind cardiovascular diseases). Due to numerous barriers, nearly half of all Americans with serious mental illnesses do not seek treatment.

Important among these barriers are a failure to recognize the symptoms of mental disorders, lack of awareness regarding how and where to obtain help, the belief that effective treatments are not available, financial barriers to receiving care, and stigma

associated with having a mental health or substance abuse problem.¹

"My name is **Rod**. Twelve years ago, I was diagnosed with a mental illness. Since then I have been bounced from doctor to doctor, medication to medication, and caseworker to caseworker.

It has not been easy for me to get what I need to survive and thrive. I have faced such obstacles as picky regulations, bureaucratic snafus, tons of paperwork, agencies that don't communicate with each other, delays, and overworked people.

I speak of bureaucratic snafus like having to wait months to get the housing I need, when it only should have taken a few weeks. Why the delay? All I heard were excuses: the paperwork was lost, filed wrong, or not completed properly. I've been bounced from agency to agency to agency for housing. Each sends me to another one.

While I have met very caring and helpful people, they are, unfortunately, very few. Among those who quit their jobs are the helpful few I've met along the way. Like the caseworker who gets up at 5:00 a.m. to drive across town to pick up a client, then drives all the way across town to take him to work. Or the case manager who gladly takes a phone call at midnight from a distraught client. However, these people soon go away. But the ones who put clients in places they don't belong and the ones who don't really seem to care - they seem to stay on and on. The good go and the bad stay. Why?

In spite of my illness, I've been able to finish school, work, live on my own, and function just like anyone else in this world. But not every mentally ill person is like me. Many can't hold down jobs. Or live on their own. And if I have problems getting the help I need, what does that say about them?"

Mental and addictive disorders are significant problems in Florida, with a prevalence and impact far beyond what the average citizen might assume. Over the course of a year, one in three Florida adults and children will meet diagnostic criteria for a

mental or substance abuse disorder. Among adults, approximately 23% will meet diagnostic criteria for a mental disorder, 12% will meet criteria for substance abuse/dependence; and 5% (1 in 20 Floridians) will meet criteria for co-occurring mental illness and addictive disorders.^{2,3}

Similar high prevalence rates occur in both children and the elderly, and exceptionally high rates occur in Floridians detained in the criminal justice system (juvenile and adult), persons who are homeless, and among assisted living facility and nursing home residents.^{2,4}

UNMET NEED

Since not all persons who meet diagnostic criteria for a mental or substance abuse disorder experience significant impairment, at issue is how many Floridians each year actually need treatment services, and how many receive them. If we conservatively limit the need for treatment to persons with substance abuse/dependence and/or severe mental illness, between 1 in 12 to 1 in 14 Florida citizens will need mental health and/or substance abuse services at some time during a given year. These estimates comport with the recent finding that 1 in 10 Floridians rates his or her own mental health as "not good" for one or more weeks during the previous month.^{2,5}

Despite limitations in our current information management system, we can reasonably estimate that annually only about 20% of all children and adults with need for MHSA services receive treatment from DCF providers. We cannot estimate, however, what percentage of the state's population in need is not served by DCF but by other state agency service providers (e.g., education programs). We suspect that within Florida jails and nursing homes, about 1 in 4 persons in need of MHSA treatment actually receives services from at least one non-DCF provider.^{2,6}

As illustrated by statistics, from a public health perspective, mental and addictive disorders are

THE SCOPE OF THE PROBLEM

- Among Florida youth ages 11 to 18, 6% have used alcohol or an illegal drug on 10 or more occasions in the previous 30 days.⁷
- About 100,000 Florida youth ages 10 to 17 are referred for juvenile delinquency every year. Of these, 60% have emotional problems and 36% have substance abuse problems.^{2, 8}
- Approximately 2% of Florida's population, or 335,000 individuals, spend time in a jail or prison over the course of a year. Of these persons, 65% have a mental and/or addictive disorder.^{2, 9}
- Approximately 73,000 episodes of involuntary mental health treatment (i.e., Baker Act) occur each year, involving approximately 57,000 individuals. For persons with multiple initiations, the average time between initiations is about one month. More than \$50 million is budgeted annually for Baker Act services.¹⁰
- Approximately 150,000 Floridians are homeless at some time during the year. Of these, 60% have a substance abuse disorder, 3% have schizophrenia, and 12% have post-traumatic stress disorder.^{2, 11}
- Approximately 138,000 Floridians (5% of the population age 65 or older) reside in nursing homes. More than half will need MHSA services, the majority of which is not related to dementia.^{2, 10, 12}
- The annual suicide rate in Florida (14.3 per 100,000 persons) is higher than the national average. In 1997, there were 2,098 recorded suicides in Florida.^{2, 13}

Table 2.1

prevalent and disabling conditions confronted by Floridians. Given limited public health resources, the frequent occurrence of mental and addictive disorders and the variability in their severity suggest a special role for the traditional system in preferentially serving people with the most severe and disabling disorders.

Overall, however, most people with mental and addictive disorders (or who are at risk of developing disorders) are not seen in the traditional MHSA system but in other treatment and community settings. The frequency of these problems has important negative consequences for both the individuals who experience them and the settings in which they live, work and are served. Many persons, including employers and family members, do not recognize that behavioral health problems can significantly reduce productivity, and that they often respond extremely well to treatment. In essence, therefore, routine coordination is needed among all the components of the combined system to promote prevention, early recognition of problems and effective treatment.

"My name is **Noreen** and I have depression which began in childhood. Alcohol abuse and domestic violence were a normal part of my home life. By the age of 23, I'd survived four suicide attempts.

By 1981 I was married and had three children. I thought that I would live happily ever after. But in 1984, a paralyzing depression left me defeated and hopeless. I was hospitalized for clinical depression but was discharged with a new diagnosis: bipolar disorder. During the next two years, I was hospitalized often and treated with many medications. I continued to search for help and seek treatment. In 1988, I was in the hospital but responding well to a new drug. As I was being discharged, a court processor served me with divorce papers. Suddenly, at the age of 41, I had lost my home, my children, and all my hope for the future.

The next year, I nearly died from another suicide attempt in a place that was supposed to keep me safe--a hospital. My doctor wanted to put me in a state mental hospital, but I really needed a place in the community where I could rebuild my life. My attorney found a halfway house and encouraged me to become an advocate for others with mental illnesses. Since 1991 I've served two four-year terms on the Human Rights Advocacy Committee for Mental Health."

PREVENTION VERSUS DEEP END CRISIS SERVICES

Prevention is currently a low priority in mental health, although it is a priority in substance abuse. Instead, the traditional mental health system emphasizes deep end services and crisis interventions.

Research shows clearly that prevention and early intervention strategies can be effective in reducing illness and disability in both mental and addictive disorders. Crime and delinquency, drug use, child abuse, and HIV infection are all specific outcomes that respond well to prevention efforts. For example, controlled studies have shown that preventative interventions with disruptive classroom behaviors (which are predictive of later problems) in first grade children, significantly reduce arrests later in life. These interventions even reduce smoking rates in adolescence.¹⁴ However, prevention benefits are not widely understood, and proven strategies are not widely utilized. There is a wide gap between what has been identified by scientific research as “best practice” and what is available in educational and other settings throughout Florida.

“...there is a unique disconnect between the scientific facts and the people’s perception about drug abuse and addiction. We need to overcome this disconnect if we are to make any real progress. We now have the science base, but it isn’t being used. Science can replace ideology as the foundation for drug abuse and addictive prevention, treatment, and policy strategies.”

**Dr. Alan Leshner, Director
National Institute of Drug Abuse**

In substance abuse, on the other hand, Florida’s Office of Drug Control has taken a strong role in aggressively pursuing science-based prevention efforts and is attempting to develop a state prevention plan involving all state agencies that fund prevention of substance abuse disorders.¹⁵ DCF has implemented the federally-funded Florida Youth Initiative for Substance Abuse Prevention, a science-based prevention program in 23 communities throughout the state. A statewide Advisory Council to this project is also developing a prevention plan to coordinate effective state prevention strategies. Such initiatives are based on a new understanding that alcohol and other drug dependence is a primary, chronic and progressive disease. Substance abuse and dependence are, in fact, treatable and subject to preventive measures.

Funding for substance abuse prevention, however, has not kept pace with research knowledge. Federal dollars are the primary source of funds for prevention through research grants and direct block grants to states. State agencies administer these funds, largely at the local level. A recent survey of state agency support for substance abuse prevention suggested that prevention accounts for less than 10% of most agency operating budgets. Only about one third of prevention activities have a primary substance abuse prevention focus, representing approximately \$73.2 million, an amount that appears large but is spread across all prevention programs statewide, including schools.¹⁶

Before **Walter** turned 18, he had already been charged with more than seven counts of armed burglary and other felonies. He was raised by an abusive father who often held a knife to his neck to torture him. His father beat his mother daily. At 14 he began using heroin and became heavily addicted.

Today, however, he has completed 14 months of residential treatment in a community drug treatment program for youthful offenders, and Walter feels as though he has been reborn. “I’ve gained more here in 14 months than I had gained in my whole life before,” he says. “I have a normal life now, and I’m proud of that. It’s got to be better than sticking a needle in your arm and not caring about anything.”

In mental health, services within the traditional system have focused primarily on persons with more severe illnesses and disability. The lack of prevention in mental health -- and under-funding of these services in substance abuse -- mean that some individuals become more severely ill and disabled than they might have had they received proven preventative intervention measures. Thus it is possible that the demand for deep end, specialty services provided by DCF could be substantially reduced through the provision of effective prevention and early intervention strategies, as well as support for consumer-run community programs, including drop-in centers and consumer-operated businesses. Throughout the combined system, understanding where and how preventative interventions are implemented requires a coordinated leadership function and collaboration with experts.

DIAGNOSIS AND TREATMENT HAVE IMPROVED DRAMATICALLY

The diagnosis and treatment of mental and addictive disorders have improved dramatically.

Science has made tremendous strides in the last 20 years in understanding how the brain interacts with biological, psychological and social factors to influence thought, behavior and emotion. This knowledge has given rise to remarkably effective new medications, therapies and rehabilitation techniques that allow persons with even severe illness to function in society and lead productive lives. Schizophrenia, depression and anxiety disorders are all good examples.

We also know that people with mental and addictive disorders recover most effectively when they participate in their own treatment. Their care should be based on a philosophy of self-determination; respect for privacy; and informed choices by consumers, family members and caregivers.

STIGMA AND EDUCATION

Mental and addictive disorders are still stigmatized to a great extent. Education is a critical part of the solution.

Professionals, consumers and family members throughout the state have consistently indicated a significant need for better, more extensive education about mental and addictive disorders. Many myths and misunderstandings about mental health and substance abuse are a consequence of a lack of education regarding the causes, symptoms, treatment and potential for recovery from these disorders. These in turn result in stigma and discrimination that create perhaps the most important barriers to timely and effective care. Education for all Floridians about mental and addictive disorders, effective treatments, and the potential for recovery is critically important. Education on the biological bases for some mental illnesses could be included in primary and secondary school curricula.

"Only my immediate family knew I suffered from manic-depressive illness. I paid for my medication and doctor's visits out of my own pocket, as I didn't want to establish a paper trail. I was worried about the stigma associated with mental illness."

Consumer

MULTIPLICITY

Multiple service settings, funding sources, funding streams, resource use expectations, and constraints regarding resource flexibility have created a fragmented, conflicting, and frequently ineffective MHSA system of care.

Multiple agencies and treatment settings address multiple client needs. Many agencies have their own regulations and requirements, which may conflict or duplicate the efforts of others. Inconsistent standards and expectations exist among numerous funding sources. Consumer-operated programs are often subject to inappropriate rules and regulations that negatively impact the services they provide. Treatment providers labor under a huge burden of required (and often redundant) documentation. Most importantly, no one entity has responsibility for treatment outcomes for persons receiving care in multiple programs.

Persons seen throughout the non-DCF system often have great difficulty obtaining the services and supports they need because of difficulty accessing resources and a pervasive lack of knowledge regarding the symptoms of mental and addictive disorders. For example, individuals with depression seen in primary care settings may not be diagnosed quickly or correctly by their primary care physicians. Even if mental health or substance abuse problems are recognized, fear of stigmatization and financial barriers may preclude access to effective specialty services.

Persons with the most severe disorders who are served in the traditional system often have difficulty obtaining the support and rehabilitative services (such as housing, transportation, etc.) that they need to recover. Their complex needs cannot be well met in a system that is restricted by categorical funding requirements and an absence of parity between physical health and mental health insurance benefits. This disparity in insurance status creates a cascading host of additional problems, including

barriers to access, discontinuity of care, fragmented services, and stigma and discrimination. Similarly, it is difficult if not impossible to hold agencies accountable for client outcomes when they do not have access to a full range of resources to meet the complicated needs of persons with significant disability.

LACK OF OVERALL SYSTEM COORDINATION

There is a marked lack of coordination among the components of the combined system of care for Floridians with mental and addictive disorders.

James grew up in a home filled with violence. At the age of six, he took a gun to his elementary school and fired it on the playground. The school contacted the juvenile justice system and protective services, but the family received no help. At the age of eight, James was placed in foster care, leaving behind a mother and younger brother who were frequently victimized by the father.

At age nine, James began getting in trouble with the police, breaking into neighborhood homes and stealing. He was referred to the Department of Juvenile Justice, but his illegal activities continued and he was finally placed in a group home. James is frequently tearful and aggressive with other boys in his cottage. At age 11, he has begun counseling for the first time. His counselor is employed by the group home and has a high school diploma but no professional education or training. James' needs have never been formally assessed.

Florida does not have a comprehensive, coordinated system for providing services for mental and addictive disorders across health, human services, educational and correctional settings. In non-DCF service settings, a fragmented assortment of treatment venues has

evolved among agencies, all of which have a primary mission that is distinct from treating MHSA disorders. Persons with mental and addictive disorders in these settings may not be quickly and accurately diagnosed. Even if their problems are recognized, they may not receive timely, effective treatment due to limited expertise in MHSA issues and constraints on resources.

For example, research shows that parents wait an average of two years from the first signs of MHSA problems in their children before seeking help. The primary health care setting in which children are initially seen, however, is ill equipped to respond more quickly. Earlier intervention might significantly alter the problem trajectory for these children.¹⁷

With a lack of integrated information about systemic functioning across these diverse settings, we do not understand the interaction among service settings and the impact that this lack of coordination has on Florida's citizens. For example, the Commission's analyses indicate that difficulties in the mental health emergency response and community care system underlie the increased presence of persons with severe mental illness - and often substance abuse - among jail and prison inmates. Addressing these problems requires a systemic perspective, as well as data systems, that allow us to observe relationships among the various components of the entire system.

"The shame of it all is that we know how to effectively treat most people with mental illnesses. We just don't make these treatments available to people. De-institutionalization has become "trans-institutionalization." Today, we institutionalize people with severe mental illnesses in jails and prisons instead of hospitals."

Consumer

LACK OF STRATEGIC STATE POLICY AND LEADERSHIP ACROSS THE NON-DCF SYSTEM

Each of the state agencies that serve people with mental and addictive disorders has planning, quality assurance and accountability functions related to its primary mission. However, there is no governmental entity responsible for state strategy, policy and leadership across the combined system in mental health.

The Florida Office of Drug Control, on the other hand, has been effective in developing a statewide strategy for reducing substance abuse in Florida. The Governor's Drug Policy Advisory Council includes representatives of state agencies and communities throughout Florida who work together to affect a coordinated law enforcement, prevention and treatment approach to substance abuse.

As described in Chapter 1, across the combined system, no governmental entity is responsible for the definition of boundaries of responsibility; accountability and performance measurement; information collection and management; and public education across the system. No one is measuring overall outcomes, helping to frame statewide policy questions, and suggesting collaborative strategies based on these data. Beyond the individual efforts of service sectors, no one is asking if the current investment of resources across systems is achieving the desired policy effect overall, even when each of the individual components of the system is meeting its own primary objectives.

The lack of a recognized leadership function has important implications for both the traditional and non-DCF systems. Without it, policies and practices within individual agencies are designed to optimize performance relative to that particular

agency's mission, without considering the implications of these decisions for other parts of the system – or more importantly, the individuals and families who need help. Knowledge about effective practices in treatment and rehabilitation is slow to influence practice in the traditional system. Given the multiple missions in the non-DCF service sector network, knowledge about effective practices is even less likely to influence practice than in the traditional system.

An excellent example is the role conflict that schools are experiencing about dispensing medications to their students. While drug therapies for addressing children's health and behavioral health needs have improved, schools are not well equipped to administer or monitor medications. Nonetheless, they are expected to serve this function because of their extensive contact with children. Thoughtful leadership focusing broadly on the overall system would increase the likelihood of identifying problems like these and suggesting more comprehensive and effective solutions.

EXPENDITURES FOR TREATING MENTAL AND ADDICTIVE DISORDERS

Florida's current services system for mental and addictive disorders involves enormous financial investment from federal, state, local and private sources.

While the exact amount of expenditures cannot be directly calculated due to limited data, it is estimated that nearly \$5 billion is spent annually across all public and private expenditure sources in Florida in the combined traditional and non-DCF system (leading payer sources include private insurance, Medicaid, Medicare, general revenue and out-of-pocket payment for services)^{2,18}, (see Table 2.2, page 28). Nearly \$3 billion (58%) of this total (which includes in-hospital, out-patient/residential, prescription drugs, and insurance administration expenditures) is public money. Eighty-six percent is allocated for mental health services. Prescription drugs account for over three fourths of a billion dollars in

annual expenditures. Surprisingly, annual expenditures for the traditional DCF system and state-hospital system combined amount to less than 20% of all expenditures. Thus, it is clear that the traditional DCF system is an important - but by no means the only -- provider of mental health and substance abuse services. State funding may also not be sufficient to meet the needs of mental health consumers. Yearly per capita expenses for mental health in Florida are \$43.80, giving Florida a national ranking of 37th, with less than half the per capita expenditures of states including Maine, Massachusetts, New York and Michigan.¹⁹

Although the trend has clearly been toward outpatient treatment, a high percentage of mental health treatment costs still occur in inpatient facilities. On an aggregate level, more than one billion dollars is spent annually (1/5 of total expenditures) on inpatient MHSA care (mostly mental health), compared to about \$500 million for community-based DCF MHSA services. The inpatient total does not include state hospitals, which treat 4,300 individuals yearly (.03% of Florida's population). In state hospitals, the average annual cost per bed is \$100,000, and \$275 million (or roughly 5% of total expenditures) is spent annually.²⁰ Current data indicate that much inpatient care could be avoided if competent community-based services were available.

Medicaid, a federal program administered by the Agency for Health Care Administration, has emerged as an important payer of public mental health expenses, though not of substance abuse services. Commission testimony, however, indicated that Florida may not be optimally leveraging federal Medicaid funding and taking advantage of all available federal funding sources. It is imperative that all available federal funding opportunities be utilized.

Problems identified with Medicaid include the fact that it is a highly prescriptive program with strict eligibility criteria, and its fee-for-service reimbursement mechanism may create provider

Table 2.2 Estimated PUBLIC and PRIVATE Mental Health and Substance Abuse Expenditures in Florida in 1998

Payer and Provider Type	MH Costs			SA Costs			MHA Costs	
	Costs (thousands)	% of all MH Costs	% of all MHA Costs	Costs (thousands)	% of all SA Costs	% of all MHA Costs	Costs (thousands)	% of all Costs*
PAYER								
Public								
Medicare	\$1,026,965	23.9%	20.6%	\$91,587	13.2%	1.8%	\$1,118,552	22.4%
Medicaid	\$725,825	16.9%	14.5%	\$132,286	19.1%	2.6%	\$858,111	17.2%
Other Federal	\$121,213	2.8%	2.4%	\$95,580	13.8%	1.9%	\$216,793	4.3%
Other State and Local	\$591,281	13.7%	11.8%	\$126,994	18.3%	2.5%	\$718,275	14.4%
Private								
Out-of-Pocket	\$681,768	15.8%	13.6%	\$67,581	9.7%	1.4%	\$749,348	15.0%
Insurance	\$1,051,986	24.5%	21.1%	\$160,793	23.2%	3.2%	\$1,212,779	24.3%
Other Private	\$103,378	2.4%	2.1%	\$19,498	2.8%	0.4%	\$122,876	2.5%
PROVIDER TYPE								
Hospital-based ^a	\$979,588	22.8%	19.6%	\$85,658	12.3%	1.7%	\$1,065,246	21.3%
Other Outpatient/Residential ^b	\$2,384,290	55.4%	47.7%	\$602,171	86.7%	12.1%	\$2,986,461	59.8%
Retail Prescription Drugs ^c	\$752,335	17.5%	15.1%	\$3,156	0.5%	0.1%	\$755,491	15.1%
Insurance Administration ^d	\$186,202	4.3%	3.7%	\$3,333	0.5%	0.1%	\$189,535	3.8%
TOTAL – All Payers/Providers	\$4,302,415	100.0%	86.1%	\$694,318	100.0%	13.9%	\$4,996,733	100.0%

^a **Hospital-based** services include all services owned and operated by hospitals – inpatient, outpatient (including clinics and home health), and residential facilities (including nursing homes).

^b **Other out-patient and residential care** includes all providers except hospital-based services, retail prescription drugs, and insurance administration. Note: hospital-based services include outpatient services which are thus excluded from the “other out-patient and residential care” category. This latter category captures most out-patient and non-hospital based services to MH/SA clients.

^c **Retail prescription drugs** includes prescriptions obtained through retail (pharmacy or mail order) distribution. Inpatient drug treatment and facilities which dispense drugs through public programs, such as methadone clinics, are not included in this category, but rather as part of the specific facility expenditure.

^d **Insurance administration** includes the administrative expenses of all third-party payers and profit and reserve adjustment for private insurers.

incentives for inappropriate service provision. Additionally, disparities exist in the ability of providers to access Medicaid reimbursement as well as in the amount of reimbursement available and the availability of licensed professionals through public insurance programs.

A goal of focused funding requires that we be able to catalogue our expenses and understand their effects. Given the lack of overall information about services in the non-DCF system, it is not possible to separately identify the MHSA expenditures for each state agency outside the Department of Children and Families. Without these data, as well as data related to performance in each component, it is impossible to estimate the efficiency and effectiveness of our resource expenditures.

ADDITIONAL RESOURCES ARE NEEDED

Many essential MHSA services need additional resources - and a better resource allocation system - in order to effectively serve all those who need care.

While a great deal of money is spent in the aggregate to treat MHSA problems, each of the workgroup reports appended to this Commission report describes specific areas in which resources are not available in order for the combined system to function effectively. All age groups need more effective and assertive case management and outreach services to assist persons with severe disabilities in negotiating our fragmented system.

Outreach, in particular, is key to serving Floridians who experience difficulty in accessing public services and in supporting these individuals in their natural settings. A lack of transportation services further frustrates access. Since many adults with severe mental illnesses become impoverished due to their disorder, they need assistance in finding and keeping safe and affordable housing. Enhanced vocational rehabilitation and educational services

are desired by most adult clients and hold promise for significantly improving their rates of employment. The latest medications can also be very expensive, and many persons with severe illnesses need help in obtaining them.

"We must be in the business of helping people cope with their disabilities in terms of housing, transportation, etc. [Persons with mental illnesses] usually have multiple needs and are often poor, so they may need financial assistance. Systems of care should respond to all these issues."

**Martin Cohen, President and CEO,
Metro West Community
Healthcare Foundation,
Framingham, MA.**

While the Commission heard consistent testimony throughout the year on the desperate need for expanded services, the lack of any systematic needs assessment data frustrated efforts to be more specific. Without these data, for example, it is impossible to confidently estimate the degree to which service capacity should be expanded to adequately meet need, or the degree to which existing resources could be shifted to be more responsive to client needs. This lack of system-wide data significantly undermines effective, targeted planning.

Additionally, the Commission collected data indicating that we may not appropriately participate in all of the federal programs that are available for MHSA problems. In 1998, Florida's population made up 5.5% of the total U.S. population, yet the state received only 4.5% of the community MHSA block grant funds from the Substance Abuse Mental Health Services Administration. This relative difference of 1% is not trivial, as it amounts to about \$16 million in available public funding. Moreover, this relative under-funding has been observed each year since 1993, contributing to a cumulative under-funding effect.

DEFICIENT DATA SYSTEM

Data at both the state and local levels are unavailable or poorly integrated.

No single data system contains information on the overall MHSA system. Consequently, it is difficult, and in many cases impossible, to link individual client data across service sectors. Because data and collection methods are not standardized, treatment strategies, costs and outcomes cannot easily be tracked over time.

The absence of an integrated information management system has numerous adverse consequences. Despite today's technology, the true magnitude of unmet need for MHSA services cannot be determined; aggregate costs of treatment by diagnosis and other case mix variables cannot be calculated; the relative value of different combinations and sequences of treatment programs across service systems cannot be evaluated; weak links in the system cannot be pinpointed; and accountability for treatment outcomes cannot be systematically monitored. Thus, like most other states, Florida currently lacks the capacity on a system-wide basis to evaluate which MHSA treatment strategies result in favorable client outcomes, as well as their corresponding cost effectiveness.

Major progress has occurred, however, during the last five years in the development of data systems within the traditional DCF system. DCF Program Offices routinely track the number of persons being served by contracted providers, the types of MHSA services being provided, the costs of these services, and client outcomes. Nevertheless, there are limitations with the current DCF data system, which currently cannot link the patterns of services received to the characteristics of persons served. We, therefore, know how many persons were enrolled in care, and how many services were provided, but not how many services were received by which individuals or the outcomes that these individuals achieved.

QUALITY AND PERFORMANCE MANAGEMENT

Although great progress has been made in developing performance management systems across state government in the last several years, more work is needed in this important area.

When **Sarah** was three years old, she was removed from her home following physical and sexual abuse by her parents and possibly by an older brother. After living in several foster homes, Sarah was adopted at age 11. The first year in her new home was traumatic for everyone. Sarah had frequent tantrums and crying spells, was very manipulative, and sneaked out of the house to smoke marijuana. Her adoptive parents sought therapy, but after a year of turmoil concluded they couldn't handle Sarah's problems, and they cancelled the adoption.

This development sent Sarah into a downward spiral. During the next four years, she was in nine foster homes and residential treatment centers and was seen by a variety of mental health professionals, who diagnosed her with depression, marijuana dependence, intermittent explosive disorder, conduct disorder, borderline and paranoid personality disorder, and post-traumatic stress disorder. She had "aged out" of foster care and had no job skills or independent living skills, no family, and no place to call home. Sarah was recently included in a class action lawsuit due to the long-term lack of focus on her mental health and substance abuse needs by the current system.

The traditional MHSA system was among the first in state government to begin implementation of performance based budgeting systems, and much has been learned about the success of MHSA programs in improving

treatment outcomes. However, much is yet to be done. Measurement must be improved, indicators refined, and better methods used for estimating change. Although well intended, some of the performance measures actually provide incentives to preferentially serve individuals who are relatively less impaired. For example, client outcomes and the performance of DCF-contracted providers tend to be evaluated by societal indicators such as average days spent in the community. These societal indicators often lack clinical relevance, and they also tend to create a perverse incentive for providers to shun persons most in need of treatment.

However, because MHSA services are provided in multiple service settings and data are not standardized and integrated, currently we can neither estimate the percent of unmet treatment need for Florida's citizens with MHSA disorders (other than within DCF) nor evaluate on a system-wide basis both how and why individual treatment "successes" and "failures" occur. For example, we strongly suspect that the fact that many Floridians with mental health and substance abuse disorders are detained in criminal justice settings reflects an overall lack of early recognition and coordinated care across the entire system. Unfortunately, the architecture of the current information management system is inadequate to rigorously study the real world experiences of Floridians with MHSA disorders.

"Drug courts are the 'crown jewel' in the current treatment system. Coercion works; no one volunteers for treatment through the courts. We need incentives to get people into treatment."

**James McDonough, Director
Florida Office of Drug
Control Strategy**

SPECIFIC CRISIS AREAS

EMERGENCY SERVICES

Emergency behavioral health services are in crisis throughout Florida.

During Commission meetings, we repeatedly heard testimony about the serious problems in Florida's emergency response system, particularly for persons with mental illness. (The Commission did not hear extensive testimony regarding

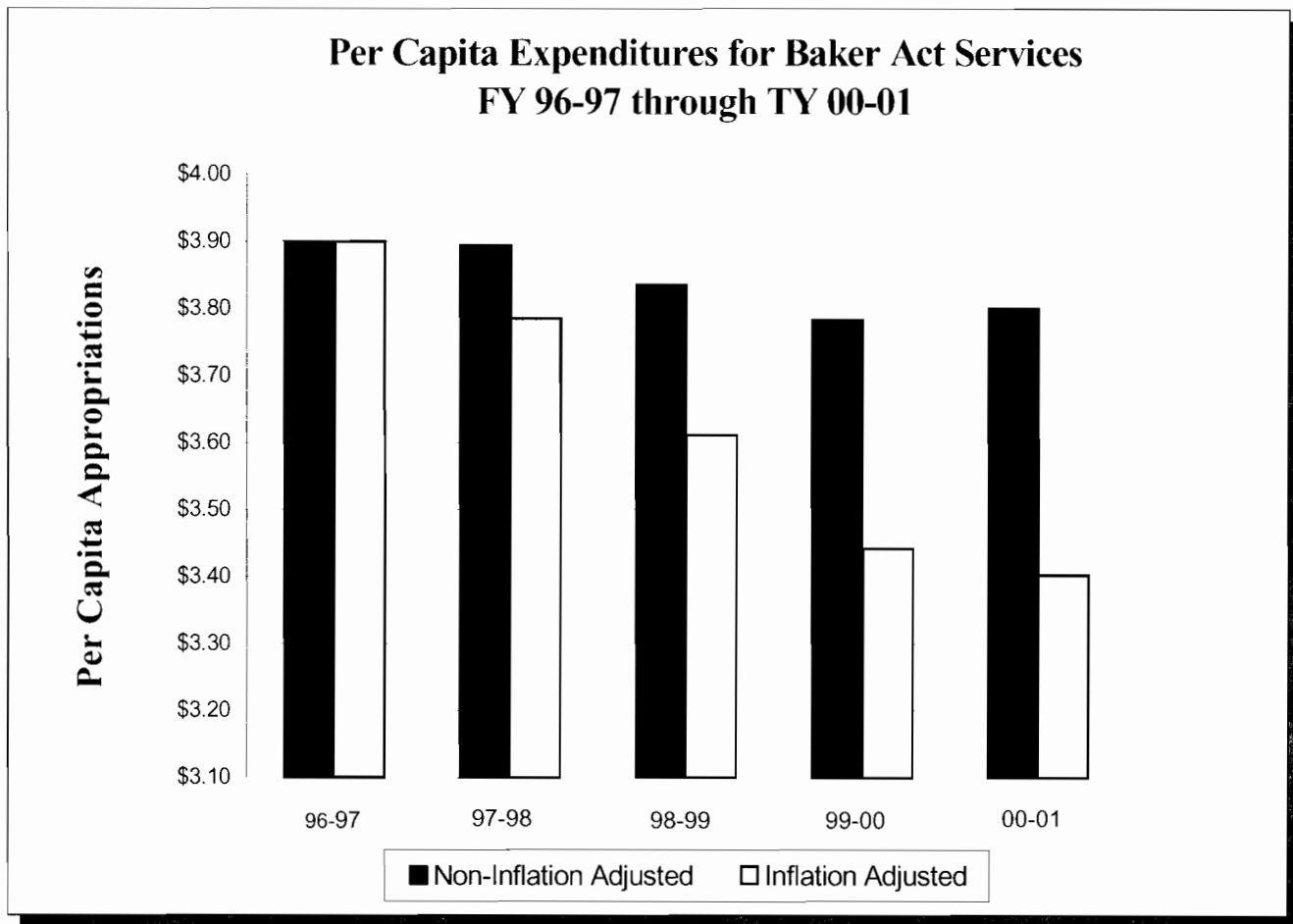
Steven is the stepfather of a young man named **Kirk** with paranoid schizophrenia, who was killed by law enforcement officers during a Baker Act procedure two years ago. He was 30. At the time of the shooting, Kirk was living in his own apartment and driving his own car.

"Kirk had been deteriorating before the shooting," remembers Steven. "The day we called the police, he had gone by his grandmother's, and his behavior was upsetting her so she asked him to leave."

That evening, we went to his apartment to take him some dinner. At that point, he was calm but clearly delusional. We knew he needed to be in custody. We went to a pay phone to call the police. One officer came and we told him we needed to have our son Baker Acted.

"The policeman did not have a clue how to handle someone with a mental illness. He went to Kirk's apartment door with a flashlight and banged on the door. This set Kirk off into extreme anger and delusions and started a 1 and 1/2 hour siege. Kirk had taken out a steak fork and was demanding to be left alone. Four police officers were at the apartment door, and they just took the hinges off. One had his gun drawn. They emptied a can of pepper spray into his apartment. Kirk struck out with the blunt end of the fork. They shot five times and hit him three times. One bullet went through his heart.

"I understand that the police are trained to shoot to kill when there is a threat. And Kirk was definitely a threat. But he had a serious mental illness and was delusional. He was frightened, and he just wanted to be left alone."



* Estimates include both adult and child Baker Act appropriations adjusted for population growth and inflation in medical costs.

Table 2.3

emergency substance abuse services and the Marchman Act). Problems described in testimony include inadequate capacity for emergency mental health care; pressures to shift responsibility for emergency care between hospital emergency rooms and crisis stabilization units (CSU); inconsistent standards of care; inadequate training for law enforcement personnel; a lack of knowledge regarding the statutory requirements in the Baker Act; and a lack of integrated data systems.

Under the Baker Act, a person in crisis can be held involuntarily for 72 hours for examination by a mental health professional. The Commission heard testimony that the Baker Act is frequently used

inappropriately throughout Florida. Hospital emergency departments have patients who are often held for days at a time without treatment, according to a number of emergency physicians. There is a severe shortage of available crisis intervention services, beds and trained caregivers, and there is too little after-care follow up. Diffuse responsibility for emergency services within a service region often contributes to these problems in the delivery of emergency care.

Funding is an important part of the problem. Per capita Baker Act funding has decreased by 13% in the past five years ²¹ and many experts say it was inadequate five years ago.

MENTAL HEALTH AND SUBSTANCE ABUSE IN THE CRIMINAL JUSTICE SYSTEM

The fact that many persons with mental illnesses and/or substance abuse problems end up in jail or prison can be seen as a marker of barriers within the traditional system, in particular, to identifying and treating MHSA problems.

Lacking early intervention, responsive emergency services and appropriate, affordable follow-up care (including help with finding affordable, decent housing and other psychosocial supports), many individuals guilty of minor infractions find themselves in criminal justice settings rather than treatment settings. In fact, in every major category of mental and addictive disorders, the prevalence rate for individuals in jails dramatically exceeds that in the general population.

The following data exemplify the large MHSA treatment burden being placed on Florida's correctional system (as previously referenced). Throughout the state, we estimate that 335,000 persons are detained in a jail or prison at some time each year (2% of the state's population), and that 218,000 of these individuals (65%) will meet diagnostic criteria for a mental health and/or substance abuse disorder. The prevalence of substance use/abuse is exceptionally high among jail and prison inmates. In addition, about 100,000 Florida youths between the ages of 10 and 17 (or 7% of the juvenile population) are referred for juvenile delinquency each year. Of these youth, 60% or more have emotional, mental, and/or substance abuse problems. A recent survey among Florida county jails reveals that less than 25% of jail inmates with a mental illness or substance abuse disorder receive MHSA services, and that jails in general have limited effectiveness in providing adequate services to inmates with MHSA treatment need, especially the smaller rural jails in Florida.²²

"Of all crime, 60% to 80% is related to substance abuse."

**James McDonough, Director
Florida Office of Drug
Control Strategy**

It is important to note that we are not concluding that most persons in jail or prison should not be incarcerated. When untreated MHSA problems contribute to the illegal behaviors of some individuals, however, early identification and treatment is appropriate and important. Incarcerating individuals with mental and addictive disorders for minor offenses as a substitute for adequate care is neither sensible nor morally defensible.

Law enforcement personnel testified that they are frustrated with emergency services that either release clients following minimal stabilization or that require officers to wait for hours in hospital emergency rooms until clients are admitted to care. Police officers and sheriffs report having to transport individuals from crisis stabilization units to hospital emergency departments and back again. Their testimony indicated that no one wants to accept responsibility for individuals with mental and addictive disorders. Frustrated, the police may pursue incarceration as a way to assure the safety of the individual and the community and, possibly, to access treatment.

Jail diversion (both pre-arrest and post-arrest) is the name given to efforts to redirect individuals with MHSA disorders who commit minor offenses away from incarceration and into community-based treatment. Crisis Intervention Teams (CIT) and response models originating, variously, with the police and mental health professionals are used increasingly around the country (including Florida) with success. Research shows that these programs are effective in keeping people with mental illnesses

out of jail, minimizing police time, and maintaining community safety.²³

"My name is **Daryl**, and I am an addict. I was born in the mid-1950s in a rural Tennessee farming community. My early life was like a scene from a Norman Rockwell painting. I learned to work hard as a kid.

At 18 I was accepted to the University of Tennessee. In college I began drinking and experimented with a smorgasbord of drugs, everything from pot to acid.

I did manage to graduate, but drugs and alcohol were firmly rooted in my life. I never thought I had a problem. I was functional. I had a loving wife, two kids, a house, two cars, etc. All that changed when in 1985 I ran up on crack cocaine. From the first hit, I was hooked. The house, cars, kids' college educations, relationships – gone.

My downward spiral continued. In my first 40 years, I'd never seen the inside of a jail. After that, I couldn't live outside a jail. A series of events in jail led me to ask for help with my addiction. I was introduced to the 12 Step Recovery Program. I owe my life today to this program and to my higher power.

And what a life I now have. Each day I discover something new and worthwhile about me. Today I work on being the best person I can be for that day only. Fractured relationships with my family and friends are being mended. I again have respect and admiration from my children. Most important of all, I am regaining me. My life isn't a bowl of cherries, but today I know how to deal with the problems of everyday life without drinking or doing drugs. By the grace of God, it's been two years since I've found the need to use."

Florida has been among the pioneers in jail diversion efforts. The second drug court established in the United States originated in Broward County. Drug courts, as an alternative to incarceration, have been demonstrated to be effective in reducing re-arrest and improving the recovery of individuals diverted from jail. Broward County also led the nation in establishing the first mental health court.

There are numerous models available to divert persons from punitive settings into emergency and community treatment. However, local resources and existing diversion programs, as well as mental health and substance abuse assessment and treatment services within correctional and juvenile justice settings, are far from sufficient to meet current demand.

The Commission has concluded that the lack of emergency response capacity and adequate follow-up services are important contributing factors to the incarceration of persons with MHSA disorders. Persons with both substance abuse and mental illness are particularly difficult to serve and, as will be discussed below, require special integrated treatment programming that is largely unavailable in Florida.

ADULTS WITH SERIOUS MENTAL ILLNESSES (SMI) AND CO-OCCURRING DISORDERS

Floridians with serious mental illnesses, as well as those with and co-occurring mental and addictive disorders, are under-served by the traditional system. Integrated services to address multiple needs are almost nonexistent.

Among Florida adults and older adults, the estimated annual rate of serious mental illnesses (SMI) (not including substance abuse/dependence) is 5.5%.^{2,25} According to Commission testimony, Floridians with serious mental illnesses such as schizophrenia, bipolar disorder, major depression and trauma disorders may be particularly under-served by the current DCF system. Individuals with these severe disorders are more likely to experience significant disability and have multiple needs such as medical problems, low income, and difficulty maintaining employment and accessing affordable housing.

Many individuals who are most in need of services are not identified. Assessment, access, and flexible, consumer-driven funding and services are lacking. In Florida, of the estimated 610,000 adults (ages 18 to 64) with SMI, less than 25% receive services from the Department of Children and Families^{2, 24, 25} although some may be served in other settings.

While we suspect that the overall needs of persons with severe mental illness are not being adequately met, individuals with both mental illness and substance abuse or addiction (also called co-occurring disorders, co-morbidity, or dual diagnosis) may be particularly poorly served. Persons with co-occurring disorders are classic examples of individuals who fall through the cracks in the traditional system of care.²⁶ Research clearly indicates that these individuals have greater treatment success when they receive integrated care. Although models of integrated care exist, they are rarely used in Florida. Both capacity and resources for persons with co-occurring disorders are grossly inadequate to meet current need.

“Addiction is a brain disease expressed as compulsive behavior. Both developing it and recovering from it depends on behavior and social context. People can’t ‘just stop’ because they’re in a different brain state. That’s why treatment is so essential.”

**Dr. Alan Leshner, Director
National Institute of Drug Abuse**

Nationally, among persons age 15 to 54, more than 40% of those with a substance abuse disorder also had a mental disorder within a given year. Similarly, more than 20% of individuals with a mental disorder also had a co-occurring addictive disorder within a year. Lifetime occurrence of co-morbidity is even higher, as is substance abuse among individuals with severe mental illness.^{27, 28} Five percent of Floridians meet criteria for both mental

and addictive disorders each year. However, only 12% of these individuals receive MHSA services from DCF providers.^{2, 29} While we do not know how many of these persons are served in other treatment settings, it seems unlikely that they are well represented in the non-specialty sector. Recent attempts to implement integrated services in some Department of Corrections facilities is one example of attempts outside the DCF system to better meet the needs of this population.³⁰ Given the prevalence of these problems and the marked functional difficulties that individuals with these disorders confront, it is imperative that we work to better understand where they are seen and to implement integrated models of care for their treatment in these settings.

SPECIFIC FINDINGS

According to the Commission’s Adult Workgroup, in addition to findings described elsewhere in this chapter, the following problems also occur in the public adult MHSA system:

- No uniform, statewide standards for quality of care exist.
- Consumers are not empowered to recover through programs that focus on individual’s strength and abilities, promote accountability and coordination, and demonstrate sensitivity to special needs.
- The need for mental health services exceeds current supply. Funding must be sufficient to meet needs and must be adjusted for inflation and population changes.
- Community-based treatment is currently insufficient to meet the expected demand if state hospitals are closed and patients are released to community care.
- Florida not only does not receive an appropriate share of Medicaid, HUD and other federal funds, but most HUD dollars are diverted to individuals with modest incomes rather than to

persons with psychiatric disorders. This creates a severe shortage of safe, affordable housing for some of Florida's most vulnerable citizens.

- Clients in assisted living facilities (ALF) must relinquish their SSI and OSS allotments. The monthly stipend of \$43 they receive is not nearly adequate to cover clothing, hygiene, co-payments for treatment services, transportation and other expenses.
- Individuals with histories of abuse often experience an exacerbation of symptoms when they are placed in restraints, further traumatizing them and potentially necessitating further treatment.

CHILDREN'S MENTAL HEALTH AND SUBSTANCE ABUSE

Many of Florida's children with mental health and substance abuse problems cannot access coordinated, individualized, affordable services.

Current estimates indicate that 10% of Florida's children have serious emotional disturbances, and 20% have a diagnosable mental disorder. Nine percent of preschool-age children between ages two to five already have serious mental health problems. Many are not identified and treated.³²

"For 1 in 5 children and adolescents, the criminal justice system is the gateway to mental health treatment."

**Alberto de la Torre, M.D.,
Medical Director,
Renaissance Behavioral
Healthcare Systems
Jacksonville, FL**

The substance abuse situation is hardly more encouraging. A recent study suggested that within the previous 30-day period, 31% of Florida high school students have used alcohol, and 35% report the use of alcohol or an illicit drug. More than 23% report binge drinking during the preceding two weeks. Among middle school students, 8% report the use of an illicit drug during the preceding 30 days.³²

Juan just turned 14. He is one of many children in a poor Miami family. Even at his young age, he has a history of drug abuse and mental illness. He has been in trouble with the law several times, most recently for misdemeanors like petty theft and animal cruelty. His case appeared before the Honorable Judge Jeri Cohen, a Dependency Court Judge in the 11th Judicial Circuit Court in Dade County. Judge Cohen serves on the Florida Commission on Mental Health and Substance Abuse.

Juan desperately needs specialized juvenile services for both mental health and substance abuse, but there are no services available to meet his needs. There are no therapeutic foster homes, no facility for dually diagnosed adolescents, and no residential program.

The Court and his advocates must choose among numerous poor alternatives, such as sending him home untreated; illegally keeping him in juvenile detention, where no services are provided; or having him placed in an unsecured, inappropriate facility where he would not get the help he needs and might run away.

"I've got a situation that's typical of hundreds that I see every year. It's incredibly frustrating," says Judge Cohen. "There is no care at all available for Juan at this time. Juan could probably be rehabilitated with the proper mental health and substance abuse treatment. He could be helped before it's too late. But I have nowhere to send him. I wish to God I did."

Many youngsters have both mental health and substance abuse problems. Of those treated for substance abuse, 80% to 85% also have a mental disorder.³³ Florida's troubled children find

themselves in a variety of settings. Seventy five percent of children in foster care have mental health and/or substance abuse problems. About 100,000 Florida youth ages 10 to 17 are referred for delinquency each year in the juvenile justice system.^{2, 35}

Children with troubled parents are at extremely high risk for problems. Fifty percent of adults involved in the state's substance abuse system are parents, and 80% of children in the child welfare system have parents with mental and addictive disorders. Approximately 70,000 cases of maltreatment of Florida children are documented annually. (This translates to one of every 50 children and adolescents in the state but is likely an underestimate, as many cases of maltreatment are neither reported nor investigated).²

According to the Commission's Children's Workgroup, many of Florida's children with mental and addictive disorders have serious difficulty accessing coordinated, affordable treatment services. The Department of Children and Families estimates its unmet need for its target population groups at 77% for children and 86% for adults. In particular, many children who are being seen in the juvenile justice or child welfare systems are not being treated for their substance and mental health issues.

SPECIFIC FINDINGS

According to the Commission's Children's Workgroup, problems with the current children's MHSA system include:

- The prevalence of MHSA problems appears to be increasing, with problems developing at earlier ages. Numerous public agencies are involved in treatment, but there is little integration or coordination of services. Planning, funding and service delivery are extremely fragmented.
- Inadequate resources to implement mandated programs exist in numerous areas.
- There is no coordinated, comprehensive,

integrated prevention program for children's mental health.

- Adequate insurance coverage is lacking for many children and families.
- Medicaid funding potential is under-utilized.
- Little routine screening is conducted to identify problems.
- There is too little family involvement and family choice in treatment.
- Some aspects of the residential treatment system are characterized by questionable care, a poorly trained workforce and lax oversight.
- Racial and ethnic diversity are not adequately considered in planning and delivering services.
- A critical need exists for public education (particularly for parents seeking help) and stigma reduction.

OLDER ADULTS

Tremendous unrecognized and unmet need exists for MHSA services among older adults, and Florida has no system in place to address this need.

Nationally, but particularly in Florida, MHSA issues in elders will soon become a major public health problem due to the changing demographics of our state and nation. Florida is already the "oldest" state in the nation, and all projections indicate that this trend will continue.

A significant percentage of older adults have mental health and substance abuse needs. Dementia, depression and schizophrenia all present special problems in elders. Depression in elders is particularly prevalent and under-diagnosed, both in epidemiological studies and in treatment settings.^{2, 36} Nationally, geriatric depression is projected to affect up to 15 million elders by 2030.³⁷

“We should be sending professionals out to places where elders live or gather, rather than expecting them to come to professionals or seek help, which is often contrary to their habits and long-standing approach to dealing with problems.”

**Dr. Gema Hernandez, Secretary
Florida Department of Elder Affairs**

While little Florida-specific data are available, nationally it is estimated that 22% of persons older than 60, and more than half of all nursing home residents, have mental or addictive disorders. We estimate that one in five Florida elders may have MHSA needs. Substance abuse in elders is especially under-recognized and under-treated. Many symptoms mimic physical disorders in the elderly, and health professionals lack understanding of the problem as well as appropriate screening tools.

SPECIFIC FINDINGS

According to the Commission’s Older Adult Workgroup, specific findings regarding the crisis in Florida MHSA elder care include:

- Elder care is currently not a priority for state and local governments.
- The availability of mental health and substance abuse services has dramatically decreased during the past decade.
- The MHSA service utilization rate for Florida’s elders is among the lowest in the United States.
- There currently is no unified, integrated system of care to respond to elder’s needs, nor is there a

statewide policy for MHSA care for older adults in Florida.

- Programs that do exist are scarce, of variable quality and under-funded.
- Ageism and stigma are significant problems.
- Little outreach is undertaken to identify elders in need of help.
- There is a shortage of caregivers, and few receive adequate training.

CONCLUSION

The Commission has concluded that we must acknowledge and better understand the realities of the combined MHSA system. We must design leadership and information systems that will help us more fully understand the implications of decisions made in one component of the system on service settings in other components. We must work to improve the relationship between our science and our practice and move our interventions “up stream” to identify problems earlier in normalized settings and effectively intervene to either prevent or ameliorate the symptoms of illness before the onset of disability.

For persons who have developed significant disabilities from a mental or addictive disorder, we must establish single points of responsibility for their care, integrated services, and flexible funding approaches that allow them to get what they need to recover or improve. We must hold ourselves accountable for the outcomes of these individuals and for all our state’s citizens. In the next chapter we will outline a set of proposed solutions to address both the problems of the traditional DCF system and the broader challenges inherent in the combined system.

Chapter 3

Recommendations

The fundamental assumption of these recommendations is that significant changes have occurred in our understanding of mental and addictive disorders that have not been accompanied by changes in the system's management or leadership structure. Further, these changes have not been fully reflected in the statutory and regulatory structure that governs the system.

The Florida Commission on Mental Health and Substance Abuse, therefore, concludes that:

Florida's laws and regulations must be modified to accommodate the new realities of the traditional (i.e., DCF) and non-traditional mental health and substance abuse (MHSA) systems.

The state leadership, purchasing and accountability infrastructure must be redesigned to:

- increase efficiency and effectiveness
- recognize and treat MHSA problems in the natural settings where they occur
- decrease the need for more intensive and expensive services
- promote independence and recovery for persons with MHSA disorders
- use preventative interventions to reduce the rate of illness in the general population

The statutory role of the traditional system for mental health and substance abuse must be more clearly defined, and the traditional system must be given the resources and tools needed to accomplish its newly defined statutory role.

We have demonstrated that mental health and substance abuse problems powerfully affect a broad range of state and local programs and ultimately all

aspects of our communities. A central principle of the Commission is that all Floridians should have access to appropriate, science-based care when they have behavioral health problems. It is in our communities' interest to effectively address these problems in the settings where they occur.

We also know that the actions of each of the components of the traditional and overall system affect all others. We realize that no single entity of government has responsibility for assessing the adequacy of the overall system and dealing with the effects of the interactions of its component parts. Without this leadership, the system's health and functionality cannot accurately be assessed.

The Commission, therefore, recommends that:

1 A statewide Coordinating Council for Mental Health and Substance Abuse Policy be created in statute as part of the Office of the Governor.

Responsibilities of the Coordinating Council

This Council should be charged with leadership of the overall system, which will be accomplished through:

- ◆ the production of a statewide strategy for mental health and substance abuse services that maps the overall system, specifies its goals, and describes roles and responsibilities for each component.
- ◆ assembling information systems - often using existing data sources - that will permit evaluation of the statewide strategy in meeting strategic objectives, including benchmarks of system performance and community MHSA status.

Composition of the Coordinating Council

- ◆ The Council will be composed of the leaders of the following departments and state agencies:
 - Department of Children and Families
 - Department of Health
 - Department of Corrections
 - Department of Juvenile Justice
 - Department of Elder Affairs
 - Agency for Health Care Administration
 - Florida Department of Law Enforcement
 - Department of Education
 - Department of Community Affairs
 - Office of Drug Control
 - Governor's Budget Office

Additionally, it will be composed of representatives from the following stakeholder groups:

- at least three primary consumers of MHSA services and three family members of consumers
- at least two representatives of county government
- other interest groups that are currently represented on the Florida Commission On Mental Health and Substance Abuse
- the Florida Chamber of Commerce

Operation of the Coordinating Council

- ◆ Activities of the Council will be coordinated with those of the Office of Drug Control to integrate statewide strategy and policy.
- ◆ The Council will be provided the resources that are necessary to accomplish its mission, including an executive director with proven

leadership skills and extensive knowledge of MHSA system design and administration.

- ◆ At least quarterly, the Coordinating Council will meet to:
 - review the functioning of strategies for the overall system
 - identify ways to improve its functioning
 - solve inter-system problems
- ◆ Annually, the Council will be required to report to the Governor, Senate President and House Speaker on:
 - the state of the overall system
 - the statewide management strategy
 - the mental health and substance abuse status of Florida's citizens
- ◆ Annually, the Council will review the budget requests from each of its constituent departments to determine if adequate attention is being given to MHSA issues within each department and the Council will make recommendations to the Governor regarding the adequacy and coordination of budget requests.

The Coordinating Council will work with all its members to:

- **Improve Data Integration** to maximize the extent to which MHSA service-related data can be linked across different service sectors and funding streams
- **Improve Information Accessibility and Dissemination** to enhance the amount and quality of MHSA-related information that is readily available and disseminated to the public, policymakers and providers
- **Improve Needs Assessment** to develop processes that monitor current and emerging need for MHSA services that reflect consumer preferences as well as effective technologies

- **Improve Performance Monitoring Systems**, including use of outcomes measures, that are appropriate for the level of the system that is being monitored and the purpose of the monitored program within the overall system of care

2 The Coordinating Council will provide and coordinate a wide range of public education and preventative activities that reflect best practices including:

- ◆ Public education regarding the symptoms of mental health and substance abuse disorders and the availability of effective treatments
- ◆ Public education designed to reduce stigma and combat discrimination
- ◆ Consumer education regarding appropriate care to help ensure that consumers understand and request best practices from service providers
- ◆ Establishment of a statewide toll-free number to respond to public questions and concerns
- ◆ Development and implementation of K-12 curricula regarding the signs, symptoms, treatment and prevention of mental and addictive disorders
- ◆ Leadership to assure that proven preventative interventions are effectively implemented throughout the overall system and that unproven interventions are replaced with those having an adequate scientific basis
- ◆ Knowledge about the potential of early interventions for reducing disability
- ◆ Innovative strategies to assist natural helpers and community residents to recognize and respond to MHSA needs

The private sector should be engaged in these prevention activities.

3 Part of the state statute related to the traditional mental health and substance abuse system must be updated to better conform to current needs and circumstances. The statutory base must recognize the unique expertise represented by each component of the overall system and provide for the needed management flexibility and integration of services to better meet the needs of individuals with both mental and addictive disorders.

Objectives of Mental Health Statute Revision

The current law authorizing the public mental health system (394, Part IV F.S.) is very broadly drawn and reflects an earlier era. This statute must be redrawn to more clearly delineate the contemporary role of publicly funded mental health services, provide an accountability framework to assure that services are delivered to those most in need, and enable localities to develop systems that best meet the needs of their communities. Part IV of Chapter 394 F.S. should be revised to focus exclusively on the planning and financing of mental health and substance abuse services. Provisions for local funding need to be rewritten to more clearly articulate the match obligations of providers and local governing bodies. The Department of Children and Families should be given authority for implementing prototype integrated mental health and substance abuse programs and services using current licensing and designation authorities under Chapters 394 and 397 F.S.

The realities of the current publicly funded mental health services require that the functions of the traditional mental health programs, funded by state general revenue and Medicaid, be more narrowly focused to:

- assure adequate emergency behavioral health services throughout the state
- provide counseling and supportive services to individuals regardless of their ability to

pay in order to avoid crisis and/or provide follow-up services following crisis stabilization

- provide continuing care services for individuals with disabling mental illnesses who cannot or should not be served in other areas of the overall system

Substance Abuse Statute Revisions

The current law authorizing the public substance abuse system, the Marchman Act, was revised in 1993 to integrate alcohol and drug abuse services into a single statute. In 1999, Chapter 397 F.S. was revised again, adding a section for children's substance abuse prevention and treatment services. The Office of Drug Control was also established with this revision. The system of care principles reflected in Chapter 397.97, children's substance abuse services, should be applied with appropriate revisions to adult substance abuse services, reinforcing an integrated family focus for preventing and treating substance abuse.

Principles for Statute Revision

The principles that should guide the redesign of mental health and substance abuse statutes and systems include:

- ♦ Practices in the traditional system should conform to standards of care based on the current state of the science.
- ♦ All services must be sensitive to the widely differing cultural groups that comprise Florida's population including differing gender, racial, and ethnic groups.
- ♦ Services must be structured and delivered in a way that is sensitive to the complexity of problems that service recipients confront and their multiple physical, mental and sensory handicaps. For persons with a disabling illness, services must include income support, educational, housing and employment interventions to promote independence and maximum community functioning.
- ♦ Clinical and rehabilitative services should be provided to individuals regardless of their ability to pay, but on a variable fee basis that helps to assure access to services for everyone.
- ♦ Single points of responsibility should be established within geographic areas to:
 - assure the provision of a continuum of services
 - assure accountability for persons with the most severe and disabling illnesses
- ♦ Purchasing and funding mechanisms should be implemented that provide equitable distribution of resources throughout the state, the most effective integration of Medicaid and DCF funds, and optimal flexibility to purchase state-of-the-art services within an accountable system.
- ♦ Funding mechanisms should contain costs and provide incentives to promote consumer choice and to foster independence and recovery.
- ♦ Research and evaluation should be conducted as part of a performance management system to determine if services are being delivered effectively, consumer expectations are being met, and appropriate outcomes are being achieved.
- ♦ Responsiveness to local circumstances is essential for the development of effective service systems. Local advisory groups composed of all of the key stakeholders in the services system should be empowered to assist in the development and administration of MHSA services in localities. Adequate community representation, including persons with MHSA disorders, is essential on local advisory groups.

Operationalizing these Principles

The Commission recommends that DCF initiate a process similar in structure to that which it has undertaken in Family Safety. Specifically, the Commission recommends that DCF:

- ◆ Utilize the Community Alliances (or other suitable groups as locally determined) to serve as the local advisory entities to MHSA systems.
- ◆ Establish a managing entity in each area of the state that will be the accountable entity for DCF MHSA services in that area, including emergency, continuing care services and other services purchased with public resources. The structure of this entity should be variable to accommodate local resources and needs. The composition of the managing entity should be jointly determined by the Community Alliances and DCF.
- ◆ Assure that the managing entity has flexibility in its management of the local services system to guarantee that the system fully utilizes available local resources and is responsive to citizens' needs. These mechanisms may include pooled funding and centralized purchasing authority by the managing entity.
- ◆ Use epidemiological estimates consistent with those of the Coordinating Council to derive population-based need assessments that can be used to determine the allocation of state resources to each locality.
- ◆ Based on these need estimates and local resource estimates for MHSA services, the state will provide an allocation to each area that will include DCF general revenue and Medicaid resources.
- ◆ DCF will define and establish procedures for assessing the service needs, strengths and goals of individuals who enter the DCF system. The data collected as part of this assessment process will be used to identify individuals in priority groups for DCF-funded services and to evaluate the effectiveness of the system. These prioritized groups will include:
 - persons experiencing a MHSA crisis
 - persons who have a disabling mental illness or substance abuse disorder who will require extended services in order to recover from their illness
 - persons who need brief treatment or supportive interventions to avoid crisis or disability
- ◆ DCF will assure that substance abuse preventative services are provided consistent with the overall plan of the Coordinating Council for preventative activities.
- ◆ DCF, in conjunction with the Coordinating Council, will establish benchmarks to evaluate the adequacy of system performance in meeting the needs of the priority groups. These measures will include both system and program level indicators and will involve change measurements for samples of individuals who are enrolled in treatment as well as indicators of overall community wellness.
- ◆ Services should include innovative, new pilot projects that have proven to be successful.

4 Florida's behavioral health emergency services require numerous changes. Consistent with the provisions of the Baker and Marchman Acts, emergency services should be provided to individuals who have a mental illness or substance abuse impairment and are thought to be subject to self neglect or a danger to themselves or others.

- ◆ Consistent, quality emergency services for individuals in a psychiatric or addictive crisis should be available to every resident of the state regardless of their ability to pay for services.
- ◆ Consistent with the general needs assessment activities referenced earlier, DCF, in conjunction with the Coordinating Council,

should contract with a qualified consultant to develop actuarial models to project the emergency capacity required in each geographic area in order to assure that adequate resources will be available to operate the emergency care system. Local variations in the structure of the emergency care system must be accommodated in the actuarial models to assure flexibility and creativity in system design.

- ◆ The Commission enthusiastically supports
 - increasing funding for the emergency care system to restore it to its historic level of funding in real dollar terms including both general revenue and federal resources
 - removing counterproductive regulatory barriers to receiving services
- ◆ Local government should have a responsibility to help fund emergency care services.
- ◆ Annual appropriations should adjust for inflation, population growth, and experience with revenue mix to assure adequate local capacity.
- ◆ The DCF will contract with a local accountable entity that will assure that quality services are available on a regional basis and that these services are linked to other ambulatory, residential, inpatient, and support services. These entities will be the single points of accountability for a geographic area and will regulate the emergency care system in that area of the state. The accountable entity may be composed of networks of existing providers, be a newly created administrative service organization that is independent of the local provider agencies, or be a component of local government, depending upon local preferences.
- ◆ Service quality indicators should be monitored and include measures such as:
 - clinical improvement of individuals served
 - rates at which persons receive follow-up care after emergencies

- reduction of jail admissions
- satisfaction of key constituents such as consumers and families served, law enforcement, juvenile justice, local government and others as appropriate for the locality

- ◆ The Commission realizes that effective law enforcement training is a key element of an effective emergency response care system. We therefore recommend that all law enforcement officers receive expanded training in working with persons experiencing mental health crises and that a sufficient number of officers in each service area receive Crisis Intervention Training (CIT) to assure appropriate law enforcement crisis response.
- ◆ The Commission recommends that state and local authorities aggressively seek to implement the recommendations from the Supreme Court Commission on Fairness regarding needed improvements in the Baker Act.

5 Continuing Care Services

Continuing care services are those longer-term services provided to individuals with ongoing mental and addictive needs. The Commission recommends that persons who experience significant MHSA disability be provided continuing care services that are developmentally appropriate for their age and sensitive to their cultural context.

- ◆ The Commission recommends that continuing care services be developed based on a model that promotes consumer and family choice, ensures dignity and autonomy, provides information about best practices in treatment and rehabilitation, and promotes treatment in the least restrictive, integrated, community-based setting and promotes the recovery of individuals, with their independence from formal supports as soon as possible.

- ◆ Individuals whose clinical and functional status indicates the need for these services will be enrolled in the continuing care system by name. These persons will then be eligible for a range of treatment, rehabilitative and support services until they no longer need the services to maintain or improve their level of functioning. Given the long-term nature of some mental and addictive disorders, continuing care services should be sensitive to the variable needs of individuals across time and designed to help assure easy access for persons with these ongoing problems.
- ◆ Persons will be enrolled in the continuing care program based upon the use of standardized screening criteria that includes at least the following three factors:
 - meeting diagnostic criteria for a mental or addictive disorder
 - significant disability associated with the disorder or likelihood that the disability will increase if appropriate services and supports are not provided
 - expected duration of the disability greater than one year
- ◆ Persons who are participants in the SSI or SSDI program by virtue of a mental impairment will be eligible for the continuing care program. Persons who exclusively have developmental disability or dementia-related disorders without other mental or addictive disorders generally will not be eligible for continuing care services.
- ◆ The Commission recommends that the local accountable entity assess and enroll individuals into the continuing care program in each locality in the state.
- ◆ The accountable agency will be responsible for providing or purchasing the services and supports that are needed by persons in continuing care. Community Alliances will determine, in consultation with the state, how best to avoid conflicts of interest for accountable agencies that provide as well as manage services. To the degree possible, consumers should be given choice in service provider and service array.
- ◆ The accountable entity, along with the person with a MHSA disorder, will determine the need for ongoing continuing care services for individuals on a regular basis, adjusting the caseload to accommodate the overall needs of individual clients and the community.
- ◆ Purchasing mechanisms should promote flexibility and responsiveness. The service array should be determined by using needs assessment and best practice models to determine the types and intensities of services and supports required by continuing care clients in order to facilitate recovery. Creative purchasing mechanisms, such as consumer-directed care, should be investigated and implemented if found to be effective.
- ◆ Recovery from severe mental illnesses requires access to safe and affordable housing, transportation services, adequate resources to meet basic personal needs, employment and educational opportunities, and meaningful community roles in addition to treatment and rehabilitative services. Failure to attend to the full range of needs will significantly slow the recovery process. The Commission repeatedly heard testimony about the inadequacy of these supports and strongly recommends that they be included in planning for the needs of clients enrolled in continuing care.
- ◆ Accountable entities will be encouraged to use innovative strategies such as assertive community treatment, consumer run services such as clubhouses and drop-in centers, respite services and other creative approaches to promote recovery of enrollees.
- ◆ Accountable entities should be required to submit data on service utilization and

outcomes to DCF for all enrolled clients and should be responsible for meeting performance expectations related to:

- rate at which individuals in the community receive services
- rate of consumer improvement (clinically and functionally)
- consumer and family satisfaction
- satisfaction of key stakeholders (e.g., courts, police, schools)

The Commission heard testimony regarding the closure of the G. Pierce Wood State Hospital in southwest Florida. While the Commission takes no formal position regarding the wisdom or appropriateness of this closure, it strongly endorses the need to strengthen the community care system in this area and throughout Florida. Adequate community resources must be in place before the closure of the hospital. The Commission supports increased funding dedicated to the GPW catchment area to add needed resources to the community system. The effectiveness of this enhanced community system should be evaluated and, if found to be effective, supported statewide.

It is anticipated that adults and elders with mental illnesses who meet continuing care criteria are at risk for state hospital and other residential placement. The Commission recommends that the state develop a multi-year plan in which state hospital resources be progressively included in the continuing care resources. Accountable organizations may choose to purchase services from the state hospitals for individuals who need such services. Such a mechanism will assure that state hospital care remains responsive to the needs of clients and that resources are used in the most efficient way possible.

6 The Commission identified a number of specific groups who are inadequately served by the current system. Their needs should be addressed by the Coordinating Council in a manner that is sensitive to cultural, gender

and age differences among individuals in each of these groups. Inadequately served groups include:

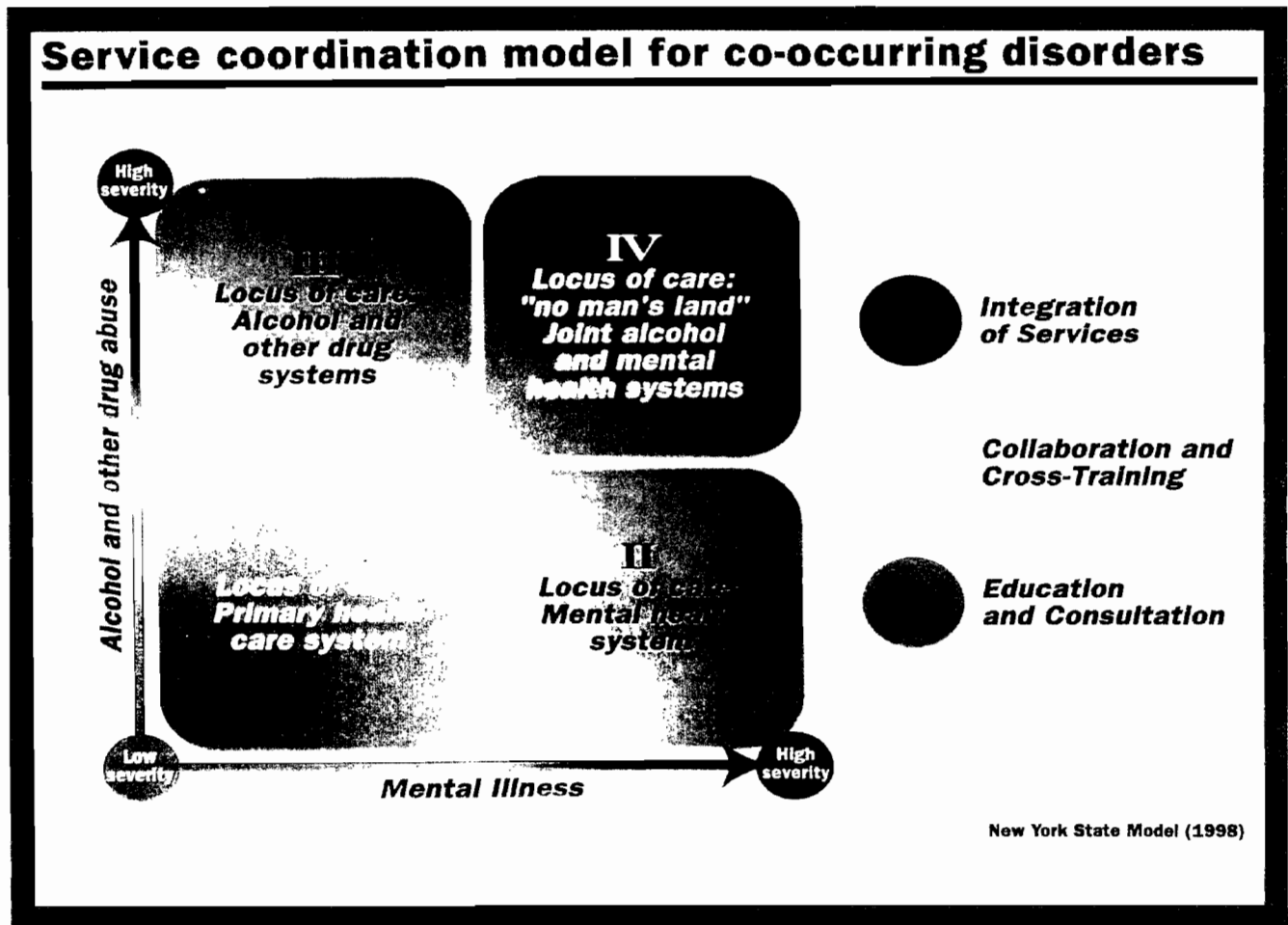
- Older adults
- Persons with co-occurring mental illnesses and addictive disorders
- Persons with multiple disabilities
- Persons with severe, low prevalence disorders that require special treatment skills (e.g., eating disorders)
- Homeless persons
- Trauma survivors
- Children and their families in juvenile justice and dependency systems
- Very young children with mental disorders

The Commission repeatedly heard testimony about inadequate services to these groups that contribute to poor and often tragic outcomes. The specific issues for each of these population groups differ, but common threads among them include poor access, providers who are not well prepared to meet the needs of these individuals, and a service system that is non-responsive to the special and often complex needs of these individuals. Clinical, support and rehabilitative needs should be considered.

Therefore, the Coordinating Council should clearly identify the needs of individuals in these populations, the adequacy of the current service system to meet their needs, and barriers to effective services. This information should be disseminated to the local accountable entities for use in program redesign.

The schematic diagram featured in Figure 3.1 may be helpful in defining the roles of the differing components of the system. The schematic portrays a strategy for assigning lead roles for differing components of the overall system for serving persons with both mental and addictive disorders. It illustrates how severity of illness helps to dictate the sector in which services are delivered (specialty or general) and the degree to which services must be integrated in order to best meet the needs of persons with complex disorders.

CONCEPTUAL MODEL FOR TREATMENT OF CO-OCCURRING DISORDERS *



* The National Association of State Mental Health Program Directors & National Association of State Alcohol and Drug Abuse Directors, Inc.

Figure 3.1

7 The Commission heard repeated testimony about the special problems of persons with mental and addictive disorders in the law enforcement, corrections and court systems and the emerging role of the legal system in promoting treatment. The Commission recommends that the Coordinating Council place particular emphasis on persons served in these systems to assure that, whenever possible, diversion from incarceration be accomplished and that, when persons are incarcerated, they receive effective treatment for their disorders.

Operationalizing these Principles

- ♦ Working with law enforcement, state attorneys and public defenders, local authorities should strengthen jail diversion programs for persons who are at risk for incarceration based primarily on their mental illnesses or addictive disorders
- ♦ State and local governments should be encouraged to provide adequate resources to assure that persons in jails receive adequate assessment and treatment for any mental and addictive disorders
- ♦ Continue to support and appropriately expand drug courts and criminal and juvenile justice programs that have been demonstrated to be an effective venue for linking persons to care and promoting their recovery
- ♦ Continue to support, expand and evaluate mental health courts as a promising practice for assisting persons charged with minor offenses related to mental disorders in accessing care
- ♦ Expand the support and continue the development and testing of other innovative strategies for diversion from incarceration

Judiciary, law enforcement, correction/detention, and legal system involvement often reflects the failure of crisis, treatment or prevention services to

adequately meet the need of populations with mental disorders. While jail diversion programs are essential given the current functioning of our system, they ultimately document the failures of our system to adequately recognize, treat and prevent these illnesses. The Coordinating Council should continue to examine the effectiveness of the overall system in reducing the incidence of persons with mental and addictive disorders in the legal system.

8 Access to effective MHSA services underlies many of the problems that plague this system. The Commission recommends that DCF and the Coordinating Council continue to focus on the problems of access and choice.

Specifically, the Commission recommends that:

- ♦ Floridians be assured timely access to state-of-the-art pharmaceutical treatment including the use of standardized decision (algorithms).
- ♦ Financial barriers to the receipt of care should be removed through the provision of insurance benefits for mental, addictive and general health conditions that are at parity with general health benefits. No longer should it be acceptable to discriminate against persons with MHSA disorders in terms of insurance coverage.
- ♦ The Coordinating Council should assure that Florida aggressively pursue federal grant-in-aid and matching programs (such as Medicaid, Housing and Urban Development, etc.) to enhance the access to an array of services available to our citizens. Education, consultation and technical assistance in maximizing federal participation should be provided to Council member agencies and localities. Using federal funds to supplant state resources is an unacceptable and dangerous long-term strategy because not all persons in need can participate in federal programs.
- ♦ Licensed providers should be encouraged to



participate in the Medicaid system by opening provider eligibility to those licensed under F.S. 490 and by improving the fee schedule.

- ♦ The Coordinating Council should promote policies to increase consumer choice. Specifically, the Commission recommends the following activities:
 - pilot and rigorously evaluate creative programs such as the self-directed care model and other consumer-run alternatives and implement those shown to be effective
 - actively promote self-help and mutual support approaches to care
 - give consumers full choice of qualified, licensed providers for those services that require licensure

9 Professional education is key to improving the overall functioning of the system. The Commission recommends that the Coordinating Council promote the development of educational programs to help assure access to information for both Florida's citizens and the professional and para-professional communities.

Specifically, the Commission recommends that the Coordinating Council:

- ♦ Evaluate the adequacy of professional and para-professional education relative to the needs of the overall system by examining graduate and undergraduate curricula in Florida's higher education system. The perspectives of consumers and family members must be formally incorporated into training curricula (e.g., training regarding sensitivity).
- ♦ Recommend curricular changes to increase the responsiveness of professional education to current needs.
- ♦ Examine the adequacy of continuing education and licensure requirements to assure the ongoing competence of the workforce.
- ♦ Develop education for the judiciary, law enforcement, correctional/detention and other legal professions regarding the recognition and treatment of MHSA disorders.

Enabling Legislation

1 accounting of patient fees that are earned on behalf of a
2 specific client.

3 Section 4. Commission on Mental Health and Substance
4 Abuse.--

5 (1) FINDINGS.--The Legislature finds that: major
6 changes and improvements have occurred in how mental health
7 and substance abuse services are planned, purchased,
8 delivered, coordinated, and accounted for; the management of
9 the state's substance abuse and mental health services system
10 delineated in part IV of chapter 394, Florida Statutes, has
11 not been systematically reviewed and updated in over 15 years;
12 and the management of the state-supported mental health and
13 substance abuse system has not kept pace with improvements in
14 the field, thereby diminishing the potential efficacy of its
15 investment in mental health services and substance abuse
16 services. Therefore, it is the intent of the Legislature that
17 a systematic review of the overall management of the state's
18 mental health and substance abuse system be conducted and that
19 recommendations for updating part IV of chapter 394, Florida
20 Statutes, and other related statutes be formulated.

21 (2) CREATION.--There is created, within the Department
22 of Children and Family Services, the Commission on Mental
23 Health and Substance Abuse.

24 (3) DUTIES.--The duties of the Commission on Mental
25 Health and Substance Abuse include the following:

26 (a) Conducting a review and evaluation of the
27 management and functioning of the existing publicly supported
28 mental health and substance abuse systems and services in the
29 Department of Children and Family Services, the Agency for
30 Health Care Administration, and all other departments which
31 administer mental health and substance abuse services. Such

1 review shall include, at a minimum, a review of current goals
2 and objectives, current planning, services strategies,
3 coordination management, purchasing, contracting, financing,
4 local government funding responsibility, and accountability
5 mechanisms. The commission shall coordinate its activities and
6 recommendations with the Office of Drug Control within the
7 Executive Office of the Governor.

8 (b) Addressing the unique mental health and substance
9 abuse needs of older persons shall be an integral component of
10 the duties of the commission as specified in paragraph (a).

11 (c) Addressing access to, and financing of, and scope
12 of responsibility in the delivery of emergency behavioral
13 health care services.

14 (d) Addressing the quality and effectiveness of
15 current mental health and substance abuse services delivery
16 systems, and professional staffing and clinical structure of
17 services, roles, and responsibilities of public and private
18 providers, such as community mental health centers, community
19 substance abuse agencies, hospitals, including emergency
20 services departments, law enforcement, and the judicial
21 system.

22 (e) Addressing priority population groups for publicly
23 funded mental health and substance abuse services, a
24 description of the comprehensive mental health and substance
25 abuse delivery systems, district mental health and substance
26 abuse needs assessment and planning activities, and local
27 government responsibilities for funding mental health and
28 substance abuse services.

29 (f) Formulating recommendations to the Governor and
30 Legislature regarding the mission and objectives of
31 state-supported mental health and substance abuse services and

1 the planning, management, staffing, financing, contracting,
2 coordination, and accountability mechanisms which will best
3 foster the recommended mission and objectives.

4 (4) MEMBERSHIP.--The commission shall be composed of
5 23 members.

6 (a) One member shall be a member of the Senate and
7 shall be appointed by the Senate President.

8 (b) One member shall be a member of the House of
9 Representatives and shall be appointed by the Speaker of the
10 House of Representatives.

11 (c) One member shall be the Secretary of Children and
12 Family Services or his or her designee.

13 (d) One member shall be the Secretary of Health or his
14 or her designee.

15 (e) One member shall be the Director of Health Care
16 Administration or his or her designee.

17 (f) The following members shall be appointed by the
18 Governor:

19 1. One consumer of publicly funded mental health or
20 substance abuse services.

21 2. One family member of a consumer of publicly funded
22 mental health or substance abuse services.

23 3. One representative of county government.

24 4. One representative of the Florida Mental Health
25 Institute.

26 5. One corporate employer of a corporation which
27 provides mental health and substance abuse benefits to
28 employees but is not in the business of providing mental
29 health or substance abuse services.

30 6. One representative of an acute care hospital with
31 psychiatric beds or a mental health program.

- 1 7. One representative of a community mental health
2 provider.
- 3 8. One representative of a community substance abuse
4 provider.
- 5 9. A licensed psychiatrist working within the mental
6 health or substance abuse delivery system.
- 7 10. A licensed psychologist working within the mental
8 health or substance abuse delivery system.
- 9 11. Two other licensed mental health or substance
10 abuse professionals.
- 11 12. An emergency room physician.
- 12 13. One representative of an insurer offering
13 behavioral and physical health insurance benefits.
- 14 14. One representative of a specialty hospital
15 licensed pursuant to chapter 395, Florida Statutes, providing
16 mental health care and addictive services.
- 17 15. One representative from law enforcement.
- 18 16. One representative from the judicial system.
- 19 17. One representative of a child welfare agency
20 involved in the delivery of behavioral health services.
- 21 (5) ADVISORY COMMITTEES.--The commission shall appoint
22 at least one advisory committee representative of all state
23 agencies involved in the delivery of mental health and
24 substance abuse services, and consumers, family members of
25 consumers, and current providers of public mental health or
26 substance abuse services.
- 27 (6) STAFF.--The Department of Children and Family
28 Services shall appoint an executive director recommended by
29 the commission, who shall provide professional expertise and
30 arrange for required consultation, analysis, and secretarial
31 and clerical support for the commission. Additional staff

1 support shall be provided by the Department of Children and
2 Family Services.

3 (7) MEETINGS; REPORTS.--

4 (a) The commission shall conduct its first meeting no
5 later than September 1, 1999.

6 (b) The commission shall meet as often as necessary to
7 fulfill its responsibilities.

8 (c) Committees shall be assigned as needed, composed
9 of representatives of the commission and the advisory
10 committee and employees of the involved state agencies.

11 (d) All commission meetings shall be open to the
12 public and shall be held at various locations around the state
13 to facilitate public participation.

14 (e) The commission shall elect a chairperson from
15 among its members.

16 (f) The commission shall, as one of its first duties,
17 adopt rules of procedure, which shall, at a minimum, include a
18 requirement that the recommendations of the commission be
19 adopted by at least two-thirds of those commission members
20 present.

21 (g) The commission shall submit an interim report to
22 the Governor, the President of the Senate, and the Speaker of
23 the House of Representatives no later than March 1, 2000.

24 (h) A final report with recommendations, including any
25 modifications to current law, shall be submitted to the
26 Governor, the President of the Senate, and the Speaker of the
27 House of Representatives no later than December 1, 2000.

28 (i) Authorization for the Commission on Mental Health
29 and Substance Abuse expires effective May 15, 2001.

30 Section 5. Subsections (8), (9), and (10) are added to
31 section 397.419, Florida Statutes, to read:

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