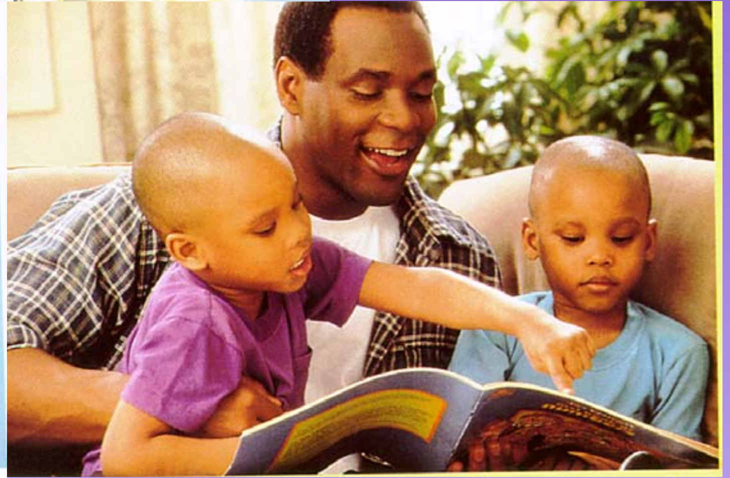

Mental Health and Substance Abuse Services Plan: 2003-2006

January 1, 2004

Jeb Bush, Governor **Jerry Regier, Secretary**

NOTICE OF FILING

Reporting Agency:	Department of Children and Families
Recipient Agency:	
Subject:	State Mental Health and Substance Abuse Plan: 2003-2006
Report Due Date:	January 1, 2004
Statutory Requirement:	Section 394.75, F.S.

Abstract:

Section 394.75, F.S., requires the Department of Children and Family Services to submit a state master plan every three years, beginning in January 2001, to the Legislature regarding the delivery and financing of a system of publicly funded, community-based substance and mental health services throughout the state.

The plan is to be updated annually and submitted to the Legislature by January 1st of each year.

The annual update provides a progress report on key strategic issues, program performance, budget and financial aid, and key trends and conditions. It also describes strategic activities for 2003.

Copies of this report may be obtained by contacting:

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Copies of the report may also be downloaded through the department's website at:

http://www.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/publications/index.html

CF 1610, Oct 96 (Replaces HRS Form 1610 which may be used)

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State Substance Abuse and Mental Health Plan 2003-2006

Introduction

Section 394.75, Florida Statutes, (F.S.), establishes the planning process for the state's publicly-funded substance abuse and mental health service system. Every three years, beginning in 2000, the Department of Children and Families, in consultation with the Agency for Health Care Administration (AHCA), is required to submit a state master plan for the delivery and financing of a system of publicly-funded, community-based substance abuse and mental health services throughout Florida. This document represents the three-year plan covering 2003-2006. The plan has been developed consistent with all statutory requirements.

The substance abuse and mental health goals and strategies in this plan are derived from national and state directions and current trends and conditions, as well as stakeholder feedback.

National strategic directions for substance abuse and mental health are derived from the following:

- Mental Health: A Report of the Surgeon General;
- From Neurons to Neighborhoods: The Science of Early Childhood Development;
- Disintegrating Systems: The State of States' Public Mental Health Systems: A Report by the Bazelon Center for Mental Health Law;
- The National Suicide Prevention Strategy
- Eliminating Barriers Initiative - the National Discrimination and Stigma Reduction Campaign;
- The Well Being of Our Nation: An Intergenerational Vision of Effective Mental Health Services and Supports;
- Adoption and Safe Families Act (ASFA), (Pub. L. No. 105-89);
- Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid's role in Preventing Custody Relinquishment: A Report by the Bazelon Center for Mental Health Laws, November 2002;
- Ending Chronic Homelessness: Strategies for Action;
- Achieving the Promise: Transforming Mental Health Care in America - The President's New Freedom Commission on Mental Health;
- The National Drug Control Strategy;
- Access to Recovery; and
- The National Treatment Plan Initiative

State strategic directions include:

- Executive Direction;
- Legislative Initiatives;
- Florida Drug Control Strategy;

- Florida Drug Control Summit;
- Partnering with the Governor’s Task Force on Suicide Prevention;
- Governor’s Changing Alcohol Norms (CAN) Workgroup;
- Florida’s Program Improvement Plan (PIP); and
- Stakeholder input from individuals served by the program, families and others with interest in substance abuse and mental health services.

The trends and conditions of the state's publicly-funded substance abuse and mental health system also serve as major drivers in the development of the goals and strategies contained within this plan.

The Substance Abuse and Mental Health Programs value input from individuals and groups with interest in substance abuse and mental health services. Stakeholder input was obtained and is reflected in the development of the substance abuse and mental health goals and strategies.

This plan has been organized to assist the reader in understanding the scope of services, diversity of programs and needs of the populations served by the department. It addresses goals and strategies related to substance abuse and mental health, collaborative issues (substance abuse and mental health), financial management, data, performance management and contracting. The plan also includes information about the development of the district plans, including stakeholder input and highlights of the individual district plans.

Chapter 1: National and State Strategic Directions

National Strategic Directions

Mental Health

The past five years have seen an unprecedented interest and focus on mental health and the treatment of mental illness. The impetus for this interest has been the evolving understanding of the etiology of mental illness, increasingly effective treatments for behavioral disorders and the realization by both the medical community and the public of the inseparable link between physical and mental health. There have been several recent national efforts that have helped to crystallize this interest and to establish a vision and a plan for a mental health service delivery system that builds on this knowledge base.

Mental Heath: A Report of the Surgeon General

The United States Congress declared the 1990's the "Decade of the Brain," a recognition of the advancements made in the last two decades in the areas of neuroscience, genetics and human behavior. The first ever Surgeon General's report on mental health was issued in 1999 with the implicit promise of using this enhanced knowledge to move toward a comprehensive policy that would "advance the state of mental health in the nation."[1]

The report represented the federal government's recognition of key principles that continue to be a foundation for research and public policy in the identification and treatment of individuals with mental illnesses. These principles were: (1) mental health is essential to physical health; and (2) mental disorders are real health conditions that have both a personal and societal impact as significant as other chronic diseases and disabling conditions. The report also included an extensive review of scientific research, treatment experience and reports from individuals with mental health needs. The report concluded that there are effective treatments for most mental illnesses and that mental health must become a part of the national health care dialogue.

To illustrate the impact of untreated mental illnesses on society, the Surgeon General cited data from the *Global Burden of Disease* study that found that mental illnesses were second only to cardiovascular disease in cost to society in lost productivity.[2] The Report described a vision for the future of mental health and recommended actions to move the nation toward this new vision, including; continuing to build the science base; overcoming stigma; improving public awareness of effective treatments; ensuring a supply of mental health services and providers, facilitating entry into and delivery of state-of-the-art treatments tailored to age, gender, race, and culture; and eliminating financial barriers to treatment.

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[1] United States Secretary of Health and Human Services, Donna E. Shalala, 1999.
[2] U.S. Department of Health, Mental Health: A Report of the Surgeon General, Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, National Institutes of Health, and National Institute of Mental Health, (1999), p. ix.

The Surgeon General's Report set the stage for continued evolution of a national dialogue on the state of the mental health service delivery system and the integration of research-based knowledge into that system.

From Neurons to Neighborhoods: The Science of Early Childhood Development

The Institute of Medicine and the National Research Council Board on Children, Youth and Families created The Committee on Integrating the Science of Early Childhood Development to update and describe the state of scientific knowledge in the area of early childhood development. The work of the committee was motivated by the recognition that "Two profound changes over the past several decades have coincided to produce a dramatically altered landscape for early childhood policy, service delivery and child rearing in the United States." [3] The first of these changes is scientific advancement in understanding human behavior, growth and development through research in neurology, biology, behavioral science and sociology. This knowledge has resulted in a greater understanding of the interactive effect of genetics and environment on child development. More significantly, it has illuminated the importance of relationships and experience in early childhood on later social, emotional and educational success. The second major change has been the transformation of American family life through the changing nature and scheduling of work, economic hardships, cultural diversity, expansion of child care and increased stress on the family. These changes have constrained the application of this new knowledge.

In their report released in January 2001, the Committee called for a "fundamental reexamination" of how the nation approaches meeting the needs of young children. The conclusions and recommendations were built upon four overarching themes, grounded in research and practice. These themes were:

- All children are born wired for feelings and ready to learn.
- Early environments matter and nurturing relationships are essential.
- Society is changing and the needs of young children are not being addressed.
- Interactions among early childhood science, policy, and practice are problematic and demand dramatic rethinking.

The report was notable for its focus on strategies that addressed increased attention to the mental health needs of young children and the need to better understand and ameliorate the effects of parents' untreated mental illness, family violence and neighborhood disintegration. The Committee emphasized the inseparability of emotional health and success in later life and its recommendations continue to serve as a blueprint for a comprehensive approach to meeting the needs of young children.

Disintegrating Systems: The State of States' Public Mental Health Systems: A Report by the Bazelon Center for Mental Health Law

This Bazelon report was issued in 2001 and built upon the findings of the Surgeon General, but focused on the mental health system at the state level. The report decried

[3] Jack P. Shonkoff and Deborah A. Phillips, eds., From Neurons to Neighborhoods: The Science of Early Childhood Development (Washington, DC: National Academy Press, 2000), p. 1.

the “unraveling of the nation’s public policy for meeting the needs of people with major mental illnesses.” The authors noted that innovative and effective programs existed but were the exception rather than the rule and could not compensate for the failure to systemically apply research-based policy and practice. The report was “a call to action” and described comprehensively the systemic problems that needed to be addressed at the state level before the vision articulated in the Surgeon General’s report could be realized.

National Suicide Prevention Strategy

To reduce the occurrence of individuals committing suicide, the federal government launched the National Strategy for Suicide Prevention in May 2001. This effort spanned several federal agencies within the Department of Health and Human Services, the Centers for Disease Control’s National Center for Injury Prevention and Control, and the Office of the Surgeon General, as well as extending to state governments, nonprofit organizations, and communities. In launching the strategy, Department of Health and Human Services Secretary Tommy Thompson declared that “even one death by suicide is one death too many". SAMHSA Administrator Charles G. Curie noted that more than 90 percent of individuals who commit suicide are associated with mental illness. In 2001, suicide was the eleventh leading cause of death for persons age 19 to 85 and the fourth leading cause for persons under age 18 in the US. In Florida, suicide is the ninth leading cause of death for adults age 19 to 85 and the fourth leading cause for children ages 1 to 18.[4] The Mental Health Program Office is partnering with the Governor and the Office of Drug Control Policy through the Florida Task Force on Suicide Prevention to assess Florida’s current suicide prevention activities and recommend future initiatives.

Eliminating Barriers Initiative – the National Stigma Reduction Campaign

In 1999, the Surgeon General identified discrimination and stigma surrounding the receipt of mental health treatment as a significant barrier that discourages individuals from seeking care. In early June 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Elimination of Barriers initiative (EBI), a three-year pilot program aimed at helping more Americans understand the facts surrounding mental illnesses, reducing stigma and discrimination and increasing public acceptance of seeking care for mental health problems. The EBI was envisioned as means to inform the public of advances in diagnosis and treatment of mental illnesses and to convey that recovery is not only a desired outcome but a reasonable expectation. Eight states (including Florida) were chosen to be part of this national strategy. Funding for a technical assistance grant in the amount of $4.5 million was provided to support a series of meetings in each of the states to develop consensus on how to effectively combat the stigma sometimes experienced by people with mental illnesses. Florida will focus on educating the general public and the business community about mental health, its importance to society and stigmatizing attitudes and behaviors.

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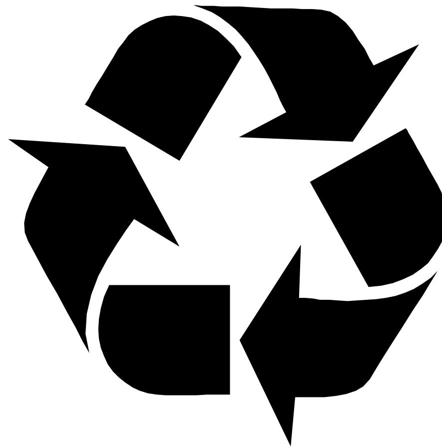
[4] Centers for Disease Control, National Center for Injury Prevention and Control, Office of Statistics and Programming, 10 Leading Causes of Deaths, United States, 2001, (On-line, available: http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html).

Stigma and Discrimination



Homelessness, economic poverty, lack of social supports

Increased symptoms, social isolation, increased potential for admissions to detention facilities and crisis units

The above diagram depicts the negative self-perpetuating effects of stigma and discrimination in the community. By breaking this cycle, recovery for individuals living with mental illnesses could be enhanced and promoted more easily.

The Well Being of Our Nation: An Intergenerational Vision of Effective Mental Health Services and Supports

In September 2002, the National Council on Disabilities issued a report that represented a broader systemic view of the problems described by the Surgeon General and the Bazelon Center. The Council's report called for a radical departure from the limited view of "treatment" for mental illnesses to the adoption of a value system that accepted recovery as an achievable goal for persons with serious mental illnesses. This visionary view of recovery becomes possible through a cross-system array of services and supports that address the needs of the whole person, at every stage across the lifespan. The report described the failure of the mental health system and social and health service systems that required that an individual reach a crisis or bottom out before services (which are often inadequate and inappropriate) are made available. The Council noted that "this approach is shared by systems serving children, youth, adults and seniors creating dependency and perpetuating failure, sometimes literally from cradle to grave."[5]

The intergenerational approach advocated by the Council called for a series of activities aimed at addressing systemic issues that cut across the artificial boundaries of categorical programs. The recommendations proposed strategies that called for a restructuring and integration of policy and practice in child welfare, public education, juvenile justice, welfare reform, health care, and the judiciary. The Council proposed "fundamental reform" that would create systems of care that "can invest – over a lifetime, if necessary – in adequate mental health services and supports that will allow children to

[5]National Council on Disability, The Well Being of Our Nation: An Inter-Generational Vision of Effective Mental Health Services and Supports (2002), p.4.

live with their families in the community, and will allow adults and seniors to seek recovery from the effects of mental illnesses and to achieve economic self-sufficiency." [6]

Adoption and Safe Families Act (ASFA) (P.L. 105-89)

The Adoptions and Safe Families Act (ASFA), enacted into law on November 19, 1997, is the most recent amendment to the 1935 Social Security Act with regard to child welfare. ASFA significantly changed the 1980 Adoption Assistance and Child Welfare Act (P.L. 96-272) benchmark legislation that emphasized securing permanent families for children. Both of these laws tie federal funds provided to states under Title IV-E of the Social Security Act to substantive reforms at the state level. ASFA also amended the Family Preservation and Support Services Program, authorized under Title IV-B, Subpart 2 of the Social Security Act, and renamed it Promoting Safe and Stable Families. ASFA was passed in response to growing dissatisfaction with the ability of state child welfare systems nationwide to achieve the goals of safety, permanency, and well being.

The key principles of ASFA include the following:

- The safety of children is the paramount concern that must guide all child welfare services
- Foster care is a temporary setting and not a place for children to grow up
- Permanency planning efforts should begin as soon as the child enters foster care and should expedited by the provision of services to families
- The child welfare system must focus on results and accountability
- Innovative approaches are needed to achieve the goals of safety, permanency, and well-being

The four major overall goals of ASFA include the following:

- Promote the safety of children first and foremost.
- Decrease the time it takes to achieve permanency for children.
- Promote adoption and other permanency options.
- Enhance state capacity and accountability for both safety and permanency.

Florida has developed and initiated a Program Improvement Plan (PIP) as a formal response to the Federal Child and Family Services Review (CFSR) of Florida's child

[6] Ibid., p. 71.

welfare system, which is based on the issues of child safety, permanency and child and family well being.

Avoiding Cruel Choices: A Guide for Policy Makers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment

In November 2002, the Bazelon Center for Mental Health Law released a report titled, *Avoiding Cruel Choices: A guide for policy makers and family organizations on Medicaid's role in preventing custody relinquishment*. The report highlights a national issue facing many families of children with serious mental or emotional disorders. The problem exists when private insurance is unavailable or inadequate and a family's income exceeds the limits for publicly funded programs. Trapped between the private and public sectors, families often feel that giving up custody of their children to the state is the only way to access necessary treatment services for their child.

The report references data compiled by in 1998, by the Kaiser Commission on Medicaid and the Uninsured and underlines the following issues:

- It is estimated the uninsured rate for children was 15.6 percent, and with the downturn in the economy this rate would likely increase.
- Close to one third of uninsured children live in families where both parents work and 85 percent reside in families where one parent is employed.
- Many families who have private health coverage encounter caps on mental health services. These "underinsured" families face limits on both inpatient and outpatient mental health care.
- 94 percent of health maintenance organizations place restrictions on mental health benefits. This limits the number of outpatient sessions and inpatient days covered, and these limits are on the rise.
- Private health plans do not cover the array of intensive community based rehabilitative services for children with severe mental or emotional disorders that would assist them to successfully remain in the community with their families.

The report offers the Tax Equity and Financial Responsibility Act (TEFRA) and the Home and Community Based Waiver (HCBW) as two federal policy alternatives to assist states in bridging the gap between public and private health coverage.

- Tax Equity and Financial Responsibility Act (TEFRA), also known as the Katie Beckett Option of Medicaid law would permit eligibility to all children regardless of family income as long as they meet specific eligibility requirements Major concerns that have prevented many states from adopting the TEFRA option include the overall cost, ability to control the number of children who would become eligible, and raising funds for state match.

- The Home and Community Based Waiver (HCBW) authorizes states to cover children under Medicaid who would otherwise be excluded, based on family income, and to offer them community-based services, in lieu of an institution. Potential

barriers to implementation by states of the HCBW include lack of funds to cover the state's share of Medicaid costs, the federal rule which does not permit children in or at risk of placement in a residential treatment center to be eligible and the requirement of community services to be no more expensive than the alternative institutional placement.

Ending Chronic Homelessness: Strategies for Action

Beginning in March, 2001, the Secretary of the Department of Health and Human Services' office initiated several activities to improve the HHS response to the services needed by persons experiencing homelessness. In early 2002, he established the Secretary's Work Group on Ending Chronic Homelessness to conduct a comprehensive review of the Department's relevant programs. The Work Group was to report recommendations for a Department-wide approach that would contribute to the Administration's goal of ending chronic homelessness and improve HHS' ability to assist persons experiencing chronic homelessness. The Work Group was assigned the task of developing a comprehensive approach to homelessness and identified four tasks:

- Defining chronic homelessness and identifying effective treatments and services;
- Understanding how relevant HHS programs respond to the identified treatments and services;
- Identifying objectives and desirable outcomes that would improve responsiveness;
- Formulating a comprehensive action plan.

To develop a plan, eight assistance programs of the Department were identified as relevant to the treatment and service needs of chronically homeless persons and were asked to enumerate barriers and opportunities on service use for this population. The eight programs were Medicaid, Temporary Assistance for Needy Families, Social Services Block Grant, Community Services Block Grant, Community Health Centers, Ryan White Programs, Substance Abuse Prevention and Treatment Block Grant, and the Community Mental Health Services Block Grant.

In March 2003, the Secretary of Health and Human Services issued the "Report from the Secretary's Work Group on Ending Chronic Homelessness" with three major goal statements:

- Help eligible, chronically homeless individuals receive health and social services
- Empower our State and community partners to improve their response to people experiencing chronic homelessness.
- Work to prevent new episodes of homelessness within the HHS clientele.

Each of these goals had specific recommendations such as strengthening outreach and engagement activities, improving the eligibility review process, helping states develop specific action plans to respond to chronic homelessness by providing incentives for them to coordinate services and technical assistance, identifying risk and protective factors to prevent future episodes of chronic homelessness and promoting the use of effective, evidence-based homelessness prevention interventions.

Achieving the Promise: Transforming Mental Health Care in America
Final Report of the President's New Freedom Commission on Mental Health

On February 1, 2001, President George W. Bush announced *The President's New Freedom Initiative,* pledging to tear down barriers to equality that face many of the 54 million Americans with disabilities. The President sent several proposals to Congress that would help Americans with disabilities by increasing access to assistive technologies, expanding educational opportunities, increasing the ability of Americans with disabilities to integrate into the workforce and promoting increased access to daily community life.

As part of the President's commitment to eliminate inequality for Americans with disabilities and promote full access to community life, *The President's New Freedom Commission on Mental Health* was established. The Commission's task was to study the national mental health service delivery system and provide the President with methods for improving the nation's mental health system. In the final report released in July 2003, *Achieving the Promise: Transforming Mental Health Care in America,* the Commission made recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn and participate fully in their communities. This report was the culmination of the research and policy recommendations articulated in previous reports and served to provide a unified focus for planning system reform.

The Commission's study of the mental health system suggested that nationally, mental health services and supports remain antiquated, fragmented and inadequate in spite of overwhelming evidence that recovery from mental illness is possible and that life in the community is an achievable goal. Disjointed reforms and policies account for many of these problems. Rather than creating patchwork policy to focus on incremental policy change, the Commission recommended a fundamental transformation of the nation's mental health service delivery system to ensure mental health services and supports that actively facilitate recovery and build resilience to face life's challenges.

According to the Commission, a transformed mental health system rests on two principles:

1. Services and treatments must be consumer and family-centered, and geared toward giving individuals with mental illnesses real and meaningful choices about treatment options and providers — not oriented to the requirements of bureaucracies.

2. Care must focus on increasing individuals' ability to successfully cope with life's challenges, on facilitating recovery and building resilience and not only just on managing symptoms.

The Commission issued a vision statement describing "a future when everyone with a mental illness will recover; a future when mental illnesses can be prevented or cured; a future when mental illnesses are detected early and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning and participating fully in the community".

In order to realize the vision of community living and innovative service delivery models, the Commission noted that Americans must have effortless and continuous access to the most advanced treatments and support services. New developments in mental health research and technology can provide powerful means of transforming the nation's mental health system. To achieve the promise of improved access to quality care and services, the Commission proposed a combination of goals and recommendations that together will provide a solid plan for action.

In accordance with the President's New Freedom Commission goals, the department's Mental Health Program Office has aligned existing and proposed program strategies with the Commission's recommendations. The national goals and strategies are cited below. Appendix A includes a full discussion of Florida's initiatives related to the federal directive.

GOALS AND RECOMMENDATIONS
In a Transformed Mental Health System

GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
1.2 Address mental health with the same urgency as physical health.

GOAL 2: Mental Health Care Is Consumer and Family Driven

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
2.3 Align relevant Federal programs to improve access and accountability for mental health services.
2.4 Create a Comprehensive State Mental Health Plan.
2.5 Protect and enhance the rights of people with mental illnesses.

GOAL 3 Disparities in Mental Health Services are Eliminated

3.1 Improve access to quality care that is culturally competent.
3.2 Improve access to quality care in rural and geographically remote areas.

GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

4.1 Promote the mental health of young children.
4.2 Improve and expand school mental health programs.
4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated.

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

GOAL 6: Technology Is Used to Access Mental Health Care and Information.

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
6.2 Develop and implement integrated electronic health record and personal health information systems.

Substance Abuse

National Drug Control Strategy

The Office of National Drug Control Policy released its 2003 Drug Control Strategy with three core priorities identified: stopping drug use before it starts, healing America's drug users and disrupting the market. The department's Substance Abuse Program is developing a series of prevention and treatment strategies to address two of the core priorities: prevention and rehabilitation. The third core priority of disrupting the market is primarily handled by law enforcement and the military.

The first core strategy of the National Drug Control Strategy advocates for the enhancement of prevention efforts in local communities through greater collaboration between schools, parents, places of worship, the workplace and civic/social organizations. The goal is to provide a consistent message to youth that using drugs is harmful and to reaffirm positive social values. Over the past five fiscal years the Substance Abuse Program has significantly enhanced the number and scope of prevention services for youth and young adults (age 18-24). These services are provided through collaboration on the part of schools, law enforcement, health care, faith-based entities, and housing communities.

The second core strategy advocates for better access to treatment through enhancements in the processes for identifying substance misuse, abuse, and dependence. The strategy indicates that 16 million Americans use drugs monthly and nearly 6 million Americans meet the clinical criteria for treatment. This strategy also emphasizes the need for families, friends, and recovering individuals to intercede with persons experiencing substance abuse problems and for employers, faith-based entities, law enforcement, and other community organizations to play greater roles in supporting substance abuse identification and intervention.

Access to Recovery

The Bush Administration has proposed $200 million in funding for federal fiscal year (FFY) 2004 ($600 million over three years) for a new voucher program entitled “Access to Recovery” to promote improved access to treatment through a wider array of service providers and enhanced individual choice as it relates to choice of providers. These options may include health clinics, primary care physicians, faith-based organizations, hospitals and other non-traditional treatment providers. The department’s Substance Abuse Program is developing guidelines in response to this initiative for screening/assessment, intervention, treatment and other appropriate services. If approved by Congress, the department will be ready for expeditious implementation of any funding received. The three primary principles include:

- **Individual Choice** – Individuals would use vouchers to obtain substance abuse services from programs and providers of their choosing, ensuring enhanced access to publicly and privately funded providers.
- **Results Oriented** – Providers participating in the voucher system must demonstrate individual achievement of outcomes such as abstinence, reduced involvement with the criminal justice system, employment, stable living situations.
- **Increased Capacity** – Each year the Access to Recovery program would support treatment for an additional 100,000 individuals nationwide through enhancements to detoxification, treatment, and other programs that promote recovery.

National Treatment Plan (NTP) Initiative

In 1998 the Center for Substance Abuse Treatment (CSAT) began a national treatment plan initiative to achieve consensus among substance abuse professionals, administrators, and individual advocacy groups in communities across the nation on the best strategies for improving substance abuse intervention and treatment services. The plan, entitled “Changing the Conversation”, gathered input through five expert panels and six public hearings across the country. The panels and hearings focused on the following issues:

- Closing the Treatment Gap;
- Reducing Stigma and Changing Attitudes;
- Improving and Strengthening Treatment Systems;

- Connecting Services and Research; and
- Addressing Workforce Issues.

Over the past three years, the department's Substance Abuse Program's service initiatives and requests for resource enhancement have mirrored the main findings and recommendations contained within the National Treatment Plan. Five of the national strategies and the Program's initiatives are outlined below. The State's response is contained in italics directly following each national strategy.

- **Invest for Results:** The National Treatment Plan emphasizes the need to close the treatment gap through enhanced services capacities, for improvements in financing and reimbursement mechanisms and increased use of performance outcomes to guide resource allocation.

  Over the past four fiscal years the Substance Abuse Program has sought and received resources to purchase additional capacity for detoxification and treatment services for adults and children. The Substance Abuse and Mental Health Programs are in the process of restructuring the systems for contracting and financing of services. The desired result will be a more accountable system that ensures achievement of contractual performance outcomes with an efficient expenditure of funds. AHCA also recently received funding from the Robert Wood Johnson Foundation's "Resources for Recovery" program to work with the Substance Abuse Program on strategies to maximize financial resource utilization, including Medicaid, for individuals with substance abuse needs.

- **No Wrong Door to Treatment:** The National Treatment Plan recommends that states improve individual access to care through evidence-based approaches to assessment, referral and treatment. A key to its success lies within improvements in services and policy coordination across community-based agencies and state agencies.

  In recent years, the Substance Abuse Program has significantly improved its information and referral systems, a primary entry point for individuals into the system of care, through legislative mandates and additional funding. The Program has also received funding over the last three fiscal years for family intervention specialists to assist child protective services workers in identifying caretakers in need of substance abuse intervention or treatment. During the 2003 legislative session the Program was appropriated funding to improve screening, referral, brief intervention, and brief treatment for adults age 60 and older, a population that has not historically accessed the traditional system of care at a high rate. The Program is working with the Florida Mental Health Institute (FMHI) and community-based providers in two areas to pilot the development of model systems of care for this population through fiscal year 2004-2005.

- **Change Attitudes:** The National Treatment Plan recommends the development of public education campaigns to reduce stigma and discrimination against persons

with substance abuse problems.

The Substance Abuse Program is using fiscal year 2003-2004 funding for the development and dissemination of statewide media campaigns to educate the public on signs of substance abuse problems and the availability of services in local communities.

- **Build Partnerships:** The National Treatment Plan encourages the formation of forums for government agencies and local communities to collaborate on the identification of the needs of individuals with substance abuse, appropriate services, and the enhancement of existing systems of care.

  The Substance Abuse Program works closely with the Governor's Office of Drug Control Policy and the Florida Alcohol and Drug Abuse Association (FADAA) on the development of state and local service initiatives involving a wide array of governmental and community-based providers and advocacy groups. The Substance Abuse Program has funded a number of community coalitions to promote local ownership of substance abuse issues, which has been most prominent in the area of prevention. The Substance Abuse Program also works in collaboration with the faith-based community on a number of treatment and professional development initiatives to help enhance the system of care and provide additional services for those in need.

  To improve services for older adults, the Substance Abuse Program and the Office of Drug Control Policy have developed a workgroup comprised of representatives from the department's Adult Services and Mental Health Programs, the Department of Elder Affairs, Department of Health, Department of Veteran's Affairs, AHCA, the Florida Alcohol and Drug Abuse Association (FADAA), Florida Council on Community Mental Health (FCCMH), and several community-based provider agencies. The main strategies of the workgroup include: 1) improving service coordination; 2) enhancing the identification of substance abuse and mental health needs among older adults; and 3) facilitating development of best practice care models for statewide dissemination.

- **Commit to Quality:** The National Treatment Plan recommends that substance abuse systems of care integrate findings from best practice research. This can be accomplished through working partnerships between governmental agencies, academic institutions, and community-based providers and professionals. These partnerships can identify best practices and establish standards for training, education, and certification of substance abuse professionals.

  The Substance Abuse Program has developed a number of partnerships with academic institutions throughout the state to encourage the integration of research and practice. The Program has requested and received technical assistance trainings from the Center for Substance Abuse Prevention (CSAT) on best practice models for aftercare, follow-up and services for women with dependent children.

The program has been integrally involved with the Research to Practice Consortium, comprised of state and local agencies and the University of South Florida, identifying best practices in prevention and treatment and programs that treat persons with co-occurring disorders. The University of Miami is a participant in the national Clinical Trials Network sponsored by the National Institute on Drug Abuse. The networks conduct studies of behavioral and pharmacological treatment interventions and disseminate their findings to practitioners to improve science-based treatment services. Training, education and credentialing of substance abuse professionals has improved significantly in recent years. The Certification Board for Addiction Professionals of Florida (CBAPF) has established comprehensive credentialing requirements for substance abuse professionals, with specialty certifications available for prevention and criminal justice.

The Substance Abuse Program is also developing a clinical consultation (peer review) program to assist non-accredited agencies in identifying and implementing evidence-based care models. The program is in its final phase of development, with implementation scheduled for fiscal year 2003-2004. This includes conducting clinical peer review in six provider agencies.

State Strategic Directions

<u>Executive Direction</u>

The statutory mission of the department is to "work in partnership with local communities to ensure the safety, well being and self-sufficiency for the people we serve". Secretary Regier has established strategies essential to achieving this mission. These strategic goals, listed below, serve as the foundation for the department's policy direction and program planning and for the strategies contained in this plan:

- Ensure Safety, Well Being and Self Sufficiency of the People We Serve;
- Improve Shared Stewardship;
- Provide Effective and Enhanced Prevention Services;
- Realign and Refocus the Workforce; and
- Strengthen Accountability.

These goals serve as guiding principles for the major reforms that have shaped the department's evolution to the community-based care model of service delivery. This new paradigm of service delivery places responsibility for planning and delivery of services at the community level with the state as a partner and contract manager. The move to community-based care has necessitated realignment and refocusing of department resources to support an infrastructure that is more accountable and responsive to community needs. Community substance abuse and mental health treatment services have been contracted to community providers since the early 1970's. Since effectively meeting the needs of persons with substance abuse and mental health problems requires an integrated, systemic approach, the redesign of child welfare, adult

services and economic self-sufficiency programs will have a significant impact on planning and service delivery. Representatives of Substance Abuse and Mental Health Program Offices have participated at the state and local level in planning for community based care.

Legislative Guidance and Intent

The organizational structure of the Department of Children & Families is described in Chapter 20.19, F.S., which establishes the department's role as the executive branch agency responsible for publicly funded substance abuse and mental health services.

Pursuant to Chapter 394, Part VI, F.S., and s.397.305, F.S., the department is responsible for the planning, evaluation and implementation of comprehensive statewide programs of mental health and substance abuse. These programs include adult community services, receiving and treatment facilities, children's services, and research and training as authorized and approved by the Legislature. Under s.394.457 (1), F. S., the department is designated the mental health authority of Florida. Chapter 397, F.S., provides legislative policy direction for implementing a community-based system of substance abuse prevention, intervention and treatment services. It also provides for the licensure of substance abuse services and grants the department authority to promulgate rules.

The Agency for Health Care Administration is designated by Chapter 20, F.S. as the chief health policy and planning entity for the state and has among its responsibilities administration of the Medicaid program. The department works closely with AHCA on the design and implementation of substance abuse and mental health programs supported by Medicaid funds.

The department's Substance Abuse and Mental Health Programs are the main points of contact for the federal Department of Health and Human Services agency on all issues pertaining to substance abuse and mental health in Florida. The programs work collaboratively with the department's child welfare/community-based care programs as well as schools, juvenile and criminal justice agencies, the judicial system, corrections, health care providers, individuals served by the program, and other stakeholders.

In addition to providing direction to the department for its overall operation, governing statutes require development of specific performance measures designed to strengthen the accountability of both the Substance Abuse and Mental Health Programs. Performance levels are specifically set by the Legislature and are continually measured and reported by the department.

Legislative Initiatives

During the 2003 Legislative session there was heightened interest in the delivery and financing of substance abuse and mental health services. As a result, the Legislature

began a redesign of the structure through which services are planned, financed, and evaluated.

Senate Bill 1454

The 2003 Florida Legislature passed legislation, Senate Bill 1454, which created the "Local Funding Revenue Maximization Act". This legislation enhances the ability of agencies, including this department, and local political subdivisions to achieve maximum federal matching of funds for as many people and health and human services needs as possible. This bill provides legislative intent to authorize the use of certified local funding for federal matching programs only after available state funds have been utilized. This will increase the department's capacity to meet the needs of the people it serves. Each year Congress appropriates funds to individual states for specific health and human service needs. If the federal funds are appropriated on a matching basis and states do not take advantage of the match, the funds may revert to the federal government. The Substance Abuse and Mental Health (SAMH) Programs are implementing a revenue maximization program to increase the state's potential to earn additional Medicaid federal matching funds. The SAMH Office is developing a system to claim administrative costs associated with its contracted public substance abuse and mental health providers to increase the capacity of the public substance abuse and mental health system.

Senate Bill 2404

This restructuring was enacted in Senate Bill 2404 (Chapter 2003-279, Laws of Florida). The major provisions of this legislation will have a long-term impact on the publicly funded substance abuse and mental health service delivery system. The provisions include:

- The Florida Substance Abuse and Mental Health Corporation, a private non-profit independent corporate entity, shall be created. The Corporation is responsible for making policy and resource recommendations that will improve the coordination, quality and efficiency of the substance abuse and mental health service delivery system. The Corporation is composed of twelve members appointed by the Governor, Speaker of the House and President of the Senate and three ex officio members, who are the Secretary of the department, the Secretary of the Agency for Health Care Administration and a representative of the Florida Association of Counties. The Corporation is charged with reviewing all state agencies that deliver or purchase substance abuse or mental health services and making recommendations for improving the integration of those services. The Corporation was created to both enhance the integration of planning efforts and increase the visibility and public awareness of substance abuse and mental health needs in Florida. The Corporation will submit an annual report to the Governor and the Legislature, with the first report due in December 2004.

- The creation of a Deputy Secretary for Substance Abuse and Mental Health to

increase the coordination and collaboration between the Substance Abuse and Mental Health Programs and other programs in the department, other state agencies, local programs and the Legislature. In addition, the Substance Abuse and Mental Health Program Directors were given line authority over all district substance abuse and mental health staff and operations, as well as all state mental health treatment facilities. This includes program budgets and contracts. These changes have a significant impact on the delivery of substance abuse and mental health services in Florida, setting the stage for statewide consistency and efficiency among programs and services, coordination of resources, increased support and collaboration, and a system more responsive to both internal and external demands.

- A joint agreement between the Agency for Health Care Administration and the department. An agreement has been developed that provides for joint review of policies and administrative rules affecting the operation of substance abuse and mental health programs. This review will identify areas where increased consistency in standards and accountability mechanisms can reduce duplication of monitoring. The Agency for Health Care Administration and the department will also coordinate and collaborate in legislative budget development and jointly participate in developing procurements that support best practices, individual choice and support of Community Based Care.

- The Agency for Health Care Administration and the department will work together to support implementation of prepaid and capitated behavioral health care by July 1, 2006. The Agency and the department continue to work with legislative leaders and other stakeholders to define the parameters of this initiative.

- The department and AHCA will develop a plan for implementing new Medicaid procedure codes that can be funded by certification of un-leveraged state or local match funds. Both state agencies are focusing their efforts on the viability of making treatment and supervision components of crisis stabilization programs or residential programs that serve less than 17 people Medicaid compensable. The Agency for Health Care Administration and the department are analyzing the current number of Medicaid bed days provided by these programs and current rate structures to determine potential earnings and set rates.

- The department shall adopt rules that contain additional standards for monitoring and licensing accredited programs that are not specifically covered by the accreditation standards. This allows the department to retain the authority to monitor for service delivery, to investigate specific complaints, and to measure compliance with federal or state requirements that are distinctly covered by accreditation inspections. The department, in consultation with Agency for Health Care Administration, is developing a rule that will not duplicate standards and processes covered by accreditation. Subsequent to rule drafting, the department will begin the rule promulgation process. The department has developed administrative monitoring tools and a user guide for use by district staff and has completed the training of district staff in the use of these monitoring tools.

- A requirement that the department file a State Project Compliance Supplement pursuant to s.215.97, F.S., for behavioral health care services and to rely upon certified public accountant audits when monitoring financial operations of contractors. The department may conduct desk reviews of independent audits and may conduct onsite monitoring in relation to problems cited in independent audits. Standardized Substance Abuse and Mental Health monitoring tools rely upon certified public accountants (CPA) in determining the depth of fiscal review to be conducted by contract performance units. The department is continually improving on policy and protocols for desk reviews, onsite monitoring, and tests of validity of independent audits at three-year intervals.

- A requirement that the department work with community-based agencies to establish managing entities in Districts 4 and 12 to oversee substance abuse service delivery for persons involved with the child protective services system. Both substance abuse and child welfare agencies are working together to identify critical service requirements of child welfare recipients, engaging substance abuse agencies in service network development, and defining the specifications and role of a managing entity. The legislation requires the department to expediently implement this initiative.

Behavioral Health Service Delivery Strategies

Section 394.9082, F.S., authorizes the department to implement two different approaches to managed behavioral health care. The first model, implemented in District 1, permits the department and the AHCA to contract with the same managing entity for mental health services. District 1 has had success in improvement of a data system that will support a managed care system by harvesting data from multiple sources and focusing on outcomes. District 1 has had particular success in implementing the Minkoff Model for integrating mental health and substance services for people with co-occurring disorders and in improving care for children in the child welfare system.

Significant progress has been made in District 1 in the implementation of the new financing strategies authorized under s.394.9082, F.S., and in an operational data system. The implementation of multiple initiatives at the same time (e.g. the funding initiative, Prepaid Mental Health Plan (PMHP), Community-Based Care (CBC), and Statewide Inpatient Psychiatric Program (SIPP), has allowed the district to bring child welfare and substance abuse and mental health services for Medicaid and non-Medicaid eligible individuals under a single management structure.

The second model entails the formation of a provider network for substance abuse and mental health services in District 8. The district has had success in network formation and service expansions that emphasize rehabilitative services and individual self-determination. The district has procured a managing entity that will perform specific managed care functions in support of the provider network. The managing entity

function will include utilization management, quality improvement, data support, and establishment of clinical care protocols for District 8.

The Districts 1 and 8 approaches to managed behavioral health care have been reviewed by independent evaluators at the Florida Mental Health Institute and have been found to be making good progress.

Self-Directed Care Project

In addition to the pilots in Districts 1 and 8, the department has implemented, under legislative direction, the Florida Self-Directed Care (Florida SDC) Program pilot in District 4. Florida SDC is an approach to providing publicly funded behavioral health care services in which the individual is granted a high degree of self-determination in choosing services and providers necessary for their recovery from mental illness. This program provides mental health treatment and support services for adults who have serious mental illnesses. The program grants the individual control of the mental health funds allotted for his/her treatment to directly purchase the services from the vendor of choice. The program became operational in October 2002 and has achieved capacity (100 enrollees).

The Institute of Health and Human Services in the School of Social Work at Florida State University serves as the administrative services organization for the FloridaSDC pilot project. The ASO's responsibilities include, but are not limited to, the following:

- Consultation and management;
- Data systems integration;
- Fiscal processing and fiscal intermediary services; and
- Most importantly, the purchase of direct services for individual served.

The project is overseen by a project director. Additionally, two recovery coaches and several recovering coaches (peers) also assist participants, as needed.

The FloridaSDC model is successful because it utilizes self-determination at each point in the service delivery process. Recipients of mental health services in the traditional delivery system have guided the development of this program, including development of forms for reporting and planning, development of operational policies and procedures and development of the provider network. As a result, there is confidence that the model enhances the ability of each participant to maximize his or her ability to live and function as independently as possible, enjoy an improved quality of life, and demonstrate successful outcomes to be specified and measured during the two-year program.

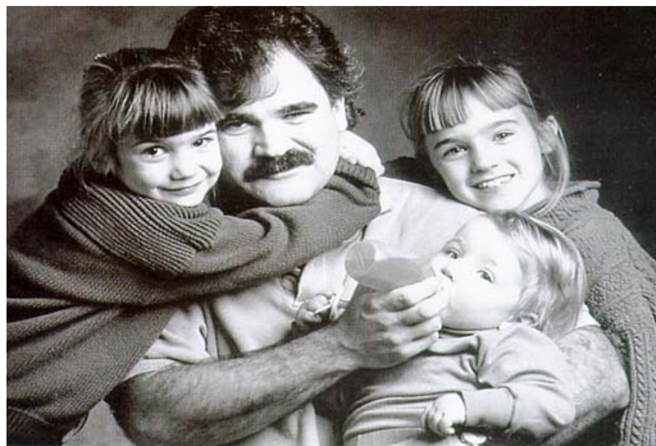
A common thread of these strategies is Florida's continued effort to plan and implement local or regional managing entities such as administrative service organizations (ASOs) or networks of substance abuse and mental health providers that offer multiple points of

access to all services purchased by the state. The envisioned system of care will have single points of accountability for community-wide outcomes and promote service flexibility, integration and coordination. Establishing local networks will enable individuals and families to access all services in the network without having to navigate multiple providers to obtain needed services.

FloridaSDC has been recognized as a positive success by national experts in the field of self-determination for people with disabilities and received top honors in the Social Support category awarded by the Eli Lilly Re-Integration Award Committee. FloridaSDC continues to be well received by advocates (local, state and national), program participants and their significant others and by many of the department's mental health participating providers.

Florida's Program Improvement Plan (PIP)

Florida developed and initiated a Program Improvement Plan (PIP) in response to the Federal Child and Family Safety Review (CFSR) of Florida's child welfare system, which reviews the major goals outlined in the Adoptions Safe Families Act (ASFA) of safety, permanency and well being. The PIP is a compact between state, local and federal partners that strives to adequately address complex and diverse provision of quality services to families in need, while establishing a common understanding of how the system was functioning in Florida at the time of the Child and Family Services review (August, 2001). The PIP became operational on April 1, 2003, and addresses the areas indicated as needing improvement.



The timely assessment of mental health needs and the provision of mental health services and supports to children and their parents or caregivers are critical to conforming to the federally mandated goals of child safety, permanency and child and family well being. The Mental Health Program Office is participating with the Child Welfare/CBC Program Office on the PIP to address the following general areas:

- The timely assessments of mental health needs of the child, family and caregiver completed by quality providers;
- The timely provision of individualized services to meet the mental health needs of the child or youth, family and caregiver;
- Provision of follow-up services recommended by the assessment.

Sexually Violent Predator Program

In 1998, the Florida Legislature enacted Part V of Chapter 394, Florida Statutes, known as the "Jimmy Ryce Involuntary Civil Commitment for Sexually Violent Predators' Treatment and Care Act." The act provided for the civil commitment of persons who are determined to meet the criteria for a "sexually violent predator". Persons who have been previously convicted of a sexually violent offense and are determined to have a "mental abnormality or personality disorder" and be likely to commit further violence can be committed to the Department of Children & Families and held in a secure facility for treatment. Enacted to protect communities by confining persons likely to commit sexual offenses and to provide treatment to those committed, the legislation was based on a similar Kansas statute. The Kansas statute had been ruled on by the United States Supreme Court in Kansas v. Hendricks, 117 S.Ct 2072, 65 USLW 4564 (U.S. 1997) and found to be constitutional.

The Sexually Violent Predator Program began providing secure confinement and treatment services for court-ordered detainees at the 90-bed Martin Treatment Center (MTC) in Martin County in January 1999. The South Bay Sexually Violent Predator Detainee Unit opened in September 1999 to house the overflow from MTC. In December 2000, MTC was closed and those residents were relocated to the Florida Civil Commitment Center (FCCC), which was formerly the vacant Main Unit at DeSoto Correctional Institution. Renovation and construction at FCCC permitted the closure of the South Bay facility in May 2002. The FCCC now provides secure beds for up to 530 residents.

The program operates under the auspices of the department through a contract with Liberty Behavioral Health Corporation, and is located at a former prison in Arcadia. Since the year of its passage, the program has evaluated 14,113 offenders and 155 have been committed for treatment.

Florida Drug Control Strategy

In 1999, Florida advanced in its fight against illegal drug use by creating and implementing a Florida Drug Control Strategy. In September 1999, after intense study of the problem, the Governor published a strategy to reduce illegal drug use by fifty percent by 2005. The strategy used a three-pronged approach of reducing demand through prevention and treatment and reducing supply through effective law enforcement. The strategy set objectives, outlined programs and policies that would enable the achievement of objectives and provided for accountable resources that would ensure steady and disciplined progress toward their accomplishment.

Time has altered the conditions in which some of the objectives were originally set, and further analyses and experiences have shown new ways of addressing the problems and meeting traditional and emerging challenges. In September 2002, the strategy was revised and, where appropriate, objectives were adjusted by adding to or otherwise

modifying some of the parameters. Performance measures to be accomplished by the end of 2005 are summarized below:

- Reduce drug abuse in Florida to four percent or less.

  Assessment: *This most important measure is on target. The latest National Household Survey on Drug Abuse indicates Florida's current use rate is at 5.5 percent, down from the 8.0 percent base existing when the strategy was first initiated.*

- Reduce drug abuse by Florida's 6th through 12th grades as follows:

  - Cocaine, crack cocaine, and heroin to one percent or less;
  - Ecstasy, GHB, Ketamine, and other 'club drugs' to three percent or less;
  - All drugs to eight percent or less;
  - Tobacco use to 14 percent or less; illegal sales to eight percent or less; and
  - Alcohol use to 20 percent or less; illegal sales to eight percent or less.

  Assessment: *The rise of new trends (i.e., the genre of club drugs) and concerted, special-interest nationwide efforts to legalize marijuana (i.e., so–called "medical" marijuana and other decriminalization efforts) have had their effects on impressionable youth. Those who report they believe use of such drugs to be "harmless" or even "beneficial" comprise the vast majority of youth using these drugs (i.e., a child who sees illegal drugs as benign is nine times as likely to use them as one who does not). Nonetheless, overall trends are moving in the right direction. Hard drugs are being rejected wholesale and club drugs among 6th through 12th graders have been contained well below marijuana use levels. However, there is also a recent surge in the rates of oxycodone, hydrocodone and other prescription painkiller use and abuse among youth and young adults. Over-the-counter preparations such as dextromethorphan (DXM) are also being abused by youth. Consequently, youth and young adults are being admitted to detoxification and treatment services due to abuse of or dependence on these substances. Although youth and young adults tend to use drugs – often in experimentation – at higher rates than the population at large, the ultimate target must be to get these numbers as low as possible. Although the prevalence of alcohol use is on the decline it remains the most commonly used substance among middle school and high school students.*

- Increase the average age of first-time drug use to 17 years or older.

  Assessment: *A recently implemented standardized measurement has shown that trends are positive. Middle school remains the break years. Lowering usage rates there will close us in on our goal.*

- Decrease drug use in the work place by 50 percent.

  Assessment: As overall use has come down, workplace drug use has come down proportionally (the large majority of drug users work). As we expand drug free workplaces we can make greater strides toward this target. Currently, any businesses that do contracted work for the state must be drug-free workplaces.

- Reduce the number of chronic users of illicit drugs by 50 percent.

  Assessment: The gap between those who need treatment and those who obtain it is narrowing, but there remains a long way to go. Fiscal year 2003 estimates indicate that 848,246 adults and 353,159 children are in need of substance abuse services. Research shows that approximately half will seek treatment and other substance abuse services. The department's Substance Abuse Program is currently meeting the needs of 13 percent of adults with substance abuse needs and 22 percent of children with substance abuse needs. This does not include the percent of need met by private substance abuse providers and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous.

- Reduce deaths of individuals due to heroin, cocaine and prescription overdose 50 percent.

  Assessment: After almost tripling between 1995 and 1998, deaths of individuals due to heroin flattened in 1999 and 2000, then rose by 30 percent in 2001 and 20 percent in 2002. Deaths of individuals due to cocaine continued to drop from 1998 to 2000, then rose by seven percent in 2001 and 18 percent in 2002. Deaths of persons who overdosed on prescription drugs, a category unmeasured before 2000, showed increases in 2001 and 2002. Deaths of persons that were prescription-drug related increased by five percent from 2000 to 2001, then rose by 18 percent from 2001 to 2002. Deaths of persons that were hydrocodone and oxycodone related

increased by 32 percent and ten percent, respectively, from 2001 to 2002. The total number of deaths of persons in 2002 involving prescription drugs such as oxycodone, hydrocodone, benzodiazepines, and non-prescription methadone exceeded the number of individuals with deaths involving illicit drugs. The number of deaths of individuals related to hydrocodone and oxycodone showed a decrease of five percent and four percent, respectively, during the first six months of 2003 compared to the last six months of 2002.

- Reduce the health costs associated with drug abuse by 25 percent.

  Assessment: *Data tracking on health costs trail by several years. Anecdotal information such as emergency medical facility reports, lost employee time in drug-free workplaces, tobacco-related health problems, juvenile delinquency incidences, etc. indicates that where successful prevention, treatment and law enforcement efforts have come together, associated costs of substance abuse are decreasing.*

- Reduce the supply of illegal drugs by 33 percent.

  Assessment: *A joint intergovernmental and interagency intelligence assessment in 2000 estimated annual cocaine flow in Florida to be 150-200 metric tons annually and heroin at three metric tons. Seizures (in both the transit and arrival zones) and deterrence brought those amounts down (as well as for all other illegal drug use). Seizures in 1999, 2000, and 2001 were high. Some trafficking has been detoured to other parts of the nation (by making entry more difficult, seizures more likely, penalties stiffer and prosecutions more successful in Florida). Drug prices have variously spiked, then flattened again. Overall, indications are that this performance measurement can be met.*[7]

The Florida Drug Control Strategy has a proven track record. Total funding for substance abuse increased by 23 percent from $196 million in fiscal year 1999-2000 to $241 million in fiscal year 2002-2003.[8] The number of individuals served increased by 11 percent between fiscal year 1999-2000 and fiscal year 2002-2003. A total of 230,000 individuals were served by the department, Department of Corrections, and the Department of Juvenile Justice in fiscal year 1999-2000, increasing to 255,000 individuals served in fiscal year 2002-2003. Drug Courts have played a significant role in combating substance abuse. The number of drug courts in the state increased from 34 in 1999 to 82 in 2003, with a projected increase to 93 by 2004. The number of certified treatment and prevention professionals increased from 2,458 in 1999 to 4,125 in 2003, a 68 percent increase. The number of drug free workplaces in the state increased by 49 percent, from 7,006 in 1999 to 10,461 in 2002. The number of counties

[7] Florida, Office of Drug Control, Executive Office of the Governor, Florida Drug Control Strategy 1999-2005, p. U-14.

[8] The figures for total funding for fiscal years 1999-2000 and 2002-2003 include the Department of Children and Families, Department of Corrections, and Department of Juvenile Justice funding for substance abuse.

in the state with community coalitions increased by 184 percent from 2000 to 2003, increasing from 19 in 2000 to 54 in 2003.

The 2003 Florida Youth Substance Abuse Survey confirms that Florida's school children (i.e., grades 6-12) have increasingly rejected drug use over the past several years. Survey results show that current usage (i.e., past-30 day use) rates for virtually every area has steadily declined since baseline data was collected in fiscal year 1999-2000.[9]

Trend lines for substance abuse among Florida's middle and high school children are down significantly. For example, use of LSD/PCP is down 47 percent since 2000; cocaine use is down 40 percent; heroin use is down 50 percent and use of amphetamines is down 32 percent. Ecstasy use was first measured in 2001 and is down 46 percent. Since 2000, of the 21 separate areas measured, 16 have decreased (two others show no change). Trend lines for youth alcohol and tobacco usage is also down. Alcohol use is down by 10 percent, cigarette use is down by 38 percent and smokeless tobacco use is down by 40 percent.

Governor's Changing Alcohol Norms (CAN) Workgroup

Although alcohol use is down, alcohol continues to be the drug-of-choice for all generations. Alcohol continues to be the most noted drug on intake of adults into treatment. For youth, the *Florida Youth Substance Abuse Survey* (FYSAS) shows that even before the great decreases in youth cigarette use resulting from the Florida Tobacco Initiative, twice as many 12 to 17 year olds were using alcohol regularly as were smoking cigarettes. The regular use of alcohol by youth is almost three times that of marijuana. However, there are more youth receiving treatment services for marijuana use than for alcohol, a phenomenon with implication for both prevention and treatment services.

The FYSAS also measures factors that are associated with alcohol and other drug use. Some indicate risk of future use and others protect against use. The strongest factors that influence alcohol use are availability of alcohol in the community, a personal or parental attitude favorable toward use of alcohol, low neighborhood attachments due to high levels of transition and mobility, and a family history of alcohol use. In order to achieve a sustainable low rate of youth alcohol use, the impact of these factors need to be lessened.

The *Florida Drug Control Strategy* recognizes that alcohol is a drug and that state and local entities need to address prevention needs of youth and treatment needs of both youth and adults. The *Florida Prevention System*, the state's comprehensive drug prevention plan, recognizes that alcohol is the most abused drug by youth and that the effective reduction of key risk factors is key to successfully lowering prevalence rates. There are a number of model prevention strategies that have been tested and proven

[9] The 2003 survey results showed that school children (i.e., grades 6-12) used less than 1% of each of the following drugs: methamphetamine, crack cocaine, heroin, LSD or PCP, rohypnol, GHB, Ketamine and steroids.

effective for reducing the presence of risk factors and alcohol use. The Florida Prevention System recommends the implementation of these model programs by local providers and community-wide environmental strategies by local community anti-drug coalitions.

The Substance Abuse Program Office is participating on the Governor's Changing Alcohol Norms (CAN) Workgroup, Florida's initiative to lower youth alcohol use. CAN's broad membership includes representatives from prevention, health, k-12 education and higher education, law enforcement, local anti-drug coalitions, parents, media, and transportation. The Office of Drug Control will publish a white paper in this topic in early 2004. This paper contains recommendations for strengthening national, state and local policies, public awareness of the problem and solutions, and coordination of family, school, community and law enforcement efforts.

Florida Drug Control Summit 2003

On May 29, 2003, Governor Bush and First Lady Columba Bush hosted the 5th Annual Florida Drug Control Summit sponsored by the Office of Drug Control. Leaders representing professionals from the field of drug treatment, prevention and law enforcement were in attendance. Charles Curie, Administrator, SAMHSA, U.S. Department of Health and Human Services, and Richard H. Carmona, Surgeon General of the United States, were the keynote speakers at the summit.

The first summit held in February 1999 was designed to develop a formal and comprehensive drug control strategy, which was subsequently published by the Governor in September 1999. During the following three years annual summits were held to discuss future trends in Florida. Much of the work of these summits was transformed into subsequent legislation and policies. The focus of last year's summit was to revise and enhance Florida's existing drug control strategy from 1999. Based on the input from the 2002 Drug Control Summit the current strategy was published in September 2002.

The 5th Annual Drug Control Summit reiterated Florida's commitment to a comprehensive approach to drug control that balances and integrates efforts in prevention, treatment, and law enforcement. Prevention means stopping drug abuse before it begins. Addiction is chronic and debilitating. Treatment works, but not without periods of relapse along the way to full recovery. Recognizing this, Florida's objective is to expand the treatment base so that it offers a continuum of treatment to address a range of needs and the necessary incentives to improve the probabilities for success. The third part of the triad, law enforcement, works to decrease illicit drug activity and keep the supply of drugs down. The strategy advocates a holistic approach that scrutinizes seaports, airports, highways, railways, parcel mail and other avenues or locations of entry.

Participants at the Summit were divided into six breakout groups with each group presided over by a moderator. Each breakout session was given a set of issues to discuss and a charge to identify barriers and resolutions.

- Treatment: Drug Courts;
- Treatment: Elder Substance Abuse;
- Prevention: Community Coalitions;
- Prevention: Prescription Drug Abuse;
- Law Enforcement: Prosecuting Drug Trafficking; and
- Law Enforcement: Integrated, Intelligence-Driven Operations.

The Drug Court breakout session focused on strategies for maintaining adult, juvenile, and dependency drug court capacities and expansion of courts in other communities. There are currently 83 operational drug courts and 10 additional drug courts will be implemented once funding becomes available.

The Elder Substance Abuse breakout session focused on the unmet needs of older adults with substance abuse problems, effective programs that are currently operational, and the need to develop and initiate programs emphasizing screening, referral, brief intervention and treatment to reduce the need for out-of-home care.

The Community Coalitions session involved discussions on the current status of community coalitions, the need for expansion of coalitions in various communities throughout Florida, and the expanded focus of coalitions to include all age groups.

The Prescription Drug Abuse session focused on the increased incidence of abuse of prescription pain medicines such as oxycodone, hydrocodone, and non-prescription methadone. The session also involved discussions on the increased rate of individuals with deaths involving prescription drugs in recent years and Florida's efforts to reduce those death rates.

The law enforcement sessions focused on the successful drug interdiction strategies employed to date and their effects on the availability of illicit and diverted prescription drugs in Florida. Collaborative efforts between federal, state, and local law enforcement and local communities were also covered.

Chapter 2: Mental Health Program Services Overview

Program History

Although asylums date to the 18th century in America, it was during the 19th century with the ascendancy of the asylum movement that practice of isolating persons with serious mental illness from the rest of society began and government assumed a more prominent role in assuring that the public was protected from "insane persons". During the early 19th century, Florida residents with mental illness were sent to Georgia State Hospital in Milledgeville and to South Carolina State Hospital in Columbia. Florida was charged $250 per person annually for their care. In 1876, Florida opened its first civil mental hospital. Located in a former civil war arsenal in Chattahoochee, the hospital typified the large institutions that existed in many states – large, self-contained, mini-cities located in rural areas. With no effective means of treating individuals' mental illnesses, institutions were basically custodial environments designed to ensure the safety of the public. The primary function of treatment available at the time was to control behavior and assure that persons confined to the institution did not injure staff, other residents or themselves.

Florida State Hospital was the primary means for Florida residents with serious mental illnesses to obtain publicly funded care from its opening in 1876 until 1947 when G. Pierce Wood Hospital was opened in Arcadia on the site of a World War II training grounds and air field. Tremendous increases in Florida's population after the war resulted in overcrowding in the two state mental health treatment facilities and by the late 1950s two other facilities were opened in MacClenny and Pembroke Pines.

During this time, advances were being made in the development of medications that were effective in the treatment of mental illnesses. The by-product of research in anesthesia and pain control, medications signaled the beginning of a revolution that would lead to a complete reformation in the treatment of mental illness. For the first time persons long confined to the "back wards" of state institutions could be offered treatment that allowed them to receive treatment in the community. At that time, community-based mental health services in Florida consisted primarily of small guidance clinics funded through county governments, United Way and other voluntary sources. Visiting nurses from the Board of Health conducted aftercare for individuals discharged from state mental health treatment facilities. No organized, comprehensive, publicly funded community mental health services system existed.

In 1963, Congress passed the Community Mental Health Centers Act. This act established community-based programs and provided federal funding to the states for developing community-based systems of care. In 1965, Congress passed the Community Mental Health Services Act that enabled newly constructed comprehensive mental health centers to receive direct federal funding for the provision of mental health services. These federal initiatives played a seminal role in shaping public expectations regarding mental health treatment, the design of service delivery systems and

essentially began the expansion of community-based systems of mental health care in Florida and the nation.

In 1971, the Florida Legislature passed the Florida Mental Health Act, also known as the Baker Act, Part 1 of Chapter 394, Florida Statutes. This act provided due process in involuntary admission proceedings and set uniform criteria for persons being admitted to state treatment facilities. Considered model legislation at the time, the Baker Act built on case law that established the requirement of due process for persons being committed involuntarily and defined the concept of least restrictive environment. One of the most influential cases in defining the rights of persons with mental illness arose from Florida. Kenneth Donaldson, a patient at Florida State Hospital, brought suit against the hospital and its clinical director alleging that he was simply confined against his will and was receiving no treatment for his mental illness. The United States Supreme Court ruled in Donaldson v. O'Connor that the state had no right to confine an individual "without more", establishing the principle of right to treatment for persons with mental illness who are civilly committed.

The advent of effective treatment and the development of community treatment resources spurred a national move away from institutional care. The rapid growth of the deinstitutionalization movement was also predicated on the need to contain state government expenditures on large aging facilities. Unfortunately, in many states the funds that were to be transferred from facilities to the community never materialized and the existing community mental health system was unprepared to provide the services necessary for persons moving into the community. Florida was one of the few states to attempt an organized response to deinstitutionalization through the creation and funding of Adult Residential Treatment Systems (ARTS) and Geriatric Residential Treatment Systems (GRTS). These programs established a continuum of residential services in the community for persons being discharged from state mental health treatment facilities.

When the Florida Constitution was revised in 1968, state agencies were reorganized and health and social services were assigned to the Department of Health and Rehabilitative Services. Although initially assigned to the State Board of Health, in 1974, the Legislature created the Division of Mental Health within the Department of Health and Rehabilitative Services. The creation of the Department was one of the first examples of an integrated health and human service delivery system in the nation. The integrated service model was based on the observation that persons who require health and social services often have complex needs that are not effectively addressed through categorically distinct programs.

In 1970, Part IV of Chapter 394, Florida Statutes, the Community Mental Health Act, was enacted to establish a methodology for the distribution of federal funds through the state agency rather than directly to the community mental health centers and clinics. In addition to federal funds, the state had committed to funding community mental health services and for the first time, the legislature required that local governments participate in the cost of services in the community. The law required local governments to match

state funds at a ratio of one local dollar for every three state dollars. In order to assure local participation in the funding of services, the legislation created a structure at the local level for planning and allocating state and federal funds for services. The Act created Mental Health Boards in each of the service areas described by the Division, to be composed of local citizens appointed by county commissions. The duties of the boards included assessing service needs, evaluating programs, and disbursing funds from public and private sources through contracts with community providers based on a district plan. The boards were funded by the state but were independently staffed and many incorporated as private non-profit corporations. With the exception of state mental health treatment facilities, all mental health services were provided through board contracts with private providers.

In 1975, the Department of Health and Rehabilitative Services underwent the first of many legislatively mandated reorganizational efforts. To better implement the integration of services at the local level, eleven geographically defined service districts were created that would serve as the basis for planning and contracting for services. Each district had staff assigned to programs under the purview of the department. At the same time, the old division structure was eliminated and program offices were created. The responsibilities of the Alcohol, Drug Abuse and Mental Health (ADM) Program Office included establishing program standards and performance objectives, reviewing and monitoring program standards, evaluating programs, and developing an allocation methodology. The program offices had no line authority over district mental health programs, which were accountable to the District Administrator.

Over the course of time, it became clear that with the creation of the district program offices, many of the functions of the mental health boards were more appropriately within the purview of the district structure. Funds were allocated to district offices, allocated to the mental health boards through contracts, and the boards then contracted for services with the community providers. Administrative overhead for the boards consumed what were becoming increasingly scarce service dollars. In addition, conflicts between the district offices, boards, and providers became disruptive, occasionally resulting in legal action. In 1984, the Legislature enacted sweeping revisions to Chapter 394, Parts I and IV, revising the Baker Act and eliminating the mental health boards, and replacing them with planning councils who had similar planning and evaluation duties but did not allocate funds. The district offices were vested with the responsibility for contracting directly with providers for services consistent with the district plan.

As federal funding became less generous and with the advent of block grants, pressure mounted to develop alternate mechanisms for funding services to persons with serious mental illnesses. The 1980s were the beginning of the shift in funding community mental health programs through Medicaid Community Mental Health Services Rehabilitation and Targeted Case Management programs. The 1990s saw the continued expansion of Medicaid funding for mental health services. The Agency for Health Care Administration (AHCA), through its role as the state Medicaid authority, became a critical funding and planning partner for community-based mental health

services. Medicaid funding now accounts for over half of all state expenditures for the publicly-funded mental health system.

The late 1980s and 1990s brought significant changes in many of the legal and social assumptions upon which the mental health service delivery system had evolved. Rapid advancement in the fields of neurobiology and pharmacology saw unprecedented success in the treatment of the most intractable forms of mental illness. At the same time class action suits increased the pressure on states to provide appropriate community services. As a result, state mental health treatment facilities became smaller and demand on community resources increased. Persons with mental illnesses and their families became increasingly articulate spokespersons for the need for system reform and for their inclusion as full participants in the planning and delivery of services. Overwhelming evidence that recovery from serious mental illnesses was possible generated new energy and required a complete rethinking of the design of the service delivery system.

The 1990s were also a period in which accountability became a driving principle in mental health policy development. The passage of the Government Accountability Act and increasing demands on state resources required that the department and providers be accountable for measurable outcomes. The Legislature established target populations that were the priority groups to receive services funded by the state. The collection of outcome data on the services provided became a required element in contracts with providers. This focus on accountability was also fueled by escalating health care costs. As demands on state resources increased, restructuring payment mechanisms for mental health services became increasingly important.

In 1996 the Legislature reorganized the Department of Health and Rehabilitative Services, creating a separate Department of Health and creating the Department of Children & Families. This reorganization also created separate program offices at the state level for Alcohol, Drug Abuse and Mental Health, although the separation did not extend to the district level. Due to the explosive population growth since the 1975 reorganization, the original eleven districts were expanded to fifteen.

In 2003, the legislature enacted changes that represented the next step in the evolution of Florida's human service delivery system. Privatization of child welfare services had become a priority. Contracting with private community providers, a long standing practice in mental health and substance abuse, was envisioned as a means of promoting a more cost effective and responsive service delivery structure. Changes were also enacted that shifted line authority for mental and substance abuse services. For the first time since the creation of the department, the Mental Health and Substance Abuse Program Offices were given line authority over district programs and state mental health treatment facilities. In response to concerns that the mission of the mental health and substance abuse programs was not a high priority within the department, the legislature created a Deputy Secretary for Substance Abuse and Mental Health, with accountability directly to the Secretary. To further elevate the importance of services to persons with mental illness and substance abuse problems, the Legislature established

the Florida Substance Abuse and Mental Health Corporation, independent of the department, to review the service delivery system, assess needs for services, manpower and resources, and provide a forum for direct advocacy with policymakers.

Program Mission

The 1999 Report of the Surgeon General on Mental Health advanced a view of mental illnesses based on scientific evidence that shows a clear link between brain functioning and the manifestation of emotional and thought disorders. It issued a call for recognition that mental and physical illnesses were not separate issues, but rather, expressions of difficulties in organ systems within an individual. The report defined mental disorders as "diagnosable conditions that impair thinking, feeling and behavior, and interfere with a person's capacity to be productive and enjoy fulfilling relationships." The report characterized mental health and mental illness as points on a continuum, but acknowledged that mental health is hard to define because of differing values, cultural norms, and personal interpretations. Citing documented changes in the brain as a result of medication and psychotherapy as evidence of the inseparability of brain and mind, the report calls for the recognition that treatment can make a difference when it is elevated to the level of importance of other health conditions.

Schizophrenia is a devastating brain disorder, by far the most chronic and disabling of the severe mental illnesses. The first signs of schizophrenia, which typically emerge in adolescence or young adulthood, are confusing for families and friends. Hallucinations (auditory and visual), delusions, disordered thinking, unusual speech or behavior and social withdrawal impair interactions with others and make it difficult for persons with the disorder to complete their educations or maintain employment. Most persons with schizophrenia suffer chronically or episodically throughout their lives. While news and entertainment media often characterize persons with schizophrenia as violent, most are not violent toward others but prefer to be left alone. In the U.S., slightly over one percent of the population age 18 and older in a given year has been diagnosed with schizophrenia. The risk of suicide is serious in persons with schizophrenia.

Depression is a serious medical condition. In contrast to normal emotions of sadness, loss or passing mood states, clinical depression is persistent and can interfere significantly with a person's ability to function. There are three main types of depressive disorders: major depressive disorder, dysthymic disorder and bipolar disorder (manic-depressive illness). Symptoms of depression include sadness, loss of interest or pleasure in activities once enjoyed, changes in appetite or weight, difficulty sleeping or oversleeping, energy loss, physical slowing or agitation, feelings of worthlessness or inappropriate guilt, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. Severe depression may be accompanied by symptoms of psychosis as well. A

diagnosis of major depressive disorder is generally made after an individual has experienced five or more symptoms and significant impairment in usual functioning every day during the same two-week period. Major depression often begins between the ages of 15 and 30, but may occur in children. Episodes typically recur. Dysthymic Disorder is a less severe but chronic condition that may be disabling as well.

Episodes of depression also occur with persons diagnosed with Bipolar Disorder. Bipolar Disorder, or manic depressive illness, is a serious brain disease that causes extreme shifts in mood, energy and functioning. About 1.2 percent of American adults live with this disorder. Men and women are equally likely to be diagnosed with this disorder which typically emerges in adolescence or early adulthood. In this disorder, depression alternates with mania, which is characterized by an abnormally and persistently elevated mood or irritability and symptoms including overly inflated self esteem, decreased need for sleep, racing thoughts, increased talkativeness, distractibility, physical agitation and excessive risk taking. Although the most common presentation involves alternating periods of either depression or mania, some persons with bipolar disorder experience “mixed” states in which symptoms of mania and depression present at the same time. The symptom picture for this type may include agitation, trouble sleeping, significant change in appetite, psychosis and suicidal thinking.

In children and adolescents, mental disorders must be considered in the context of family, peers, school, home and community. Most disorders are diagnosed based on their symptoms as well as the functional impairment to the child or adolescent. One commonly used measure of how the child or adolescent is functioning is the Global Assessment of Functioning (GAF) Scale, which provides a numerical estimate of the functional impairment a child or adolescent is experiencing in their social, psychological, and occupational areas for a given period. The goal of assessment and treatment is to understand the degree of functional impairment a child or adolescent is experiencing in all areas of their life and assist them to improve in these areas, which in turn improves their quality of life. Some mental health disorders are more common among children and adolescents than adults.

Adjustment Disorder is defined as an unusually negative response to a normal, psychosocial stressor generally last no more than six months. A clinician will often give a child or adolescent a diagnosis of Adjustment Disorder because a more severe diagnosis is not appropriate or necessary to explain the child’s symptoms and provide guidance for appropriate therapeutic interventions. There is a natural hesitation to diagnose a child or adolescent with a serious mental health disorder, based on issues that have a good chance of being resolved within six to 12 months.

Attention Deficit Hyperactivity Disorder (ADHD), sometimes inaccurately referred to as Attention Deficit Disorder (ADD) is a disorder usually first diagnosed in infancy, childhood or adolescence. There are four recognized types of ADHD, which include Predominantly Inattentive Type; Predominantly Hyperactive-Impulsive Type; Combined type (inattention and hyperactivity-impulsivity); and ADHD - Not otherwise specified.

There is a high level of correlation between children with ADHD and other psychiatric illnesses.

Regardless of the sub-type of the disorder, these children often experience low self-esteem, and have difficulty with interpersonal relationships. Their attitudes and behaviors often include mood swings, low frustration tolerance, temper tantrums, bossiness, negativism, obstinacy, and poor response to authority. Often these children are seen as lazy, stubborn, unmotivated, or noncompliant and defiant, resulting in conflict at school and at home.

Conduct Disorder is essentially a disorder in which the child or adolescent violates the social norms and rights of others. The seriousness of these behaviors is what differentiates this disorder from the common mischief and antics of children and adolescents and results in impaired functioning in social, academic, and occupational settings. Those with this disorder are habitually in trouble, either with parents, teachers or peers. Despite presenting a tough image to those around them, they have a low self-esteem. Their frustration tolerance, irritability, temper outbursts and recklessness are hallmarks. Conduct Disorder may lead to adult Antisocial Personality Disorder.

Children are more at risk of developing Conduct Disorder if there is a family history of Antisocial Personality Disorder, Conduct Disorder, ADHD, or Substance Abuse. Other risk factors include poor parenting skills of care givers, physical and/or sexual abuse, absence of parental figures, rejection or instability in the home environment, and association with delinquent peers.

Oppositional Defiant Disorder (ODD) is a disorder in which children ignore or defy adults' requests and rules. They may be passive, finding ways to annoy others, or active, verbally saying "no". They tend to blame others for their mistakes and difficulties. When asked why they are so defiant, they may say that they are only acting against unreasonable rules. They are different from children with conduct disorders in that they do not violate the rights of others. These behaviors are present at home, but not necessarily in other situations, such as school, or with other adults

Children and adolescents with Bipolar Disorder and depression experience some of the same symptoms as adults. In children and adolescents, depression can be manifested by irritability rather than sadness. Children may express feelings of guilt, sadness, crying spells, self-reproach, a sense of worthlessness, feelings of inadequacy, and harsh self-judgment. When asked about the future they report a sense of hopelessness and pessimism. Other symptoms may include anxiety, preoccupation with physical health, fears, and panic attacks. Suicidal ideation or thoughts of death may be present. The child has decreased motivation which is affected by fatigue, apathy, or slowness of response. These children may misinterpret events and assign blame to themselves when the events are clearly out of their control. In adolescents there is increased sensitivity to being criticized or rejected by others. There also may be poor hygiene, substance abuse, and increased lack of cooperation at home and school.

In children, manic behavior is characterized by euphoria, excessive and inappropriate cheerfulness, giddiness, and silly behavior. Speech is rushed and verbose, with grandiose and/or delusional content and flights of ideas. The child or adolescent will have difficulty focusing and concentrating and may have trouble selecting relevant from irrelevant stimuli. They become easily distracted by noises, details, or objects in their environment.

Disorders of anxiety and mood are characterized by repeated experiences of intense or emotional distress over a period of months or years. Feelings associated with these disorders may be those of unreasonable fear and anxiety, lasting depression, low-self esteem or worthlessness. Syndromes of anxiety and depression commonly co-occur in children.

Section 394.455(18), F.S., defines the term "mental illness" to mean "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. The term does not include mental retardation or developmental disability, intoxication or conditions manifested only by antisocial behavior or substance abuse impairment."

Untreated mental illness is as devastating and costly to society as any other condition that comes to mind when the term "chronic illness" is used. Thought disorders, depression, anxiety, and mood swings, all products of brain dysfunction, can be treated.

The mission of the Mental Health Program Office is to "provide a system of care, in partnership with families in the community, that enables children and adults with mental health problems or emotional disturbances to successfully live in the community, to be self-sufficient, or to attain self sufficiency at adulthood, and realize their full potential."

In response to the department's statutory mandate to provide mental health services to persons living with mental health disorders, an array of mental health services are available. Target population groups served are defined in more detail later in the plan, and include adults with severe and persistent mental illnesses, adults in mental health crisis, adults with forensic involvement, children with serious emotional disturbances, children with emotional disturbances, and children at risk of emotional disturbances.

Mental health services are therapeutic interventions and activities that help to eliminate, reduce or manage symptoms or distress for persons who have severe emotional distress or a mental illness. These services help individuals effectively manage the disability that often accompanies a mental illness so that they can recover, become self-sufficient for their age and live in a stable family or in the community.

Mental health services include the following:

- Treatment services such as psychiatric medications and supportive psychotherapies intended to reduce or improve the symptoms of severe distress or mental illness;
- Rehabilitative services that are intended to reduce or eliminate the disability associated with mental illness. These services may include assessment of personal goals and strengths, readiness preparations, specific skill training, and assistance in designing environments that help individuals maximize their functioning and community participation; and
- Case management services that are intended to assist individuals in obtaining the formal and informal resources needed.

Mental health services may be delivered in a variety of settings, such as crisis stabilization units, residential facilities, mental health treatment facilities, individual homes, community support services, clubhouses, drop-in centers and other community settings.

Adult Mental Health Conditions and Trends

Conditions

According to the Global Burden of Disease study conducted by the World Health Organization, World Bank and Harvard University, mental illnesses, including suicide, account for over 15 percent of the burden of disease in established market economies, such as the United States. Most significantly the study shows that the burden of psychiatric conditions has been heavily underestimated. Of the ten leading causes of disability worldwide in 1990, measured in years lived with a disability, five were psychiatric conditions: unipolar Depression, Alcohol Use, Bipolar Affective Disorder (manic depression), Schizophrenia and Obsessive-Compulsive Disorder. Unipolar Depression alone was responsible for more than one in every ten years of life lived with a disability worldwide. Altogether, psychiatric and neurological conditions accounted for 28 percent of all Years Lived with a Disability (YLDs), compared with 1.4 per cent of all deaths and 1.1 per cent of years of life lost.[10] This burden is greater than that caused by all cancers. The same study found that major depression is the leading cause of disability (measured by the number of years lived with a disabling condition) worldwide among persons age five and older.

Mental illnesses, including depression, bipolar disorder and schizophrenia, account for nearly 25 percent of all disabilities. Nationally, "more than 3.5 million people rely on public mental health systems every year. These systems represent a safety net for families whose incomes are limited or who are uninsured or underinsured, particularly

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[10] Christopher J.L. Murray, The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 (Boston, MA: Harvard University Press, 1996), (On-line, available: http://who.int/msa/mnh/ems/dalys/intro.html).

for persons with more serious mental disorders." [11] When this safety net fails, persons with mental illnesses may face incarceration or become homeless. Each year 284,000 adults with serious mental illnesses are placed in jails and prisons. An estimated 25 percent of all homeless people have serious mental illnesses.

The 1999 Surgeon General's report on mental health laid the foundation for research and public policy in the identification and treatment of individuals with mental illnesses. The report's emphasis on the integration of research-based knowledge in understanding the etiology of mental illnesses, the promise of effective treatments that promote recovery, as well as the declaration that mental health is essential for an individual's physical health, set the stage for a national dialogue.

Homelessness

The National Resource Center on Homelessness and Mental Illness estimates that 25.5 percent of persons in Florida who are homeless have mental illnesses. The homeless population in Florida in 2002 was estimated at 72,632; application of the 25.5 percent to this figure indicates that approximately 18,521 of these individuals have mental illnesses. A significant number of persons who are homeless may also have co-occurring substance abuse problems and mental illnesses. The 2002 National Survey on Drug Use and Health reported that among adults with serious mental illnesses, 23.2 percent (4.0 million) were dependent on or abused alcohol or illicit drugs.

The Criminalization of Mental Illness

National advocates and policy experts have declared that jails and prisons are becoming America's new mental health treatment facilities. According to the Council on Disabilities report, nationally there are between 600,000 and 1,000,000 people jailed each year who may have a mental illness. This is eight times the number admitted to psychiatric hospitals. "On any given day, between 2.3 and 3.9 percent of inmates in state prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1 and 18.6 percent major depression, and between 2.1 and 4.3 percent bipolar disorder (manic episode). A substantial percentage of inmates exhibit symptoms of other disorders as well, including between 8.4 and 13.4 percent with dysthymia, between 22.0 and 30.1 percent with an anxiety disorder, and between 6.2 and 11.7 percent with post-traumatic stress disorder."[12] Many of these people are homeless and arrested for misdemeanors that result from their lack of access to needed mental health supports and services.

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[11] Bazelon Center for Mental Health Law, Disintegrating Systems: The State of States Public Mental Health Systems. (2001), p. 3.

[12] Bonita M. Veysey and Gisela Bichler-Robertson, "Prevalence Estimates of Psychiatric Disorders in Correctional Settings," The Health Status of Soon-to-be-Released Inmates, A Report to Congress, vol. 2 (April 2002), (On-line, available: http://www.ncchc.org/pubs/pubs_stbr.vol2.html).

In recent years Florida has experienced a substantial increase in the number of individuals committed to the department as incompetent to proceed to trial or not guilty by reason of insanity pursuant to Chapter 916, F.S. Forensic commitments of individuals to state forensic mental health treatment facilities has increased from 863 in Fiscal Year 1998-1999 to 1,190 persons in Fiscal Year 2002-2003, an increase of 39 percent.

Civil Commitments of Sexual Offenders

One group of offenders that has become the responsibility of the department is habitual sexual offenders. In 1997 the United States Supreme Court, in Kansas v. Hendricks, gave constitutional approval for civilly confining what the court termed "mentally abnormal" sexual offenders most likely to commit new sexual crimes. Since that time, 15 states have enacted legislation similar to Florida's Jimmy Ryce Act. Each state has placed administrative responsibilities in the social services agency with the goal of establishing facilities that are highly secure, but that also pursue rehabilitation of those sexual offenders who are amenable to treatment. Assessment and treatment modalities for this population are relatively recent developments.

Unemployment

The unemployment rate for people with serious mental illnesses is very high, estimated at 85 to 90 percent.[13] The average monthly income for persons with serious mental illnesses is estimated to be $506 and only 11 percent of this group worked one or more days per month. Clearly most individuals with serious mental illnesses do not currently receive their primary financial support from employment. However, assistance in securing and maintaining employment is a key factor to their success in the community. Supported employment is considered an evidence-based practice and many individuals with serious mental illnesses can be successfully employed with support and assistance in managing the routines of employment and interaction with employers and peers.

Community Support Services and Funding

Over the last several decades, deinstitutionalization allowed many people with serious mental illnesses to live in their own communities rather than in state mental health hospitals. However, nationally and in Florida, sufficient federal and state funds have not been available to provide the services and supports necessary for recovery and successful community life. The landmark U.S. Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999) has become a powerful impetus for a national effort to increase community-based alternatives and eliminate instances of persons being unjustly placed in institutions.

Nationally, appropriations by the states for mental health services are far lower (in inflation-adjusted dollars) today than 1955 (the peak year for numbers of persons in state institutions).

[13] Bazelon Center for Mental Health Law, p. 8.

Trends

The above evolving economic and social conditions require ongoing assessment and development of appropriate responses in policy and practice. Additionally, there are several major trends that shape the design of services and supports for persons with serious mental illnesses. These trends include: cost containment, lack of parity, evidence-based and recovery-oriented treatment, advances in neurobiology and pharmaceuticals, enhanced integration of mental health services with other systems of care, and the development of mental health courts.

Cost Containment

The critical shortage of public funding available for services and supports requires that all agencies keep a watchful eye on escalating costs. Mental health is no exception. The economic downturn across the country has resulted in major cuts in mental health services in many states. Although Florida has had financial struggles, they have been significantly less than those of other states. Florida's mental health services have been preserved and, in fact, have grown slightly. Florida has closed one state mental health treatment facility, G. Pierce Wood Memorial Hospital (GPW), and the $39 million that supported the facility annually has been transferred to the community. This funding supports an expanded set of services and supports to promote recovery of persons with serious mental illnesses living in their communities. However, tax dollars are scarce and cost containment has become a prudent strategy to maintain these services.

Lack of Parity

Parity calls for equality between mental health and other health coverage. The lack of parity results in many persons not receiving necessary treatment for serious mental health disorders. In fact, the Surgeon General's Report estimates that only 15 percent of adults and 21 percent of children age 9-17 receive needed mental health treatment in a year. Untreated mental illness can impact emergency room costs, law enforcement, inpatient care and the criminal justice system.

Families with sufficient health insurance coverage for physical health care find that, when faced with mental illness, their insurance limits or excludes that type of coverage. These families are then forced to turn to public programs for assistance. Medicaid has become the predominant funding source for community mental health services for persons with low incomes and chronic disabling conditions.

Evidence-Based and Recovery-Oriented Treatment

Although using research to provide more effective treatment for mental illnesses is accelerating, there simply is not scientifically validated treatment data for every condition. Evidence-based practices are supported by research data. *Best practices* are those that most closely match what is known about treating an illness with what can

be done given the present circumstances. *Promising practices* are those that are well-known by professionals, but have been evaluated less rigorously. *Emerging practices* are those that hold some promise for treating specific problems or types of people, but are not well-known, and therefore not yet scientifically evaluated. Consensus guidelines present practical clinical recommendations based on a wide survey of expert opinion. As the research base expands, many best, promising, and emerging practices will be validated by scientific methods, and communicated to providers of mental health services, resulting in better treatment outcomes for people with mental illnesses.

The President's New Freedom Commission on Mental Health (2003) defined recovery as:

> "…the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms."

Mental health interventions must be designed to promote recovery. The Council on Disabilities report states that "pubic mental health systems must be driven by a value system that sees recovery as achievable and desirable for every person who has experienced mental illness." Recovery from serious mental illnesses requires much more than the traditional treatment approaches. True transformation of the system to one in which recovery is the norm requires that individuals have access to housing, transportation, employment and peer supports. Evidence-based practice represents the combination of the knowledge and skills of the practitioner, values and desires of the consumer, and the best research evidence that links a particular intervention with a desired outcome.[14]

Evidence-based practice has become the touchstone for reforming the delivery of services through emphasis on interventions derived from research. However, a gap exists between research on effective practices and communication of those practices to providers of mental health services. Barriers to dissemination of information include a lengthy process from conducting a study to having it published and made accessible to professionals in the field, and translating published studies into educational materials communicable to providers. Changing current practices requires a commitment from the leadership of provider organizations. There is some resistance among providers of mental health services and the people they serve, as evidence-based practices are perceived as homogenous, "cookie-cutter" approaches to unique individual needs, and that personal choice may be diminished. In fact, the opposite is true. Rather than forcing people with mental illnesses to conform to the treatment that the provider offers, evidence-based and recovery-oriented practices conform to the individual's needs and choices.

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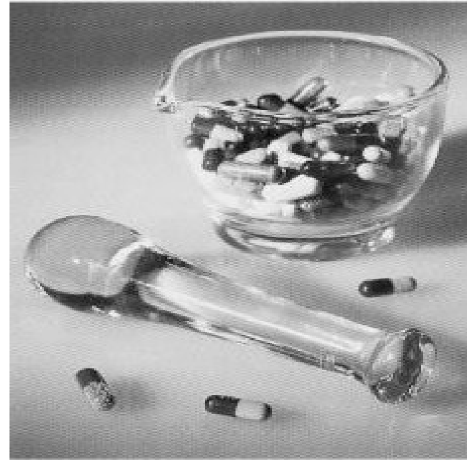
[14] The Technical Assistance Collaborative, Inc., Turning Knowledge Into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices, (2003), p. 4.



Advances in Neurobiology and Pharmaceuticals

Advances in imaging technology now allow examination of the living brain, comparisons of functional and diseased brains, and measures of specific outcomes in real time. When coupled with behavioral data, these techniques hold significant promise for further advances in the treatment of brain disorders. Newer and more effective psychotropic medications continue the promise of recovery and further lessen the need for institutional care for those with chronic, disabling mental disorders. Appropriate early diagnosis with effective medication shows promise in preventing some of the more disabling chronic effects and frequent relapses often noted in persons diagnosed late in their illness or who received earlier generation antipsychotics, antidepressants, and mood stabilizers.

Enhanced Integration of Services

The need for enhanced integration of the publicly-funded mental health system with other systems of care is evidenced by the inadequate access to services and fragmentation of services for the people the department serves. The President's Commission report highlighted the importance of understanding that mental health is essential to physical health. The need for adult mental health systems to be more integrated with other programs such as vocational rehabilitation, health care, housing and economic support is essential to the successful implementation of a recovery-based approach. The Secretary's strategic goals have established a framework for Florida to successfully address the need for greater integration of mental health with other systems to improve access and service coordination and to promote recovery.

Mental Health Courts

Across the nation many jurisdictions have created mental health courts through local initiatives, based on the success of the drug courts. The purpose of mental health courts is to obtain mental health treatment for persons with mental illnesses accused of crimes and divert them from the criminal justice system. Some of these courts use the authority of the court to require compliance with treatment as a condition of participation. Failure by the person to comply with treatment can result in the individual's case being returned to the traditional criminal justice system.

According to the National Mental Health Association, "The concept of mental health courts has been promoted in order to respond to the increasing number of people with mental illness entering the criminal justice system. The failure of American society to make good on the promise of community-based care is one of the reasons for this

increase. America has never committed the resources necessary to provide adequate community mental health services for people who are at risk of commitment to or being discharged from institutions (including hospitals and jails). Additionally, lack of education contributes to the prejudice, stigma and discrimination against persons with psychiatric disabilities. Increased enforcement, especially of misdemeanor offenses, has criminalized symptoms of mental illness and co-occurring substance abuse disorders."

Mental Health Courts are currently in operation in Broward, Alachua, Lee, Sarasota and Brevard Counties. These are post arrest diversion programs serving individuals with mental illnesses who have been charged with a non-violent misdemeanor offense. The focus of these courts is on reducing the amount of time these individuals spend in jail and on obtaining treatment for them. The courts are informal, non-coercive, and when compared to other misdemeanor courts, provide these individuals greater access to treatment.

A Felony Mental Health Court was established in Broward County in November 2003 to serve individuals with mental illnesses who have been charged with low level felony offenses. This court has a similar purpose of reducing the time these individuals spend in jail and providing these individuals with access to treatment versus incarceration and punishment.

Children's Mental Health Conditions and Trends

Conditions

In Florida and throughout the country, increased attention has been placed on evidence-based practices for children. These practices specifically focus on child and adolescent mental health services, psychotropic medications, relinquishment of custody to access mental health treatment, early mental health interventions for infants and toddlers, recognition of the high incidence of children with emotional disturbance in the child welfare and juvenile justice populations, and the treatment needs of children with co-occurring disorders.

Trends

Evidence-Based Practice in Child and Adolescent Mental Health

Research in the area of evidence-based practice for children and adolescent mental health services is still emerging and mainly addresses the effectiveness of specific treatment interventions and services for a particular population of children and youth. However, literature in this area consistently refers to therapeutic foster care, home-based services, intensive case management, school-based mental health services and multi-systemic therapy as examples of evidence-based practices that have been effective in treating children and youth with mental health and behavioral needs.

Psychotropic Medications

The use of prescription medications to treat children and youth with emotional, behavioral, and mental health issues has increased in recent years, in part because of both the availability of new psychotropic medications and an increased awareness of the treatment needs of children and youth with serious emotional disturbances. This has resulted in a heightened awareness and concern regarding the increase in prescribing psychotropic medications for children and adolescents at both the state and national level. There are few studies to provide a reliable estimate of how many children nationally are currently receiving psychotropic medications. However, two recent national studies of school age children receiving special education services provides some estimate of the level of use of these medications. These studies show that psychotropic medication use is highest among middle-school age children, with 22 percent of children age 10-12 years receiving these medications. They were followed by the children age 13 -14 years with 21 percent, and 17 percent for the children age 6-9 years being prescribed psychotropic medications. For youth, the rate declines to 18 percent.

Relinquishment of Custody

Numerous national research and advocacy groups such as the Children's Defense Fund, the Packard Foundation, and Robert Wood Johnson Foundation have reported that a significant number of children are either uninsured or under-insured for behavioral health. Data show that 94 percent of health maintenance plans and 96 percent of other plans have restrictions on mental health benefits. As a result, many children with the most severe mental and emotional disorders cannot afford to access the treatment they need. Families learn that Medicaid is their only option to obtain the comprehensive array of services and supports necessary to meet the emotional needs of their child. If they do not qualify for Medicaid, some families have been turning to the juvenile justice or the child welfare systems to relinquish custody of their children to access the needed treatment services.

Early Mental Health Intervention

Recent research shows that even very young children suffer from clinical depression, traumatic stress disorder, and other mental health concerns. Currently, over 40 percent of the children who enter Florida's child welfare system are under the age of five. These children have been traumatized by domestic violence, physical abuse, sexual abuse, and extreme neglect.

Child Welfare and Juvenile Justice

According to the National Council on Disability, each year there are more than one million youth who come into contact with the juvenile justice system and more than 100,000 are placed in some type of correctional facilities. National studies show that the incidence of emotional disturbance is higher in these groups than in the general public. The Council's report states that as many as 60 to 75 percent of incarcerated youth have a mental health disorder; 20 percent have a severe disorder and 50 percent have substance abuse problems.

Child Welfare and Mental Health

Researchers estimate that 30 to 40 percent of the children and adolescents in out-of-home care have a serious emotional disorder and as many as 75 percent need mental health services. These children and adolescents have experienced risk factors such as domestic violence, abuse and neglect prior to removal and have an array of social, emotional, behavioral and mental health needs in varying degrees. Children and adolescents in the child welfare system tend to be very vulnerable. Research has consistently shown that they are at high risk for health, developmental and mental health problems. The Surgeon General's Report reviewed research on the mental health needs of children and adolescents in out-of-home care and findings show an association between abuse (physical and psychological) and insecure attachment, psychiatric disorders and post-traumatic stress disorder, conduct disorder, ADHD, depression and impaired social functioning with peers.

Co-occurring Disorders

Historically, treatment for youth with co-occurring disorders (substance abuse and mental health disorders) has been in parallel systems. Primary diagnosis was dependent on which "door" to the system a person entered and could result in neither system addressing his or her treatment needs. Research shows that treatment

outcomes for both children and adults have been poor due to the lack of integrated treatment services and supports.

Individuals Served and Estimated Prevalence of Mental Illnesses

Demographic Information for Individuals Served in FY 2002-2003

The demographic profile for adults and children, located in Appendix D, provides the reader with the general statistical profile for the population served in community mental health agencies and in the state mental health treatment facilities. Following each general statistical profile are the individual dimensions for gender, race, ethnicity, age and diagnosis for adults and children served in the community and adults served in state facilities.

Adults Served in the Community

Chapter 394.9082, F.S., defines three groups of adults as target populations for community mental health services. The three groups are:

- **Adults with severe and persistent mental illness (SPMI):** This group includes persons 18 years and older who have a diagnosis or diagnostic impression of Axis I or Axis II mental disorder, according to the Diagnostic and Statistical Manual IV, and meet any of the following criteria:
  - Has documented evidence of long-term psychiatric disability.
  - Receives Income due to psychiatric disability *(SSI, SSDI, Veterans or other)*.
  - Is over age of 59 and demonstrates inability to perform independently in day-to-day living *(e.g. personal hygiene, dressing appropriately, obtaining regular nutrition and housekeeping).*

- **Adults in mental health crisis:** There are two sub-groups in this population. *Adults with Serious and Acute Episodes of Mental Illness* includes persons 18 years and older who have a presenting mental health problem and meet criteria for admission to a mental health receiving facility. *Adults with Mental Health Problems* includes persons 18 years and older who have a presenting mental health problem and meet any of the following criteria:
  - Show evidence of a recent severe stressful event and problems with coping; or
  - Displays symptomatology placing person at risk of more restrictive intervention if untreated. *(With short-term intervention - less than one year – an individual's symptomatology can be reduced or eliminated).*

- **Adults with forensic involvement:** This group includes persons adjudicated as adults and who meet any of the following criteria:
  - Have an "incompetent to proceed (ITP)" court order due to mental illness; or
  - Have a "not guilty by reason of insanity (NGI)" court order; or
  - Are on conditional release due to mental illness.

Estimate of Prevalence

Prevalence rates for severe and persistent mental illnesses (SPMI) are determined using estimates developed by the federal Center for Mental Health Services. These estimates indicate that 2.4 percent of persons over the age of 18 in Florida have severe and persistent mental illness.

Because all adults with SPMI will not need or use publicly-funded services, a more conservative estimate of approximately 1-1.5 percent (1.3 percent estimate) is used to determine the adult population that can be expected to access these services. Based on this estimate, approximately half (54 percent) of the 166,469 persons over 18 with severe and persistent mental illnesses estimated to need publicly-funded mental health services in Florida accessed some type of service in FY 2002-2003 (***Table 1***).

Table 1: Estimated Prevalence Rates of SPMI and Number of Persons Served Florida Fiscal Year 2002-2003

Population	Prevalence Rate	Est. Number of Adults	Actual Adults Served
Adults 18-54		8,197,663	
Adults 55+		4,607,618	
All Adults		12,805,281	
SPMI	2.4%	307,327	89,267***
SPMI with public services**	1.3%	166,469	89,267

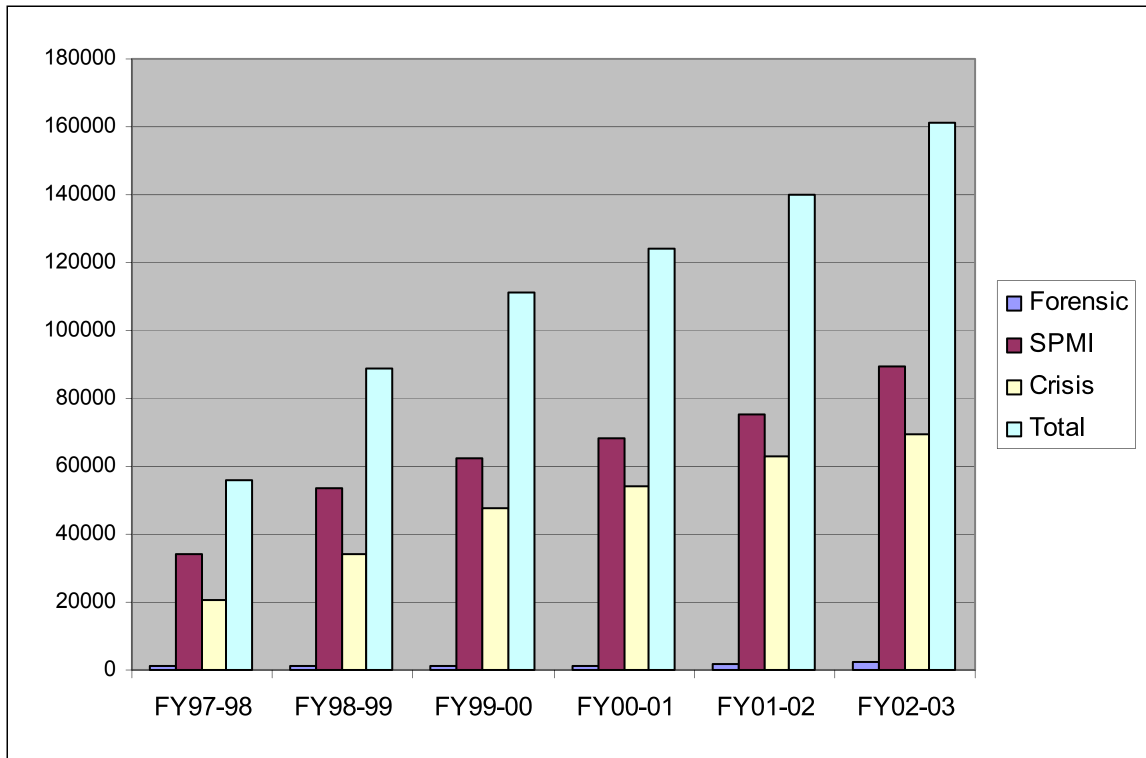
*** The 1.3% is the median of two national prevalence rates, obtained from a study by the National Alliance for the Mentally Ill, ranging from 1% to 1.5% of adults.*

**** The 89,267 actual individuals with SPMI served include those adults with SPMI served in the community. It does not include SPMI individuals served in the State Treatment Facilities.*

Number of Adult Individuals Served by Target Population Groups

The number of adults served in the community by target population group from FY 1997-1998 through FY 2002-2003 is shown in ***Figure 1***. The total persons served increased 188 percent over the last six years, from 55,809 in FY 1997-1998 to 160,991 in FY 2002-2003. By target population for the same six year period, adults in crisis increased by 237 percent, persons with SPMI increased by 137 percent, and persons with forensic involvement increased by 84 percent.

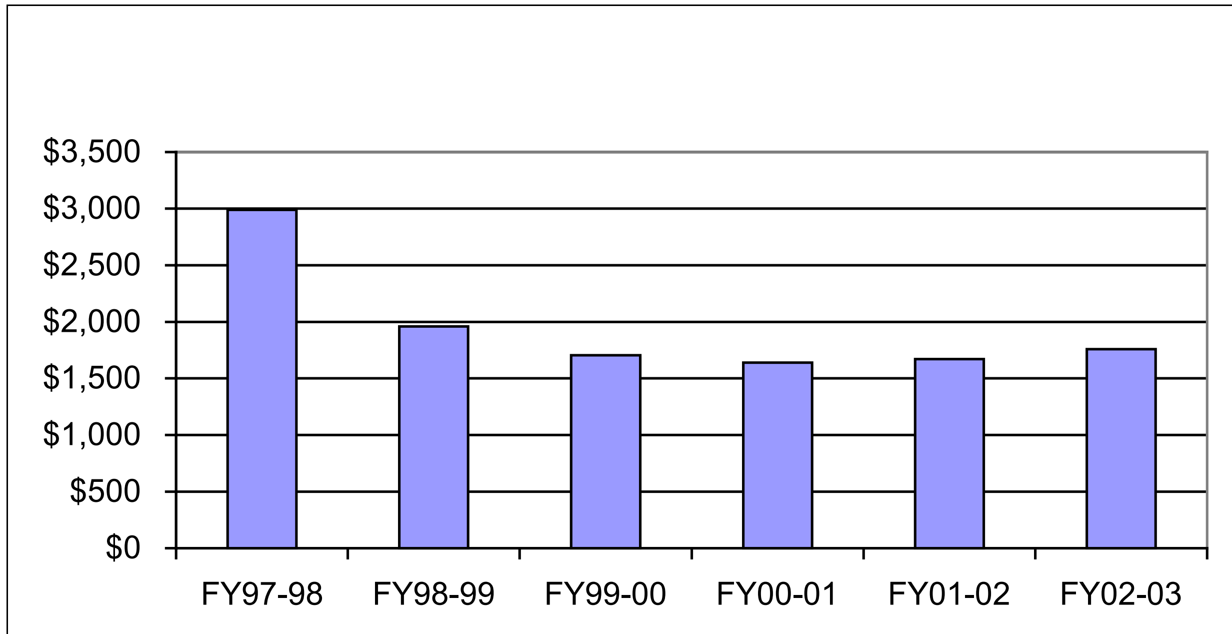
Figure 1: Total Adult Target Population Individuals Served
Fiscal Years 1997-1998 to 2002-2003



Target Population	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
Adults with severe & persistent mental illness	34,051	53,736	62,261	68,137	75,298	89,267
Adults in mental health crisis	20,639	34,382	47,789	54,288	62,995	69,665
Adults with forensic involvement	1,119	896	1,055	1,464	1,717	2,059
Total	**55,809**	**89,014**	**111,105**	**123,889**	**140,010**	**160,991**

The average per person expenditure of state mental health funds (not including Medicaid) in each of the last six fiscal years is shown in ***Figure 2***. The calculation is based on the total number of individuals served (target population groups are combined) divided into the appropriation for each fiscal year. The graph illustrates the decline in dollars spent per person served, suggesting a reduction over time in the ability of the system to sufficiently meet the needs of persons seeking services.

Figure 2: Adult Community Mental Health Budget Per Person Served
Fiscal Years 1997-1998 to 2002-2003



NOTE: The above amounts do not include Medicaid expenditures.

Children Served in the Community

Section 394.493, F.S., defines three groups of children as target population for community mental health services. The three groups are:

- **Child with serious emotional disturbance**: A child under the age of 18 who meets one of the following criteria:
  - Diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder or personality disorder, or
  - Currently classified as a student with serious emotional disturbance by a local school district, or
  - Currently receiving Supplemental Security Income benefits for a psychiatric disability, or a combination of the following two criteria
  - Has allowable diagnosis other than those listed in item 3 *(i.e.: 293; 294; 297; 299; 300; 302; 306-314, & 316)* and
  - Has Children's Global Assessment Scale (C-GAS) score of 50 or below.

- **Child with emotional disturbance**: A child under the age of 18 who meets one of the following criteria:
  - Currently classified as a student with an emotional handicap by a local school district, or
  - Has allowable diagnosis other than those listed in item 3 *(i.e.: 293; 294; 297; 299; 300; 302; 306-314, & 316*

- **Child at risk of emotional disturbance:** A child under the age of 18 who has a mental health presenting problem and meets one of the following criteria:
  - Does not have a mental health diagnosis but has factors associated with an increased likelihood of developing an emotional disturbance (such as homelessness, family history of mental illness, abuse or neglect, domestic violence exposure, substance abuse, chronic physical illness, or multiple out-of-home placements), or
  - Current referral for placement in Emotionally Handicapped (EH) program in accordance with Individuals with Disabilities Education Act (IDEA).

Based on an October 2000 report of the Data and Needs Assessment Workgroup, prepared by Kevin E. Kip, Ph.D., for the Florida Commission on Mental Health and Substance Abuse, the statewide estimate of the one-year prevalence of serious emotional disturbance (SED) is 7.9 percent for children under the age of 18.

With a total child population estimate of 3,776,205, there are an estimated 298,320 Florida children with serious emotional disturbances.

Table 2: Estimated Prevalence Rates and Number of Children with Serious Emotional Disturbances (SED) in Florida FY 2002-2003

Population	Prevalence Rate	Estimated Number of Children	Actual Children with SED Served
All Children		3,776,205	
Total SED*	7.9%*	298,320	53,248**
SED with private insurance	4.582%	173,026	
SED with Medicaid coverage	1.975%	74,580	31,695***
SED with KidCare coverage	.395%	14,916	6,339***
SED uninsured	.948%	35,798	15,214***
Total SED needing public services (Medicaid and State)	**3.318%**	**125,294**	**53,248****

* *This is a Florida-specific prevalence rate based on a meta-analysis of 17 prevalence studies, by Kevin E. Kip, Ph.D., for the Florida Commission on Mental Health and Substance Abuse.*

** *Number served is children enrolled in the target population as "seriously emotionally disturbed."*

*** *Approximate number of individuals served based on the percentages in second column divided by 3.318 times 53, 248.*

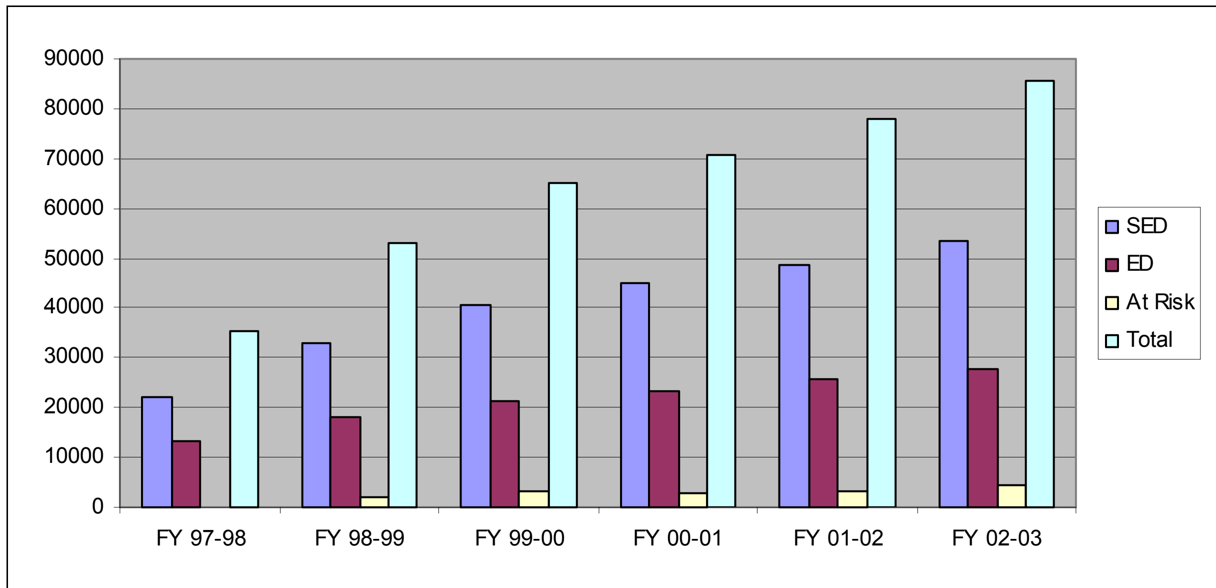
A 1999 U.S. Census Bureau report on health insurance indicates that nearly 60 percent of children in the state's population who have serious emotional disturbances have private insurance coverage. However, the adequacy of their coverage for mental health treatment is unknown. The remaining children are either covered by public insurance – Medicaid or KidCare – or have no insurance. Of Florida children served, approximately 59 percent are on Medicaid, an additional 11.9 percent have coverage through KidCare and the remaining 28.6 percent of the children are considered uninsured.

The percentage of children with serious emotional disturbances who need publicly-funded services is estimated as 3.318 percent of the under 18 population. Using this rate, there are an estimated 125,294 children with SED in Florida in need of publicly-funded services. The 53,248 children who received services in FY 2002-2003 represent a 42.5 percent penetration rate for children in need of services.

Number of Children Served by Target Population Groups

The number of children served in the community by target population during FY 1997-1998 through FY 2002-2003 is shown below. The number of children served in the community has increased by 152 percent in the last six years, from 35,205 in FY 1997-1998 to 85,616 in FY 2002-2003, as illustrated in ***Figure 3***.

Figure 3: Children Target Population Served
Fiscal Years 1997-1998 to FY 2002-2003

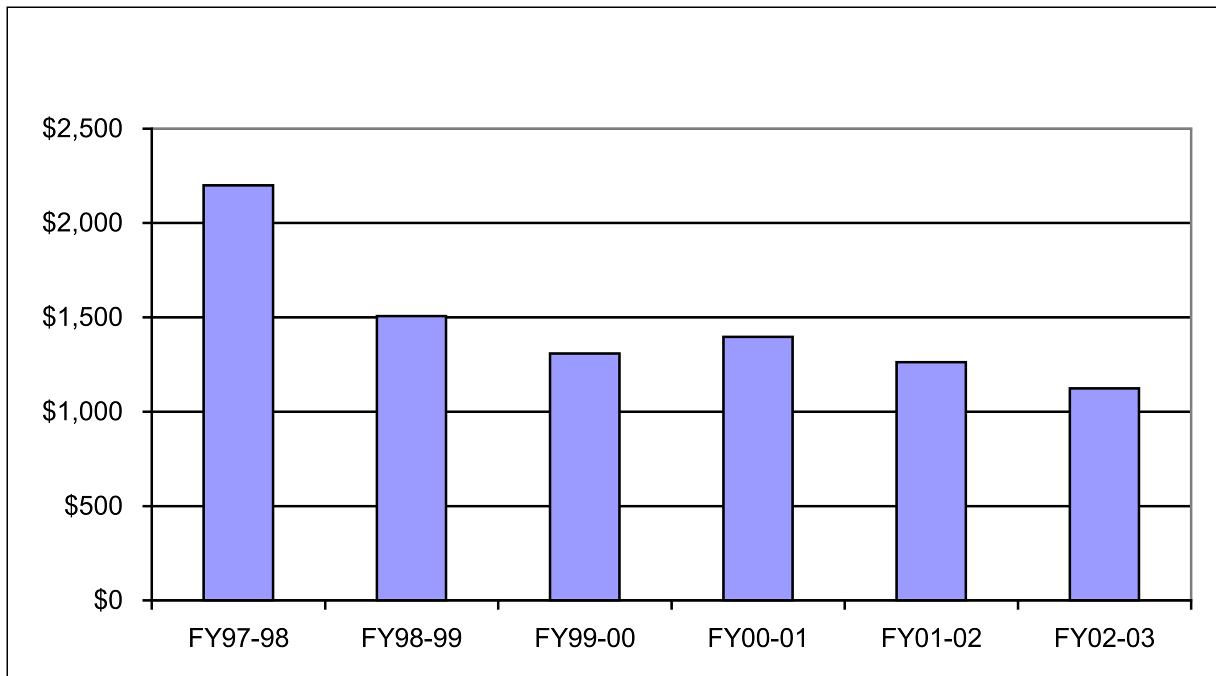


Children's Mental Health Target Population Served from FY 1997-98 through FY 2002-03						
Target Population	**FY 1997-98**	**FY 1998-99**	**FY 1999-00**	**FY 2000-01**	**FY 2001-02**	**FY 2002-03**
Children with Serious Emotional Disturbances - SED	22,104	32,817	40,517	44,834	48,785	53,248
Children with Emotional Disturbances	13,101	18,272	21,284	23,197	25,667	27,814
Children at Risk of Emotional Disturbances	NA	1,931	3,256	2,832	3,351	4,554
Total	**35,205**	**53,020**	**65,057**	**70,863**	**77,803**	**85,616**

The average cost per child and adolescent served for each of the last six fiscal years (not including Medicaid) is shown in ***Figure 4***. The calculation is based on the total number of children served (all children's mental health target groups, including JITP, combined) divided into the appropriation for each fiscal year. As for adults, this chart

shows a declining amount of funds available to each child. As the demand for services grows, the gap between needed services and supports and available services widens.

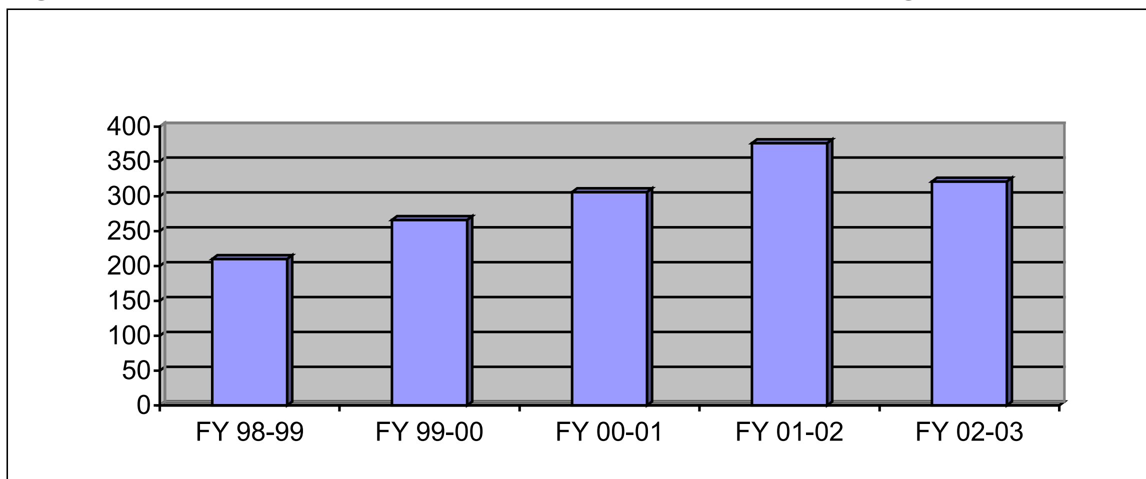
Figure 4: Children's Community Mental Health Budget Per Person
Fiscal Years 1997-1998 to 2002-2003



NOTE: The above amounts do not include Medicaid expenditures.

The total number of children served as Juvenile Incompetent to Proceed (JITP) in FY 2002-2003 was 321. The bar chart below shows the number served annually from FY 1998-1999 through FY 2002-2003. The clinical profile of these children shows that they were diagnosed with mental illnesses (64 percent), mental retardation (27 percent) and dually diagnosed (9 percent).

Figure 5: Number of JITP Individuals Served FY 1997-1998 through FY 2002-2003



Adults Served in the State Mental Health Treatment Facilities

Florida serves two target population groups for adults in state mental health treatment facilities. The two groups are defined as meeting the following requirements:

- **Adults meeting civil commitment criteria:** This group includes persons 18 years and older and meet the following criteria:
  - Committed in accordance with the provision of services provided in Chapter 394, Florida Statutes, also known as the Baker Act.
  - Admitted on either a voluntary or involuntary basis.
  - Committed in accordance with the provision of services provided in Chapter 394, Part V, Florida Statutes, Involuntary Civil Commitment of Sexually Violent Predators.

- **Adults meeting forensic commitment criteria:** This group includes persons over the age of 18, and juveniles adjudicated as adults.
  - Authority for provision of services is provided in Chapter 916, Florida Statues, and Rules 3.210-219, Rules of Criminal Procedure.
  - Individuals must have been charged with a criminal offense.
  - Admissions include persons adjudicated Incompetent to Proceed or Not Guilty by Reason of Insanity.

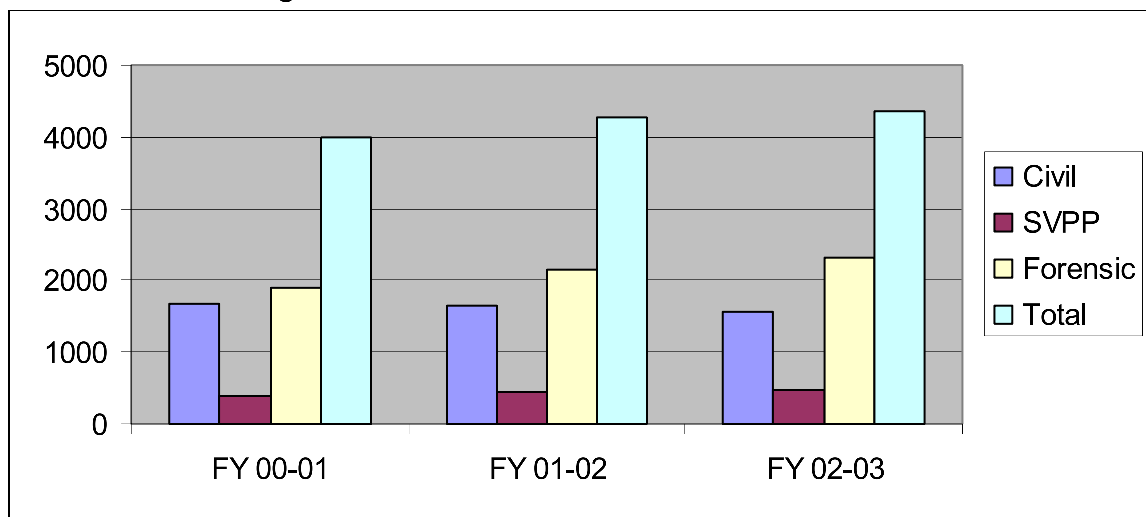
Number of Adult Individuals Served by State Mental Health Treatment Facilities

Table 3 and ***Figure 6*** below show the number of adults served in state mental health treatment facilities by target population from FY 2000-2001 through FY 2002-2003. As seen in this table, the number of adults in civil commitment has decreased since FY 2000-2001 from 1,676 to 1,578 in FY 2002-2003, whereas the number of adults in forensic commitment has increased from 1,913 to 2,312 during the same time period.

Table 3: Individuals Served in State Treatment Facilities
Fiscal Years 2000-2001 to Fiscal Year 2002-2003

Target Population	FY 2000-2001	FY 2001-2002	FY 2002-2003
Adults in civil commitment per Chapter 394, F.S.	1,676	1,662	1,578
Adults in civil commitment per Chapter 394, Part V, F.S.	393	457	465
Adults in forensic commitment per Chapter 916, F.S.	1,913	2,143	2,312
Total	**3,982**	**4,262**	**4,355**

Figure 6: Individuals Served in State Mental Health Treatment Facilities FY 2000-2001 through FY 2002-2003



Individuals residing in a state mental health treatment facility differ from individuals served in the community primarily because they are more likely to suffer from neglect or refuse to care for him/herself, pose a real and present threat of substantial harm to him/herself or others, are likely to inflict serious bodily harm to him/herself or others, and all available less restrictive treatment environments have been judged inappropriate. As shown in Appendix D, there is a significant difference between individuals served in state mental health treatment facilities versus community placements. For example, during FY 2002-2003, 54 percent of individuals served in state mental health treatment facilities were diagnosed with a psychotic disorder versus 29 percent of individuals served in the community. Individuals diagnosed with a psychotic disorder require more intensive services in order to stabilize their symptoms and to ensure compliance with treatment following discharge. Additionally, 19 percent of individuals served in a state mental health treatment facility are diagnosed with a personality disorder (Axis II). Individuals may require a structured behavioral treatment modality, such as Dialectical Behavior Therapy (DBT), which is specifically designed to treat behaviors that are symptomatic of this disorder (e.g., self injurious behavior). DBT services are available at all civil state mental health treatment.

Table 4. Average Length of Stay for Individuals Discharged from a Civil Mental Health Treatment Facility during Fiscal Year 2002-2003

	# Discharged	Average Length of Stay (Number of Days)
Florida State Hospital	207	1,175
Northeast Florida State Hospital	171	1,188
South Florida State Hospital	264	632

The average length of stay for individuals at Florida State Hospital and Northeast Florida State Hospital appears to be impacted by the discharge of several long-term

individuals who had been at the facility for ten years or longer. These discharges increase the average length of stay.

The next two graphs (***Figure 7*** and ***Figure 8***) show the average number of persons served per bed in civil and forensic facilities for FY 2002-2003. The principle reason for the difference in the higher average number of persons per bed in forensic facilities is related to the mission of these facilities. Forensic facilities are charged with restoring the competency of individuals to proceed to court. Competency restoration requires a shorter stay than is needed for individuals admitted to civil facilities. Alternatively, civil facilities provide residents with treatment, rehabilitation and stabilization services.

Figure 7: Number of Adults Served Per Bed – Civil Facilities FY 2002-2003

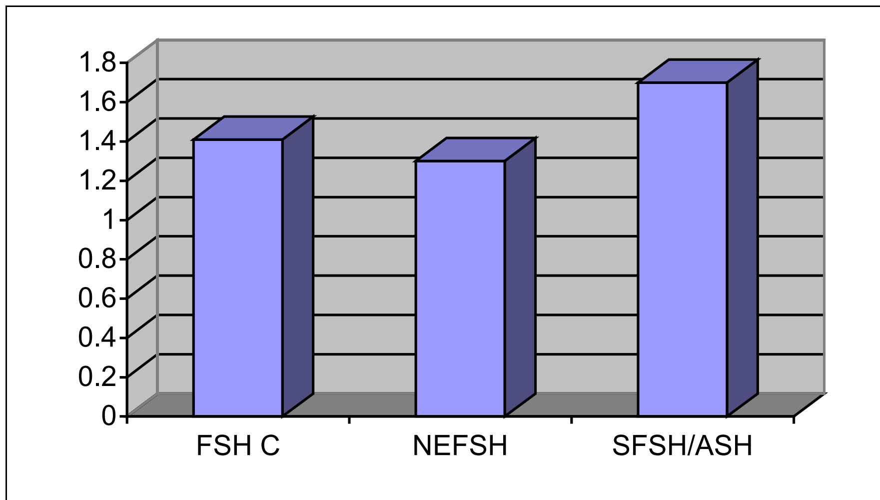
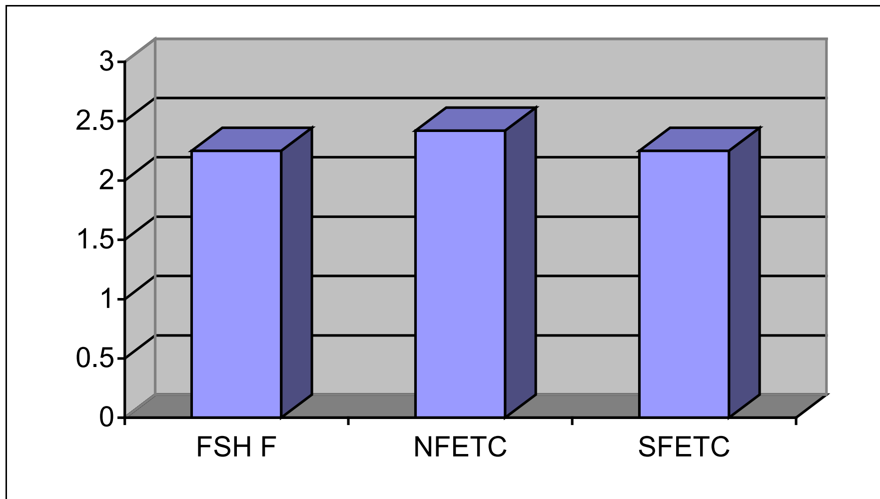
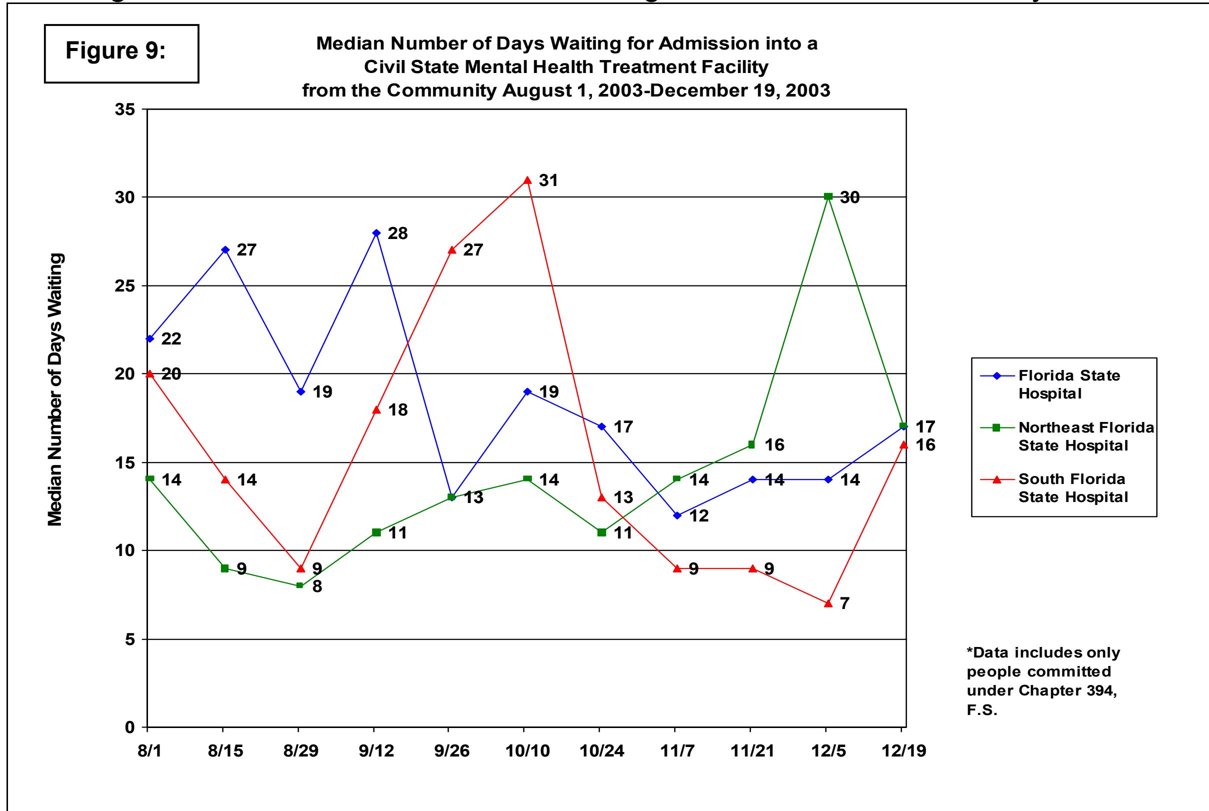


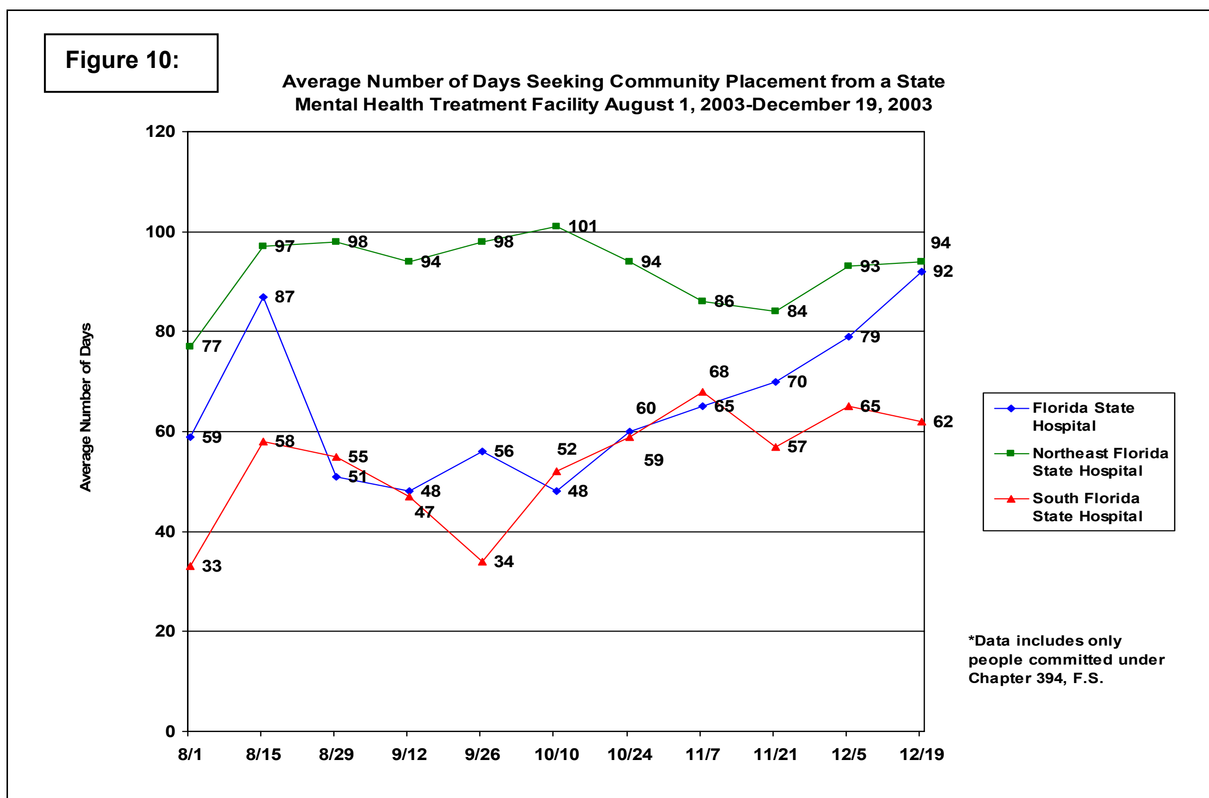
Figure 8: Number of Adults Served Per Bed – Forensic Facilities FY 2002-2003



Figures 9 and 10 below provide information on median days that persons with mental illnesses waited for admission to civil state treatment facilities and the average number

of days persons with mental illnesses waited for community placements following discharge from state treatment facilities during the latter half of calendar year 2003.





Service Provision

Community Services for Adults and Children

The total state budget for services provided in the community in FY 2002-2003 was $363,429,263, as shown in ***Table 5*** below. This table provides the budget breakdown by mental health service activities for adult and children's mental health programs. As seen in this table, emergency stabilization and residential care services account for more than 50 percent of the budget for both programs. The largest budget items are the emergency stabilization for adult mental health program (30 percent) and the residential care for children mental health program (41 percent).

Table 5: Fiscal Year 2002-2003 State Budget for Community Mental Health Programs

Mental Health Service Activities	Adult MH		Children MH		Adult and Children	
	Total	Percent	Total	Percent	Total	Percent
Emergency Stabilization	$79,048,628	30%	$17,837,641	18%	$96,886,269	27%
Residential Care	$56,518,599	21%	$39,305,425	41%	$95,824,024	26%
Case Management	$19,619,410	7%	$4,430,739	5%	$24,050,149	7%
Outpatient Services	$41,724,196	16%	$20,160,231	21%	$61,884,427	17%
Community Support Services	$29,345,103	11%	$8,696,225	9%	$38,041,328	10%
ACT Teams	$40,227,294	15%		0%	$40,227,294	11%
Juvenile Restoration Support		0%	$6,515,771	7%	$6,515,771	2%
Total Mental Health Services	$266,483,230	100%	$96,946,032	100%	$363,429,263	100%

Note: The $96,946,032 Children's mental health budget includes $4,020,000 for Behavioral Network (BNet) services and $6,515,771 for Juvenile Incompetent to Proceed (JITP) services.

Services may include an individualized mixture of the following:

- **Emergency Stabilization and Support** – These non-residential care services are generally available 24 hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include: mobile crisis, crisis support, crisis/emergency screening, crisis telephone, and emergency walk-in.

- **Case Management** - Case management services consist of activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery, and evaluating the effect of the services received.

- **Community Support** – Services are specifically designed to enable the individual to be maintained in the community while receiving treatment. Services may include: prevention/intervention day programs, respite services, supportive employment, supportive housing/living, aftercare and information and referral.

- **Outpatient Services** - Services are provided in community settings and include assessment, day/evening treatment programs, psychiatry services (including medication management), outpatient counseling, sheltered employment, mental health overlay services in certain residential programs including nursing homes, drop-in and self-help programs, "in-home" and "on-site" treatment and outreach services.

- **Residential Services** - Persons who need short-term, intensive treatment in a 24-hour care facility may be placed into a licensed facility, such as a therapeutic foster or group home.

Specialized Services Provided:

- **Assertive Community Treatment** – Florida Assertive Community Treatment (FACT) programs are based on the Program of Assertive Community Treatment (PACT) model. The PACT model is a community-based service delivery model that has substantial empirical evidence for increasing successful community integration, psychosocial interactions and recovery of adults with symptoms of mental illnesses. The model involved the redesigning of services in order to support persons with the most challenging symptoms of mental illness, enabling them to live successfully in the community. The overarching tenet governing FACT teams includes operating as a single point of accountability for community care. Teams are self-contained and multi-disciplinary and assume responsibility for directly providing needed treatment, rehabilitation and support services to identified persons to be served who have psychiatric disabilities. Persons served by the FACT team:

  - are rarely referred to outside providers for supports and services;
  - are provided services on a long-term basis with continuity of caregivers over time;
  - receive the majority of the services and supports (75 percent) outside offices; and
  - have individual preferences, choice, outreach, relationship building and individualization of services and supports.

- **Behavioral Network (BNet)** - delivers comprehensive behavioral health benefits to Title XXI (SCHIP) eligible children with special health care needs in order to ensure a high level of integration of physical and behavioral health care. The program provides intensive service treatment annually to 370 children with serious emotional disturbances or substance abuse problems. Children's Medical Services (Department of Health) and its network of providers provide the physical health care needs. The behavioral health benefits are delivered through a consortium of contracted manage care providers with the department's Substance Abuse and Mental Health district offices. A BNet liaison is located in each district office to ensure coordination of all medical and behavioral health needs. Services include treatment planning and review, evaluation, case management, rehabilitative and therapy services, family support and alternative wrap-around services.

- **Juveniles Incompetent to Proceed (JITP)** - provides intensive competency restoration services for juveniles who: (1) have been charged with a delinquency offense which would be a felony if committed by an adult; and (2) are found by the court to be incompetent to proceed to trial due to mental illness and/or mental retardation. Restoration services include assessments, evaluation, case management and intensive competency training and treatment to allow the juvenile to return to court and participate in his or her court proceedings.

Juveniles determined by the court to be in need of treatment in a secure residential setting are served at the Apalachicola Forest Youth Camp (AFYC). AFYC is located on a 78-acre site in a wilderness area of the Apalachicola State Forest in Liberty County. The facility consists of six eight-person cabins with individual bedrooms, (eight female beds and 40 male beds), an education building with six classrooms, a professional building with 24-hour nursing coverage and an administrative building. AFYC provides intensive competency restoration services that include educational services, behavioral programming and group and individual competency training.

- **Community Competency Restoration Services** - These services are provided to 90 juveniles statewide. Competency restoration services are provided in the home, foster home, detention and school. Case management and competency training are the focus of the program. Mental health services are coordinated by the district mental health office. For juveniles with mental retardation, case management services are coordinated through the Developmental Disabilities office.

- **Sexually Violent Predator Program (SVPP)** – The SVPP administers the Involuntary Civil Commitment of Sexually Violent Predators Act, Chapter 394, part V, F.S. SVPP receives referrals of persons convicted of a sexually violent offense who are approaching release from incarceration in the Departments of Corrections and Juvenile Justice, as well as persons who were confined as not guilty by reason of insanity, for a sexually violent offense. SVPP performs a risk assessment and evaluation, as needed, for all referrals and makes recommendations to the State Attorneys as to whether or not a petition seeking civil commitment should be filed. Persons detained or committed under the Act are placed in department custody and are confined at the Florida Civil Commitment Center (FCCC). SVPP administers FCCC through a contract with a private provider.

- **State Mental Health Treatment Facilities** – The mental health treatment facilities operated by the department include Florida State Hospital in Chattahoochee (civil and forensic); Northeast Florida State Hospital in MacClenny (civil); North Florida Evaluation and Treatment Center in Gainesville (forensic) and South Florida Evaluation and Treatment Center in Miami (forensic). South Florida State Hospital

in Pembroke Pines (civil) is privatized and operated via a management agreement between the department and Atlantic Shores Healthcare, Inc. These facilities have a combined capacity to serve 2,280 individuals, including 1,364 in civil facilities and 916 in forensic facilities. In addition, West Florida Community Care Center in Milton, Florida, has 80 state civil treatment beds. The facility is operated by Lakeview Center through a contract with the department. Lakeview Center is a local non-profit community mental health center serving individuals from District 1 only.

The state mental health treatment facilities work in partnership with local communities to provide services and supports for adults with severe and persistent mental illnesses. These individuals generally require extended treatment and ongoing psychiatric rehabilitation services.

All individuals admitted for services in a state facility must meet the criteria contained in Chapter 394, F.S., (civil), or Chapter 916, F.S., (forensic). Individuals admitted under the civil statute have been determined to present a substantial risk in the community due to danger to themselves or others or refusal to care for themselves. A person may be admitted to a civil facility on either a voluntary or involuntary basis. Individuals committed under the forensic statute have been adjudicated not guilty by reason of insanity or incompetent to proceed through the judicial process. The majority of these individuals have been found incompetent to proceed. Each of the state's treatment facilities offers a variety of treatment, rehabilitation and enrichment services with an emphasis on addressing the therapeutic needs of each individual receiving services. Based on an assessment of individualized needs, a written plan for the delivery of services is developed using a person-centered approach involving the individual. In general, services included in a service/treatment plan include:

- ***Basic Support Services*** - include provision of the basic requirements for survival such as shelter, food, clothing and a sense of personal safety.
- ***Health Care Services*** - are intended to identify and treat physical illness and promote good health. The priorities of health services are 1) routine health assessment, treatment and education; 2) rapid response to acute illness or injury; 3) on-going management of chronic conditions; and 4) clinical pharmacology.
- ***Psychiatric Rehabilitation Services*** - consist primarily of psychiatric diagnosis, assessment of primary problems leading to hospitalization, treatment planning to stabilize acute psychiatric symptoms, psychotropic medication and side-effect management.
- ***Continuity of Care Services*** - include internal case management services and community linkages designed to ensure that essential services are being provided consistent with the individual's service or support plan and personal preferences.
- ***Competency Restoration Training and Evaluation Services*** – involve group and/or individual processes. The focus of the training is on helping individuals to

understand the judicial process, the role of the court, the nature of their charges, the possible penalties and their personal legal rights. Competency evaluations are completed, as needed, and competency evaluation reports are prepared for the courts indicating the individual's progress, as required.

Chapter 3: Mental Health Program Strategies

Consistent with the Secretary's mission statement and strategic goals, and building on the recommendations of national and state strategic directions, trends and conditions and input from stakeholders, the Mental Health Program Office has identified a set of strategic activities to guide policy and practice for the next three years. These strategies are consistent with national strategic directions such as the Surgeon General's Report and the President's New Freedom Commission Report. The overarching purpose of this plan is begin the transformation of Florida's mental health service delivery system to one in which "everyone with a mental illness at any stage of life has access to effective treatment and supports" that allow him/her the opportunity to participate fully in life in his/her community. These departmental goals, mental health strategies and courses of action are outlined below. As part of the department's change management procedures, a detailed implementation plan will be developed that includes performance targets, responsible parties and progress reports.

Department Goal #1: Ensure the Safety, Well Being and Self-Sufficiency of the People We Serve.

Care that is driven by the recognition that individuals are active participants rather than passive recipients is the first step in designing a system which individuals feel a part of the solution and are encouraged to take part in their recovery. Systems that encourage rather than punish efforts to return to work and that respect individual preferences rather than forcing "one size fits all" treatment are key.

Strategy #1: Support Life in the Community for Adults and Children with Mental Illness

The key mental health strategy directed toward the goal of supporting life in the community for persons with mental illnesses will include projects that encompass both the traditional domains of the mental health service delivery system and activities designed to put into practice newer, evidence-based interventions. Activities will include expanding the specialized therapeutic foster care services, analysis of the special needs of residents of state treatment facilities, development of community strategies for persons with forensic involvement, enhancing capacity for crisis and residential services in the community, use of algorithms for psychotropic medication management and development of evidence-based practices including supported employment, strength-based case management and early identification of treatment needs and intervention for young children. The Single Point of Access (SPOA) initiative begun in 2001 will be enhanced through the integration of mental health services with the community based care agencies using the "Substance Abuse and Mental Health/CBC Readiness Assessment" which was developed in 2003.

Project A: Complete Integration of Children's Mental Health Services and Child Welfare System (Community-Based Care) to Provide Ready Access and Quality Services.

Strategic Course(s) of Action:

1. Improve Access to Services through Single Point of Access (SPOA).

   - As child welfare services are transferred to local community-based care (CBC) lead agencies, the Mental Health Program Office will work with the CBC lead agencies to assist them in ensuring that the services currently provided through the district/region SPOA for the children in the department's care continue through the transition period to CBC. This will be accomplished by integrating the functions of the SPOA with the lead agency and ensuring that active partnering is accomplished between the district SPOA and the lead agency in those functions that remain within the District Mental Health Program.
   - During 2003, the Mental Health Program Office conducted a series of quality reviews of the SPOA programs in the districts/region. During 2004, the lessons learned from those reviews will be used to provide a best practices publication and technical assistance training to the districts/region to assist them in completing the issues identified in the child welfare Performance Improvement Plan (PIP), child wellbeing measures.
   - During 2004, the Mental Health Program Office will work with the Child Welfare/CBC Program Office to expand mental health services for the children in the department's care. This will include increasing the number of children that can access Medicaid-funded services and identifying promising practices, which will decrease the time children are in the custody of the department by providing early assessment of mental health service needs and early provision of family-centered, child-specific services.

2. Implement Mental Health/Community-Based Care Integration Guidelines.

   - To ensure the department's successful transition to CBC, guidelines have been developed to provide a blueprint for district/region Substance Abuse and Mental Health Program staff in working with the CBC and behavioral health service providers. These guidelines include a "Substance Abuse and Mental Health/CBC Readiness Assessment". The department will continue to work with its mental health service providers and CBC lead agencies using the readiness assessment during the contract negotiation and start-up periods for a successful transition to CBC to ensure the continued provision of behavioral health services for the children in the department's custody.

   - To track implementation, the Substance Abuse and Mental Health Program Offices will participate as part of the district peer review team for CBC. These reviews provide the district and the contracted CBC provider agency with an evaluation of their readiness to initiate their service contracts and

recommendations to increase their likelihood for success.

3. Expand Specialized Therapeutic Foster Care Services (STFC) for Children.

   - During 2004, the Mental Health Program Office will partner with the Office of Child Welfare and Community-Based Care to explore the expansion of STFC services through identification of general revenue funding currently spent for similar services. STFC is an evidence-supported practice for treating children with severe emotional disturbances in the community. Other activities involved in improving access to STFC include improved financial management of the current available line of credit allotted to the districts/region.

4. Enhance the Independent Living Program to Include Children with Severe Emotional Disturbances.

   - The Mental Health Program Office will work with the Office of Child Welfare and Community-Based Care to enhance independent living services for youth with serious emotional disturbances who are ready to transition from foster care. The Mental Health Program Office will continue participation in the legislatively mandated Independent Living Services Workgroup charged with assessing "the implementation and operation of the system of independent living transition services". The Mental Health Program Office will work in conjunction with the pre-independent living services and the life skills services programs to provide the appropriate wraparound services for the child. These services will be provided in a wraparound plan including natural and provider-based services to stabilize the youth in his/her home environment and empower him/her with the tools he/she needs to become resilient and learn to deal with his/her emotional disabilities. Education, training and services necessary to obtain employment and acquire the skills needed to become self-sufficient will be provided.

Project B: Streamline the Children's Mental Health Program to Coordinate Care and Maximize Revenues.

Strategic Course(s) of Action:

1. Improve Treatment Outcomes and Maximize Revenues for Behavioral Health Overlay Services (BHOS).

   - During 2004, the Mental Health Program Office will work with AHCA to streamline BHOS to maximize revenues and improve coordination of care among child welfare and juvenile justice populations. BHOS was developed under the Medicaid Community Mental Health Services Program to provide medically necessary substance abuse and mental health services for children who are placed in group shelters, residential group care settings or low-to-moderate risk Department of Juvenile Justice commitment programs.

- The Florida Mental Health Institute (FMHI) will conduct a study of the characteristics of and treatment obtained by children receiving BHOS. This activity will provide an overview of BHOS, which will be used to both develop effective policy to ensure improved treatment outcomes and maximize the use of funds.

2. Seek Medicaid Eligibility for "Non-Medicaid Eligible Children" in Residential Treatment.

   - During 2004, the Mental Health Program Office will work with AHCA to explore federal Medicaid policy for children to become Medicaid eligible as a "family of one". Allowing eligibility under "family of one" will provide Medicaid coverage for children following 30 days in a residential treatment center. This assistance will reduce the number of families seeking to place their children in the foster care system to access mental health treatment.

3. By 2005 the Mental Health Program Office Will Partner with the Department of Health to Increase Access to Part C of the Individuals with Disabilities Education Act (IDEA) for Children with Mental Health Needs Age Birth to Three Years.

   - By January 2005 a working alliance with the Department of Health will be established through the development of a Memorandum of Agreement to establish clear policy and practice linkages between the two departments to enhance coordination and integration of infant mental health services. The goal of this agreement is to strengthen relationships between the two departments and enhance interventions targeting the optimal social and emotional development of infants and toddlers.

Project C: Reduce the Days in Institutions and Shift to Days in the Community.

Strategic Course(s) of Action:

1. Complete an Analysis of Persons with Special Needs.

   - By January 2005 the Mental Health Program Office will implement a Community Needs Assessment tool to identify service needs and reduce lengths of stay of individuals residing in mental health treatment facilities. Use of this tool promotes collaborative discharge planning with the person beginning at admission to the facility and continuing throughout the hospital stay. The desired outcome is to assess and secure needed services to successfully re-integrate individuals with severe and persistent mental illnesses into their communities by increasing collaboration and accountability of community mental health providers and the state treatment facility.

2. Complete a Facility Capacity and Community Resource Analysis.

- To enhance the provision of a recovery focused continuum of care in the community, a workgroup comprised of mental health facility staff, Program Office staff, district leadership staff, and information system staff will implement a web-based, secure program to share community needs assessment (CNA) information with hospital treatment team staff, community providers, and district staff. The CNA will facilitate the community re-integration of hospitalized individuals by enhancing the service and discharge planning process and strengthening district/region planning process for the provision of community care. The CNA is expected to be operational in July 2004.

- The Mental Health Program Office will continue to monitor the admission and discharge data of individuals served in the mental health treatment facilities to ensure maximum utilization of facility resources. Trend analysis will be conducted to ensure people are admitted to and discharged from the state mental health treatment facilities in a timely manner. The length of stay and discharge barriers of individuals in the facilities will continue to be monitored to ensure the most appropriate and least restrictive placement possible. A Discharge Community Needs Assessment will be implemented statewide and will assist the facilities, districts, and communities in identifying necessary community services that will be needed during transition and following an individual's discharge. Districts will be able to project an individual's service needs based on results of the community needs assessment. A community resource analysis will be conducted based on the current existing services and the individual's projected needed services.

3. Divert Appropriate Individuals Away From State Forensic Mental Health Treatment Facilities to Appropriate Community Based Services.

- The Mental Health Program Office monitors individuals on the forensic waiting list daily and identifies persons potentially appropriate for diversion to community-based services. The district forensic coordinator and district legal counsel are notified of individuals who may possibly be diverted, the case is reviewed and, when appropriate, alternative services are coordinated and legal action is initiated to vacate the commitment and obtain an order for alternative community-based treatment and services.

- The state mental health treatment facilities are monitoring the progress of longer-term individuals and identifying non-restorable incompetent to proceed individuals and not guilty by reason of insanity individuals in forensic and civil step-down facilities who can be treated in a less restrictive setting or who no longer meet commitment criteria. Individuals are transferred to civil, conditional release plans are developed or efforts to dismiss charges are initiated in an effort to reduce the number of days individuals stay in institutions.

- To promote the provision of care in the community for individuals diagnosed with severe and persistent mental illnesses who have been deemed incompetent to proceed on non-violent felony charges, eight of the fourteen districts/region have implemented community-based competency restoration programs. Three additional districts are developing programs which will be implemented in early 2004. Forensic mental health specialists in each district seek to divert these individuals and other non-violent individuals adjudicated not guilty by reason of insanity to community placement, rather than state forensic mental health treatment facilities.

- Access to the Living Environment Activities Preference (LEAP) website will help to expedite the discharge planning process for service teams and individuals identified as ready for discharge by reducing the time required to identify and select an appropriate community placement for individuals being discharged to their communities.

Project D: Increase Capacity for Community-Based Short-Term Residential Treatment and Acute Care.

Strategic Course(s) of Action:

1. Increase the Effectiveness and Efficiency of Baker Act Procedures through Statewide Training.

   - The Mental Health Program Office will provide biennial statewide Baker Act training. Trained staff will ensure individuals are appropriately admitted and discharged in a timely manner to clinically-appropriate settings, thereby increasing the capacity for short-term treatment and acute care.

2. Provide Training on Advance Directives to Advance Self-Determination.

   - The Mental Health Program Office will provide training and technical assistance for mental health advocates including persons with mental illnesses, service providers, and district staff on the use of advance directives in eleven areas of the state. Advance directives provide individuals the opportunity to determine their own treatment options and goals.

3. Enhance Services Provided by Crisis Stabilization Units.

   - The Mental Health Program Office will offer technical assistance in the areas of clinical care and quality improvement. Emphasis will be placed on implementing clinical best practices throughout the state including risk assessment, medication management, and treatment.

   - Increasing emergency stabilization capacity in the community is an essential

component of this strategy. It ensures that children and adults experiencing a mental health crisis have access to clinically appropriate, immediate short-term treatment to stabilize the individual's condition and allow for assessment of the need for further services. These services represent a safety net and provide individuals sufficient access to crisis services, and assist in reducing hospitalizations, admissions to jails and emergency rooms. Additional funding for enhanced capacity is being requested.

- The Mental Health Program Office currently monitors the length of time it takes for an individual to be admitted to a state mental health treatment facility from a crisis stabilization unit or receiving facility. Additionally, the state mental health treatment facilities are monitoring the interval between readiness for discharge and successful community placement. These processes are in place to ensure continuity of care for individuals transitioning between the communities and facilities. Data will be analyzed to determine efficiency and identify barriers.

Project E: Support Evidence-Based and Psychosocial Rehabilitation Practices for Adults and Promising Practices for Children and Adolescents.

Strategic Course(s) of Action:

1. Promote Evidence-Based Practices (EBP) and Psychosocial Rehabilitation for Adults with Mental Illnesses.

   Over the past decade research in the field of mental health has demonstrated that there is consistent scientific evidence that some specific practices work well in improving outcomes and the quality of lives of individuals diagnosed with severe and persistent mental illnesses and children with serious emotional disturbances. Such practices can also be considered cost-effective in that they assist people served by diverting hospitalization, reducing their length of stays in hospitals and facilitating a more rapid discharge of individuals to their communities. The federal government recognizes six evidence-based practices, of which Florida has active initiatives:

   - Supported employment is the direct placement of persons with mental illnesses in competitive employment with ongoing supports.

     - During 2004, the department will continue collaboration with the Division of Vocational Rehabilitation and the Florida Developmental Disabilities Council and stakeholders to identify several strategies to overcome barriers. To decrease the time frame between referral and eligibility determination, DVR has instituted "presumptive eligibility" for individuals receiving case management that have Supplemental Security Income/Social Security Disability Income due to a psychiatric disability. In order to address the need for continuity of ongoing employment supports, DVR modified the interpretation of follow-up services, which will drastically increase access to the initial supported employment services funded by DVR. The new Medicaid

procedure codes will allow for payment of extended supported employment services, which will also markedly decrease the roadblocks.

- ❑ By Spring 2004 the Mental Health Program Office will establish district-specific targets to increase the number of adults involved with supported employment programs. Mental Health Program Office staff will track and provide technical assistance to districts in meeting these targets.
- ❑ The Program Office, in conjunction with DVR, will develop pilot projects in four FACT teams statewide by placing DVR staff on the FACT teams to access additional federal funds to facilitate employment of FACT recipients. The pilot project design will include a change in the DVR payment bench marks for individuals with severe and persistent mentally illnesses. The Interagency Agreement will facilitate the following collaborate training initiatives to promote supported employment:
  - Technical assistance to districts 7,8,9,10,12 and the Suncoast region to maximize existing supported employment programs; and
  - Statewide training for mental health and DVR providers regarding rehabilitation-oriented comprehensive service planning, extended vocational services which maximize natural supports, readiness for employment assessments, and job development skills.
- ❑ During 2004, training funded by the Able Trust will be provided to mental health providers to decrease the knowledge deficit regarding benefit retention, using Ticket-to-Work guidelines, and increasing the development of natural supports at the work site. Additionally, the Mental Health Program Office will ensure the statewide distribution of a national resource kit for supported employment services, developed by SAMHSA and the Robert Wood Johnson Foundation when it is made available for distribution by SAMSHA.

➢ Family psychoeducation programs include the provision of emotional support, education, resources during periods of crisis and problem-solving skills. In FY 2002-2003 the Mental Health Program Office contracted with the National Alliance for the Mentally Ill (NAMI), Florida, Inc., for various instructor training and community-based classes and groups. Family psychoeducation programs supported 15,158 individuals/families in FY 2002-2003.

- ❑ The Mental Health Program Office will continue its collaboration with NAMI, Florida, Inc., to make available to service recipients and families a series of resources and services that promote psychoeducational programs.
- ❑ The Program Office will analyze the psychoeducational SAMHSA tool kit compared to the NAMI curriculum currently in use in Florida.
- ❑ During the next two years the Program Office will disseminate the tool kit and provide training on psychoeducation programs.

➢ Co-occurring disorders and integrated dual diagnosis treatment mean that an individual receives treatment from one clinician or treatment team through one program that combines appropriate treatment for both disorders. Chapter 6, the

collaborative initiatives chapter, provides strategic directions for improving co-occurring services over the next three years.

- Assertive Community Treatment (ACT) programs within Florida are based on the Program of Assertive Community Treatment (PACT) model. These programs have involved the redesigning of services in order to support persons with the most challenging symptoms of mental illness, enabling them to live successfully in the community. Available data shows a total of 2,475 adults received FACT services in FY 2002-2003.

  Specific strategies include:

  - Develop in-state training capacity and a reduced reliance on FACT national experts, as described in the Provider Workforce project.
  - Following the development of this in-state training capacity, Mental Health Program Office staff and selected FACT team leaders will provide technical assistance to FACT teams across the state.
  - The Mental Health Program Office staff, in collaboration with NAMI, Florida, Inc., will also provide assistance to help the teams more fully develop the roles of Advisory Committees and peer specialists, promote family education and develop a better understanding of cultural competence in service delivery.
  - Medication algorithms are practice guidelines based on clinical research to help clinicians make complex clinical decisions in medication treatment for individuals with serious mental illnesses. Specific actions related to this evidence-based practice can be found in Goal 1, Strategy 1, Project G, Action #5.
  - Illness management and recovery includes a broad range of health lifestyle, self-assessment and treatment behaviors by individuals with mental illnesses, often with the assistance and support of others, so they are able to take care of themselves, manage symptoms and learn ways to cope with their illness. Self management includes psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training and cognitive behavioral treatment. Florida's Self-Directed Care project (FloridaSDC) in District 4 is an example of an illness self management program. FloridaSDC grants the individual a high degree of self-determination in choosing services and providers to help with their recovery from mental illnesses. The program is described more fully in "Legislative Initiatives" found in Chapter 1. During the next three years planned activities to promote self-directed care in Florida include:

    - Receive an evaluation of FloridaSDC from the FMHI;
    - Expand SDC in District 4 to include children and their families. These concepts will also be expanded to include providing services for adults in District 8; and

- Revise targeted case management training for adult and children's case managers. Make related revisions to the associated administrative rule and policy to enhance the competency of mental health case managers to incorporate the principles of self-directed care.

- The Mental Health Program Office is also implementing other psychosocial rehabilitation practices for adults with serious mental illnesses. These include strength-based case management, supportive housing, and utilization management. The foundation of strength-based case management is based on the principles of self-determination and personal choice, reflecting a move away from traditional models of case management to person-centered recovery support.
- The Mental Health Program Office is rewriting the case management rule to reflect this principle. During FY 2004-2005 the Mental Health Program Office will train adult and children's case managers and implement the revised rule statewide.

- Supportive housing is an array of individualized services and supports to assist each person with a serious mental illness to choose, receive and keep regular, integrated, safe and affordable housing. The following actions will be completed over the next three years:

  - The Mental Health Program Office will implement the supportive housing strategic plan by providing training and technical assistance to district and provider staff regarding access to housing, funding for housing and appropriate supports for individuals living in their own homes.
  - The Mental Health Program Office will promulgate rules for supportive housing to ensure uniform, statewide standards and implementation of these standards.
  - Each district will develop a housing plan to address the local need, establish targets for increasing the number of adults living in supportive housing and identify the local process to achieve its goal.

- In an effort to promote the treatment of individuals with mental illnesses in the least restrictive setting possible, the Mental Health Program Office will analyze utilization management information to monitor the use of costly state mental health treatment facilities and residential care. The information will be used to ensure that these settings are used only when less restrictive care models are not clinically appropriate. This data-driven approach enhances the collaboration between civil mental health treatment facility staff and community mental health case managers.

2. Promote Promising Practices for Children and Adolescents with Emotional Disturbances

- SAMHSA is partnering with the National Association of State Mental Health Program Directors (NASMHPD) to identify promising practices for children and adolescents with emotional disturbances. The identification of promising practices by SAMHSA and NASMHPD for this population of children and adolescents will result in the development and dissemination of resource tool kits, as was done for adults with severe mental illnesses.
  - The Mental Health Program Office is monitoring the SAMHSA and NASMHPD project and researching recent collaborative efforts by the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association to identify promising practices for children and adolescents with emotional disturbances.
  - Once developed, the Mental Health Program Office will disseminate the promising practices tool kits to mental health service providers and other stakeholders to support the implementation of the identified promising practices.
  - Over the next three years, the Mental Health Program Office will partner with NASMHPD, other department program offices, AHCA, state universities, advocacy organizations and mental health service providers to disseminate information on and implement promising practices recognized as being effective in addressing the needs of children and youth with emotional disturbances.

- Although research in the area of promising practices for children and adolescent mental health services is still emerging and fairly limited, current literature in this area identifies approaches that have shown to be effective in addressing the needs of children and adolescents with emotional disturbances. The Mental Health Program Office has active initiatives in five of these commonly referred to promising practices:
  - Multi-systemic therapy
  - Parent-Child Interaction Therapy
  - Treatment Foster Care
  - Intensive Case Management
  - Home Based/Family Focused Services

- Multi-systemic Therapy (MST)- The goal of MST is to develop independent skills among youth who have behavior problems and their parents to cope with family, peer, school and neighborhood problems through brief (three to four month) and intense (sometimes daily) treatment. Research supporting the effectiveness of MST as a promising practice was completed with the juvenile justice population. However, a recent study indicates that MST may also be effective in safely reducing the rate of emergency psychiatric hospitalizations among children and adolescents with serious psychiatric impairments. Careful consideration of this preliminary research is required to determine if the MST model can be effective in addressing the needs of children and adolescents with severe and often times complicated mental health needs.

- ❑ The Mental Health Program Office is reviewing recent studies on the effectiveness of MST with children and adolescents with severe emotional disturbances to determine if research supports the use of MST with this population.
- ❑ In 2004, the Mental Health Program Office will research the use of MST by other states with children and adolescents with severe emotional disturbances to identify successful efforts.
- ❑ Over the next two years, the Mental Health Program Office will partner with Child Welfare and AHCA to review the effectiveness of MST with children and adolescents with emotional disturbance and pursue implementation of the MST model, if applicability and effectiveness are indicated.

➢ Parent-Child Interaction Therapy- Parent-child interaction therapy fosters secure attachments and promotes positive interactions and relationships between the infant and their parent/caregiver during a critical time in the child's developmental process. Research in the area of early childhood development and recent neurobiological research on brain development indicate that nurturing responses by caregivers contribute to children's healthy physical, emotional and social development. The Mental Health Program Office is promoting parent-child interaction therapy through the following activities:

- ❑ Recently dispersed pilot projects start-up funds to five more communities within the state to enhance their capacity to provide relationship-based, family interaction therapy for young children. The Mental Health Program Office will continue to provide administrative guidance and technical assistance to these pilot sites during the development and implementation of their projects.
- ❑ Partnering with the Center for Prevention and Early Intervention, Florida State University to offer a statewide training of infant mental health clinicians in the parent-child therapy model during the FY 2003-2004.
- ❑ In 2004, continue to explore access to Part C funding to support the provision of services and supports to young children, age zero to five.

➢ Treatment Foster Care- Treatment foster care (TFC) provides specially trained foster parents and community mental health services in a foster home setting for children and adolescents with emotional disturbances. TFC has been available statewide since 1995 and will expand as funding is made available.

- ❑ In 2004, the Mental Health Program Office will partner with the Office of Child Welfare and Community-Based Care to explore expansion of treatment foster care through use of funds that are currently used for similar services.

➢ Intensive Case Management - Intensive Case Management (ICM) utilizes qualified and specially trained professionals as case managers to work intensively with a child/youth and their family to coordinate with teachers and other helpers to develop an individualized comprehensive service plan. The goal and focus of the service plan is to assist the child/youth to live successfully in the community. Intensive case managers have caseloads limited to twelve recipients

and offer a 24-hour a day, 7-days a week response capacity. Studies on the use of ICM indicate that children and youth spent significantly more days in the community between episodes of emergency psychiatric hospitalizations and were hospitalized for fewer days than prior to receiving this service. Case management services are currently available and are provided to many children and adolescents in Florida with severe emotional disturbances. However, caseloads can range up to twenty recipients and the involvement of the case manager is much less intense than with ICM.

- ❑ In 2004, the Mental Health Program will research the use of ICM by other states to identify effective implementation of this practice and explore options to pilot ICM with children and youth who have had multiple emergency psychiatric hospital admissions.
- ❑ Partnering with AHCA to revise its Targeted Case Management Handbook and will explore options for developing ICM as a Medicaid and general revenue funded service for children and youth who have had multiple emergency psychiatric hospitalizations.

- ➢ Home and Community-Based Services- An array of home and community based mental health services, such as individual and family therapy, behavioral assessment and intervention services, parent support and training are currently available to children and adolescents with emotional disturbance. Research on the effectiveness of home and community based services indicate positive results in assisting children and adolescents to successfully remain in the community, thus decreasing institutional placements. The Mental Health Program Office is promoting this promising practice through the following activities:
  - ❑ Partnering with AHCA and other stakeholders to revise its Community Mental Health Services and Limitations Handbook to provide an array of community-based “wrap around” services that promote person-centered, family-focused services and the use of community supports in additional to traditional mental health services.
  - ❑ Once the revision of the handbook is finalized, the Program Office will redefine community mental health services funded by general revenue dollars to align them with those funded by Medicaid.
  - ❑ Over the next three years, the Program Office with continue to partner with AHCA to improve home and community-based mental health services to address the needs of children and adolescents with emotional disturbances, youth with severe emotional disturbance transitioning to adulthood and at-risk children age zero to five.

Project F: Increase Community Capacity to Safely Work with Individuals in the Forensic System.

Strategic Course(s) of Action:

1. Direct Districts to Identify and Examine Recidivists in Their Local Criminal Justice Systems.

   - The Mental Health Program Office has directed districts to identify individuals with mental illnesses who are repeatedly involved with the criminal justice system, examine why these individuals fail in the community, and use this information to effect future programmatic/service changes to better meet their needs and to prevent further recidivism.

2. Require District Monitoring of Forensic Individuals to Promote Community Placement and Discharge Planning.

   - The Mental Health Program Office has directed each district to closely monitor the progress of individuals in state mental health treatment facilities, to work cooperatively with treatment facility staff and community mental health provider agency personnel to address barriers to discharge and to develop, in a timely manner, appropriate re-integration plans that provide the necessary services and supports to allow each individual to live successfully in his/her community.

3. Continue to Support Implementation of the Forensic Reform Initiative

   - The Mental Health Program Office will continue to support the implementation of the forensic reform initiative, which involves a coordinated effort to systematically improve the efficiency and effectiveness of the delivery of services to individuals with mental illnesses who are involved in the criminal justice system. Efforts include maximizing utilization of our state mental health treatment facilities through improved efficiency and "best practice" approaches to treatment and service delivery; improved communication, cooperation and coordination of services among the treatment facility, community and judicial stakeholders; the establishment of forensic commitment targets for each district to encourage early identification of individuals at risk for forensic commitment and to increase the number of individuals diverted from commitment to a state forensic treatment facility to appropriate community-based treatment and service alternatives with regular monitoring and reporting of district performance; and general revenue funding to support diversion initiatives and provide the courts with alternatives to forensic commitment through services such as competency restoration programs and appropriate residential placement alternatives in the community. This initiative supports treatment in the least restrictive setting and promotes life in the community for individuals with mental illnesses.

Project G: Improve Access to Appropriate Medications and Promote Best Practice Medication Management.

Strategic Course(s) of Action:

1. Safeguard Psychotropic Medication Use with Children.

   - Because the efficacy of most psychotropic medications has not yet been studied in young children, the Program Office will ensure that providers and prescribing clinicians stay current with the latest information regarding the use of psychotropic medications with children by sending out Federal Drug Administration updates routinely. The department is contracting with the University of Florida, Department of Psychiatry, to provide a toll free psychotropic medication consultation line which will provide direct information and consultation to prescribing physicians, child welfare workers, foster parents and judges.

   - By June 2004, the Mental Health Program Office will update its guidebook, entitled *Medication for Children and Youth with Emotional, Behavioral and Mental Health Needs,* for parents, guardians and others. This guidebook can be found at the following web site:

     http://www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/psychotropicmeds.pdf

   - The Program Office will develop policy and procedures to collect data on all children in its foster care who are prescribed psychotropic medications. The database will include the ability to provide alerts for children who are transitioning between home or adoptions to ensure that proper follow-up is provided. The department is currently conducting a review of the number of children in out-of-home care settings who are prescribed psychotropic medications and the prescribing practices of the physicians working with these children. This review is being conducted in collaboration AHCA and FMHI. Future actions will be determined once the data has been reviewed and analyzed.

   - During 2004, the department will collaborate with the Florida Psychiatric Association and the Florida Medical Association to develop continuing education regarding pediatric medication for providers and mental health case managers.

   - During 2004-2007 the Mental Health Program Office will work with AHCA Medicaid Pharmacy staff to determine if there are trends in prescribing practices by location and/or physician. If utilization rates exceed established norms in specific districts, the data will be carefully evaluated to determine the types of additional support to be provided.

     - ❑ The Program Office will also work with AHCA to develop a prescriptive practice feedback system to physicians to enable direct peer and practice

comparisons. This will provide effective parameters and guidelines in prescription practices.

2. Monitor Medication Practices in State Mental Health Treatment Facilities.

- The Program Office will annually review and update the training and reference manual for the comprehensive management and monitoring of the use of psychotropic medications in mental health treatment facilities to reflect the changes in psychopharmacology practice.

- The Program Office will provide annual monitoring and peer review at each facility.

3. Implement a Statewide Community Mental Health Clinical Advisory Committee.

- The Mental Health Program Office will work with the Florida Council for Community Mental Health to develop a statewide Community Mental Health Clinical Advisory Committee to be implemented in 2004. This Committee will be made up of the medical directors of the community mental health providers, psychiatrists from the FACT teams and the Chief of Psychiatry of the Mental Health Program Office. It will provide a forum for discussion of best practices within the community. Ongoing educational programs focusing on best practice guidelines, treatment protocols, and medication information will be arranged for the committee.

4. Evaluate State Mental Health Treatment Facilities' Medication Utilization Data.

- Promoting open access to all psychotropic medications while trying to manage the increasing expenditures for these medications has been a concern for the staff of mental health treatment facilities. To address this issue, the Mental Health Program Office will work with the facility's Pharmacy and Therapeutics (P&T) Committees to evaluate psychopharmacology practices, which include, but are not limited to, poly-pharmacy (the use of more than one medication in a single therapeutic class) and prescribing more than the recommended therapeutic dose. The Committees are researching best practices that can assist in addressing this issue and will implement identified practices within their facilities and, if needed, outside consultants will assist. Additionally, two facilities are implementing medication algorithms (evidenced-based medication guidelines designed to promote treatment efficacy and assist in reducing poly-pharmacy) for the treatment of individuals with schizophrenia. Within the coming year, this practice will be expanded to include the study of individuals with major depression, bi-polar disorder, and schizo-affective disorder.

5. Phase-In Use of Florida Algorithm (FALGO).

- The Mental Health Program Office will implement an evidence-based medication

algorithm for treatment of individuals with schizophrenia and related disorders to 15 providers statewide during 2004. (An algorithm is a clinical pathway that operates like a decision tree for determining which medication is most effective for treating an individual with a particular mental illnesses.)

- The Program Office plans to expand the use of the FALGO statewide by 2006. In a public-private partnership, the Program Office has been working with Florida State University (FSU), FMHI, Florida Council for Community Mental Health, pharmaceutical companies and the creator of the Ohio Medication Algorithm in this effort.
- The website www.falgo.org will be continuously updated to include links to various evidence-based medication practice sites. The website has the capability of receiving and stratifying data from providers who can then have real-time medication utilization data and track prescribing trends of physicians.

6. Promulgate Rules for Indigent Drug Program (IDP).

- The Indigent Drug Program provides critical psychotropic medications for individuals with mental illnesses who do not have insurance or other means to purchase medications. The Program Office will write rules that establish the clinical and financial eligibility of people who may receive services under the Indigent Drug Program, the requirements that community-based mental health providers must meet to participate in the program, and the sanctions to be applied for failure to meet those requirements.

7. Partner with the Florida Sheriff's Association on Medication Purchasing.

- The Florida Sheriff's Association has been granted $20 million in spending authority to allow them to participate in the Mental Health Program Office's bulk psychotropic medication purchasing program currently in place to supply medication to the Indigent Drug Program. The Program Office will develop a plan to implement this arrangement in partnership with the Sheriff's Association and work with the Association to ensure that the program operates efficiently by reviewing the policy and procedure at least annually.

8. Standardize Functional Assessment Best Practices Statewide to Promote Psychiatric Rehabilitation.

- The Functional Assessment Rating Scale (FARS) will be introduced and implemented to community and mental health treatment facilities in 2004. When the FARS is successfully implemented measures currently being used, such as the Global Assessment of Functioning (GAF), the Positive and Negative Syndrome Scale (PANSS) and the Multnomah Community Ability Scales (MCAS), will gradually be phased out. Completion of the implementation will allow a meaningful comparison of outcomes of individuals served across a variety of treatment settings.

Department Goal #2: Provide Effective and Enhanced Prevention Services.

Prevention services driven by empirical studies which have identified key risk factors, effective interventions and effective modes of communication need to be developed and implemented. The goal is collaboration with providers in all areas of public health, shared funding, and shared resources.

Strategy #2: Prevent or Reduce the Disabling Aspects of Mental Illness. Reduce the Occurrence and Negative Mental Health Outcomes of Child Abuse, Domestic Violence and Other Traumatic Events.

The key mental health strategies directed toward achieving this goal include projects that provide timely and appropriate responses to crisis, early childhood intervention, linkages with primary health care and traditional primary prevention through public education and outreach. Linkages with other programs and capitalizing on resources available through federally funded initiatives such as Temporary Assistance to Needy Families (TANF) will be an important element in effecting this strategy.

Project A: Focus Services to Provide Quick and Effective Responses to Trauma and Crisis.

Strategic Course(s) of Action:

1. Improve Single Point of Access (SPOA) Assistance to Child Welfare Counselors in Assessing and Accessing Crisis Services.

   - The SPOA can assist in providing early identification of critical crisis services before the child is referred to foster care by providing mental health consultation during the early intervention period. One barrier to providing these early intervention crisis services is the lack of Medicaid eligibility for children in the care of a relative. The Mental Health Program Office will work in partnership with district child welfare/CBC staff to improve the availability of mental health consultation to CBC counselors and to identify and address barriers to Medicaid enrollment for all children in out-of-home care.

2. Improve the Crisis Response System of the Behavioral Health Network (BNet).

   - The Mental Health Program Office will ensure the effective responsiveness of persons who have experienced trauma or are in crisis in its BNet program by reevaluating the program requirements relative to trauma and crisis response resources and procedures, especially as expressed in the BNet model contract. Requirements will be made specific and outcomes will be defined. The Program Office will foster the identification and implementation of methodologies to evaluate and measure contractor responsiveness so that deficiencies can be identified and corrected.

3. Reduce Need for State Custody.

    - Some of Florida's families consider relinquishing custody of their children to the state in order to access necessary mental health services for those children. Because many families cannot afford or insurance does not cover mental health services, the pressure on families to give custody to the state increases. In support of families, the Mental Health Program will intensify its efforts to provide families needed mental health services and retain children in their homes. This will be accomplished by providing community-based behavioral health services to the child and his/her family at the intensity and duration needed to maintain the child in the home.

    - During 2004 the Program Office will explore Medicaid waivers for children in need of residential treatment to define them as a "family of one". This waiver will enable families who do not otherwise have access to needed treatment the opportunity to receive needed mental health services in their community, without relinquishing custody of their child to the state. These services will include providing wrap-around services to children in their homes to decrease the need for out-of-home care.

4. Change From Current Treatment Modalities to Best Practices.

    - Children's Mental Health:

        - The Mental Health Program Office will contract for the evaluation of the Specialized Therapeutic Foster Care program to determine program fidelity and make recommendations for program improvement.
        - As a result of the infant mental health pilot projects, programs to assist in the early identification of behavioral health service needs of the child and his/her caregivers will be expanded. The lessons learned from these pilot projects will assist in the continued development of the Comprehensive Behavioral Health Assessment so that it better meets the needs of children from birth through age 5 placed into shelter care by the department.
        - The Mental Health Program Office will partner with AHCA and state universities to redesign children's case management training programs. It will continue to work with local service providers across the state and with state universities to identify promising practices in providing effective and timely services for children and their families that are in crisis and victims of trauma. Part of this process will be to seek grants to establish evidence-based practices across the state. The Mental Health Program Office will also continue to work with family organizations such as the Florida Institute for Family Involvement (FIFI) to help develop Federation of Family chapters across the state. This will assist the department in developing a strong family-centered system of care which focuses on the prevention of child abuse, domestic violence and other traumatic events. Florida has three

federal SAMHSA grant projects. These grants are designed to help develop community-based children's mental health systems of care. The Mental Health Program Office will continue to identify projects developed by SAMHSA for replication and sustainability.

- State Mental Health Treatment Facilities

  - The state mental health treatment facilities will continue to implement new projects based on national best practices in mental health. All mental health treatment facilities have embraced the initiative to reduce and eliminate the use of seclusion and restraint. It is recognized that many of the persons residing in treatment facilities may have experienced trauma in their lives. In an effort to reduce the effects of trauma and abuse on state hospital residents, the facilities will work individually with them to develop a de-escalation plan. The plan will outline a process or technique to follow when an individual needs assistance to remain safe and calm.
  - The Living Environment Activities Preference (LEAP) website has been developed by one of the state mental health treatment facilities to provide facility service team members and residents access to information regarding residential placements and community services statewide. This intranet website provides information such as admission criteria, costs, services available and includes photographs of residential programs from assisted living facilities (ALFs), residential treatment facilities (Levels 1-5), and nursing homes in urban and rural areas throughout the state. The website will enable residents to explore placement options and make more informed placement choices with reduced travel. It will be available to service teams and residents in each of the state civil and forensic mental health treatment facilities.

- Forensic Services

  - The Mental Health Program Office will continue to promote efforts to develop community competency restoration programs throughout the state, as a strategy to address the growing number of individuals committed to forensic programs in state mental health treatment facilities. Many of the individuals adjudicated incompetent to proceed to trial do not require placement in a secure forensic setting. Community competency restoration programs provide services for these individuals in the community or while in the county jail awaiting disposition of their cases. While the initial numbers are small, these programs have helped to divert unnecessary admissions of adults to state mental health treatment facilities and further promote a national trend toward community based care.
  - Nationally recognized forensic consultants completed a review of Florida's forensic mental health system in 2002. As a result of their "best practice" recommendation, general revenue funding was used to contract for Forensic

Mental Health Specialists to serve in eighteen of the state's twenty judicial circuits. The Forensic Mental Health Specialist program will continue to be developed throughout 2004 to promote community living for individuals with mental illnesses involved in the forensic system.

Project B: Improve Access to Behavioral Health Care Services in Primary Health Care Settings.

Strategic Course(s) of Action:

1. Review Care in Medicaid Funded Health Maintenance Organizations (HMOs) and in the Florida Healthy Kids Program.

   - The Mental Health Program Office will work with AHCA to contract with an external quality review organization, for continuity of data and process, to review both Medicaid HMO services and Florida Healthy Kids Program, and will recommend that a focused review of care related to behavioral health diagnoses be included. The Program Office will participate in developing the behavioral health review criteria and process for use by the review organization. The review will include elements such as prevalence of care (volume of care relative to volume of need), timeliness and appropriateness of care, medications, and appropriateness of referrals made to behavioral health professionals when indicated.

2. Develop Interagency Cooperative Agreements with Federally Qualified Health Care Centers and Public Health Departments.

   - The Mental Health Program Office is working in cooperation with the Department of Health, Florida Council for Community Mental Health and Florida Association of Community Health to develop an interagency agreement template that could be used by the federally qualified health care centers and community mental health centers to develop cooperative arrangements to provide non-duplicative behavioral services. This is especially important in rural areas where behavioral services are not otherwise available. Telemedicine practice will be explored as a possible method to deliver psychiatric evaluation and consultation for individuals being served by primary care physicians.

Project C: Implement the Campaigns to Reduce Discrimination, Stigma and Suicide.

Strategic Course(s) of Action:

1. Implement the Federal Grant to Eliminate Barriers in Treatment.

   - Florida is one of eight states to pilot the "Eliminating Barriers Initiative (EBI)", a national campaign to fight stigma and discrimination. With a technical assistance

grant funded by SAMHSA, the Mental Health Program Office will develop a strategic marketing plan that will address stigma and discrimination through launching a multi-media campaign. The goals of this effort are to build public support for the principle of recovery, raise awareness and reduce discrimination.

2. Partner with the Governor and the Office of Drug Control Policy through the Florida Task Force on Suicide Prevention to Reduce the Number of Persons Who Commit Suicide.

   - The Mental Health Program Office has aligned its prevention plan with the Governor's Task Force to address the over-arching strategy of increasing the awareness of suicide risk factors, protective factors and appropriate interventions during crises. The Program Office will convene a department-wide suicide prevention workgroup that includes staff from Adult Community Mental Health, Children's Mental Health, Family Safety, Education and Training, Substance Abuse and other departmental offices to further delineate the following tasks:

     - Develop training which can be duplicated throughout the state using materials, methods and venues that minimize costs.
     - Continue to support and improve the expertise of the department's district offices and stakeholders as they evaluate satisfaction outcomes locally.
     - Coordinate state-funded crisis services including adult and children's crisis stabilization units (CCSUs), FACT services and mobile crisis response services with existing community suicide prevention programs.
     - Review the literature on suicide prevention guidelines and evidence-based practices developed by organizations such as SAMHSA, the Centers for Disease Control and the World Health Organization.
     - Utilize venues to raise awareness of stigma and barriers for individuals receiving mental health treatment and increase the likelihood of individuals seeking mental health treatment.

Department Goal #3: Realign and Refocus the Workforce.

It is critical to provide optimal care for the people served by the department. To accomplish this, efforts must be made to provide the best training, support and supervision strategies to the workforce at all levels of the organization.

Strategy #3: Increase Quality of Service and Supports.

The key mental health strategy directed toward this goal of increasing the quality of services and supports provided to Floridians with mental illnesses is to develop sufficient capacity for competent administrative and clinical support to the delivery of quality services. A workforce capable of sustaining a service delivery system responsive to the needs of persons with mental illnesses will need to master new skills. To achieve the competency necessary for evidence-based practices, training provider

staff will be of the highest priority. Training content will include the Baker Act, Assertive Community Treatment, evidence-based clinical practices and cultural competency.

The realignment of organizational structures is also a key component of achieving a transformation in the delivery of services. Direct line authority from a central structure provides for continuity of policy and consistently applied practice and facilitates knowledge transfer across organizational and geographic boundaries. The organization of districts into zones and the ongoing development of the central office and district relationship will continue to be primary activities in support of this goal.

Project A: Refocus District/Central Functions to Support System Redesign.

Strategic Course(s) of Action:

1. By January 2005 the department will Realign the Mental Health Program Office to Support the Functions of Substance Abuse and Mental Health Local Offices and State Mental Health Treatment Facilities.

2. Direct Line Authority

   - The Substance Abuse and Mental Health Program Offices have established direct line authority over district operations. Memoranda of Agreement have been signed with each district/region outlining the responsibilities of staff and the reporting structure between central office and the field.

3. Improve Oversight of District Operations.

   - The Substance Abuse and Mental Health Program Offices analyzed the alignment of staff to ensure coverage for critical tasks/responsibilities to correspond with the new operational and programmatic functions for each district/region.

4. Budget Functions.

   - The Substance Abuse and Mental Health Program Offices are developing procedures to ensure accurate, timely and appropriate expenditure of funds through the enhancement of spending plans. Each district/region will be expected to manage their budgets in accordance with the spending plans.

5. Contract Functions.

   - The Substance Abuse and Mental Health Program Offices are developing guidelines for district/region contract managers to ensure appropriate oversight of provider performance, improve contract manager competencies, and to ensure the consistent application of contract policies and procedures.

Project B: Other Personal Services (OPS) Conversion

Strategic Course(s) of Action:

1. Ensure Continuity and Stability of the Workforce

   - Legislative approval is needed to add 66 Full Time Equivalent (FTE) positions to replace Other Personal Services (OPS) positions. These positions provide essential functions that enhance the safety of communities by providing the necessary administrative and programmatic support to ensure quality service provision for people with mental illnesses served by the department.

   - District/region offices provide support and coordination for the courts, sheriffs' offices, schools, child welfare, and families. Additionally, the conversion of these positions will allow for fair compensation at a level necessary to provide increased monitoring and accountability of contracted programs.

Project C: Increase Capacity of Provider Workforce.

Strategic Course(s) of Action:

1. Provide Training for Florida Assertive Community Treatment (FACT) Teams.

   - As a critical step toward development of in-state training capacity, during 2004, up to six FACT teams will be identified as potential training sites as part of a certification process. The certification process will identify FACT teams that can assist in training teams that are having difficulty replicating the PACT model. These teams will ensure that the FACT Teams are providing services and supports to increase FACT recipients' potential for independent community living, employment and a reduction in state hospitalization.

   - FACT Teams will receive side-by-side training by out-of-state PACT and National Alliance for Mental Illness (NAMI)-certified expert trainers. Mental Health Program Office FACT staff and selected team leaders from teams identified as potential training sites will participate in this training. This will result in a reduced reliance on PACT expert trainers. In-state technical assistance can be provided using local resources, at a much lower cost.

   - The Mental Health Program Office will continue its collaboration with NAMI Florida to make available to service recipients and families a series of resources and services such as:
     - ❑ Family & Consumer Information Help Line & NAMI Web Site;
     - ❑ Family-to-Family Education;
     - ❑ Peer-to-Peer learning program;
     - ❑ NAMI Consumers Advocating Recovery through Empowerment (C.A.R.E.); and

- ❑ In Our Own Voice.

2. Develop Clinical Training.

   - ➢ The Mental Health Program Office will ensure that providers receive training in the most effective practices available. The Program Office, in partnership with universities, will provide training in evidence-based practices using the most economical venues possible. However, studies have shown that training alone is not sufficient to ensure change in practice. Because knowledge of the field of mental health treatment is evolutionary, providers also need to be engaged in the process of implementing and improving service delivery by engaging in both quality assurance (QA) and quality improvement (QI) activities, especially as best practices evolve. These processes will be included in the training materials developed by the Mental Health Program Office.

3. Revise Case Management Training.

   - ➢ The Mental Health Program Office is developing targeted case management training that is both strength-based and uses evidence-based approaches to promote recovery. Consideration will be given to instituting a certification process requiring continuing education to ensure that direct service and support providers remain current with promising practices and research-based strategies for promoting recovery for persons with serious mental illnesses.

4. Evaluate and Address Turnover and Staffing Issues in Institutions and Community Mental Health Centers.

   - ➢ The mental health treatment facilities and community mental health centers have targeted staff retention as a strategic objective. Approaches taken during the next three years will include: managing unscheduled leave and improving staff schedules; strengthening employee wellness programs; improving the use of reinforcement for positive behavior; providing educational leave; and improving the selection of staff by studying the characteristics of high performing staff.

5. Establish Staff Competency Levels for Community Mental Health Centers.

   - ➢ Section 394.478(2), F.S., provides the department with rulemaking authority to establish standards of education and experience for professional and technical personnel employed in substance abuse and mental health programs. Furthermore, ss.394.4572, 394.4781(4)(c) and 394.457(6)(a), F.S., require that the department establish standards for employment screening of substance abuse and mental health staff, personnel standards for children's residential programs, as well as education and experience standards related to the operation and administration of Florida's Baker Act. In addition to the statutory requirements, the Mental Health Program seeks to establish competency-based training for community mental health center employees that is evidence-based,

recovery-oriented and culturally competent. The intent of increasing these staffing standards is to increase the quality of care provided for the individuals served by the department.

- The Mental Health Program Office will continue drafting a comprehensive mental health rule chapter for all of its programs and services. This rule will include establishing staff competencies for community mental health providers. As part of the rule promulgation process, the Mental Health Program Office will review the standards set forth by the International Association of Psychosocial Rehabilitation Services as a basis for establishing standards in rule.

6. Evaluate Cultural Competency at the Provider Level and Institute Change.

- The Mental Health Program Office conducted a needs assessment that was intended to identify, in part, the extent, nature and methods of cultural competency training currently being provided. The results of the needs assessment will be used to develop a training program. The Program Office will serve as an information clearinghouse for best practice information in order to improve the capacity of the providers to offer culturally competent care.

- Throughout 2004-2007 the Mental Health Program Office will work with the Child Welfare and CBC Program Office to identify and promote culturally appropriate interventions for Native American populations, as well as Hispanic and Creole individuals and their families. This will ensure that "like services", as required by Title IV, are provided. This will be done through development of strength-based competencies which recognize the importance of honoring the unique cultural understanding and sensitivity of the child and his/her family when developing and providing mental health services.

Department Goal #4: Strengthen Accountability.

Please see Chapter 8 for a detailed description of the four key projects designed to meet this goal.

Department Goal #5: Improve Shared Stewardship.

Shared stewardship implies a system in which different agencies and agents work together to most effectively provide coordinated care, exchange relevant information and minimize costs for the people they serve. It demands a coordinated effort by all areas of the health service delivery system and is a true public health view.

Strategy #5: Maximize Revenues and Create a Network of Community Providers to Render Service.

Key mental health strategies directed toward this goal include maximization of revenues through coordinated initiatives with the AHCA Medicaid office and creation of a network

of community providers to render services. Maximization of resources has become an essential element in restructuring the delivery of services for persons with mental illnesses. Service costs previously funded entirely by general revenue funds are now eligible expenditures for federal financial participation by Medicaid. This leveraging of federal funds allows for enhanced capacity and supports the development of a comprehensive service array. Alternative financing strategies necessitate the design of more efficient networks of service providers that will improve the coordination, integration and management of service delivery for persons with mental illnesses. More effective system design will allow for the redirection of resources to support recovery-focused strategies.

The mental health service delivery system in Florida has been developed through a successful long-term partnership with persons with mental illnesses and their families, contracted provider agencies, local governments and community leaders. The Mental Health Program Office will continue to build on this partnership through community-based needs assessment and planning, monitoring utilization of community resources, and working with communities to ensure access to critical services.

Project A: Maximize Revenue and Service Provision through Collaborative Work with the Agency for Health Care Administration (AHCA)

Strategic Course(s) of Action:

1. Jointly Develop Policy and Administrative Rule and Incorporate Changes by the Beginning of Fiscal Year 2004-2005.

    - The Mental Health Program Office and AHCA have jointly reviewed current departmental and agency policies and administrative rules affecting the operation of community mental health, substance abuse and targeted case management programs to identify policy modifications necessary for consistency in service definitions, standards, and accountability mechanisms. These changes will be made through rule promulgation during the first six months of 2004. Training will be provided to district offices and provider agencies following rule adoption.

    - The Mental Health Program Office and AHCA will collaboratively establish policies (Medicaid Handbook and departmental policy) that, within available resources, are designed to provide the maximum benefit available to the public, are aligned within the parameters allowed by federal and state regulations, incorporates key partners and stakeholder input, and promote recovery and family based care.

2. Develop Coordinated Budgets Annually.

    - To the extent possible, the department and AHCA will collaborate in the development of their respective annual legislative budget requests for community mental health, substance abuse and targeted case management programs.

- The department and AHCA will develop a plan to establish new procedure codes for emergency and residential services using certified local and state matching funds (described in Chapter 8).

3. Collaborate in the Development of Procurement Documents.

   - The department and AHCA will incorporate requirements for the use of best practices, increase access and consumer choice, and support of community-based care requirements for children and families in the child protection system to be included in procurement documents.

4. Establish Monitoring and Quality Assurance Standards and Protocols.

   - The department and AHCA's contracted provider developed a network of qualified evaluators (QEN) that provide suitability assessments to determine if a child in the care and custody of the department requires residential treatment to help resolve behavioral health issues and to determine if such treatment would benefit the child. Every 90 days, during a child or youth's treatment at a residential treatment facility, the contracted qualified evaluators conduct an on-site face-to-face independent review of the child or youth's continued need for this level of care. This initiative will continue and will be evaluated for effectiveness during the next three years.

   - Additional initiatives are described in Chapter 8.

Project B: Expand Network Development

Strategic Course(s) of Action:

1. Continue Development of District 1 Network Pilot (described in Chapter 1).

   - Evaluations by FMHI will be conducted annually to determine progress the level of progress being made toward creating a system of care that is integrated and seamless, accountable, and more person-centered.

   - Collaborate with the managing entity to develop a plan by early 2004 for transferring monitoring of sub-contractors involved in the pilot to the managing entity. A key element of this plan will involve training managing entity staff on the new monitoring tools.

   - Use the community-based care service delivery workgroup to ensure that families' service needs are met, barriers to service are identified, and access to services is improved.

   - The managing entity also holds the community-based care contract with child welfare. Efforts to better integrate SAMH and child welfare services will continue.

- The District 1 SAMH managing entity will submit a plan specifying how the provider network will be expanded to provide for individual choice of providers within a single managed care plan.

- The managing entity will identify opportunities for maximizing Medicaid funding in providing mental health and substance abuse services (the district's managing entity is also the managing entity for the Medicaid Prepaid Behavioral Health Care Plan).

2. Establish an Administrative Service Organization (ASO) in District 8 (described in Chapter 1).

   - The ASO was awarded through competitive procurement in December 2003 to Central Florida Behavioral Health Network and will implement a plan to be fully operational and incorporate the conditions of the contract with the district SAMH office by April 2004.

   - Evaluations by FMHI will be conducted annually to determine the level of progress being made toward creating a system of care that is integrated and seamless, accountable, and more person-centered.

   - Continue service development in the direction of person-centered services.

   - Continue service upgrades aided by clinical path technology.

   - Coordinate district-wide cross-provider planning.

   - Continue integrating care across service systems.

3. Educate the District Offices and Providers About the Principles of Network Development.

   - Collaborate with consultants and the Florida Council for Community Mental Health to develop a plan to provide educational information to the districts about network development and share best practices in purchasing strategies, clinical pathways, network governance, and report streamlining.

Project C: Expand Self-Directed Care (FloridaSDC)

Strategic Course(s) of Action:

1. Support and Expand the Principles of Self-Directed Care (FloridaSDC).

   - The FloridaSDC program is a self-directed care model for adults with serious mental illnesses that promotes recovery and self-determination of personal goals. The department will secure an independent evaluation of the FloridaSDC

Program to evaluate the efficacy of this approach by collecting data and information and producing reports that will assist the department and AHCA in determining the relative effectiveness and costs of the program as compared with treatment as usual. These reports will also be used as a basis for building on program strengths to ensure effective implementation in other settings.

- Over the next two years the Mental Health Program Office will work in collaboration with AHCA to apply for a 1115 waiver for FloridaSDC expansion. Approval of this waiver would provide a stable funding source with federal participation, as well as greater flexibility in the delivery of services.

Project D: **Community-Based Needs Assessment and Planning**

Strategic Course(s) of Action:

1. Provide Technical Assistance to the State Mental Health Planning Council (SMHPC).

   - The SMHPC is mandated under federal law to conduct three major functions. These include: 1) monitor the adequacy of the publicly-funded mental health service system; 2) advocacy; and 3) review of the mental health block grant application. Both the Adult Community Mental Health and Children's Mental Health staff will continue to provide technical assistance to the SMHPC. The staff assistant for the Adult Community Mental Health Unit will continue to provide support staff assistance to the Council, both at its quarterly meetings and throughout the year. Through this continuing technical assistance the SMHPC will improve its role in community-based needs assessment and planning.

2. Increase Oversight of Individuals Residing in Limited Mental Health Assisted Living Facilities (LMH-ALF) through the District Mental Health Plans.

   - The Mental Health Program Office directed the districts to expand stakeholder review in the development of their limited mental health assisted living facility (LMH/ALF) portions of the district mental health plans. As part of the planning process, districts hold public meetings to solicit comments from individuals, families, ALF operators, service providers and other key informants regarding the mental health service needs of persons residing in ALFs.

   - Increase oversight of persons in ALFs:

     - ❑ Review of district plans with stakeholders, ALF administrators, providers and district staff will be conducted in each zone.
     - ❑ Regular information/issue updates will be held by phone or in person with representatives of the Florida Assisted Living Affiliation.
     - ❑ Site visits to one district per quarter to meet with district staff, stakeholders, service providers and visits to limited mental health facilities will occur.

3. Complete and Implement a Service Needs Assessment Tool.

- The Mental Health Program Office developed two assessment documents that include quantitative and qualitative needs assessment tools. The quantitative needs assessment compares current funding appropriations within a district to a proposed "ideal" model of service delivery. As part of the development of the needs assessment a consensus group was used to make determinations about the types and levels of intensity of services that should be available for persons at various levels of functioning. The qualitative needs assessment provides a structured interview format to assess districts' infrastructure capacity to manage a successful mental health service delivery system.
- The Mental Health Program Office, in collaboration with the district/region program supervisors, will review the results of the quantitative needs assessment, identify major gaps, prioritize services needs and consider modifications to the service delivery system in each district.
- The Mental Health Program Office staff will disseminate the qualitative needs assessment to district SAMH staff for their self-evaluation. The results of the qualitative needs assessment will be used to improve the districts' infrastructure capacity to manage their SAMH systems.

Project E: Be Responsive to Legal and Contractual Mandates

Strategic Course(s) of Action:

1. Monitor Baker Act Access and Lengths of Stay for Individuals.

- The Mental Health Program Office will continue to monitor individuals' access to CSUs through the development and use of an online system which tracks individuals who are waiting for services. The Mental Health Program Office will also monitor lengths of stay in CSUs using the data collected in the Alcohol, Drug Abuse and Mental Health Data Warehouse. The waiting list and lengths of stay data will be used to analyze acute care access and as a guide for improving the acute care system.

2. Increase Capacity in the Juvenile Incompetent to Proceed (JITP) Program.

- The Mental Health Program Office provides legislatively required competency restoration services through the JITP program for juveniles found incompetent to proceed due to mental illness, mental retardation or a combination of both. These juveniles are ordered by the courts as incompetent to proceed on felony charges and are in need of treatment and training consistent with public safety. During 2003 the JITP program implemented practices to ensure that juveniles were admitted and discharged in a timely fashion. One example is to ensure that the provider and district are in frequent communication with one another on such issues as discharge planning. The Program Office will also conduct quality

assurance activities aimed at increasing the efficiency of the program.

3. Structure Confinement and Treatment Services in the Sexually Violent Predator Program to Maintain Constitutional and Statutory Compliance.

   - Chapter 394, Part V, Florida Statutes, charges the department with providing long-term control, care, and treatment of persons civilly committed as sexually violent predators in a manner that conforms to constitutional requirements. The law regarding constitutional requirements for civilly committed sexually violent predators continues to evolve as court decisions are handed down in this relatively new area. The Sexually Violent Predator Program will follow and respond to legal developments and will monitor the operation of the sexually violent predator secure confinement and treatment facility to help ensure that constitutional standards of care are met.

Chapter 4: Substance Abuse Program Services Overview

Program History

Prior to 1970, the Florida Alcoholic Rehabilitation Program oversaw alcohol services. This program was established as a separate agency under the Board of Commissioners of State Institutions. The program was considered a demonstration effort, consisting of an inpatient treatment center located in Avon Park and five outpatient clinics located in Jacksonville, Miami, Orlando, Pensacola and Tampa. The inpatient facility was a 58-bed psychiatric hospital specializing in the treatment of alcoholics. Primary services included detoxification, group, individual and family therapy.

In 1970, Public Law 91-616 was enacted at the federal level creating the National Institute on Alcoholism and Alcohol Abuse (NIAAA). The following year, Public Law 92-255 was enacted creating the National Institute on Drug Abuse (NIDA). These laws created formula grants for the states, created single state agencies (alcohol) and single state authorities (drug abuse), and required states to develop separate annual plans for alcohol and drug abuse services. In the early 1970s, the Florida Legislature responded to these initiatives by enacting separate state statutes for alcohol (Chapter 396) and drug abuse (Chapter 397).

During this time period, the Office of Drug Abuse was created at the state level. This office, along with the Alcoholic Rehabilitation Program, was administered under the Florida Department of Health and Rehabilitative Services (HRS). In 1974, the Division of Mental Health was created under HRS. The Alcoholic Rehabilitation Program and the Office of Drug Abuse were reorganized and became bureaus under the Division. In 1975, HRS went through a major reorganization creating eleven district offices in the state. At the state level, the Division of Mental Health was renamed the Alcohol, Drug Abuse and Mental Health (ADM) Program Office. District ADM Program Offices were created in each of the eleven districts to implement planning, contracting and licensing efforts.

Beginning in 1981, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) block grants replaced certain Federal funding sources. In the years that followed the institution of the block grant, a number of changes were made in state funding, contracting and planning efforts including various reorganizations of the state ADM Program Office and district ADM Program Offices. The most significant changes were the consolidation of alcohol and drug abuse at the state and district levels, the consolidation of administrative rules for alcohol and drug abuse and the consolidation of statutes for alcohol and drug abuse.

The Legislature created a revised Chapter 397 in 1993, effectively repealing Chapter 396 and the existing Chapter 397. The new statute provided greater clarification of legislative intent, duties of the department, departmental regulatory authority and requirements for provider quality assurance. The statute also provided for the creation

of a statewide substance abuse coordinator and creation of specialists at the district level. During the years following the creation of Chapter 397, the statutes went through several amendments. Perhaps the most significant was in 1998 when the Legislature created new provisions for children's substance abuse services, including the development of demonstration model service networks for children.

In January 1997, HRS was reorganized to become the Department of Children & Families. A part of that reorganization included separating the offices of substance abuse and mental health at the state level. However, the office still achieves significant collaboration with the mental health program through shared functions and initiatives. At the community level, the department has maintained a combined alcohol, drug abuse, and mental health program effort within the department's sub-state structure.

The current statutes, Chapters 394 and 397, F.S., provide the authority for instituting a community-based, integrated system of substance abuse services based upon planning. In terms of legislative intent, sections 394.66(1) and 397.305(2) and (3), F.S., provide for integration and continuity of services. The authority for planning is provided for under sections 394.75 and 397.321(1), F.S. Authority for funding substance abuse services through a contractual system is found under section 394.74. Authority for licensure and regulation of substance abuse programs is found under section 397.401, F.S. In addition to the statutory authority cited above, Chapter 65D-30, Florida Administrative Code, adopted in May 2000, provides extensive requirements for the licensure of substance abuse programs. The rules provide standards that apply to substance abuse programs generally and standards for specific service components (e.g., residential, outpatient, etc.). The rules apply to providers operating under a state contract and to those that operate solely on a fee-for-service basis.

Program Mission

The mission of the Substance Abuse Program is to support the prevention and remediation of substance abuse through the provision of a comprehensive system of prevention, emergency/detoxification and treatment services to promote safety, well-being and self-sufficiency among individuals and families at risk for or affected by substance abuse.

The department is responsible, pursuant to Chapter 397, F.S., for the provision of a comprehensive continuum of substance abuse prevention and treatment services accessible to all persons in need. The Substance Abuse Program Office works in partnership with providers throughout the state to provide prevention and treatment services within the local communities. These communities, through partnership with the department, are able to better serve their residents and reduce costs of substance abuse-related problems (health care, crime, unemployment, etc.).

Substance Misuse, Abuse and Dependence

Alcohol and other drugs are mood altering substances that are physically and psychologically addictive — use of these substances over time can lead to dependence. Individuals who become "addicted" or dependent on the use of these substances typically progress through a series of stages. SAMHSA defines substance misuse, abuse and dependence as follows:

- ***Substance Misuse*** - use of alcohol and/or other drugs is done on an occasional basis to satisfy curiosity, to socialize, reduce social inhibitions or to produce sensations of pleasure. The individual user may experience temporary problems such as hangovers but there is generally little noticeable difference in behavior.
- ***Substance Abuse*** - use of alcohol, illicit drugs and prescription medications is done to seek pleasure, alter mood or overcome uncomfortable feelings. The user's interests shift from occasional use to desires for frequently obtaining and using alcohol or other drugs. Attempts to control use during this stage are often unsuccessful as the person begins to experience multiple behavioral, physical and social problems associated with use (mood swings, poor school/work performance, increased conflicts, etc.). At the abuse stage, individuals begin to experience substance-related legal problems (e.g., arrests for driving under the influence) and may use substances in situations that are physically hazardous such as operating a vehicle or machinery.
- ***Substance Dependence*** – individuals demonstrate a maladaptive pattern of substance use with significant impairment and the existence of at least three or more of the following:

  - Tolerance – the need for greater amounts of the substance to become intoxicated or achieve the user's desired effect.
  - Withdrawal – physical or psychological symptoms in the absence of substance use such as sweating, tremors, rapid pulse, nausea or vomiting, or anxiety.
  - Graduated increases in the amount used and for extended periods.
  - Unsuccessful efforts to reduce or eliminate substance use.
  - Spending considerable time obtaining, using or recovering from use of substances.
  - Reduced participation in social, recreational or work-related activities.
  - Continued use of substances despite awareness of consequences.

As an individual progresses along this continuum of misuse, abuse and dependence there is an increased need for substance abuse intervention and treatment to help abate the problem. The desirable resolution to addiction is to intervene early on in the process when individuals have not experienced a multitude of problems and the intensity and cost of substance abuse services is lower. Prevention and intervention programs serve to educate substance users and begin to provide skills for identifying and coping with problematic substance use. Treatment interventions, which are more intensive and costly, serve to reduce drug abuse and rehabilitate those who are affected.

The goal of intervention and treatment is to ultimately help individuals achieve "recovery," a process of beginning and then sustaining abstinence from alcohol or other drug use.[15] The focus of these substance abuse services is on relapse prevention and assisting addicted persons in developing individual skills and social support networks to help prevent a return to use.

Conditions and Trends

Conditions

Substance abuse inflicts enormous damage upon our state, affecting the rich and poor, educated and uneducated, white-collar and blue-collar workers, as well as students, homemakers, and retirees. The devastation resulting from substance abuse is well known: physical, mental and emotional traumas for individuals, their families, neighbors and friends, and enormous preventable fiscal costs to society. Substance abuse significantly affects the health of Floridians. Birth defects, Fetal Alcohol Syndrome, learning disabilities and low birth weight are among the consequences related to the use of substances during pregnancy. A large number of HIV infections and pediatric AIDS cases are related to high-risk behaviors of persons abusing substances.

However, treatment works. Investment in substance abuse treatment significantly reduces hospitalizations, emergency room visits, crime and other social costs. The cost-benefit ratio for treatment is 7:1. One dollar invested in treatment for alcohol and other drug problems saves taxpayers $7.14 in future costs.[16] A 1998 national survey found that addicted persons who undergo treatment are much less likely to consume drugs or commit crimes to support their use, even after five years. Completion of treatment rates in Florida have increased from 49 percent for adults in FY 1995-1996 to 71 percent in FY 2002-2003, and from 50 percent to 76 percent for children. A 2003 survey conducted by the University of Florida found that 68.4 percent of adults and 55.6 percent of children discharged from treatment were abstinent from drug use 12 months following completion of care.

Expanding the treatment capacity is central to reducing the demand for drugs. In FY 2003-2004 detoxification and treatment capacities were expanded to serve an additional 2,467 adults and children in need of substance abuse services. For FY 2004-2005 the Substance Abuse Program has requested expansion of detoxification and treatment services to serve an additional 1,677 adults and children.

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[15] U.S. Department of Health, Treatment for Alcohol and Other Drug Abuse; Opportunities for Coordination, Technical Assistance Publication Series 11, DHHS Publication No. (SMA) 94-2075), Human Services, Public Health Services, Substance Abuse and Mental Health Services Administration, and Center for Substance Abuse Treatment (1994), p. 5.

[16] National Opinion Research Center, Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA), Executive Summary, (1994) (On-line, available: www.adp.ca.gov/pdf/caldata.pdfwww.adp.ca.gov/pdf/caldata.pdf.).

Trends

Substance abuse continues to be a contributing factor in many social problems including child abuse and neglect, crime and health care. Substance abuse causes or exacerbates seven out of ten cases of child abuse or neglect. One in four persons admitted to Florida's prisons are for drug offenses. More than half of the individuals served by the Substance Abuse Program are involved with the criminal justice system, requiring the department to regularly interface and coordinate with judicial and correctional entities. The Substance Abuse Program has developed several initiatives in recent years to deal with these problems, including service integration with child protection, development of added methadone treatment capacity, enhanced services for co-occurring disorders, and increased emphasis within prevention programs on the dangers of using ecstasy, heroin and oxycodone.

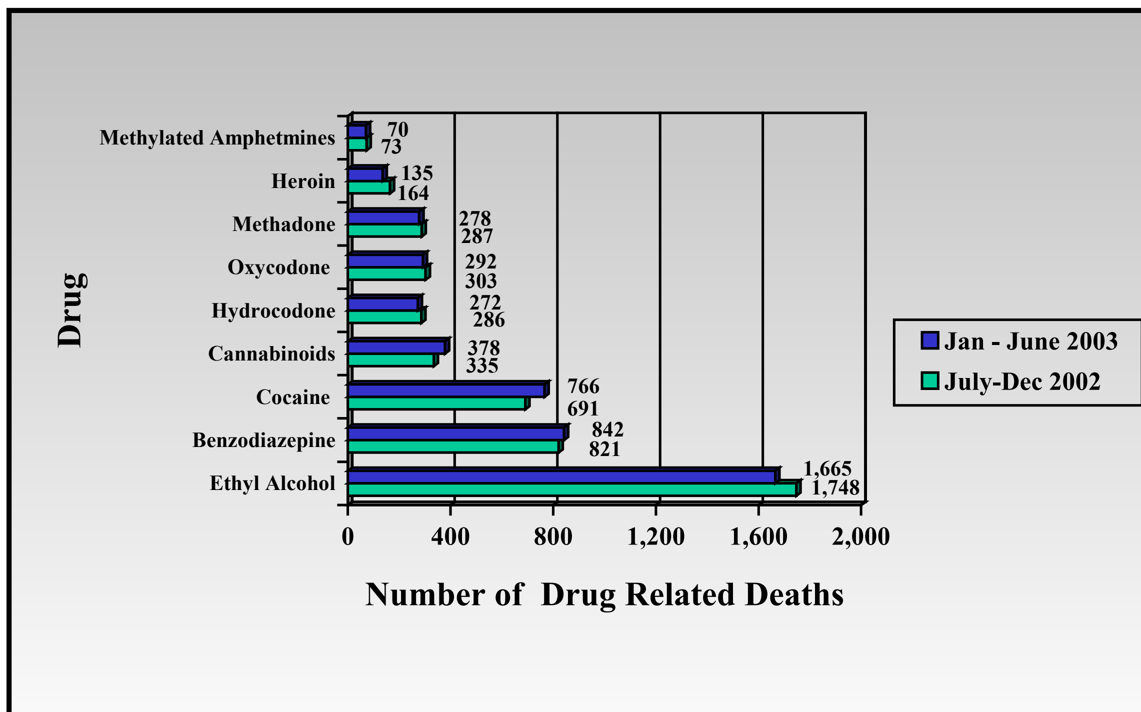
Significant Trends in Use

A major concern in Florida law enforcement is the use of prescription drugs. Pharmaceutical drug diversion is a growing problem in both Florida and nationwide. The drug-related deaths in Florida associated with prescription drugs outnumber those deaths associated with illicit drugs. According to an article dated November 30, 2003, by correspondent Rene Stutzman of the Orlando Sentinel, "At least 11 people -- including two young brothers from Winter Springs -- overdosed and died from drugs prescribed by one of the most prominent psychiatrists in Central Florida, according to an Orlando Sentinel examination of more than three years of medical records." The Sentinel also published a series of articles highlighting the significant number of individuals whose deaths were associated with hydrocodone and OxyContin, and the prescription drug abuse fraud and criminal activity that is driving this abuse. The Florida Medical Examiners *2003 Interim Report of Drugs: Identified in Deceased Persons* states that "prescription drugs continued to be found more often than illicit drugs in both lethal (60 percent) and non-lethal (66 percent) levels during the first part of this year." National drug abuse surveys estimate that more than four million individuals across the United States use pharmaceutical drugs for non-medical purposes, while a combined estimate of 2.2 million people abuse cocaine and heroin (2002 National Survey on Drug Use and Health). To combat the growing magnitude of the problem, the Florida Department of Law Enforcement supported a series of one-day trainings on pharmaceutical drug diversion for law enforcement officers across the State of Florida. The purpose of the training programs is to educate local, state and federal law enforcement personnel and investigators about the abuse and diversion of pharmaceutical drugs.

Drug-Related Deaths

The increase in the number of individuals with drug-related deaths continues to be problematic. The number of individuals with drug-related deaths was virtually unchanged from the last six months of 2002 compared to the first six months of 2003. From July to December 2002 there were 4,727 persons with drug-related deaths in Florida, compared to 4,711 individuals with drug related deaths from January to June 2003, less than a one percent change. ***Figure 11*** graphically depicts the comparison (*GHB, Ketamine, N2O, PCP, and Rohypnol are not included in the graph because of their small sample sizes*) between 2002 and 2003.

Figure 11: Comparison of Drug-Related Deaths
July – December 2002 to January – June 2003

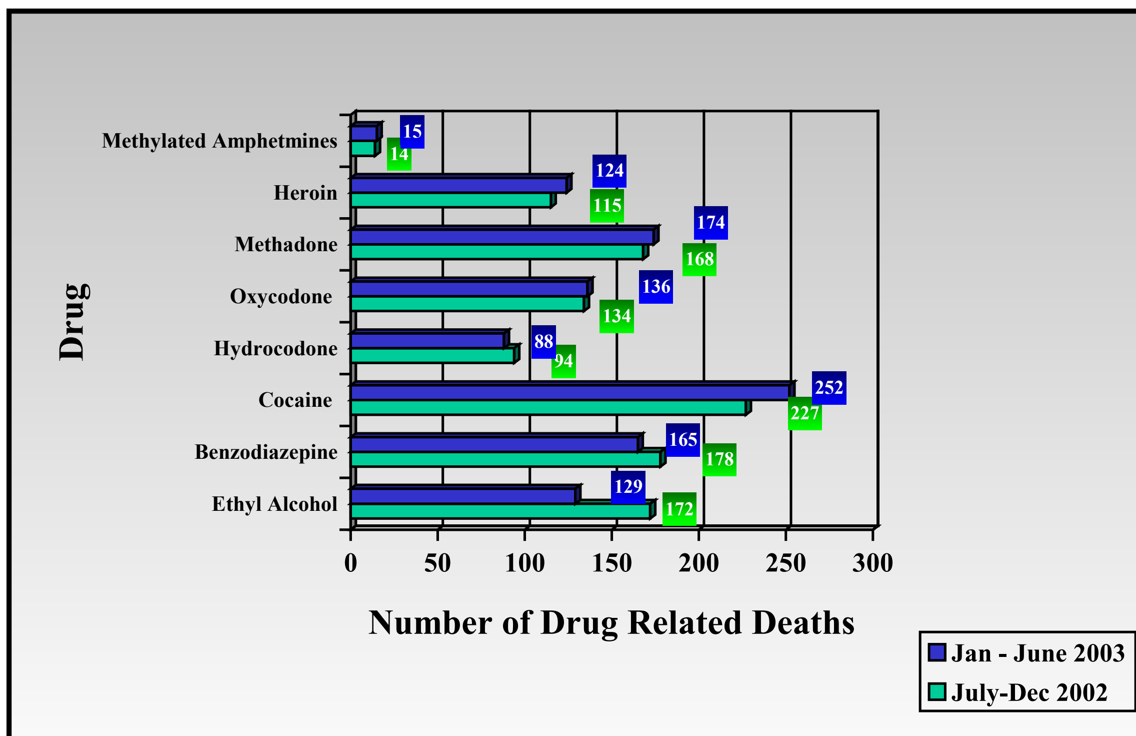


For the first six months of 2003, the Florida Medical Examiner reports that the three most frequently occurring drugs found in decedents were ethyl alcohol (1,665), all benzodiazepines (842), and cocaine (776). Comparison of occurrences in the first six months of 2003 to those in the last six months of 2002 reveals that heroin occurrences marked the most drastic change, declining by 18 percent, while cannabinoids rose at a rate 13 percent. Occurrences of oxycodone and hydrocodone showed a decrease of four percent and five percent, respectively. Similarly, methadone and methylated amphetamines (Ecstasy) occurrences decreased slightly by 3 percent and 4 percent, respectively. However, cocaine and benzodiazepines rose by 11 percent and three percent, respectively. Alprazolam (352 occurrences), commonly referred to as Xanax,

and Diazepam (308 occurrences), also known as Valium, dominate the category of benzodiazepines, making up 56 percent of all the benzodiazepines reported. Other benzodiazepines such as Temazepam (140 occurrences), Oxazepam (103 occurrences), and Nordiazepam (64 occurrences) constituted a combined 26 percent of all benzodiazepines reported.

Data from the Florida Medical Examiner's *2003 Interim Report of Drugs* reveals that the drugs that caused the most deaths in order of magnitude were cocaine (252), methadone (174), all benzodiazepines (165), oxycodone (136), ethyl alcohol (129), heroin (124), morphine (91), and hydrocodone (88) (*see **Figure 12***). Individuals with deaths caused by ethyl alcohol during the first six months of 2003 declined 25 percent when compared to the last six months of 2002, where as persons with deaths caused by cocaine rose by 11 percent for the same period. The number of deaths of individuals caused by heroin and methadone rose by eight percent and four percent, respectively. During the same period, the number of deaths caused by oxycodone increased by nearly two percent, while those for hydrocodone decreased by six percent.

Figure 12: Comparison of Deaths in Which the Drugs Named Caused Death July – December 2002 to January – June 2003



The three drugs that were the most lethal (more than 50 percent of the individuals with deaths, in which these drugs were found, were caused by the drug) were heroin (92 percent), methadone (63 percent), and fentanyl (57 percent).

In order to reduce the death rate of 5 Floridians per day killed by prescription drugs, Governor Bush has tasked the Director James McDonough of the Office of Drug Control to convene a Prescription Drug Task Force to develop an action plan to address this growing problem. Members of the task force include Attorney General Crist, Director McDonough, the Secretaries of the Departments of Health, Agency for Health Care Administration, Children and Families, and the Commissioner of the Florida Department of Law Enforcement. The task force will be addressing the illegal diversion of prescription drugs, Medicaid fraud, illegal prescribing through the Internet, and legislation necessary to curtail these activities. Ongoing public awareness, physician and law enforcement education and training, expanded prevention, detoxification, and treatment services, will also be necessary as part of the long-term response to these issues.

Club Drug Use

Another major concern for Florida law enforcement is the relatively recent RAVE movement that facilitates the distribution of designer drugs and creates an attitude of acceptance of the drug culture among Florida youth. RAVES target young people with an appeal to all-night dance parties in an atmosphere of heavy "techno-music" and psychedelic light shows. RAVES have become one of the nation's fastest growing sub-cultures and unfortunately, a widespread source of illicit drugs. RAVES quickly increased visibility by adding to its genre "club drugs" such as ecstasy, GHB, methamphetamine, heroin, cocaine and rohypnol.

RAVE activity in Florida appeals to a wide array of participants, with no distinct geographical or ethnic cluster of participation. Participants quickly gain information on locations, dates and times of RAVE parties by accessing the Internet, flyers, announcements by disc jockeys and word of mouth, affecting age groups 12-35, the highest concentration being those in their late twenties. RAVE appeal has created an open-air market for designer drugs with a tragic impact on Florida. Large cities that contain major tourist attractions or colleges in the area are affected most by RAVES.

National Household Survey on Drug Use and Health: Adults

The 2002 National Survey on Drug Use & Health (NSDUH), formerly called the National Household Survey on Drug Abuse (NHSDA), has provided statistics on the prevalence of drug use in the United States since 1971. For the first time, the 1999 survey provided state-specific estimates of illicit drug, alcohol and cigarette use by age group. According to this new expanded survey, current drug use varies substantially among states, ranging from a low of 4.7 percent to a high of 10.7 percent for the overall population. Florida-specific statistics on prevalence rates for use within the past 30 days reveal that Florida ranks:

- Ninth highest prevalence rate in the nation for the use of any illicit drug other than marijuana for the age group 18-25. Only eight states had a higher prevalence rate

for illicit drug use for age 18-25 (Colorado, Delaware, Maine, New Mexico, Oregon, Vermont, Washington and West Virginia.)

- Sixteenth worst in the nation for illicit drug use among persons age 26 and older.
- The prevalence rate for illicit drug use for Floridians age 18-25 for the past 30 days was twice that of Floridians age 12-17.
- The prevalence rates for binge drinking among Floridians age 18-25 for the past 30 days was four times the rate for age 12-17.

Florida Youth Substance Abuse Survey

The Florida Youth Substance Abuse Survey (FYSAS), begun in the 1999-2000 school year, is administered annually to Florida middle and high school students. The survey has consistently revealed that ATOD use rates are roughly the same for both genders, and that White non-Hispanic youth report the highest 30-day prevalence rates, while African American youth are the least involved with alcohol, tobacco or other drugs.

The 2003 FYSAS found that substance use is down among our youth almost across the board. Of the 21 substance categories included on the survey, past 30-day use (a measure of current use) rates decreased in 16, remained unchanged in two and increased in only three categories between 2000 and 2003. The prevalence rate for GHB use increased from 0.8 percent to 0.9 percent, and the rate for hallucinogenic mushroom use increased from 1.2 percent to 1.4 percent. Depressants, while also a relatively low-prevalence substance, showed a troubling increase in use from 1.7 percent to 2.3 percent.

Marijuana use decreased 30 percent among middle school students, and 6 percent among high school students between 2000 and 2003. However, cigarette use decreased 46 percent and 34 percent among middle and high school students respectively. Consequently, for the first time in 2002 and again in 2003, there were more current marijuana smokers than cigarette smokers among high school students.

The prevalence of alcohol use, while decreasing 10 percent from 2000 to 2003, remains the most commonly used substance at about 31 percent overall. This rate ranges from 11 percent among 6th graders to over 52 percent among seniors.

The Monitoring the Future (MTF) survey is a national school-based youth survey of 8th, 10th and 12th grade students. It includes many of the same measures as the FYSAS, and therefore serves as a good basis for comparison of Florida youth against American youth as a whole. At all three grade levels, Florida students use marijuana and other illicit drugs at a similar or lower rate than students nationally. An exception is that Florida 8th grade students use marijuana and inhalants at a slightly higher rate than their national cohort. However, Florida youth drink alcohol at a higher rate than youth nationally across all three grade levels.

A relatively unique component of the FYSAS is that it includes a large number of questions designed to assess the level of risk for and protection against substance use

that our youth are experiencing. With the survey administered at the county level in even years (2000, 2002, etc.), this allows for the creation of local Risk/Protective Factor profiles which serve as the basis for local prevention programming and as a valuable resource for local coalitions.

Figure 13: Part A. 30-Day Use Rates of Use of Various Substances by Florida 6th - 12th Grade Students.

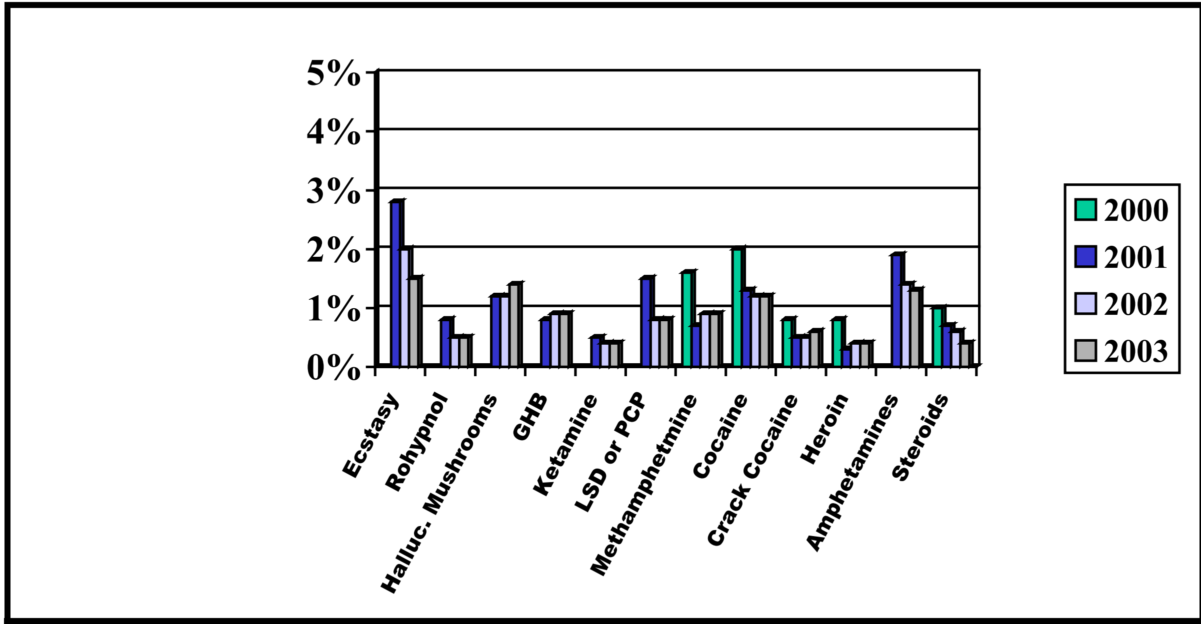
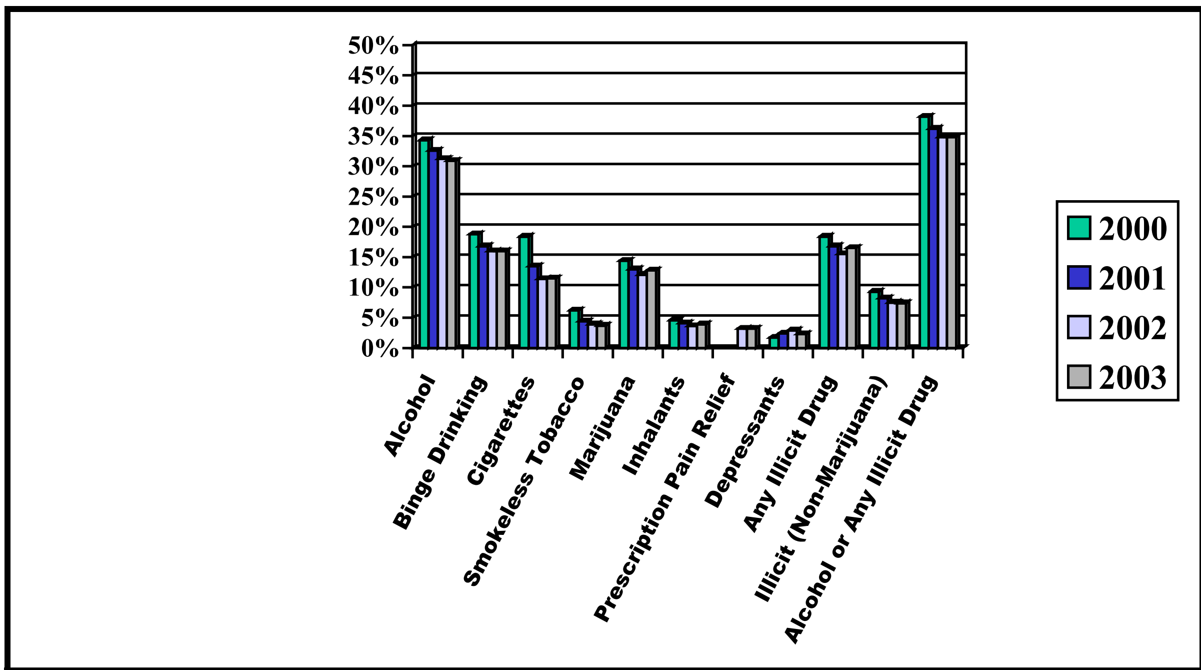


Figure 13: Part B. 30-Day Use Rates of Use of Various Substances by Florida 6th - 12th Grade Students.



Service Populations

Target Populations

For FY 2003-2004 the Substance Abuse Program Office established two primary target groups that correspond to individuals' presenting substance abuse service needs: 1) persons who are at-risk for developing substance abuse problems; and 2) persons with substance abuse problems. Prior to FY 2003-2004 the Program used seven primary target groups: three for children and four for adults. These target groups were not mutually exclusive. Therefore, individuals had to be prioritized into one of the target groups. A description of each target group and persons admitted from FY 2002-2003 are described below:

Adults

- *Intravenous Drug User* - individuals with substance use disorders with either a history of IV drug use or current drug of choice is administered through injection *(n=8,090 admissions)*.
- *Dual Diagnosis* - individuals with Axis I or Axis II mental disorder and a primary or secondary diagnosis of a substance abuse disorder *(n=8,760 admissions).*
- *Parents Putting Children At Risk* - individuals above the age of 17 with substance use disorders who are pregnant or have one or more dependents under the age of 17 for whom they are the custodial parents or the individual or his/her dependent receives services from Family Safety *(n=13,134 admissions).*
- *Persons Involved with Criminal Justice System* - individuals with substance use disorders that have been mandated by the court to receive treatment or are under community supervision of a criminal justice entity (*n=25,833 admissions).*

Children

- *Children At-Risk* – children who are at risk of initiating drug use or developing substance problems due to individual and environmental risk factors *(n=35,314 admissions).*
- *Children Under State Supervision* - children with substance use disorders who are under supervision of the Department of Juvenile Justice or are recipients of services from Family Safety *(n=20,586 admissions).*
- *Children Not Under State Supervision* - children with substance use disorders who are not under the supervision or custody of a state agency *(n=6,533 admissions).*

The new target group designations allow for exclusivity (individuals cannot be in more than one target group during an episode of care) while enabling the Substance Abuse Program to identify multiple individual characteristics within each group. For example, a person with substance abuse may have an intravenous drug use problem, have co-occurring mental and substance use disorders, and be a parent putting his or her child at risk.

During FY 2002-2003, the department provided substance abuse service funding to 169 community-based agencies. These agencies served 188,513 individuals, of whom

76,064 were children and 112,449 were adults. An additional 50,000 children and 23,000 adults received universal/selective prevention services - these services are provided to large groups and individual identifying information is not collected (and therefore is not reflected in the total individuals served counts above).

Persons At-Risk for Developing Substance Abuse

For children the "At-Risk" target group includes individuals who are likely to initiate substance use based on a series of risk factors including peer use, poor school performance, family and/or environmental factors. For adults, the "At-Risk" designation includes individuals who may or may not be actively using substances who are likely to develop substance abuse or dependence based on a series of risk factors such as workplace stress, personal loss/grief, social isolation and medication misuse. At-Risk individuals and their family members are assisted through prevention and early intervention services that help individuals identify risky behaviors and potential consequences of substance use, misuse, abuse and dependence.

Persons with Substance Abuse Target Groups

The Persons with Substance Abuse target group includes children and adults who are experiencing physical, psychological or social problems related to substance misuse, abuse or dependence. These individuals are targeted for more intensive services such as outpatient counseling or residential treatment to help them identify problematic behaviors and the consequences of their substance use, and to facilitate the development of skills to reduce or eliminate problematic substance abuse and related behaviors.

Pursuant to s.394.9081, F.S., the department was required to establish target groups for adults age 60 and older who include: 1) At-Risk of Placement in a More Restrictive Environment (residential treatment, assisted living, nursing homes, etc.) due to their Substance Abuse or Mental Illness; and 2) In Need of Substance Abuse Treatment. Data on these target groups is captured within the "Persons with Substance Abuse" target group and results are generated specific to older adults.

Prevalence and Estimated Need

Prevalence estimates are developed by the Substance Abuse Program Office using the Florida Youth Survey 2003 and the Household Survey on Drug Abuse (adults). Using census population figures for 2003, survey data on prevalence were used to determine alcohol/drug use (adults). Persons with substance abuse problems include those individuals that have progressed in their use to a point where they are abusing or become dependent on alcohol and/or other drugs. At-risk populations are targeted for

more front-end services such as prevention, intervention and outreach because the services are brief in nature and intended to prevent or reduce substance use.

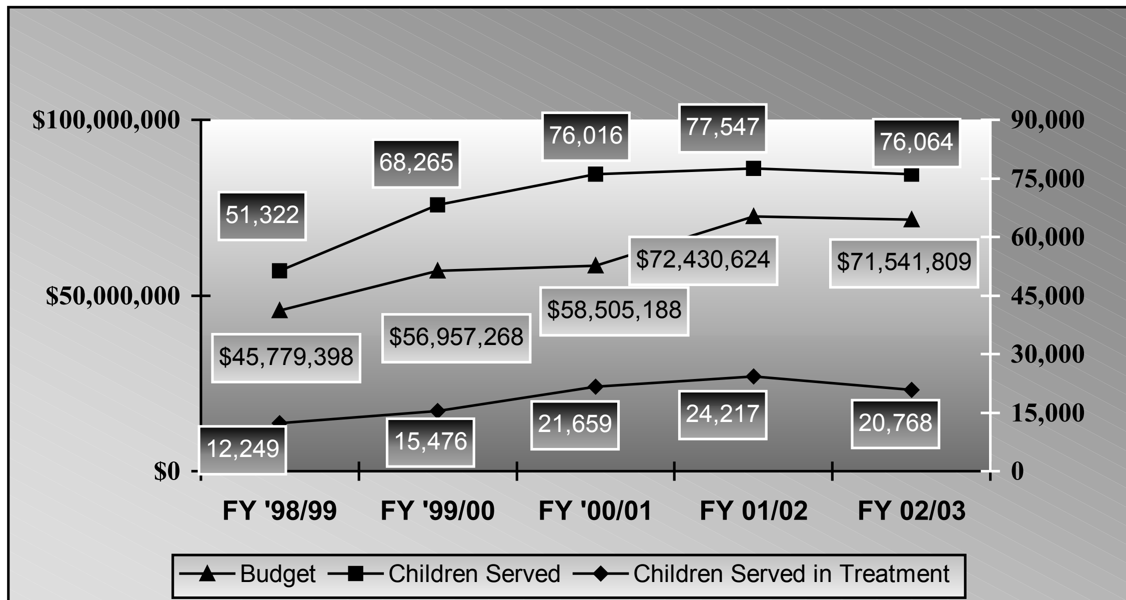
There are an estimated 848,246 adults and 353,159 children in need of substance abuse services statewide. Currently, the department is meeting 13 percent of the substance abuse treatment need for adults and 22 percent of the substance abuse treatment need for children.

Trends in Children Served and Funding

Over the past five fiscal years, through FY 2002-2003, the Substance Abuse Program has received a 56 percent increase in funding for children's substance abuse services. A significant portion of the increased funding has come through federal block grant increases. When compared to federal funding, the state contributes funding at a rate slightly higher than 1:1 for children's substance abuse services. The Substance Abuse Program has used the funding increases to strengthen service infrastructure, including expanding and enhancing prevention, detoxification and treatment. The result has been a significant increase in the number of children served in these programs.

During this time period the number of children served in indicated prevention, detoxification, treatment and aftercare services has increased 48 percent. The number of children served in residential and non-residential treatment services increased 70 percent.

Figure 14: Children Served Compared to Total Funding
Fiscal Years 1998-1999 through 2002-2003



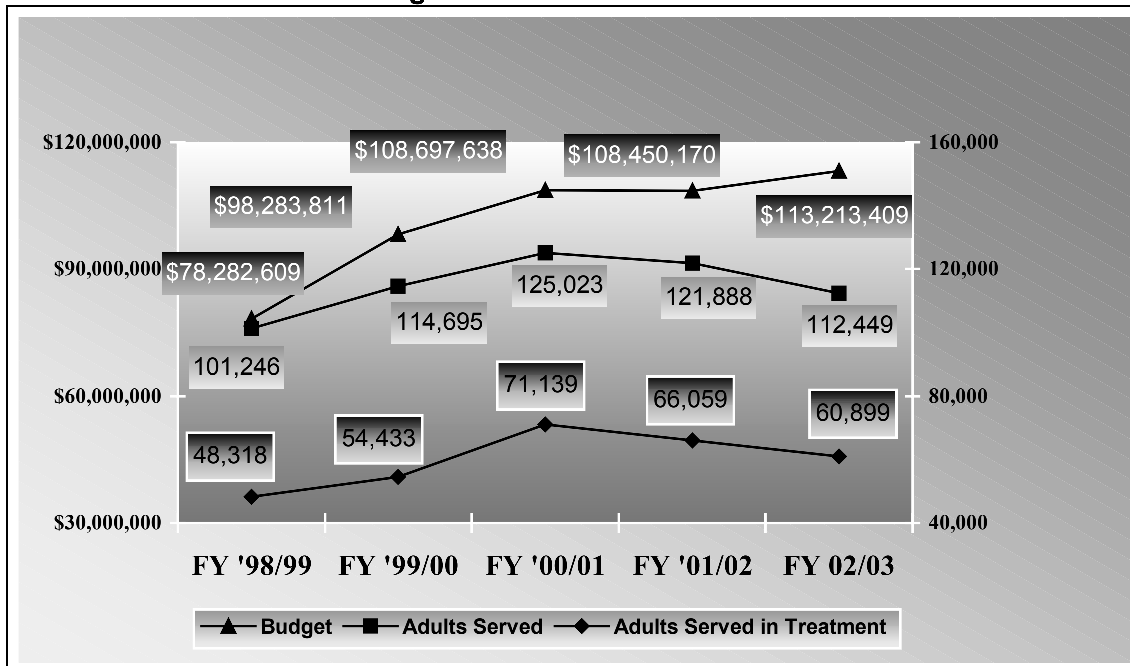
* A consistent methodology was used in the above table for identifying children served in treatment across the five fiscal years. The numbers shown for children served in treatment are slightly lower due to the shift of provider data to a new reporting system.

Adults Served and Funding

Over the past five fiscal years, through FY 2002-2003, the Substance Abuse Program has received a 45 percent increase in funding for adult substance abuse services. A significant portion of the increased funding has come through increases in federal block grant funds. When compared to federal funding, the state contributes funding at a rate of 1:4 for adult substance abuse services. The Substance Abuse Program used the funding increases to add detoxification and treatment capacity throughout the state and to strengthen service infrastructure.

During this time period the number of adults served in indicated prevention, detoxification, treatment and aftercare services has increased 11 percent. The number of adults served in residential and non-residential treatment services increased 26 percent.

Figure 15: Adults Served Compared to Total Funding
Fiscal Years 1998-1999 through 2002-2003



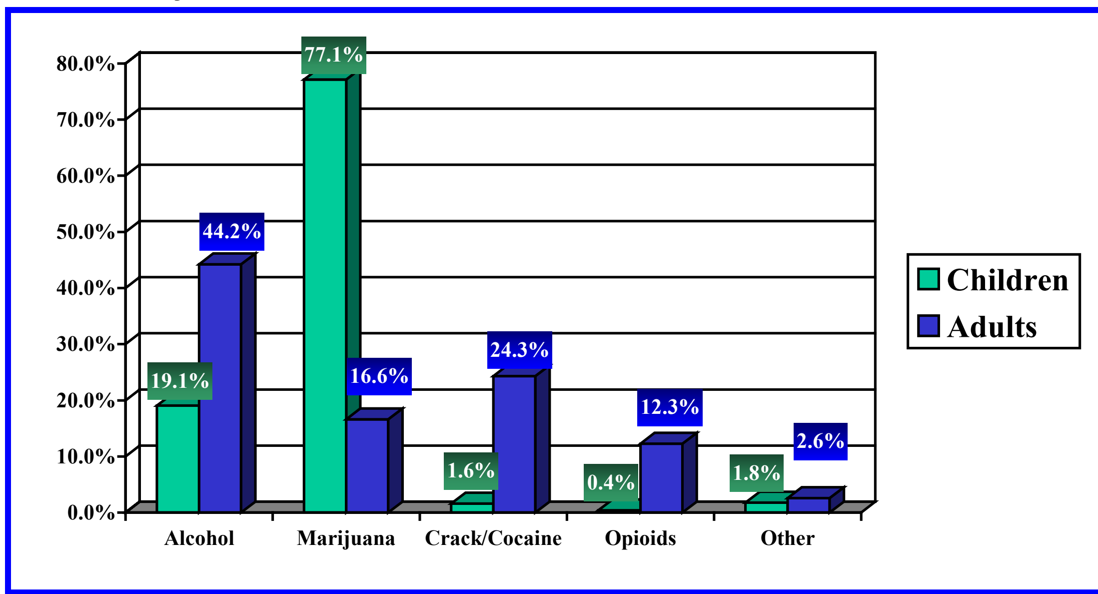
* A consistent methodology was used in the above table for identifying children served in treatment across the five fiscal years. The numbers shown for children served in treatment are slightly lower due to the shift of provider data to a new reporting system.

Primary Substance Abuse Problem at Admission

In FY 2002-2003 there were 46,394 children admitted for substance abuse services. One-third of these individuals were female and two-thirds were male. Most youth received outpatient services such as assessment, counseling, case management, and intervention. There were 63,903 adults admitted for substance abuse services and, similar to the children's group, one-third were female and two-thirds were male.

For children, the primary drugs of abuse in order of prevalence are marijuana, alcohol, and crack/cocaine. More than three of every four youth presented with a primary problem of marijuana. For adults, the primary drugs of abuse in order of prevalence are alcohol, crack/cocaine, marijuana, and opioids. Half of the adult individuals presented with alcohol as the primary problem and one in every four individuals presenting with crack/cocaine as the primary problem. As indicated earlier in this chapter, there is a significant problem in Florida relative to opioid use, specifically the use of prescription painkillers such as oxycodone and hydrocodone. The chart below depicts the specific prevalence rates for primary substance use among children and adult individuals.

Figure 16: Primary Substance Use Problem at Admission



Note: Opioids include heroin, non-prescription methadone, and other opiates such as oxycodone and hydrocodone, among other prescribed medications for pain relief.

Service Provision

Children and Adult Substance Abuse System of Care

The Substance Abuse Program Office is appropriated funding by the Legislature in three primary areas: Children's Substance Abuse (CSA), Adult Substance Abuse (ASA) and Program Management/ Compliance. The CSA and ASA funding is used primarily to contract with community-based providers for direct provision of prevention, detoxification, treatment, aftercare and support services for children and adults. Program Management and Compliance funding supports state and district Program Office staff that are responsible for administrative, fiscal and regulatory oversight of substance abuse services.

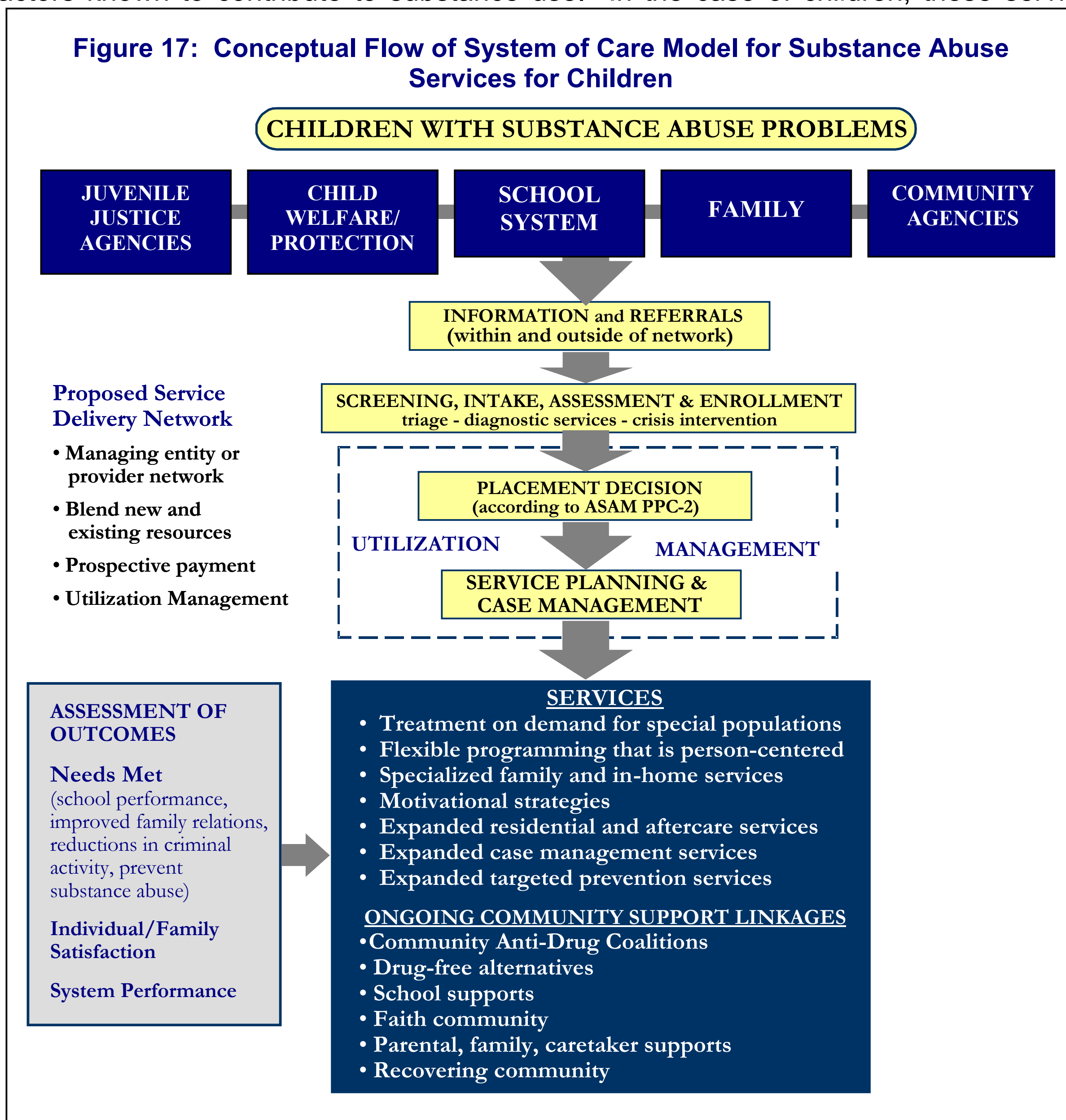
Over the past several years the Substance Abuse Program has developed a comprehensive system of information and referral sources that individuals and their

families can access to find appropriate services in their communities. Community-based agencies that provide information and referral services handle more than 200,000 calls annually. According to Substance Abuse Program data, the main sources of referral for substance abuse services for adults include self-referral, criminal justice/courts, child protection, and community-based agencies. For children, the main sources include the family, school system, juvenile justice/court system, and community-based agencies.

Service Array Overview

Prevention services include activities and strategies that are designed to preclude, forestall or impede the development of substance abuse problems by addressing risk factors known to contribute to substance use. In the case of children, these services

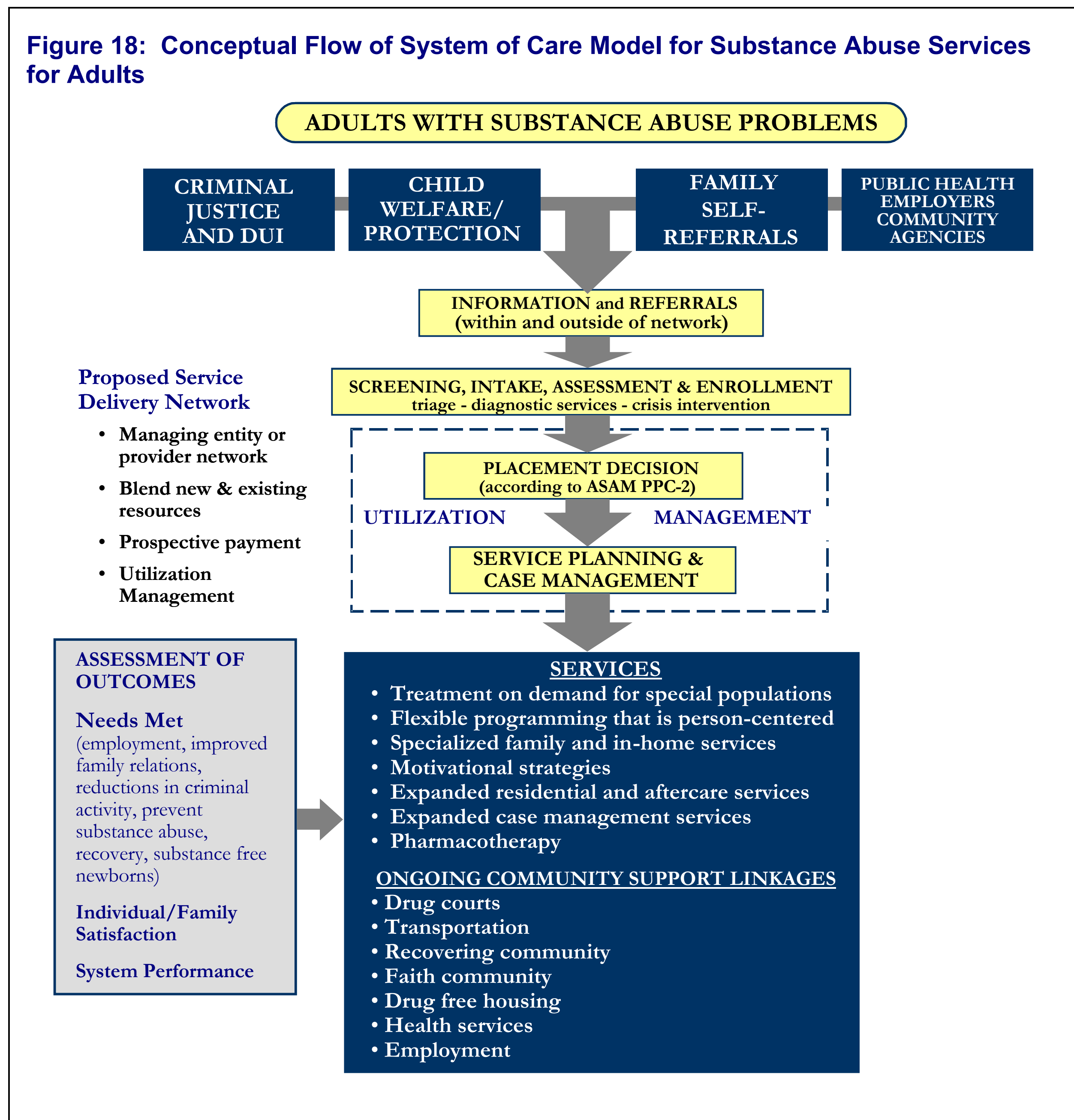
Figure 17: Conceptual Flow of System of Care Model for Substance Abuse Services for Children



may be provided in school-based settings and require parental participation. Prevention services for adults include activities and strategies that target the workplace, parents, pregnant women and other potentially high-risk groups.

Detoxification, treatment and aftercare services focus on reducing and eliminating substance use among identified populations in order to promote positive outcomes such as contributing to family unity and stability for minor children, reducing involvement in the criminal justice system and maintaining a drug-free lifestyle. Specifically, detoxification services utilize medical and clinical procedures to assist children and

Figure 18: Conceptual Flow of System of Care Model for Substance Abuse Services for Adults



adults to withdraw from the physiological and psychological effects of substance abuse. Treatment includes various levels of residential treatment and non-residential treatment, the type and duration of which varies according to the severity of the addiction. Aftercare consists of services designed to provide continued support for persons who have completed treatment and focuses on promoting recovery and the prevention of relapse. Individuals who successfully complete treatment have better post-treatment outcomes such as abstinence or reductions in use, reduced involvement in the criminal justice system, reduced involvement in the child protection system, higher earnings and improved overall health.

Uniform Placement Criteria

As part of the state's movement toward a comprehensive system of managed behavioral health care, the Substance Abuse Program Office implemented the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) on July 1, 1998. All contracted state substance abuse providers are required to use the ASAM PPC. To assist providers in implementing the ASAM Placement Criteria, the Substance Abuse Program Office developed the 'Florida Supplement,' an abbreviated reference document for clinicians. Since 1998, the department has conducted validation reviews of the use of ASAM by provider agencies. Historically, this has been conducted by the department's licensing staff as part of the regular licensing inspections. However, the system used to validate ASAM will be incorporated into the department's substance abuse and mental health data system and will be conducted as part of data system validation reviews and will be conducted on a random basis by district/region.

For services other than prevention and aftercare, admission of individuals to a specific level of care is accomplished through an initial screening process to determine whether or not a person is appropriate for substance abuse services. If appropriate for services, the individual is assessed. The assessment includes a psychosocial assessment and a medical assessment, where appropriate.

Information from the assessment is then used in conjunction with ASAM criteria to place the person in the most appropriate level of care. Using predetermined clinical criteria, placement decisions are made regarding 1) admission of a person to a specific level of care; 2) continued stay within a specific level of care; and 3) discharge or transfer of the individual from that level of care.

In 2001 the Substance Abuse Program updated the Florida Supplement to reflect changes in the ASAM-PPC-2-R. The primary changes focused on the inclusion of placement criteria for persons with co-occurring mental and substance use disorders. These treatment placement designations identified services as "dual diagnosis capable" and "dual diagnosis enhanced". Dual diagnosis capable programs have the ability to serve individuals with primary diagnoses of substance abuse and secondary diagnoses of low to moderate mental disorders. Dual diagnosis enhanced programs have the

ability to serve individuals with moderate to disabling mental disorders and co-existing substance use disorders.

Prevention

The department provides substance abuse prevention services to the people of Florida in accordance with the federal Center for Substance Abuse Prevention's six prevention strategies:

- Information Dissemination
- Education
- Alternative Activities
- Community Processes
- Problem Identification and Referral
- Environmental Approaches

Target populations range from the entire population of the state (universal prevention) to specific groups of at risk children or adults (selective prevention). Some strategies can be directly applied via direct service programs or prevention practices aimed at individuals or groups of individuals. Other strategies deal with effecting changes in the structure of our communities. For example, Environmental Approaches and Community Processes will not provide direct services for individuals, but rather seek to change community or environmental norms or conditions that are favorable to alcohol, tobacco and other drug (ATOD) use.

Other strategies usually target populations such as Children At Risk of Substance Abuse, Elderly Citizens At Risk of Substance Abuse or Parents in Need of Parenting Skills. Each of these target populations are then offered one or a combination of strategies that have been proven effective or promising in combating substance use and abuse. Substance abuse prevention requires three levels of target populations because prevention strategies reach out to the: 1) general population, both youth and adult; 2) high-risk communities; and 3) individuals.

The determination of an "at-risk" adult population to target for services differs considerably from the youth population. The Substance Abuse Program Office defines "at-risk adults" as those individuals who have experienced some physiological or social problems due to use of substances within the past year. Without timely, early intervention to assist them in reducing or eliminating their substance use, these individuals are "at-risk" of developing substance abuse or dependence problems and eventually needing higher end (and higher cost) services such as detoxification and treatment. The department estimates that 17 percent of the adult population in Florida can be categorized as "at-risk".

Level 1 Prevention (General)

All youth and adults need general prevention services, previously designated as universal or selective prevention. While children and youth are certainly the most critical prevention target, the need for prevention continues through the developmental stages of adult life. Everyone needs information and training on how to avoid problems associated with alcohol, tobacco and other drug use. There is an ongoing need for information and education on the following:

- the dangers of alcohol, tobacco and other drug use;
- the drug problem in the local community, state and nation;
- prevention strategies to use in schools, families, communities and personal lives;
- prevention and treatment services available; and
- the positive and beneficial effects of a drug-free lifestyle.

Some environments present multiple risk factors – high drug-traffic/crime neighborhoods, poverty, high unemployment, domestic violence, family history of drug use/crime. People living in these environments are affected by these risk factors; therefore sub-populations are targeted with particular information and education strategies, alternative activities and problem identification and referral services. Environmental and community organizing strategies are also needed.

Level 2 Prevention (Individual-Specific)

Some prevention services, previously designated as "indicated" programs, are tailored to the specific needs of youth based on the identification of multiple risk factors. These indicators can involve individual, as well as environmental, factors – low academic performance, favorable attitudes toward drug use/use of violence, anti-social behavior, low self confidence, poor community identification and early signs of experimentation. This target population requires the most direct and intense forms of prevention strategies.

<u>Children</u>

The emphasis for the last five years at both the state and national levels has been on serving 12 to 17 year old youth and their families. This has led to a substantial increase in model prevention programs and a significant reduction in youth substance abuse in Florida since 2000. As the science of prevention grows, so will the scope of the

department's prevention services. New initiatives will target children and youth birth to age 6 in both the child welfare system and the general population.

Adults

Research in the field of substance abuse prevention is clearly showing that prevention is a life-span issue. From birth through old age prevention issues evolve. While the most critical ages seem to be pre-adolescence and adolescence, adult developmental stages have their own substance abuse prevention challenges. The Substance Abuse Program will work to improve prevention services to adults. The first initiative will focus on 18 to 24 year olds.

Older adults have been a target group for substance abuse prevention services over the last four years. Services primarily focus on the prevention of medication misuse and/or acceleration of substance abuse/dependence by adults 60 and older due to life changes/stressors. The Substance Abuse Program funds prevention services for approximately 7,000 older adults annually.

Communities

Prevention research is also showing that a community's prevention environment and its coordination around substance abuse issues is foundational for effective direct prevention services. The Substance Abuse Program will continue to support the establishment and strengthening of Florida's local community anti-drug coalitions through the Coalition Mini-Grant Program. Coalitions consist of representatives of key local institutions and organizations who can effectively address policies, practices, policy enforcement and other social norming issues, as well as coordinated resource distribution.

Infrastructure

The Substance Abuse Program continues to strengthen the Department's substance abuse prevention infrastructure to more efficiently and comprehensively support district staff and providers effectiveness. The Florida Youth Substance Abuse Survey is the foundation of needs assessment for determining prevention needs. The Performance-Based Prevention System is a new web-based data system for program process and outcome information. The Substance Abuse Program is developing new guidance for effective contracting for and monitoring of prevention projects.

Performance-Based Prevention System (PBPS)

PBPS is a web-based data collection and reporting system that is designed specifically for the field of substance abuse prevention. Data put into the system, or transmitted out of it, are electronically encrypted (scrambled) so that it is not possible for an outside source to break the code. This is the same type of coding that is used by banking systems to transmit large amounts of money.

In addition to being secure, the PBPS system links the various components of substance abuse prevention into a coherent whole. It allows a substance abuse prevention provider to look at staff hours, participant profiles, contract requirements and service events as well as measures of performance, either separately or in terms of their relationship to each other. For example, information about the demographics of a group of program participants can be extracted. Then that group can be studied in terms of service delivery by gender, or time of year, or contractual requirements or any of a large number of variables relevant to service delivery providers, or agencies with funding or oversight responsibilities. Because the PBPS system is so flexible and interactive a single data set can be used for many purposes. For example:

- to produce reports of staff hours for payrolls, or to support invoicing;
- to track participant attendance or performance;
- to monitor fidelity to service delivery protocols;
- to track and analyze trends in service delivery over time; and,
- to compare performance of programs across geographic areas or across different populations, to name a few.

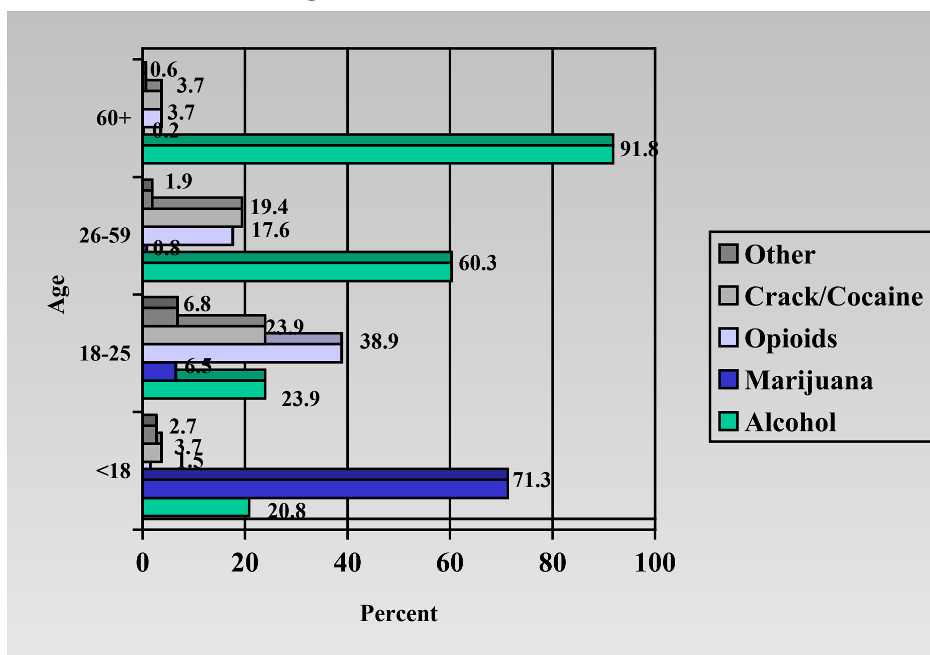
There is 40 hours per week of help available to users of the new system both by telephone and internet.

Detoxification

Detoxification programs are provided on a residential or an outpatient basis and utilize medical and clinical procedures to assist children and adults in their efforts to withdraw from the physiological and psychological effects of substance abuse. Residential Detoxification and Addiction Receiving Facilities provide emergency screening, short-term stabilization and treatment in a secure environment 24 hours per day 7 days a week. Outpatient detoxification provides structured activities 4 hours per day 7 days a week.

Detoxification services are a critical part of the substance abuse services continuum. Individuals who are physically dependent on alcohol or other drugs need medical and counseling assistance to help the body's physiology adjust to the absence of alcohol/drugs. Detoxification is essentially a phase of treatment. Once a person has physically readjusted they are ready to begin the psychological aspects of recovery and fully engage themselves in treatment. Detoxification is appropriate for individuals that need medical assistance and oversight while withdrawing from substance use. It is not a necessary precursor to participation in treatment for most individuals.

Figure 19: Individuals Presenting Substance Abuse Problems in Detoxification



Note: Opioids include heroin, non-prescription methadone, and other opiates such as oxycodone and hydrocodone, among other prescribed medications for pain relief.

Approximately six percent of children and adults in Florida are in need of treatment services; 3-5 percent of this group will also need detoxification services. In FY 2002-2003 contract agencies provided detoxification services to 20,504 adults (48 percent of the need) and 2,307 children (22 percent of the need). For FY 2003-2004 the Substance Abuse Program has contracted for 88.5 children's detoxification beds and 320.3 adult detoxification beds and estimates that an additional 1,456 adults and children will receive detoxification. In recent years there has been a significant increase in detoxification admissions due to opioid use. As ***Figure 19*** demonstrates, the presenting substance abuse problems vary considerably across age groups.

Treatment

The array of substance abuse treatment services is designed to assist individuals and families to respond to addiction problems. Many special populations throughout Florida, including individuals involved in the criminal justice system, parents with dependent children, persons with co-occurring substance abuse and mental illness, families involved in the child protection system and persons at-risk of or having AIDS/HIV are targeted for services. The Substance Abuse Prevention and Treatment (SAPT) Block Grant mandates specific services to include primary care, prenatal care, gender specific services, transportation, child care, outreach, screening/testing/counseling for HIV/TB and referral services to target pregnant women, women with dependent children, individuals awaiting admission to treatment, intravenous drug users and HIV at-risk populations.

Conceptual Treatment Model

The Substance Abuse Program Office is in the process of developing a conceptual framework for an evidence-based treatment model. The model will initially be based on the research findings of D. Dwayne Simpson, Ph.D., of the Texas Christian University. Dr. Simpson is a nationally recognized researcher and author in the field of substance abuse treatment.

The premise of the conceptual framework is that effective treatment must account for:

1. Individual attributes such as psychological functioning, level of motivation to engage in treatment, and severity of presenting problems;
2. Behavioral strategies that enhance therapeutic engagement of individuals by clinicians and promote individual participation in treatment and behavioral and psychological change;
3. Participation of family and friends in the treatment process; and
4. Identification engagement of positive support networks to reduce post-treatment recidivism relative to substance use and criminal activity.

The Substance Abuse Program will convene a workgroup comprised of representatives from the Office of Drug Control Policy, Florida Alcohol and Drug Abuse Association, community-based providers, and other interested stakeholders. The workgroup will initiate the development of the conceptual treatment framework using Dr. Simpson's model and by identifying model programs and services throughout Florida. Particular attention will be paid to the therapeutic and support needs of special populations such as women with dependent children, intravenous drug users, persons involved in child welfare, persons with co-occurring disorders, and persons involved with the juvenile and criminal justice systems.

Performance measurement will be a key role in the development of the treatment framework. The Substance Abuse and Mental Health programs are working with the Florida Mental Health Institute to develop a treatment performance measurement model. Statistical modeling will focus on establishing objective methods for setting provider performance standards based on a series of factors including: individual characteristics; severity of presenting problem(s); range of services provided, and providers' historical performance. The Florida Mental Health Institute will also be working with the department to determine the effectiveness of treatment using these variables. The results will be used in the development of the conceptual treatment framework and to identify best practices.

Drug Courts

Drug courts are another cost-effective alternative to incarceration, providing mandated substance abuse treatment in lieu of jail/prison time for non-violent offenders, conditionally based on their successful participation and completion of treatment programs. Although Florida has the second largest drug court system in the United

States, it is only able to reach a small portion of persons who offend. This situation is being further complicated by the loss of federal funding for this purpose. Federal monies initially funded many programs but current availability of continuation funds is quite limited. With the program's proven success in reducing criminal recidivism and costs, the Substance Abuse Program Office, in conjunction with FADAA, district offices and providers is exploring ways to continue these valuable programs.

The department's Substance Abuse Program Office participated in the 2003 Statewide Drug Court Conference in a forum with the Office of State Court Administration and the Drug Control Office to identify resources and support for the continuation of funds for drug courts in danger of losing funding. According to s.893.165, F.S., a local county ordinance can be created to provide funds for local substance abuse treatment programs. The Substance Abuse Program Office has encouraged district SAMH offices to participate and provide support to drug courts in their area, creating a local county ordinance to expand their funding options. Expanding access to treatment to keep pace with the expansion of drug courts remains a challenge.

In May 1999, only 34 operational drug courts existed in Florida. Four years later drug courts have expanded to 83 operational drug courts, an increase of 144 percent, with an additional ten programs in the planning stages of development.

The National Institute of Justice released a recidivism study in July 2003. Nine of Florida's drug courts participated. Estimates from this study showed 83.6 percent of drug court graduates had not been arrested and charged with a serious offense one year after graduation and 72.5 percent not within two years of graduation.

Methadone and Addiction Medicines

New methadone regulations were adopted at the federal level during 2001. The regulations are found under 42 Code of Federal Regulations, Part 8, and are summarized as follows:

The regulations require all methadone programs to be certified by SAMHSA as a condition of continuing operations. One of the conditions of certification is that methadone programs must become accredited by one of four accrediting bodies by May 2003 or have applied for accreditation by that time and receive provisional certification by SAMHSA. In Florida, all state licensed methadone treatment programs have been, or are in the process of becoming, certified.

The new regulations also permit the practice of medically managed maintenance treatment with state and federal approval. This permits a private physician to dispense methadone from his or her practice as long as the practice is connected to an approved methadone program. This practice is limited to patients who have made significant gains in treatment and do not need to attend the clinic on a frequent basis. In Florida, there are currently two providers that are approved to provide medical maintenance services. Those services are provided at the providers' facilities.

Another major provider has applied to the state to provide this service but has not yet been approved. There are currently no services being provided from a physician's private office practice. It is anticipated that more methadone providers will request permission to provide this service, particularly if it proves to be effective.

Buprenorphine

In 2002 a new federal regulation regarding the use of the drug buprenorphine by physicians to treat persons addicted to opioids was adopted. The regulation permits physicians to prescribe the drug from their private practices providing they are certified by SAMHSA and received minimal training in addictions. Buprenorphine may also be dispensed by state licensed and federally approved methadone clinics as an alternative to methadone. The Substance Abuse Program Office, through its district/regional offices, has contacted approved private physicians to encourage them to develop linkages to appropriate detoxification and treatment services for people they serve. To date, 92 physicians have been certified by SAMHSA to prescribe buprenorphine in Florida to treat individuals with opioid addiction. Florida also hosted a forum on buprenorphine in Miami sponsored by SAMHSA. The forum was conducted for the purpose on increasing awareness of the use of buprenorphine to treat opioid addiction and was attended by physicians, substance abuse providers and other interested parties. Because of the success of the Miami forum, a second forum is being planned for the Orlando area.

Special Populations and Initiatives

Criminal Justice Populations

Criminal activity and substance abuse are irrevocably related, resulting in enormous social and economic costs to society. Approximately half of the adults and three-quarters of the children receiving publicly supported substance abuse services in Florida have some level of involvement with the criminal justice system. Department-funded providers throughout the state provide an array of non-residential and residential treatment and support services for these individuals. The Substance Abuse Program Office works closely with the Department of Corrections, Department of Juvenile Justice (DJJ) and local criminal justice entities (courts, jails) to ensure offenders receive needed services. In-prison treatment programs and services were significantly reduced following the Special Legislative Session in 2001. The Department of Corrections has requested funds to restore some of this capacity.

Assessment, treatment and support services are provided to offenders through provider agencies in the community (for offenders under community supervision) or in local jails/detention facilities or commitment facilities (for incarcerated adults and committed delinquent juveniles). Treatment Accountability for Safer Communities (TASC) has been shown to be an effective alternative to incarceration, allowing substance-involved offenders to receive needed treatment and support while being supervised in the community. TASC programs monitor individual progress and compliance with court stipulations for substance abuse services and intended results such as abstinence and

attainment/retention of employment. These programs communicate individual results to designated criminal justice agencies.

Faith-Based Substance Abuse Services

In 1999 a small group of faith and community-based service organization leaders met informally to discuss the possible development of a best practice model for individuals with addictions and/or mental health problems. These meetings took more tangible form in 2002, when the Southern Coast Addiction Technology Transfer Center (SCATTC) brought together representatives from key groups to facilitate a dialogue. These groups included the Florida Alcohol and Drug Abuse Association (FADAA), Florida's Faith-Based Association (FFBA), Florida Certification Board (FCB), and the department's Substance Abuse Program Office. The Faith and Community-Based Treatment Committee (FCBT) was formed out of this dialogue to develop a process to facilitate the communication and cooperation between Faith-Based Organizations (FBOs) and Community-Based Organizations (CBOs). Members of this committee included:

- Chet Bell, Exec. Vice President, Stewart-Marchman Treatment Center
- Cleveland Bell, Executive Director, Riverside House
- John Daigle, Executive Director, FADAA
- Rev. Bernie DeCastro, President of Florida Faith-Based Association
- Kenneth DeCerchio, Director, Florida Dept. of Children & Families, Substance Abuse Program
- Rev. John Glenn, Director of Alpha Ministries
- Dr. Jean LaCour, Net Training Institute
- Charles LaCour, Net Training Institute
- Chris Yarnold, Marketing Director, Operation PAR
- Neal McGarry, Executive Director, Florida Certification Board
- Pamela Waters, Director, SCATTC
- Jim Knorp, Project Manager, SCATTC
- Brunie Emmanuel, UniVision Group, Consultant/Facilitator

The goals of the committee were:

- To create synergy between FBOs and CBOs in delivering addiction services by identifying tools and best practices for both groups;
- To expand the continuum of care for addiction services by identifying and defining faith-based services that compliment the current (CBO) continuum;
- To encourage partnerships between FBOs and CBOs by finding common ground and develop ways to collaborate;
- To facilitate state certification and licensure to FBOs who want to expand their services;
- To investigate the feasibility of a separate certification and licensing process to grass roots FBOs that is sanctioned and recognized by the FCB and DCF; and

- To develop new training on spirituality as common ground for both groups.

In addition to the goals, the FCBT developed a set of guiding principles to undergird collaboration and decision-making in their interactions:

1. FBOs provide a wealth of resources to positively impact both the continuum of addictions services and the quality of care provided through those services;
2. Quality of care is the top priority and all services provided should be focused on the needs of the individuals and their families;
3. Effective care addresses the whole person (physical, mental, emotional and spiritual); therefore, spirituality is an integral part of treatment and recovery for many people;
4. All services should be subject to objective measurement;
5. The competencies and skills defined and articulated by state licensing bodies and professional organizations are significant aspects of quality addiction treatment; and
6. FBOs and CBOs share a great deal of common ground on which to build synergy.

On November 6-8, 2003, the Net Training Institute for Counseling & Addiction Studies conducted the 2003 *Gathering the Armies of Compassion* Conference in Orlando, Florida. The conference was hosted by the Orange County Coalition for a Drug Free Community and Calvary Assembly of God. The goals of the Conference were to:

- Recognize and encourage people of faith who serve;
- Renew its vision through gratitude, fellowship and worship;
- Inspire new acts of service;
- Provide new tools, materials and insights; and
- Promote relationships and collaboration to synergize service.

The department's Substance Abuse Program Office provided scholarship support to the Net Training Institute Conference.

In June 2003, the FFBA published the *2003 The Florida Faith-Based Association Substance Abuse and Other Faith Based Human Services Directory*. The *Directory* was designed to provide the most comprehensive guide of Florida's Faith-Based Human Services programs. The department's Substance Abuse Program Office, the Catholic Charities of the Diocese of Miami and P.R.I.D.E. helped underwrite the cost of development and production of this *Directory*, which will be published bi-annually. The *Directory* is available on-line at www.flfaithbased.org.

The Florida Faith-Based Association (FFBA) is planning to hold seven training conferences around the state in 2004. The FFBA is planning for six regional conferences and one statewide conference. The 2004 statewide conference is scheduled for September 1-3, 2004, at the Hyatt Regency Grand Cypress in Orlando. The department's Substance Abuse Program Office collaborated with the FFBA on the statewide conference and provided scholarship support.

Women's Programs

In FY 2002-2003, Florida has a network of 49 pregnant women and women with dependent children throughout the state, with a funding contribution of over $13 million in Substance Abuse Prevention and Treatment Block Grant funds alone. Pregnant women, women who inject drugs and persons referred from the child welfare and community-based care program received priority for services. Thirty-nine of these programs have services specifically designed for pregnant women and 13 allow women to bring their children into treatment. Quality women's treatment programs are one of the most critical strategies for responding to the prevention, intervention and treatment needs of substance involved families involved with child protection.

In 2002 the Substance Abuse and Mental Health Services Administration, through Johnson, Bassin and Shaw, conducted a core review of Florida's Substance Abuse Prevention and Treatment Block Grant. One of the recommendations from the review was that Florida request a technical review of women's programs. In 2003 Florida responded by asking for that review.

Fourteen pregnant/post partum women and women with dependent children programs were visited on-site in May, June and August 2003. The reviews included interviews with key partner programs (child welfare and community-based care, dependency drug courts, Healthy Start and Healthy Families). Findings from the technical review focused on the strengths of current services for women and areas for improvement:

- The programs reviewed had the capacity to provide a comprehensive array of gender-specific services, either on-site or in coordination with other community programs;
- The programs consistently used appropriate, effective intervention and treatment services for pregnant women and women with dependent children, with an emphasis on parenting skills and domestic violence;
- There is evidence of strong collaboration among agencies in the community to serve this population;
- There is a need to strengthen the cultural competencies of professional staff;
- Professional development needs to be strengthened specifically in relation to treatment for co-occurring disorders, victimization, trauma, and post-traumatic stress disorder; and
- Measures need to be taken to improve retention of qualified professionals and enhance clinical supervision.

Fetal Alcohol Spectrum Disorders (FASD)

A statewide Fetal Alcohol Syndrome (FAS) Action Group was formed in 2001 with the initial collaboration of the Substance Abuse Program and the Department of Health. The action team developed a state strategy to improve Florida's prevention and intervention services. In 2002 a FAS public hearing was conducted in Clearwater, Florida, by the National FASD Center, with staffing support from the Florida FAS

Workgroup and involvement of the Governor's Office. Beneficial participation by advocates, affected families and several key Florida legislative staff occurred.

In 2003 the Substance Abuse Program Office, in coordination with the Department of Health and key FASD advocates, took the lead role in overseeing the development of a Florida Resource Guide through the Florida State University Center for Prevention and Early Intervention. The guide was designed for Florida professionals and involved families. It was released in June 2003 and disseminated statewide to substance abuse, mental health and key child professionals, as well as foster and adoptive parents in the state. The Substance Abuse Program took the lead role through contract with the Florida Alcohol and Drug Abuse Association, in coordination with the action group partners and March of Dimes, to host a statewide FASD conference. The conference was attended by over 200 participants representing professionals, parents, foster parents and advocates. Additional training opportunities included a statewide foster care training conference in mid 2003, led by a parent member of the action group.

Draft guidelines for an "Interagency Collaboration for Working with Substance-Exposed Newborns" were developed through the Building Linkages for Healthy Families Workgroup. Guidelines were disseminated for review and final approval in early 2003.

Persons with Human Immunodeficiency Virus (HIV) and Intravenous Drug Users

According to the Department of Health, Florida ranks third in the nation for AIDS cases and second for pediatric AIDS cases. The state has a mandate to provide HIV services to individuals receiving substance abuse services. HIV services are provided in each of the districts and the Suncoast Region. These services are funded through the federally funded Substance Abuse Treatment and Prevention Block Grant.

There are currently 42 service providers under contract with the department providing HIV Services. These projects are located at the substance abuse treatment site and are designed to provide the following services:

- pre- and post-test counseling;
- testing to confirm the presence of the disease and diagnose the extent of the deficiency; and
- information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system.

During FY 2002-2003 there were 26,565 substance abuse individuals discharged from care that had received HIV Early Intervention services or were referred to outside agencies for these services.

In addition to the services listed above the HIV early intervention programs provide educational workshops for churches, schools, community groups, social services organization and businesses. Education topics include issues concerning addiction, the relationship between intravenous drug use and HIV, and the types of services offered

for persons in need. Staff from the HIV projects, participate in local health fairs and other community activities that address issues surrounding HIV/AIDS. Additionally, they participate in World AIDS Day, which is always on December 1st and National HIV Testing Day. These two days are set aside to bring local, state and national attention to the issues surrounding HIV/AIDS.

Staff from the HIV projects are members of the local community planning partnerships and are represented on the HIV Statewide Community Planning Group. Community-based partnerships and the statewide group are mandated by the Centers for Disease Control and funded through a grant with the Department of Health. In addition every HIV early intervention program has an agreement with the local county health departments; and staff from the HIV projects participate in community-based groups and boards that address issues surrounding HIV/AIDS issues.

The Substance Abuse Program Office remains actively involved with the Department of Health (DOH), Bureau of Infectious Diseases, HIV/AIDS Office. The Substance Abuse Program Office and the DOH are in collaboration to sponsor a two-day workshop of representatives from around the state to produce policy for the integration of substance abuse, HIV and Hepatitis C services. The Substance Abuse Program Office continues to remain active in the statewide planning process for community-based HIV services.

The Substance Abuse Program Office serves on the Florida Annual HIV Conference, which provides educational information, training and state-of-the-art models regarding prevention, transmission and care. This training opportunity for HIV-related public and private agencies to help them establish communication networks and inter-agency linkages expand HIV/AIDS consortia and facilitate the dissemination of information concerning education and prevention.

- Florida currently has 39 community-based agencies providing SAPTBG funded HIV services. Approximately 15 percent of these agencies provide HIV services to other organizations in their communities. The Substance Abuse Program's goal is to have HIV services provided in every substance abuse agency. This may be accomplished through contracts between the state and substance abuse agency or Memorandums of Agreement between substance abuse agencies.

- Intravenous drug use accounts for 38 percent of adult exposure to AIDS. The Program's goal is to provide more outreach services to intravenous drug users. This can be achieved with the HIV dollars, providing a substance abuse counselor is either present during or providing the outreach services.

- Seventy-two percent of the cumulative number of HIV cases in Florida and 84 percent of the AIDS cases are among minorities. The Substance Abuse Program's goal over the next three-year period will be to extend HIV services to areas where the greatest identified needs exist. The statewide allocation for HIV funds is based on the number of persons with AIDS per district. The Substance Abuse Program

can ensure that dollars are going to communities with the greatest need through contractual agreements.

Homelessness

According to reports by Florida's network of 28 local homeless coalitions, based on data released in June 2003, on any given day in Florida there are 72,600 homeless persons. Of this population, 37 percent are identified as having a substance abuse disorder and another three percent are dually diagnosed with mental health and substance abuse problems.

According to the local homeless assistance continuum of care plans in 26 communities around the state, there was a need for 11,998 beds to house homeless persons with chronic substance abuse issues. Of those 11,998 beds, 7,772 beds were needed for individuals, and 4,226 beds were needed for families with children. This data reflects coverage of 39 out of 67 counties or approximately 90 percent of the state population.

Therefore, the Office on Homelessness, in concert with the statewide interagency Council on Homelessness that includes the Substance Abuse Program Office, continues to develop a strategic plan for Florida to reduce its population of homeless persons. Several objectives in this strategic plan address substance abuse issues. The incorporation of these objectives and actions into the state's plan for substance abuse prevention and treatment will improve our ability to address the needs of this homeless population.

Objective 1*:* Increase by 25 percent over 2003 levels, the percentage of Florida's homeless population that receive assistance from the Mental Health and Substance Abuse Block Grants.

Objective 2*:* Reduce by 25 percent through the implementation of a discharge planning process, persons exiting the care and custody of state funded residential substance abuse treatment programs who are released into homelessness. The residential treatment discharge plan for an individual shall address the person's available housing upon discharge. For persons discharged from residential substance abuse treatment in FY 2002-2003, no children and 3.5 percent of adult individuals indicated their residential status as homeless.

Objective 3*:* Negotiate a memorandum of agreement between the department's behavioral health programs and the Council on Homelessness to establish specific goals to help reduce homelessness. This agreement proposes to address the following actions:

- Acquire a commitment by the department to match funding in years two and three of the Interagency Council on Homelessness grant for chronic homeless supportive housing that was awarded to Broward County.

- Develop working relationships between the 45 community coalitions on substance abuse and the 30 local homeless coalitions to coordinate services for homeless individuals who have substance abuse disorders.

- Incorporate into the state's substance abuse system of care, planning for services to special populations which specifically addresses homeless persons as a part of this population.

- Develop linkages between the state's substance abuse system of care and the local homeless assistance continuums of care to enhance local homeless services for persons who are homeless chronically or long-term and who are diagnosed with co-occurring disorders.

- Investigate ways to finance additional safe haven shelters for homeless individuals with substance abuse issues.

***Objective 4*:** End chronic homelessness in Florida by 2012 by building on the Policy Academy Team on Chronic Homelessness' work developed in January of 2003 and to carry out action steps identified by the team.

Strengthening the System for Licensure

Accreditation, Licensing and Monitoring Activities

As a result of the passage of Chapter 2001-191, Laws of Florida, certain changes have been and continue to be put into place in the state's system of regulating contracted substance abuse and mental health service providers. The department and AHCA are required to accept the accreditation survey report of an accredited substance abuse and mental health provider in lieu of conducting on-site licensing inspections. The accrediting organizations are the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitative Facilities (CARF), and the Council on Accreditation (COA).

For accredited substance abuse services, the department, through its district/regional offices, conducts full licensing reviews once every three years. For non-accredited substance abuse providers, licensing reviews are conducted annually. However, all substance abuse providers must be licensed annually and this involves submitting an application for licensing, along with licensing fees. The local district/regional offices retain their right to inspect substance abuse services with cause as permitted under Chapter 65D-30, Florida Administrative Code.

For accredited mental health services, residential facilities are being surveyed on-site by AHCA every 12 to 24 months after the beginning of the accreditation cycle. Nonresidential facilities are surveyed on-site by AHCA every 24 to 36 months.

The department will continue its work on reducing duplication regarding its administrative and program monitoring of accredited, contracted providers. The department has conducted a review and comparison of the accreditation standards, administrative rule standards, audit standards and departmental operating procedures to identify overlapping requirements. Those areas that have been found to be overlapping have been and will continue to be eliminated, notwithstanding accreditation deficiencies, contract corrective actions or qualified audits. Progress will continue to be made in coordinating licensing and administrative monitoring reviews and training of district/regional staff in coordinating these activities. The Substance Abuse Program has submitted a legislative budget request for 16 FTE positions to convert OPS licensure staff and funds to develop an automated licensure database to improve monitoring capabilities.

Chapter 2001-191, Laws of Florida, also required the department and AHCA to report to the Legislature by January 1, 2003, on:

- The viability of requiring all contracted mental health and substance abuse providers to be accredited; and
- The viability of privatizing all licensure and monitoring functions through an accrediting organization.

The findings supported requiring contracted mental health services to be accredited but not substance abuse services because of the historically strong regulation of substance abuse services and the fact that nearly 50 percent of substance abuse providers are already accredited. The findings did not support turning licensing and regulatory functions over to a private accrediting organization.

Licensing Requirements

The Substance Abuse Program Office is currently exploring ways in which substance abuse services may be provided to persons with a co-occurring substance abuse and mental health needs within mental health facilities and within the context of minimal regulatory intervention. The idea is that providers serving persons with primary mental health disorders that have a co-occurring substance use disorder should be able to provide integrated services as part of their treatment protocol. Various options are beginning explored and fall generally under:

- Full regulation;
- Regulation through waivers; and
- Alternatives to regulation.

Revision of Administrative Rule 65D-30, F.A.C.

Administrative rules under Chapter 65D-30, F.A.C., entitled Substance Abuse Services, have been amended and adopted as of April 2003. The rules were amended in part to update licensing requirements and to streamline the process of licensing reviews in

accordance with accreditation requirements under Chapter 2001-191, Laws of Florida, and the Governor's streamlining initiative regarding licensing and monitoring of substance abuse facilities. The major revisions include:

- Eliminating duplicative requirements and allowing greater flexibility with regard to service provision for providers;
- Removal of unnecessary requirements, making the rule less prescriptive; and
- Providing for exemptions from certain requirements for the Department of Corrections and DJJ as permitted under Chapter 397, F.S.

Implementation of Evidence-Based Practices

The Substance Abuse Program Office has developed a series of collaborative initiatives with statewide training/service associations, community-based agencies and universities to improve the quality of services for the people they serve. Emphasis is placed on the identification and development of evidence-based "best practice" models. This may include the replication of nationally recognized service models or validation of community-based agency models. The results and findings of these initiatives are disseminated via the department's internet site and through publications and reports.

Peer Review – Florida Clinical Consultation Treatment Improvement Project (FCCTIP)

Independent Peer Review is a requirement articulated in Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant regulations [45 CFR part 96, §96.136]. These regulations require that five percent of all programs receiving SAPT funding be reviewed annually by professional peers to assess the quality, appropriateness and efficiency of their treatment services. Chapter 397, F.S., requires that substance abuse treatment providers have quality assurance plans.

In order to meet the federal requirement, the department contracted with the University of Miami (UM) to develop a statewide Peer Review Program design, compatible with and complementary to the Department of Children and Families' Quality Improvement Program. The contract required the provider to design a process that would examine admission criteria/intake process, assessment, treatment planning (including appropriate referral), documentation of treatment services, discharge and continuing care planning, treatment outcome indicators, and best practices. The peer review process was designed to incorporate a method for transferring knowledge developed from substance use disorders research to the provider agency to facilitate the use of this knowledge in the every day practices of the agency. In essence, the protocols were designed to allow for the technology transfer of evidenced-based practices to provider agencies. The mission of the project was to move Florida's drug abuse treatment system towards excellence in services.

The University of Miami was selected to be the contractor for the project because of its extensive research background and accomplishments in the area of addiction. The

university is the *Florida Node* for the National Institute on Drug Abuse's (NIDA) Clinical Trials Network (CTN). The major emphasis of the CTN is to empirically test clinical practice models for their effectiveness. Additionally, the CTN is interested in the transfer of these models to providers throughout Florida. The CTN is national in scope but anchored on community-level programs, thereby accelerating the pace of treatment research and its application in real-life treatment settings. In addition to UM, the department partnered with the Florida International University and the Florida Alcohol and Drug Abuse Association (FADAA) as subcontractors to the University of Miami. FADAA is a non-profit, membership organization, which represents 97 community-based substance abuse treatment and prevention agencies and over 1,000 individual members throughout Florida.

Phase I of the peer review process was implemented in FY 2000-2001. This phase entailed the design of a peer review process that examined admission criteria/intake process, assessment, treatment planning (including appropriate referral), documentation of treatment services, discharge and continuing care planning, treatment outcome indicators, and best practices. The design also included the development of the protocol to collect participant feedback (e.g., reviewers, treatment providers) on the peer review process and a mechanism for using this feedback in annual process improvement. The peer review focused on clinical best practices. Phase I was completed in June 2001.

To augment the design of the peer review process an advisory board was created consisting of providers and researchers in the substance abuse field. The advisory board reviewed the protocols and data collection instruments, provided feedback and input into the overall process including the selection of the provider panel, peer review consultant trainees, and peer review site selection. A great deal of effort went into ensuring that the process included input from stakeholders.

There were four key components to the development of the protocols in Phase I: 1) establishing the infrastructure for conducting an ongoing review of the scientific literature on the therapeutic approaches used with substance abuse treatment in specific target populations (e.g., women with children, pregnant women, adolescents and adults). Articles selected for review were rated by the level of scientific evidence in terms of research design, methods, and effect sizes; 2) providing a checklist of the necessary ingredients for each treatment approach along with references to the scientific literature supporting the evidence and where available the procedural manual(s) for that treatment approach; 3) adapting the non-confrontational "motivational interviewing" and the "motivational enhancement" techniques to be used in the training of the *peer reviewers* and to conduct the on-site interviews, a strategy designed to encourage the program and key personnel to make those organizational changes that will best support the delivery of evidence-based therapeutic approaches; and 4) providing both a menu and a plan for accessing technical assistance resources needed to move toward applying the evidence-based treatment approaches in the most effective manner.

Phase II was implemented in January 2002 and ended in June 2003.

The primary objectives for Phase II were to:

1. Continue the refinement of the protocols;
2. Develop qualifications for clinical consultants;
3. Beta test the protocols;
4. Develop a training manual to train peer consultants;
5. Conduct training of the peer consultants on the protocols; and
6. Pilot test the protocols at two sites.

The accomplishments for Phase II are as follows:

- Revised the peer review protocols and data collection instruments developed in Phase I;
- Developed qualifications for clinical consultants;
- Developed process to solicit and select clinical consultants;
- Beta tested the protocols in July 2002;
- Developed the peer review training manual in September 2002;
- Trained ten peer review consultants on October 1-2, 2002;
- Evaluated the peer review training;
- Pilot tested the peer review protocols at two provider sites (Oct. 16-18, 2002 and Oct. 23-25, 2002);
- Completed evaluation of the peer review process;
- Modified the protocols and data collection instruments based on evaluations;
- Developed a Protocol Manual; and
- Developed the strategy for Phase III.

Phase III was implemented in August 2003.

The Florida Clinical Consultation for Treatment Improvement Project (FCCTIP) standardizes protocols for the review of the clinical processes practiced within substance abuse service delivery agencies in the state of Florida. These protocols provide guidelines that are supported by the available scientific evidence for *"best practices"* in the addiction field. In practice, there is often a difference between standard alcohol or drug abuse treatment delivery and alcohol or drug abuse clinical practices based on scientific evidence. FCCTIP is designed to help bring standard practice more congruent with the scientific evidence.

Change is not always embraced without friction. Assisting agencies move toward evidence-based clinical practice is in itself a change process. Recognizing the inherent resistance to change, the training component for the clinical consultation relied heavily on key concepts from Motivational Interviewing (which was labeled "Brief Motivational Feedback Approach" for the FCCTIP process) at the individual level which were adapted for use at the organizational level.

At the exit interview of the clinical consultation, the agency is provided a Feedback Report, a *Resource Manual* (developed by FCCTIP), and *The Change Book* (developed by the ATTC National Network) to assist in its development of an Action Plan. The agency is encouraged to develop an Action Plan as part of its quality improvement process to address areas needing improvement identified in the Feedback Report. Two follow-ups are conducted to see where the agency is in the change process. The Southern Coast ATTC has committed to assist agencies in the change process.

The primary objectives for Phase III are to:

1. Continue to refine and finalize the protocol process and pre-site and on-site data collection instruments;
2. Continue to refine and finalize the post-site visit activities;
3. Develop a follow-up protocol to site visits;
4. Continue to refine the Resource Manual;
5. Make necessary improvements on the training manual;
6. Conduct training of 12 peer consultants on the revised and improved version of the protocols;
7. Conduct clinical consultations at six non-accredited agency sites;
8. Conduct six site visits focusing on treatment services in a residential, outpatient and day treatment settings provided to adults, children, women, and women with dependent children populations;
9. Computerize protocol instruments;
10. Develop a website for the Resource Manual and therapeutic checklist; and
11. Develop a proposal outlining the activities and responsibilities for an independent agency to administer the peer consultation process, training and protocols on a statewide basis annually.

Because of the success of the peer consultation process and the utility of the protocols, the department will seek technical assistance funding for 2004 to provide training to accredited agencies' staff. The training will be modified to enable the agencies to use the protocols in-house. Currently the peer consultation site visits are conducted on non-accredited substance abuse treatment providers.

In FY 2004-2005 and FY 2005-2006, an independent agency will continue the peer consultation process conducting clinical consultation training, conducting at least six site visits, conducting follow-ups and preparing a summary report for the department. These reviews will focus on motivating agencies to implement evidence-based practices, identifying areas in which an agency is proficient, areas in which improvements are warranted, providing information on technologies and resources available to assist an agency in making needed improvements. These reviews will each have a target population and therapeutic modality.

Best Practices

In 2001, the Substance Abuse Program Office and the Florida Alcohol and Drug Abuse Association initiated the Best Practice Awards Program to identify exemplary service initiatives and programs throughout Florida. For the past three years the results have been disseminated throughout the state to encourage replication and enhancement of provider programs. Financial awards range from $500 to $1,500 and are provided to selected agencies and programs within the following categories: grand prize for best program, best rural program, prevention, treatment, intervention, best small program, and best innovative program.

The 2003 Substance Abuse Best Practice Awards program was a competitive application process that was open to all licensed substance abuse prevention and treatment providers. Best practice means those efforts that measurably improve service outcomes and the quality of life for Florida's residents who have been afflicted with the problems and debilitating effects associated with the abuse of alcohol and other drugs. Applications were reviewed by a five-person review panel made up of people who have distinguished themselves in the fields of research and in management and development of substance abuse programs. A list of the 2003 winners in each category is contained in Appendix B of this document.

Information on all of the programs, both those that won awards and those that were recognized as promising, was published in a best practices manual. The awards were presented at the 26th Annual FADAA Substance Abuse Conference held in Orlando in August 2003.

Florida Research to Practice Consortium

The Florida Drug Control Strategy advocates the use of best practice approaches to treatment to ensure the delivery of high quality care to those in need. The Substance Abuse Program Office, recognizing that science based treatment practices must be the predominant model for improving substance abuse treatment services, established a consortium of researchers, providers of substance abuse services, state staff and staff from professional and educational organizations in 2000. The consortium serves in a planning and advisory capacity to the state office.

The goal of the Florida Research to Practice Consortium is to enhance statewide coordination in the areas of substance abuse treatment and prevention research. The Consortium consists of policymakers, practitioners, researchers and individuals served by the program who are interested in improving substance abuse treatment services through better linkage across disciplines. The Consortium is sponsored by the department, FADAA, the Southern Coast Addiction Technology Transfer Center (SCATTC) and the Suncoast Practice and Research Collaborative (SPARC)/Tampa PIC project at the University of South Florida/FMHI, with support from a number of affiliated agencies such as the Florida Office of Drug Control. The Consortium is intended to

provide an ongoing vehicle for bridging the gap between research, practice and policy communities through a set of shared activities.

The Consortium has designated an executive steering committee to provide guidance in setting policy and developing a set of core activities. The Consortium has met six times over the past three years in different locations. The last meeting was held in Tampa on September 30, 2003. The Consortium is scheduled to meet two to three times per year, with one meeting being held at the FADAA annual training conference in Orlando. In order to promote diversity in the Consortium membership, 12 individuals from across the state have been identified as core members, and are eligible to receive modest scholarships to support their travel to the Consortium meetings. The Consortium has compiled a Statewide Research Compendium, which provides a catalogue of all substance abuse research in Florida that is sponsored by federal agencies or by foundations. In addition, the Consortium is in the process of completing the statewide co-occurring disorders treatment survey. This survey was co-sponsored by the SCATTC and was circulated to the Consortium for review in December 2003.

At the September 30th meeting, members indicated the need for the Consortium to help coordinate across several different state initiatives related to evidence-based practice (EBP). Activities that might be undertaken by the Consortium include organizing EBP information and materials, identifying priority needs for the state that would be included in this state plan, serving as a clearinghouse for "practice-to-research" strategies and efforts and assisting the state to implement EBPs within treatment agencies.

In order to assist the state in implementing EBPs, those attending the September 30th meeting recommended that the Consortium, with sponsorship and coordination from the SCATTC, develop a series of consensus meeting" to achieve the following: (1) define the meaning and scope of evidence-based practices and core practices, (2) develop priorities for EBPs and core practices to be implemented by the state and its treatment agencies, and (3) establish a larger conceptual framework to identify, implement and evaluate EBPs in Florida. This framework could be used to guide the planning and implementation of a series of activities related to EBPs in Florida.

Florida Node of the Clinical Trials Network

To date, the efficacy of new treatments for drug addiction has been demonstrated primarily in specialized research settings, with somewhat restricted service populations. The National Institute on Drug Abuse (NIDA) has established the National Drug Abuse Treatment Clinical Trials Network (CTN) to better address the problem.

The CTN has two missions: 1) conduct studies of behavioral, pharmacological, and integrated behavioral and pharmacological treatment interventions of therapeutic effect in rigorous, multi-site clinical trials to determine effectiveness across a broad range of community-based treatment settings and diversified service populations; and 2) transfer the research results to physicians, providers, and people they serve to improve the quality of drug abuse treatment throughout the country using science as the vehicle.

NIDA's goal is to fund 30-40 "nodes", each of which will consist of a regional research and training center (RRTC), and five to ten community treatment programs (CTPs) that will bring to both the node and the network a variety of treatment settings and persons served. The Florida Node includes urban and semi-rural areas, and treats a diversity of populations. The node has considerable expertise in adolescent family treatment, treatment for HIV/AIDS populations, aggressive engagement of individuals who abuse drug into treatment, and microanalysis of family therapy clinical process. The five CTPs in the node provide services to over 70,000 individuals yearly, with a combined budget of over $1 million, accounting for 22 percent of the state drug abuse treatment.

The Florida Node partners consist of:

- University of Miami led by the Center for Family Studies (José Szapocznik-Principal Investigator, Daniel Santisteban-Co-Principal Investigator);
- The Village (Valera Jackson, Michael Miller);
- Spectrum Programs (Bruce Hayden, Rhonda Bohs);
- Operation PAR (Nancy Hamilton, Mark Vargo);
- Center for Drug Free Living (Dick Jacobs, Deborah Orr);
- Gateway Services (Candy Hodgkins, Chris Neunfeldt); and
- Department of Children & Families' Substance Abuse Program Office (Ken DeCerchio).

The aims and achievements of the Florida Node are as follows:

1) Conduct Drug Treatment Studies in Front Line Agencies Simultaneously Across the Country.

- **Buprenorphine/Naloxone Detoxification:** The Florida Node completed its study of detoxification at Operation Par and the Center for Drug Free Living, in collaboration with the University of Miami. The Florida team was congratulated for its outstanding work by the national lead investigators. The first set of articles presenting the study's outcomes is currently in preparation.

- **Treatment Agency Survey:** Four agencies, including the Center for Drug Free Living, Spectrum Programs, Gateway, and The Village, completed surveys that gave a description major organizational and staff characteristics that can impact transfer of technology. Florida's participation rates were among the highest in the network according to the lead investigators. This success was accomplished under the leadership of a CTP Research Coordinator, Dr. Michael Miller, of The Village.

- **Smoking Cessation Study:** This protocol to test the impact of medication and group therapy on smoking cessation and indirectly on substance abuse relapse is being tested at the Center for Drug Free Living and at Spectrum Programs, in

collaboration with the University of Miami. This study recently began enrollment of participants.

- **Women's Trauma Treatment for Substance Abuse:** This is a new protocol that was initiated in the state of Florida in the latter part of 2003. The intervention to treat trauma among substance abusing women will be tested at The Village and at Gateway.

- **Motivational Enhancement Treatment for Spanish Speakers:** This treatment study is being conducted at Miami Behavioral Health and is designed to test the effectiveness of this well-known intervention with Spanish-only speaking individuals.

2) Generate/Design New Studies That Advance the Field of Drug Addiction Treatment.

- **Adolescent/Family Therapy:** The Center for Family Studies and its Node partners have designed and proposed a protocol for family therapy designed to provide continuing care for adolescents who use drugs and their families after discharge from residential treatment.

- **Brief Strategic Family Therapy (BSFT):** The Florida Node is leading the national implementation of this family treatment designed to reduce substance abuse among adolescents. This model developed and tested at the University of Miami Center for Family Studies, is now being tested at 14 treatment agencies around the country, including Florida sites. Training has begun and enrollment is expected during the first months of 2004.

  A substantial and additional component of the BSFT protocol work has been the extension of the CTN to include a treatment agency and university in Puerto Rico. This work will take place under the guidance of the Florida Node. The Florida team, under the guidance of Drs. Santisteban and Horigian, has accomplished considerable work with the Puerto Rican team in preparing the infrastructure for this important collaboration and implementation.

3) Provide Expertise to the National Clinical Trials Network.

- **Spanish Language Translation Team:** To remove barriers to the inclusion of Hispanics in protocols and to facilitate the ability of the CTN to reach the Hispanic population, the Florida CTN has taken on the daunting task of translating CTN-related material into Spanish. Translations have included questionnaires and interviews and actual treatment manuals.

- **Research Protocols:** The Florida CTN members are working with the National Institute on Drug Abuse on the development of new research protocols that will

test novel substance abuse treatment interventions (e.g., Two-Step Facilitation, Adolescent HIV Interventions, Family Management Skills, Escitalopram, CRAFT).

4) *Disseminate Information in Florida and Nationally*

- Daniel Santisteban presented a workshop on the challenges of adopting and supervising empirically based interventions into front-line practice at the annual conference of the Florida Alcohol and Drug Abuse Association (FADAA) held on August 20-21, 2003. FADAA is Florida's major provider organization. The workshop was co-sponsored by the Southern Coast Addiction Technology Transfer Center (SCATTC). The workshop highlighted the added responsibilities of and opportunities for the supervisor of empirically based treatments, and the special issues of monitoring adherence/fidelity in the "real world".

- Major partners in the Florida Clinical Trials network participated on a panel at the annual conference of the Florida Alcohol and Drug Abuse Association held on August 20-21, 2003. The workshop was co-sponsored by the Southern Coast Addiction Technology Transfer Center (SCATTC). The panel discussed lessons learned in implementing empirically based treatments in the front lines, and in research-practice collaborations within the Clinical Trials Network. Panelists included Daniel Santisteban (Co-Principle Investigator of the Florida Node), Nancy Hamilton (CEO of Operation PAR), Dick Jacobs (CEO of The Center for Drug- Free Living), Candy Hodgkins (CEO of Gateway Services), Valera Jackson (Vice President of The Village), and Rhonda Bohs (Research Director for Spectrum Programs).

- The Florida Node has developed active relationships with stakeholders enabling the dissemination of critical information. Dr. Daniel Santisteban serves as:

  - an Advisory Board Member for the Center for Substance Abuse Treatment – Southern Coast Addiction Technology Transfer Center (SCATTC) and attends all regular meetings;
  - a core member of the Florida Research to Practice Collaborative that brings together policy makers, clinicians and researchers in the state;
  - Chair of the Blending Research and Practice Subcommittee of the NIDA National Hispanic Science Network; and
  - A close association with the State Director of Substance Abuse Programs, Ken DeCerchio, and with John Daigle, the Director of the state's provider association (FADAA).
  - Dr. Daniel Santisteban has served as a primary liaison with potential CTN partners in Puerto Rico. The inclusion of Puerto Rico in the CTN has been a goal of CTN and NIDA and the Florida Node has offered to facilitate this collaborative relationship. In May 2003, Dr. Santisteban presented the mission and mechanisms of the CTN to representatives of the Universidad Central del Caribe and of the Universidad de Puerto Rico in setting the groundwork for possible collaborations around the Brief Strategic Family

Therapy protocol. Meetings were also held to identify community treatment program (CTP) and research collaborators and to form a team that might work with the CTN.

These goals were accomplished by creating a strong CTN partnership in the state. The Florida Node Steering Committee is comprised of seven members, five of whom represent the five original treatment agencies (Nancy Hamilton-Operation PAR, Dick Jacobs-Center for Drug Free Living, Candy Hodgkins-Gateway, Val Jackson-The Village, and Bruce Hayden-Spectrum Programs) and two who represent the University of Miami (José Szapocznik-Principal Investigator, Daniel Santisteban-Co-Principal Investigator). This committee meets monthly and has ultimate responsibility for decisions regarding budget development and revision, concept scoring and participation in protocols. The Committee also establishes policies for the Node and develops recommendations for NIDA as appropriate and needed. The Steering Committee receives reports and recommendations from sub-committee and workgroup representatives, protocol team leaders and research coordinators.

A number of other communications mechanisms are used to accelerate the progress and accomplishments of the Florida CTN:

1. A monthly call for all CTN participants across the state serves as a forum for discussing administrative as well as research-related issues. Information is shared about specific studies, regarding recently published journal articles and funding opportunities; plans for participation in conferences and manuscript preparation, and CTN-wide information updates;
2. The Florida Node Research Coordinators (one from each treatment agency) meet to discuss ongoing protocol-related issues, future protocol implementation plans, and manuscript and new concept development ideas;
3. The Florida Noder, an electronic newsletter, is published at least three times a year and distributed to all node participants. This publication provides general information about CTN and node-specific activities; and
4. E-mails regarding CTN activities are disseminated as appropriate.

Professional Development and Training

Under authority of s.397.321, F.S., the department's Substance Abuse Program Office contracts with private providers for substance abuse prevention education, training and referrals of individuals for treatment. The Substance Abuse Program Office provides $307,904 from Substance Abuse Treatment Block Grant funds to train professionals and providers in the delivery of substance abuse prevention and treatment to the citizens of Florida.

Florida Alcohol and Drug Abuse Association

The Florida Alcohol and Drug Abuse Association (FADAA) provides training, technical assistance, and skill building opportunities for substance abuse treatment providers

through its three statewide conferences (prevention, women's, multi-cultural), best practices training, science based training and a substance abuse clearinghouse.

Educational resources are available for the general public and professionals through standard mail, e-mail or fax. Topics for the general public and substance abuse prevention programs include information dissemination, substance abuse prevention education and training, alternative activities, early substance abuse identification and referral, environmental strategies and community processes.

- FADAA operates the resource center clearinghouse provided to the department's Substance Abuse Program Office, public and private substance abuse treatment providers. In addition these services provide information on substance abuse treatment confidentiality issues *by subcontract* with the Legal Action Center.

- FADAA reprints four (4) of the 'Just the Facts" fact sheets, a series of easy to read, educational fact sheets about alcohol and other drugs, violence, prevention, treatment and related topics. (Topics include Women in Treatment, Culturally Based Competency and Fetal Alcohol Syndrome.)

- FADAA provides the Florida Directory of Alcohol and Drug Abuse Treatment, Intervention and Prevention Programs. This directory is now available on CD disk and on FADAA's website, www.fadaa.org.

- A website is maintained 24 hours a day, 7 days a week, for public internet access to resources and materials. The website includes links to Just the Facts, Library Services, Coalition Directory, FADAA conference presentation slides, Technical Assistance Publications (TAPs), Treatment Improvement Protocol Manuals (TIPs), State and National Resource links. Plans for 2004 include a link to the department's website for the online training manual and presentation of the Marchman Act.

FY 2003-2004 Training Events

FADAA coordinates the organization, development and delivery of the Statewide Prevention Conference through the Prevention Conference Planning Committee. The Director of the Governor's Office of Drug Control heads the committee and various agencies contribute committee members to provide direction on the planning of the Prevention Conference.

The Women's Conference explores and presents the latest models in substance abuse treatment, intervention and prevention. The impact of substance abuse in child abuse, neglect and exploitation; fetal alcohol syndrome; elder abuse, neglect and exploitation and domestic violence are included in the current year's topic planning. The Women's Conference targets the training necessary for the department's family intervention specialist by providing curricula on issues of family safety, domestic violence, mental health and substance abuse programs.

The Multicultural Conference delivers training on the identification, treatment and prevention of substance abuse in individuals representing minorities. FADAA includes state and national model programs designed to meet the needs of a multicultural substance abuse program to be presented at the conference: 1) Two one-day technical assistance forums designed to support the success in the departmental Substance Abuse and Family Safety Integration Service Initiative; and 2) A one and one-half day meeting for local prevention service providers to share ideas, issues, and changes.

Florida School of Addiction Studies

The Florida School of Addiction Studies (FSAS) on the University of North Florida campus provides a week long intensive school experience for professionals to support and expand knowledge in the addiction field, regarding drug abuse, substance abuse, alcohol use, accessing healthy alternatives and minimizing risk-taking behaviors.

Credentialing agencies for certification and professional continuing education approves the school's plennaries and course work. Scholarships and merit awards provide access and recognition to front line workers in the field of addiction studies. Alumni of the school receive newsletters three times throughout the year providing ongoing updates on addiction issues.

The school hosts a website, www.fsas.org, for easy access and coordination of services with the Department of Children & Families' Substance Abuse and Mental Health Programs, Florida's Treatment Based Drug Courts, Department of Juvenile Justice, Department of Corrections and Department of Elder Affairs, as well as universities and out-of-state programs and agencies.

Southern Coast Addiction Technology Transfer Center (SCATTC)

Substance abuse represents the nation's number one health problem and causes more deaths, illnesses and disabilities than any other preventable health condition. The Addiction Technology Transfer Center (ATTC) Network focuses on developing the knowledge, skill and attitudes of the workforce that delivers treatment. ATTC ensures that practitioners have access to leading advancements in addiction treatment.

The primary purposes of the Southern Coast ATTC are to forge partnerships in Florida and Alabama to formulate knowledge needs assessments; to enhance faculty, trainer, practitioner and the individuals' participating knowledge and expertise in addictions treatment and recover; to cultivate systems change; to develop or revise research-based and culturally appropriate substance abuse treatment curricula, training materials and other products; to provide academic/continuing education and professional development training to students and practitioners in the substance abuse treatment and related fields; and to use the latest technology to accomplish goals through a state-of-the-art ATTC website and other technology tools. These aims will be accomplished through an identified set of comprehensive goals and objectives.

Sufficient evidence exist that suggest most clinicians' practice do not reflect principles of evidence-based practices but rather tradition, their most recent experience, what they learned in their formal education setting, or what they heard from their friends (Eisenburg, 2000). This in no way is a criticism of the clinician. It does speak to the need to assist the clinician in acquiring, absorbing and synthesizing the abundant amount of information available. Both nationally and within the Southern Coast region, efforts are well underway to synthesize the vast amount of literature available on prevention and treatment services and translate into practice.

For Florida and Alabama, the Southern Coast Addiction Technology Transfer Center (SCATTC) is charged with bringing evidenced-based practice information and training to treatment practitioners. The SCATTC will serve as the knowledge synthesis arm for the field and assist in helping organizations and individuals as they adopt and adapt to using these new practices. One Florida initiative that will assist in motivating organizations to adopt evidence-based practices is the new Florida Clinical Consultation for Treatment Improvement Project (FCCTIP). This project (developed through collaboration between the department's Substance Abuse Program Office, the UM Center for Family Studies, Florida International University, and the Florida Alcohol and Drug Abuse Association) brings a team of peer consultants into state contracted treatment agencies to undertake a review of agency practices and provide feedback related those that have empirical evidence of effectiveness.

To facilitate this technology transfer, the SCATTC has developed a three-stage plan. Each phase will include specific types of training, technical assistance and information activities designed to achieve benchmarks toward implementation of appropriate evidence-based practices with fidelity. Managers and administrators, clinical supervisors and individual clinicians all have specific roles to play in moving the addiction treatment field toward better outcomes through use of evidence-based practice. In each phase of this implementation plan, the needs of these specific workforce groups will be addressed.

Phase One: Awareness

Goal: To increase familiarity with the basic concepts and vocabulary of evidence-based practice including the benefits of utilizing evidence-based practice and the resources required for successful implementation.

Activities:

1. Information dissemination to all workforce groups through the ATTC website;
2. Publications that introduce the concepts of evidence-based practice;
3. Single-day training events that review the concepts of evidence-based practice; and
4. Training of Trainers event to increase number of trainers for Phase One and Phase Two activities.

Results:

- Increase in the number of practitioners who report familiarity with evidence-based practices;
- Identification of individuals and organizations that will participate in Phase Two and Phase Three activities;
- Inclusion of evidence-based practice in strategic plans for Single State Agencies, provider associations and individual agencies;
- Publication of basic series of articles on Evidence-Based Practice; and
- Cadre of trainers for continuing Phase One training and beginning Phase Two training.

Phase Two: Selection and Skill Building

Goals: a) To provide information about specific evidence-based practices and about steps to implementing evidence-based practices.

b) To assist organizations in assessing their readiness to implement evidence-based practices.

Activities:

1. Introductory training events on the basic principles of specific evidence-based practices;
2. Training on clinical supervision for evidence-based practices;
3. Development and distribution of tools to assist organizations in facilitating implementation of evidence-based practices;
4. Training and technical assistance at the organization level to assess readiness for change;
5. Production of a training manual for an evidence-based practice selected by CSAT;
6. Technical assistance and consultation at the state systems level to assist in providing policy and practice supports for evidence-based practices;
7. Participation in “roll-out” of evidence-based practice as directed by NIDA; and
8. Continuing distribution of awareness materials.

Results:

- Organizations participating will develop specific plans for implementation of selected evidence-based practices;
- Individual clinicians will demonstrate familiarity with core concepts of the EBP on which they have been trained;
- State policy and practice changes to support evidence-based practices will take place;
- Trainers from Phase One will continue to provide awareness training;
- “Initial Implementers” for NIDA roll-out will be identified; and
- Strategic plans for both states will continue to emphasize evidence-based practices.

Phase Three: Competency and Implementation with Fidelity

Goal: To provide technical assistance and support to state systems, agencies and

individual clinicians as they implement selected evidence-based practices.

Activities:
1. Multiple-day training events on specific evidence-based practices;
2. Development and distribution of tools to assist organizations in clinical supervision and management for evidence-based practices;
3. Training and technical assistance at the organizational level to assess competence for implementing specific practices;
4. Technical assistance and consultation at the state systems level to assist in providing policy and practice supports for evidence-based practices;
5. Participation in "roll-out" of evidence-based practice as directed by NIDA;
6. Continuing distribution of awareness materials; and
7. Additional training events at the introductory level.

Results:
- A self-selected group of agencies in each state will begin implementation of a specific evidence-based practice;
- Agencies implementing evidence-based practices will achieve expected outcomes and document results;
- Additional programs will begin the process of assessing readiness to change;
- "Initial Implementers" will participate in NIDA roll-out activities as appropriate;
- State policies and practices that support evidence-based practice will continue to be implemented;
- Barriers to implementation of evidence-based practices will be identified and solutions developed; and
- Strategic plans for both states will continue to emphasize evidence-based practices.

Products

- **Southern Coast Beacon:** "The Beacon" is a new product that will be published quarterly and is designed to synthesize some of the latest research on a variety of topics related to addiction treatment and adoption of new practices. The launch of this publication brings a three-part series on evidence-based practices. These publications are on the SCATTC website (www.scattc.org).

- **Southern Coast Beacon Spotlight Compact Disks (CDs):** These new products are compilations of training materials and other treatment support publications that center on special topics. The first spotlight CD is on co-occurring substance abuse and mental health disorders.

- **Report from the SCATTC Faith and Community-based Committee:** SCATTC sponsored a Florida committee to facilitate a dialogue between faith and community-based providers of addiction services, and create a synergy for collaboration and understanding. A report of this group's work was created to summarize the efforts of this combined working group, and may serve as a model for others to emulate in

achieving a level of communication and cooperation between faith-based organizations (FBOs) and community-based organizations (CBOs).

- **SCATTC Workforce Survey - Staff Version:** In the last quarter of 2002, SCATTC administered a workforce survey in Alabama and Florida. Survey results have been analyzed and a summary report posted on the SCATTC website (www.scattc.org).

- **Training Curriculum for New Women's Treatment Improvement Protocol (TIP):** SCATTC has begun production of a curriculum package for the new women's treatment TIP from SAMHSA. This TIP is not yet published but is in final SAMHSA clearance. The companion curriculum will be ready in 2004 and will be a product of not only the SCATTC, but also of SAMHSA (available through the National Clearinghouse, NCADI).

Other SCATTC Initiatives:

- **Developing More Uniform Testing and Certification Standards:** Florida Certification Board (FCB) and the SCATTC have held a series of meetings in Florida to assist education providers towards meeting new educational requirements for persons seeking certification (that went into effect January 2004). Specifically, a workgroup reviewed the new education standards, weighted the hours per actual job performance and began to develop some models for coursework definitions (offered both through traditional academic and adult continuing education) as they relate to the Transdisciplinary Foundations and Dimensions of Professional Practice.

- **Uniform Certification Standards:** Nationally, the Southern Coast ATTC proposed to CSAT and the National ATTC network several areas to create new uniform certification standards. A task force for credentialing standards was formed under the ATTC Workforce Development Committee to address credentialing standards for addiction counselors. As CSAT has a number of workforce related initiatives including the ATTCs (the KAP contract, the current PIC projects, and AMERSA/HRSA/CSAT project), these workforce development efforts are to be coordinated within CSAT, and with workforce efforts in SAMHSA and other agencies. The first meeting of this task force took place in June 2003.

- **Role Delineation Study in Florida:** SCATTC, with participation from several other states and CSAT, will work with FCB to conduct a new role delineation study for entry-level addiction counselors (November 2003). This study will lead to the development of a new exam (also using *TAP 21* as the foundation of competency areas) that will replace the current Florida-specific exam. This will also be used as a state-specific exam in several other participating states.

- **Education Consortia:** Education consortia are newly underway in both states. Academic institutions are beginning to define the kinds of areas that they would like to address. Examples are: expand coursework for addiction studies to better prepare addiction service professionals; work to minimize the systemic barriers that

hinder the development of new credit bearing coursework; share programming options and coursework; enhance coordination between academic institutions so that each institution does not have to offer each course; find curriculum resources so colleges do not have to develop all curricula; address the needs of non-traditional students; involve the Department of Education in the finalization of a statewide course numbering system for addiction studies; explore the offering of academic credit for life experiences and for prior learning; move more towards competency-based language and education; and, recruit new professors to teach these new addiction courses.

- **Survey on Services to Persons with Co-Occurring Mental Health and Substance Abuse Disorders –** SCATTC has partnered with the Florida Research to Practice Consortium in the administration of a survey designed to measure the extent and kinds of services that are being provided in the region for persons with co-occurring disorders. Dr. Roger Peters, Dr. Deborah Ruggs, and Pam Waters presented the findings to the Florida Research to Practice Consortium on September 30, 2003.

- **SCATTC Website** - SCATTC continues to make the website a priority, adding new content weekly to all sections. Textboxes on the home page feature links to on-line resources that enhance addiction treatment service provision. Examples of topics from the past quarter are: Spotlight on Older Adults, Spotlight on Drug Courts, Child Welfare and Substance Abuse, Fetal Alcohol Syndrome, CSAT's new Directory of Alcohol and Drug Abuse Treatment Programs, the new SAMHSA Knowledge Application website, and the CSAT Recovery Month webcasts. A new section was added in the products category, *Manuals for Treatment Interventions*, to provide a one-stop-shop for public domain treatment manuals.

Southeastern School on Addictions Studies

This school has been in existence for 43 years and offers advanced training for substance abuse professionals throughout the eight-state region in the areas of prevention, intervention and treatment. The eight states of the region are Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. The University of Georgia in Athens, Georgia is host to this school.

School attendees can usually earn up to 30 contact hours by participating in full-week and half-week courses, plenaries and other activities. Annually, the school offers the weeklong Leadership Institute, which is a unique opportunity for four participants per state to promote dialogue and consensus on a topic identified as being important to the states and communities in the region. The result of the Institute is a consensus policy paper on the selected topic. This year's topic was "Spirituality and Substance Abuse."

Chapter 5: Substance Abuse Program Strategies

Through standardized needs assessment methodologies, the Substance Abuse Program estimates there are 848,246 adults and 353,159 children in need of substance abuse services. The program is currently serving approximately 110,272 adults (13 percent of the estimated need) and 77,695 children (22 percent of the estimated need). This does not include the percent of need being met by other sources, such as Alcoholics/Narcotics Anonymous, private health insurance, and the Children's Health Insurance program (Title XXI) and faith-based programs.

While access to treatment has improved over the last several years, as evidenced by declining waiting lists and increases in numbers of individuals served, there are many Floridians who do not have access to effective treatment services. Under-served populations include older Floridians, homeless individuals and families not involved in the criminal justice or child protection systems, and foster care children and individuals with co-occurring disorders who need specialized services. In order to reduce the number of addicted individuals by 50 percent by 2005, pursuant to the Florida Drug Control Strategy, treatment capacity must be expanded. The responsibility for improving access to services must be shared with the business sector (drug free workplaces), employer sponsored health insurance; other public and private insurance; the faith community; the criminal justice system; local government and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous (AA and NA).

Under Governor Bush's leadership, funding in FY 2002-2003 for substance abuse treatment in the department has been increased by 45 percent compared to FY 1998-1999 funding for adult substance abuse services and 56 percent for children's substance abuse services. This has expanded treatment services to an additional 23,784 adults and 8,519 children served annually since FY 1998-1999. Expansion of treatment services has targeted Temporary Assistance to Needy Families (TANF) recipients and individuals at risk of entering the welfare system, families involved in the child protection system, pregnant women and women with dependent children, heroin and cocaine users and individuals involved in drug courts.

Overview of Substance Abuse Strategies

In accordance with department's goals and strategies the Substance Abuse Program has developed a series of goals and strategies that emphasize improvements in the substance abuse system of care, workforce competence, service and administrative accountability and stakeholder participation. As part of the department's change management procedures, a detailed implementation plan will be developed that includes performance targets, responsible parties and progress reports. The goals, strategies and courses of action are outlined below.

Substance Abuse Program Mission: Prevent and Remediate the Consequences of Substance Abuse

Department Goal # 1: Ensure the Safety, Well-Being, and Self-Sufficiency for the People We Serve

Strategy #1: Close the Treatment Gap

Project A: Service Integration with Child Welfare

Strategic Course(s) of Action:

1. Continue to Support the Implementation and Integration of Family Intervention Specialists.

   - Thirty-five new Family intervention Specialists positions were appropriated during the 2003 legislative session, bringing the statewide total to 70. These positions provide substance abuse screening and service linkage for persons involved with the child protective services system.

2. Policy Paper Implementation.

   - In Summer 2003, the Senate conducted a senate interim project to evaluate coordination and integration of substance abuse services with child welfare and community-based care. The purpose of the project was to advise the department and Legislature about the current situation, and to identify opportunities for improvement in cases where parental substance abuse is a contributing factor to child abuse and neglect finding. The report was released in November 2003. The Substance Abuse Program Office will continue to work collaboratively with the child welfare program on the development and implementation of a policy framework for an integrated and coordinated response to address the problem of parental alcohol and drug abuse in child maltreatment and neglect cases.

3. Technical Assistance from the National Center on Substance Abuse and Child Welfare.

   - The Substance Abuse Program was one of four states to be awarded in-depth technical assistance from the National Center for Substance Abuse and Child Welfare (NCSACW) to improve outcomes for families and caregivers involved in the child welfare system that are in need of substance abuse services. The technical assistance will be made available through a statewide workgroup and local implementation sites in Volusia and Flagler counties. The technical assistance will offer a best practice model for collaborative casework. From this the statewide workgroup will develop a Florida-specific tool kit to provide

structured guidelines for introducing new practice models and promoting collaboration among state and local entities.

4. Implement Provisions of SB 2404 in Districts 4 and 12.

   - SB 2404 directs the department to establish a single managing entity for Districts 4 and 12 “accountable for the delivery of substance abuse services to child protective services recipients in the two districts.” The intent of this legislation is to “enhance the coordination of substance abuse services with community-based care agencies and the department.” The department is working to establish a single managing entity for the seven county area. Staff have met with community stakeholders to obtain their feedback for the initial specifications for the system of care requirements to improve outcomes for families involved in the child welfare system who are affected by substance abuse. The department has also procured a national consultant on behavioral health services networks to assist with the design and implementation of the initiative. It is critical that the provider services network include the full array of substance abuse providers who are serving families in the child welfare system.

Project B: Legislative Budget Request-Critical Community Capacity

Strategic Course(s) of Action:

1. Enhance Critical Residential, Outpatient and Detoxification Services.

   - The Substance Abuse Program is seeking funding from the Legislature to expand existing residential, outpatient and detoxification services capacities in identified areas. The additional capacity would enhance access to care for vulnerable populations including pregnant women, women with dependent children, older adults and persons with co-occurring mental health and substance use needs.

Project C: Legislative Budget Request -Replacement of Substance Abuse Treatment funds for participants in Drug Courts.

Strategic Course(s) of Action:

1. Continue Service Provision to Persons Involved with the Criminal Justice System.

   - The Substance Abuse Program has requested funding from the Legislature to replace current level of substance abuse treatment funding for community-based criminal justice participants in adult, juvenile and dependency drug courts and continue treatment services for an additional 8,602 adults and 2,172 children, reducing their need for incarceration.

Project D: Legislative Budget Request –Temporary Assistance to Needy Families (TANF) Continuation

Strategic Course(s) of Action:

1. Continue Treatment Services for TANF Participants.

   - The Substance Abuse Program has requested funding from the Legislature to replace current level Interventions of treatment funding for adults and children involved with the TANF Program. These funds currently serve 5,655 adults and 1,107 children annually.

Project E: Expand Federal Funding Opportunities

Strategic Course(s) of Action:

1. Resources for Recovery.

   - The Substance Abuse Program, in conjunction with AHCA and FADAA, applied to the Robert Wood Johnson Foundation for funding to analyze the substance abuse treatment system. Florida was one of five states to receive $200,000 to improve revenue maximization strategies for Medicaid funding. The department's Substance Abuse Program, FADAA and AHCA are working to develop strategies for the expansion of service capacity and coverage groups through enhanced financing and management methods. Part of the strategy is to develop case rate formulas for low, moderate and high-need individuals, using the Suncoast Region as a model. Additionally, the certifying of state and local revenues to match federal participation in the Medicaid Program will facilitate the expansion of benefits to serve more individuals in the Medicaid program affected by substance abuse.

2. Access to Recovery.

   - President Bush is advocating for the passage of legislation and annual funding in the amount of $200 million ($600 million for three years) to develop and implement a vouchering system to improve access to substance abuse services for persons in need. If passed, the Office of Drug Control and the department's Substance Abuse Program will apply for funding to implement, manage and enhance substance abuse services statewide through the inclusion of community-based providers not currently under contract with the department.

     If funded, the Substance Abuse Program will work with the Office of Drug Control, FADAA, the Florida Faith-Based Association, and community-based agencies to develop funding and service delivery mechanisms. The initial phase of development is projected to take approximately six months. Actual service provision is projected to begin in FY 2004-2005 and continue through FY 2005-

2006, and would enhance service choice options for persons in need and their families.

Department Goal #2: Provide Effective and Enhanced Prevention Services

Strategy #2: Prevent Substance Abuse

Project A: Continue Florida Youth Survey

Strategic Course(s) of Action:

1. Continue Survey in Spring 2004 to Measure Progress and Direct Future Strategy.

   - The 2004 administration of the Florida Youth Substance Abuse Survey will target approximately 65,000 middle and high-school age youth and will generate a drug use prevalence and related risk and protective factor profile for each of Florida's counties, as well as a state profile. A contract is being developed for the 2004 survey administration and related data analysis and report writing services. The logistics of co-administration of the survey with the Florida Youth Tobacco Survey are also being discussed with the Department of Health.

Project B: Implementation of Florida Prevention System Plan

Strategic Course(s) of Action:

1. Organize and Staff the Florida Substance Abuse Prevention Advisory Council (FSAPAC).

   - The State Incentive Grant (SIG) Advisory Council was transitioned to the FSAPAC and the scope of the Council was broadened from youth only to all age groups. This will begin to elevate departmental services for children and adults to the level now characterizing our services for youth.

2. Update Florida Prevention System Plan.

   - The update of this plan began at the Council's retreat on September 24-25, 2003. It reflects the newly broadened scope of the FSAPAC, making recommendations for strengthening substance abuse prevention services for children, youth and adults.

Project C: Expand Community Coalition Mini-Grants

Strategic Course(s) of Action:

1. Contract with Florida State University to Administer the Grant Program.

- A contract to administer the grant program has been executed with Florida State University. Contract activities include training on proven environmental strategies to accomplish local substance abuse prevention objectives, as well as awarding and managing an estimated 25 mini-grants. The training on environmental strategies will give Florida's local community anti-drug coalitions new skills for recognizing and addressing environmental issues that slow progress toward the prevention goals of the Drug Control Strategy. The mini-grants will support coalition activities, with an emphasis on addressing environmental issues.

2. Implement Request for Proposal (RFP) Process.

   - The RFP to strengthen the organizational structure of local anti-drug coalitions and to purchase the implementation of proven environmental and community process strategies was released on August 20, 2003. As of November 30, 2003, 24 mini-grants serving 23 counties had been awarded, representing a total of $394,250. Twelve of the awardees are established coalitions that are implementing environmental and community process prevention strategies. Twelve were awarded to either new or "growing" coalitions. A third phase of applications were due on December 19, 2003. The department expects to award eight to 12 additional grants (a coalition may only receive one grant per year).

Project D: Initiate the Performance-Based Prevention System

Strategic Course(s) of Action:

1. Contract with the University of Miami to Pilot the Performance-Based Prevention System.

   - A contract to pilot the performance-based prevention system has been executed with the University of Miami. The performance-based prevention system is a web-based data collection and reporting system that will track both process and outcome information. Activities related to the pilot have begun through a subcontract partnership with KIT Solutions, Inc. The purpose of the pilot is to test the system with up to 60 prevention service contractors. The system is designed to improve the timeliness and relevance of data reporting related to substance abuse prevention services.

2. Conduct Provider and District Staff Training.

   - This training was completed on August 29, 2003. Provider representatives and district staff were oriented to the system. They learned how to initiate a program file, track program participants, enter activity information and access related reports.

3. Conduct Performance-Based Prevention System (PBPS) Pilot.

   - The pilot project through the University of Miami and KIT Solutions began on September 2, 2003. Within two months, all participating service providers were entering substance abuse prevention program data into this system. During the pilot, the system will electronically extract information necessary for existing data systems (the ADM Data Warehouse and ONE Family).

Project E: Improve and Expand Prevention Partnership Grants

Strategic Course(s) of Action:

1. Provide Support and Assistance to District Staff on the Effective Implementation of s.397.99, F.S.

   - This support is pending the approval of a purchase order for training and technical assistance services that will facilitate the upgrading of substance abuse prevention services by funding current proven prevention strategies. The RFP is expected to identify up to 45 prevention projects.

2. Coordinate a Statewide RFP Process for FY 2004-2005.

   - The RFP is currently under review for approval. The RFP accomplishes two goals: 1) ensures compliance with s.397.99, F.S., requiring that projects be periodically re-bid; and 2) achieves cost savings resulting from state level coordination of the RFP. This will allow districts to review proposals and select providers while the administration of the RFP will be handled by the central Substance Abuse Program Office.

Department Goal #3: Realign and Refocus the Workforce

Strategy #3: Strengthen Workforce Competency and Stability

Project A: Implementation of the Secretary's Reform Plan

Strategic Course(s) of Action:

1. Direct Line Authority

   - The Substance Abuse and Mental Health Program Offices have established direct line authority over district operations. Memoranda of Agreement have been signed with each district/region outlining the responsibilities of staff and the reporting structure between central office and the field.

2. Improve Oversight of District Operations.

   - The Substance Abuse and Mental Health Program Offices analyzed the alignment of staff to ensure coverage for critical tasks/responsibilities to correspond with the new operational and programmatic functions for each district/region. This alignment was established by December 31, 2003.

3. Budget Functions.

   - The Substance Abuse and Mental Health Program Offices are developing procedures to ensure accurate, timely and appropriate expenditure of funds through the enhancement of spending plans. Each district/region will be expected to manage their budgets in accordance with the spending plans.

4. Contract Functions.

   - The Substance Abuse and Mental Health Program Offices are developing guidelines for district/region contract managers to ensure appropriate oversight of provider performance, improve contract manager competencies, and to ensure consistent application of contract policies and procedures.

Project B: Funding Recurring Salary Deficit (Legislative Budget Request)

Strategic Course(s) of Action:

1. Fund the Re-Occurring Salary Deficit by Redirecting General Revenue Funds That Will Allow Districts/Region to Maintain Full Staff at All Times, Currently 33 full-time employees (FTEs).

   - A legislative budget request was developed in August 2003 to redirect general revenue and block grant funds to cover a recurring salary deficit.

Project C: Other Personal Services (OPS) Conversion of Licensing Workforce (Legislative Budget Request)

Strategic Course(s) of Action:

1. Ensure Continuity and Stability of the Workforce Conducting Licensing inspections of Substance Abuse Providers*.*

   - Legislative approval is needed to add 16 FTE positions to replace OPS positions in affected district/regional offices throughout the department that have historically relied on OPS to fill in the gaps in what should have been FTE positions to handle licensing functions.

- As a result of this action, the department will be able to build and maintain a workforce of FTE positions dedicated to conducting licensing inspections of substance abuse service providers.

2. Increase and Improve Standards of Competency of the Workforce Conducting Licensing Inspections of Substance Abuse Providers.

   - As a result of this action, the department will be in a better position to evaluate the effectiveness of its workforce dedicated to licensing and find ways to improve on competency related to this activity.

Project D: Create Comprehensive Staff Development and Training Plan

Strategic Course(s) of Action:

1. Access District Staff Development Requirements.

   - The Substance Abuse Program Office and district/region staff are reviewing staff development needs and will identify the areas of greatest need to ensure staff attainment of necessary knowledge and skills. The needs assessment is targeted for completion by June 2004.

2. Define Core Competencies.

   - In consultation with district/region staff, the Substance Abuse Program Office will determine core competencies for field staff to successfully direct and manage substance abuse services. The core competencies will be identified by March 2004.

3. Design a Training Plan to Address Core Competencies and Staff Development Needs.

   - A comprehensive training plan will be developed by June 2004 that outlines staff development expectations at the district/region level. The training plan will be developed around the core competencies identified in the needs assessment.

Department Goal #4: Strengthen Accountability

Strategy #4: Enhance System of Care and Performance Management

Project A: Implement Senate Bill 2404

Strategic Course(s) of Action:

1. Improve the Assessment of Individual Satisfaction.

- The Substance Abuse Program Office is identifying methods for determining individuals' satisfaction with service delivery. This process was previously included in the agency-wide individual satisfaction reporting process. With the institution of direct line authority the Program Office will assume this responsibility for individuals with substance abuse needs.

2. Interagency Agreement with AHCA.

   - Pursuant to SB 2404 requirements, the Substance Abuse and Mental Health Program Offices have developed an interagency agreement with AHCA to define mutual roles and responsibilities in meeting statutory requirements.

3. Expand Provider Networks.

   - The specifications for the expansion of provider networks are being developed with anticipated phase-in over the next several years.

4. Implement a Managing Entity for Substance Abuse/Family Safety Services in Districts 4 and 12.

   - Requirements for the managing entity are being developed for the coordinated administration of child welfare and substance abuse services in Districts 4 and 12.

Project B: Improve System of Fiscal Accountability

Strategic Course(s) of Action:

1. Accommodate Technical Changes and Clarifications.

   - Language in future amendments to the SAMH Financial Rule Chapter 65E-14, F.A.C., will be added to reflect enhancements in the data gathering capabilities of the department.

2. Update Budgeting, Accounting, Invoicing and Auditing Requirements.

   - The Substance Abuse Program and Mental Health Program will continue to modernize budget, invoice and audit formats for ease of use, comprehension and data reporting capabilities.

3. Address Provider Issues.

   - The Program Offices will work with SAMH providers collaboratively to clarify requirements, amend rules and address rate issues. Training opportunities will be made available to district staff and providers on issues of common interest.

Project C: Performance Partnership Grant (SAPT Block Grant) Performance Measurement

Strategic Course(s) of Action:

1. Prepare for Implementation of the Federal Performance Measures.

   - The Substance Abuse Program, along with several other states, is working with the federal Center for Substance Abuse Treatment to develop appropriate performance measures for inclusion in the FFY 2005 federal block grant application. The department will continue to advocate for alignment of state and federal measures to reduce duplicative reporting on the part of community-based providers.

2. Revise Information System.

   - The integrated substance abuse and mental health data system is undergoing a continuous improvement process to accommodate changes in state and federal performance requirements. The department is working collaboratively across programs and with other state agencies on the development of integrated data systems to improve the efficiency and cost-effectiveness of publicly funded service provision.

3. Improve Performance Reviews at District and Provider Level.

   - The Substance Abuse and Mental Health Program Offices are enhancing methods for determining provider and district/region performance standards. Beginning in FY 2004-2005, performance targets will be set in relation to individual characteristics, service provision and funding. Reports and mechanisms for feedback to providers and districts/region are being enhanced to ensure attainment of contractual performance measures. District/region staff will receive monthly reports that identify whether a provider is on course to attain contracted performance standards.

Project D: Expansion of Evidence-Based Practices

Strategic Course(s) of Action:

1. Continue Best Practice Awards Program.

   - The Best Practice Awards Program, sponsored by the department and FADAA, will continue in 2004. The Best Practice Awards Program is a competitive application process open to all licensed substance abuse prevention and treatment providers in Florida. Applications are reviewed by a panel of experts in

the field of research and in management and development of substance abuse programs.

2. Implement Clinical Consultation Project.

   - The peer review project, known as the Florida Clinical Consultation Treatment Improvement Project (FCCTIP) is in its third and final stage. The FCCTIP is in its implementation stage and will conduct clinical consultation with six non-accredited substance abuse treatment providers in the state of Florida. This independent organization will be responsible for providing training to prospective consultants, contacting and scheduling clinical consultations with the treatment provider community, conducting the clinical consultations, analyzing results of the consultations and providing the department with year end report summarizing the clinical consultations.

3. Support Clinical Trials Network.

   - The department supports the National Drug Abuse Treatment Clinical Trials Network (CTN). The department maintains relationships with the Florida CTN Node at the UM. Jose´ Szapocznik, Ph.D., is the principal investigator for the Florida CTN Node and administers the peer review project under contract with the department. The mission of the CTN is twofold; to conduct studies and research of various treatment interventions to determine clinical effectiveness in a broad range of settings, and to transfer the knowledge gained through these science based studies to physicians, providers and others to improve the quality of drug abuse treatment. The department is currently contracting with the Florida Clinical Trial Networks to create these protocols to establish new professional development cost centers for this fiscal year to include: Brief Strategic Family Therapy, Motivational Enhancement Therapy for Spanish Speaking Individuals, and Seeking Safety as a Treatment for Women with Trauma. A portion of the training will begin immediately with subsequent training afforded in succeeding second and third waves of studies.

4. Continue Support of Addictions Schools and Training Conferences.

   - The Florida School of Addiction Studies (FSAS), on the University of North Florida campus, is financially supported by the department. The FSAS will provide a weeklong intensive school experience for professionals to support and expand knowledge in the addiction field regarding drug abuse, substance abuse, alcohol use, accessing healthy alternatives and minimizing risk-taking behaviors. Scholarships and merit awards sponsored by the department provide access and recognition to front line workers in the field of addiction studies.

   - Continue collaboration with the Southeast Coast Addiction Technology Transfer Center (SCATTC). The department collaborates with the SCATTC on many training and coordination initiatives related to substance abuse treatment and

prevention. The SCATTC is a co-sponsor, along with DCF and FADAA, of the Florida Research to Practice Consortium. The Consortium's goal is to enhance statewide coordination in the areas of substance abuse treatment and prevention research. The SCATTC partnered with the Florida Research to Practice Consortium in the administration of a survey designed to measure the extent and kinds of services that are being provided in the region to persons with co-occurring disorders. Additionally, the SCATTC will provide technical assistance to provider agencies that have undergone a peer review in assessing agency readiness for change at the organizational level. This will enhance the peer review initiative of the department. The SCATTC continues to play a vital role in Florida's substance abuse training and coordination initiatives.

Project E: Strengthening Licensure System

Strategic Course(s) of Action:

1. Implement Automated Reporting and Data System.

   - The Substance Abuse Program shall continue to seek funding for the development of an automated reporting system that will allow the department to have real-time data relative to licensure reviews, licensure status, and corrective actions needed to bring a provider into compliance with state administrative rules. This will enable the department to identify the volume and type of licenses provided and to determine necessary staffing level Interventions to license eligible programs/services on a statewide basis.

2. Implement Web-base Training Modules.

   - As a result of this action, the department will be able to evaluate the effectiveness of its workforce dedicated to licensing substance abuse service providers and ultimately the effectiveness of the training program as a medium for building competency.

Department Goal #5: Improve Shared Stewardship

Strategy #5: Enhance Stakeholder Participation

Project A: SAMH Annual Master Plan

Strategic Course(s) of Action:

1. Plan Due January 2004.

   - The Substance Abuse and Mental Health Program Offices are developing a three-year comprehensive plan for publicly funded behavioral health services. The programs will be consulting with AHCA and other stakeholders to identify

service needs and priorities consistent with SB 2404 and other substantive legislation. In years two and three of the planning cycle, updates to the primary plan will be completed that detail the status of strategic issues.

2. Strengthen Community and Stakeholder Participation.

   - District/region offices will be focusing on increasing participation of community stakeholders in the planning process. Annual planning documents at the district/region level are presented to community alliances and other planning councils prior to finalization.

Project B: Collaboration with Drug Courts

Strategic Course(s) of Action:

1. Continue to Participate on Supreme Court Treatment Based Drug Court Taskforce.

   - The Substance Abuse Program will continue to support drug courts by making community treatment resources available to the courts and will continue to seek budget increases to meet the demand of referrals from adult, juvenile and dependency courts for substance abuse treatment services (e.g., screening, assessment, counseling and residential treatment). The Program has developed fields in its data system to enhance the identification of individual involvement with drug courts.

2. Coordinate Budget Issues with Office of State Courts Administrator.

   - The Office of the State Courts Administrator (OSCA) is planning for the addition of three juvenile, four dependency and three adult courts. The Substance Abuse Program has submitted a legislative budget request to maintain the current level of services impacted by drug courts and will continue to coordinate with OSCA to seek funding commensurate with the demand for services.

Chapter 6: Collaborative Initiatives

The Substance Abuse and Mental Health Program Offices have taken the initiative to foster a system of care that is coordinated, integrated and supportive of individuals of all ages with serious mental illnesses and substance use needs. The programs work collaboratively in several areas including program development and oversight, contracting, information systems and financial management to maximize the efficient use of resources for persons served and to enhance the overall effectiveness of services. The Substance Abuse and Mental Health Programs also work with other departmental programs, and state and local agencies to reduce fragmentation within the systems of care and to improve individual outcomes. This chapter highlights several significant programs and initiatives that rely on collaboration to ensure success.

Co-occurring Disorders

The recognition that individuals with co-occurring needs (serious mental illnesses and substance abuse needs) have been treated in parallel systems leading to duplication of services or have failed to be treated for both needs, thus leading to treatment failures and costs in lost productivity and resources, has spurred an initiative to develop comprehensive, integrated services based on evidence-based practices, training that encourages early identification and treatment of individuals with serious mental illnesses and substance use needs and prevention.

Each year since 1971, the National Survey on Drug Use and Health (NSDUH) has conducted a survey of approximately 70,000 individuals aged 12 and older in the 50 states and the District of Columbia. The 2002 survey, released in September 2003 by SAMHSA, is based on responses from residents of households, non-institutional group quarters such as shelters and rooming houses and civilians living on military bases. Homeless persons who did not use shelters, active-duty military personnel and residents of institutional group quarters such as prisons or long-term hospitals were excluded from the survey. The design of the study produces a sample large enough to yield direct estimates of substance use in eight states with the largest populations (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania and Texas).

The 2002 study reported the following regarding the co-occurrence of serious mental illness with substance dependence/abuse in adults aged 18 and greater:

1. Among adults with serious mental illness (SMI) 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was 8.2 percent;
2. Adults with SMI were more likely than those without SMI to be dependent on or abuse illicit drugs (9.6 vs. 2.1 percent) and more likely to be dependent on or abuse alcohol (18.0 vs. 7.0 percent); and
3. Among adults with substance dependence or abuse, 20.4 percent also had SMI. The rate of SMI among adults not dependent on or abusing substances was 7.0 percent.

It is likely that the inclusion of data from individuals in institutions and correctional settings would significantly increase these percentages.

In April 2003 the department issued the *Florida Department of Children & Families (DCF) Policy Paper on Co-occurring Mental Health and Substance Abuse Disorders,* in which goals for improving the system of care for people with co-occurring serious mental illnesses and substance abuse needs were outlined. The plan details joint issues, system goals and outcomes, and recommendations agreed upon by the Substance Abuse and Mental Health Program Offices. The paper, in its entirety, is available at:

> http://www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/publications/cocombined.pdf

Over the last ten years the concept of integrated service provisions for individuals with co-occurring substance abuse and mental health needs has gained increasing support at the national level with the realization that failure to treat the whole person constitutes a treatment failure. As indicated earlier, the President's New Freedom Commission on Mental Health issued *Achieving the Promise: Transforming Mental Health Care in America* in which was stated, "A key challenge to developing integrated treatment programs is overcoming traditional separation between mental health and substance abuse treatment." The report cited fragmentation of systems of care and support services at the state level as further barriers to a comprehensive delivery system.

Results of a study commissioned by the Florida Research to Practice Consortium of substance abuse providers published in 2003 regarding barriers to effective treatment for co-occurring disorders identified the often cited separate funding streams, lack of personnel and services and lack of coordination of services as significant problems. In addition, providers identified the lack of trained staff, thorough assessments and integrated staffings as problems. Their findings are consistent with those reported by other studies at the national level and with needs identified since 2000 in the Department's *State Mental Health and Substance Abuse Plan: 2000-2003.*

Current statewide projects in Florida aimed at improving services for individuals with co-occurring needs are the adoption of standards requiring placement of individuals with co-occurring disorders into either "dual diagnosis capable" or "dual diagnosis enhanced" mental health and substance abuse treatment programs, and the provision that Florida Assertive Community Treatment (FACT) teams contain at least one team member trained in recognizing and treating substance abuse problems. At the district level initiatives include: the Tampa-Hillsborough County Community Action Grant on Co-occurring Disorders, the Suncoast Practice and Research Collaborative (SPARC)/Tampa Practice Collaborative (PIC), the Triad Women's Project on Co-Occurring Substance Abuse, Mental Disorders and Histories of Trauma: Tri-County Human Services, and an initiative by District 1 to integrate Medicaid, substance abuse and mental health data systems, funding and services. In addition, FADAA and

FCCMH have formed the joint Workgroup on Co-Occurring Disorders whose mission is to develop plans to improve services for individuals with multiple treatment needs.

Crisis Stabilization Unit/Addiction Receiving Facility Demonstration Models

Chapter 394, F.S., authorizes the department, in consultation with AHCA, to establish crisis stabilization unit demonstration models that integrate emergency mental health and substance abuse services for children under the age of 18. The department and AHCA have established two demonstration models (District 8 and Suncoast Region) that provide both emergency mental health and substance abuse services, allowing the mental health and substance abuse needs of the children they serve to be addressed in an integrated and holistic manner.

- The Ruth Cooper Center, located in Ft. Myers/District 8, has been operating as a ten bed crisis stabilization unit/addiction receiving facility (CSU/ARF) demonstration model for approximately two years. This model is a single point of entry for children/youth with mental health and/or substance abuse needs and continues to improve the integration of substance abuse and emergency mental health services into one comprehensive model.

- The Coastal Recovery Center, located in Sarasota/Suncoast Region, recently began operating as a ten bed CSU/ARF model this year. The Suncoast Region, department and AHCA staffs are monitoring the initiation of this model and progress to date is positive.

- The department and FMHI developed an evaluation model to determine the effectiveness of service integration within the demonstration models. The evaluation was required by statute to be completed by December 31, 2003. Ruth Cooper Center and Coastal Recovery Center were used in the evaluation to identify best practices, successful integration, and barriers to effective service delivery. As outlined in statute, the evaluation will cover the following issues:

    - status of the implementation of integrated service delivery;
    - sufficiency and appropriateness of eligibility criteria, clinical procedures, staffing requirements, and administrative/financial procedures;
    - quality of services delivered;
    - number and characteristics of individuals served and related performance outcomes; and
    - feasibility of continuing or expanding the demonstration models.

Strategic Directions for Improving Co-Occurring Services

Specific strategies to address the following goals agreed upon by the Substance Abuse and Mental Health Program Offices for improving the service system are being developed and will be implemented within the coming three years. These include:

- Promote coordinated funding of co-occurring services by the department and AHCA. Funding should be flexible enough to accommodate the needs of individuals and to ensure integrated treatment;
- Increase access to psychiatric medications for persons served in substance abuse agencies with co-occurring disorders;
- Increase access to drug testing, psychosocial substance abuse services, early intervention and outreach and support services for persons with co-occurring needs served in mental health agencies;
- Provide cross-training for clinicians and support personnel in substance abuse and mental health centers to improve the identification and treatment of co-occurring needs. Training for primary care providers is also needed since this is the only treatment provider many individuals with substance abuse and mental health issues come in contact with. This will ensure that no matter where the individual enters the service delivery system there is no “wrong door”;
- Implement statewide, systematic screening procedures to identify mental health and substance use problems in all settings;
- Integrate data systems at the state, district and provider levels and develop performance indicators. Standardize performance indicators across treatment settings in order to ensure that meaningful outcomes can be used in driving treatment decisions and for evaluation and further development of evidence-based practices; and
- Ensure that scope of practice and regulatory barriers to integrated mental health and substance abuse care are addressed.

Older Adults

Older adults suffer from the same substance abuse and mental health problems as younger adults. They have high rates of depression and anxiety and the highest suicide rate of all age groups. The elderly are at risk for substance abuse due to lifestyle events that include such things as loss of a spouse, financial difficulties or medical disabilities. Exacerbating the situation further is the fact that addiction is less likely to be diagnosed in this population. The enormity and the interconnectedness of their physical and mental health problems make the diagnosis of a substance abuse problem more complex. Provision of services to older adults is complicated further by a number of barriers including ageism, lack of awareness, clinician behavior and comorbidity.

The federal government's Center for Substance Abuse Prevention estimates that as many as one in six adults over the age of 60 experience problems with alcohol or prescription drugs. For many years, the drug treatment field has been aware of

substance abuse addiction in the older male; but it is now becoming clear that addiction is a problem among elderly women as well. The Center on Addiction and Substance Abuse (CASA) study on mature women found that, of the 25.6 million women over 59 in the United States, about 2.8 million (11 percent) abuse psychoactive drugs, in addition to even larger numbers abusing tobacco and alcohol. As baby boomer drug users cross into retirement age, we can expect to see more illicit drug use among Florida's elderly. Despite this, there are few substance abuse and mental health programs available specifically designed to serve older adults.

Problems facing the substance abuse and mental health service systems include limited public funding for community services for older adults and an inadequate number of trained and skilled clinical gerontological professionals with experience identifying and treating individuals with substance use problems. Even when programs are available in the community, older people are less likely to take advantage of the services provided. In addition, older people who reside in assisted living centers and nursing homes often do not receive adequate or appropriate mental health and substance abuse services.

Through the Center for Substance Abuse Prevention (CSAP) a multi-state workshop was established that involved the department's Substance Abuse and Mental Health Program Offices, Department of Elder Affairs (DOEA), FADAA, Florida Coalition for Optimal Mental Health and local community-based agencies, along with other states. These organizations met in Clearwater, Florida, in July 2002, to identify promising approaches to promote early identification and engagement of adults (60 and older) in the substance abuse services system. The department and the DOEA made a commitment to work with the Center for Substance Abuse Prevention to develop strategies for preventing substance abuse among older adults through enhanced interagency coordination and the training of health care professionals.

The initial CSAP workgroup evolved into the Florida Older Workgroup which is now a subgroup of the state's Drug Advisory Policy Council. The workgroup is comprised of members from the following:

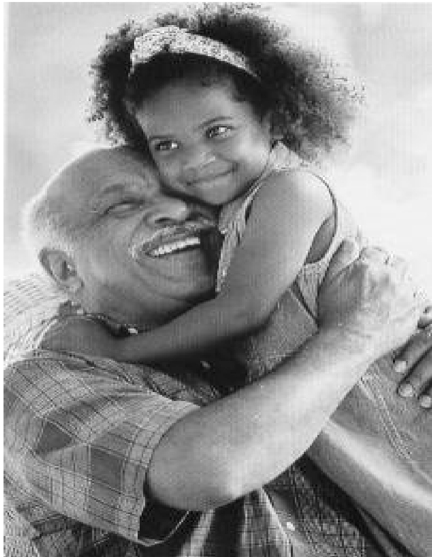
Florida Older Adult Workgroup Members	
Office of Drug Control Policy	Agency for Health Care Administration
DCF Substance Abuse Program	Department of Veterans' Affairs
DCF Mental Health Program	Florida Council on Community Mental Health
DCF Adult Services Program	Florida Alcohol and Drug Abuse Association
Department of Elder Affairs	Community-based Providers
Department of Health	American Association of Retired Persons

The Florida Older Adult Workgroup will be working to identify objectives and the development of a strategic plan for the projected fiscal year that will include interagency agreements, and state plans, multi-program legislative budget requests, standardized statewide data collection, and pharmaceutical funding initiatives.

In addition, the department continues its collaborative activities with other agencies charged with responsibilities relating to older adults with both mental health and substance abuse needs. DOEA has convened a work group to respond to legislative proviso language requiring coordination with the department to develop a policy for the identification and referral to treatment of older persons with mental health or substance abuse problems. The policy must include a requirement for reporting data gathered through DOEA screenings that serve to quantify the mental health and substance abuse needs of older adults. Representatives of the Mental Health and Substance Abuse Programs are participating in this group, which will report to the Legislature in February 2004.

Service and Evaluation Initiatives

The department received $600,000 in non-recurring funding for FY 2003-2004 to enhance the system of care for older adults experiencing substance abuse problems. Pilot projects are under development in District 10 and the Suncoast Region to provide screening, brief intervention, referral and brief treatment (SBIRT) services for elders.



The SBIRT projects will enhance local systems of care through the addition of these services and reduce the need for out-of-home placements due to substance abuse or related health issues. Screening and assessment tools will be developed to promote early identification of alcohol, illicit drug, prescription drug misuse, abuse, or dependence of individuals in primary health care and other aging services settings. The screening and assessment tools will also focus on the identification of depression and suicide risk among this population. Intervention and treatment services will be provided in-home and on an outpatient basis and are designed to be shorter in duration than traditional treatment models, focusing on maintaining the older adult in his/her community while stabilizing his/her substance misuse or abuse problems.

A portion of the funding will be used by the department to contract with the Florida Mental Health Institute to provide assistance in the developmental phases of the pilot projects with regard to screening/assessment tools, referral processes, model program/service guidelines, and performance measurement. Through this contract, the department will develop data system elements specifically tailored to the service needs and desired outcomes of older adults. The Florida Older Adult Workgroup will be working closely with FMHI on this process. FMHI will be responsible for developing a community needs assessment tool, evaluation model, and conducting regional trainings for community-based providers on the SBIRT model. During FY 2004-2005, the Institute will conduct an evaluation to determine the feasibility of expanding the SBIRT model to other communities in Florida.

Strategic Directions for Improving Services for Older Adults

The Substance Abuse and Mental Health Program Offices began working with the Department of Elder Affairs and the Florida Mental Health Institute on several initiatives in FY 2002-2003. These initiatives will enter their final phases of implementation in FY 2005-2006:

- Develop and implement program/service models for screening, brief intervention, referral, and treatment to address the substance abuse and mental health needs of older Floridians;
- Evaluate the effectiveness of the pilot SBIRT projects in District 10 and the Suncoast Region to determine feasibility of replication and expansion into other areas of the state (to be accomplished by FMHI by June 2005);
- Use the Florida Older Adult Workgroup to facilitate enhancements in service integration and coordination at the state and local levels; and
- In collaboration with DOEA, develop a policy for the identification and referral to treatment of older persons with mental health or substance abuse needs. Develop an evaluation model to determine the effectiveness of screening tools in aging service providers and primary health care settings.

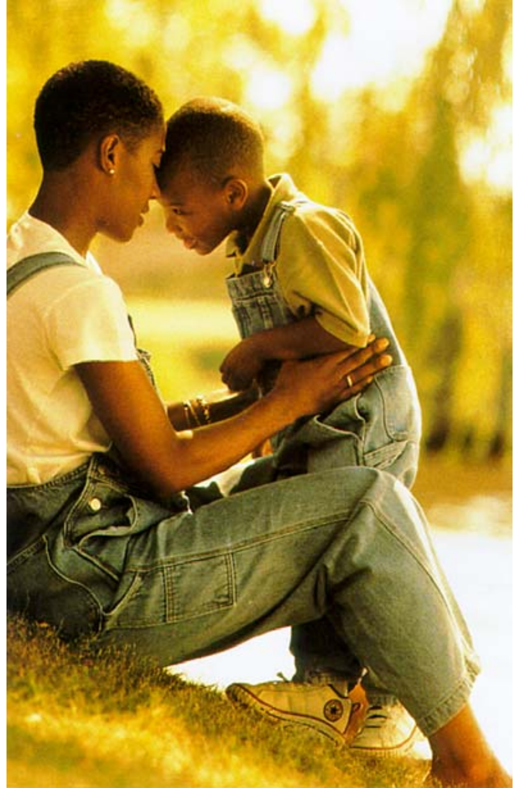
Service Integration with the Office of Child Welfare and Community-Based Care (CBC)

It is estimated that 30 percent of the children in the child welfare system have serious emotional disturbances. The Substance Abuse and Mental Health Program Offices continue to target children in the care and custody of the department due to abuse or neglect as a priority population for services. Initiatives include participating in the community-based care (CBC) peer reviews to ensure the availability of behavioral health services for children in care. These reviews provide information for the district and CBC provider to determine their readiness to initiate community-based care. The Substance Abuse and Mental Health Program Offices will participate in these reviews to determine the status of district Substance Abuse and Mental Health staff efforts to implement the SAMH “Readiness Review”. The readiness review document provides a listing of the critical elements needed to support the department’s implementation of CBC.

Additionally, to support the office of Child Welfare/CBCs’ Program Improvement Plan (PIP) response to the Federal Child and Family Services Review (CSFR), the Mental Health Program Office has implemented the Single Point of Access (SPOA). The SPOA assists the Office of Child Welfare/CBC to ensure that children who enter foster care are provided a behavioral health assessment, referred for appropriate treatment to support the permanency plan and reviews services and supports provided to improve positive outcomes. The Program Office has also worked with the Office of Child Welfare/CBC Quality Assurance unit to add review questions to the annual CSFR reviews they conduct in each district/region to ensure continued progress in the areas of well being and service array that the Federal CSFR found needed strengthening in

Florida. In addition, Mental Health staff will coordinate with the Office of Child Welfare/CBC Quality Review Teams during their audit to provide assistance as needed. As a result of these efforts, the plaintiff's in the M.E. v. Bush federal class action lawsuit have recommended dismissal and the lawsuit has been dismissed by the court.

In 2000, the department established a policy framework outlining an integrated and coordinated response to address the problem of parental alcohol and drug abuse in child maltreatment and neglect cases. The Substance Abuse and Family Safety Programs identified joint issues, system goals, desired outcomes and recommendations integral to blending and improving services for families involved in the child welfare system. A consensus was reached that both system representatives would commit to the following joint goals:



1. To protect and ensure the safety of children;
2. To prevent and re-mediate the consequences of substance abuse on families involved in protective supervision, or at risk of being involved in protective supervision, by reducing alcohol and drug use;
3. To plan for permanency and reunify healthy, intact families; and
4. To support families in recovery.

The policy framework further identified thirteen critical issues with specific recommendations, organized under seven domains, for improving Florida's coordination and integration of Substance Abuse and Family Safety services.

The need for substance abuse services for persons involved with child protective services has been highlighted through a series of federal legislation and national research studies and reports:

- In 1998, Congress passed the Adoption and Safe Families Act (ASFA, P.L. 105-89), including provisions to reduce the amount of time a child should remain in foster care to 12 months. The law mandated that a report be provided to Congress about the relationship of parental substance abuse to child protection.

- In January 1999, the National Center on Addiction and Substance Abuse at Columbia University (CASA) highlighted the magnitude of this problem in a special study. This study concluded that substance abuse causes or exacerbates seven out of ten cases of child abuse or neglect.

- In April 1999, the Department of Health and Human Services report to Congress stated that 11 percent of children in the United States live with at least one parent who is either alcoholic, or in need of treatment for the abuse of illicit drugs.

Florida's Efforts

Throughout the state, many models of coordinated service delivery have been developed. One of the most critical of these is dependency drug courts. As of October 2003 there were 16 programs in Florida, with four other courts in the planning stages.

Mental health courts are currently operating in Broward, Alachua, Lee, Sarasota and Brevard counties. These are post-arrest diversion programs serving individuals with mental illnesses who have been charged with nonviolent misdemeanor offenses. The focus of these courts is on reducing the amount of time these individuals spend in jail and on obtaining appropriate treatment. The courts are informal, non-coercive and, when compared to other misdemeanor courts, provide individuals greater access to treatment.

A felony mental health court was established in Broward County in November 2003 to serve individuals with mental illnesses who have been charged with low level felony offenses. This court has a similar purpose of reducing jail time and providing individuals access to treatment.

Another successful strategy included appropriation of FY 2000-01 funding ($2.5 million) for 35 Substance Abuse Family Intervention Specialists (FIS) and funding ($2.3 million) for an additional 35 FIS positions in FY 2003-2004. Family Intervention Specialists are contracted to substance abuse treatment providers and co-located in child welfare/community-based care offices. The Specialists evaluate parents and other family members identified by child protection professionals as needing substance abuse services. They facilitate entry to treatment and ensure linkage between the two provider systems during the treatment process.

The goal is to improve identification of individuals who need for substance abuse treatment, maximize their entry and retention in substance abuse treatment where indicated and to ensure that case planning is coordinated between the treatment service provider and the family safety protective investigator and case manager. Annual meetings for networking and training of the FIS occurred in 2000, 2002 and 2003. In 2003 skill training was provided on motivational interviewing and screening for persons with co-occurring (substance abuse/ mental health) needs.

In FY 2002-2003 there were 1,791 adults and 109 youth admitted for substance abuse services that had been referred by child welfare and community-based care. In FY 2003-2004, the Legislature appropriated $4.3 million of non-recurring funds to support substance abuse wrap around services for children in foster care. This one-time appropriation is expected to increase foster children receiving treatment, although some

of these funds most likely will support substance abuse prevention services, a critical need for these high-risk individuals.

Technical Assistance Award

Implementation of strategies to improve outcomes with families involved with child protection experiencing substance abuse needs will remain one of the highest program priorities over the next four years. In June 2003 Florida was one of four states to receive an award for a technical assistance project, with an estimated worth of up to $50,000, from the National Center for Substance Abuse and Child Welfare.

A statewide steering committee for the project held its kickoff meeting in September 2003. A local implementation workgroup and project in District 12 was selected to pilot products and develop local improvement strategies to share with the statewide steering committee and the state. A final product of the technical assistance will be a package of best practices and follow-up training to interested parties in the state, designed to facilitate technology transfer and system improvement.

In October 2003 a tentative work plan was developed to focus activities of the project on targeted best practice development and program improvement. One of the critical strategies of this project will be to implement Memorandums of Understanding (MOU) between the Substance Abuse Program and Child Welfare and CBC at the headquarters, district and provider levels. A draft MOU was developed by Summer 2003, and will be expanded to include the courts prior to its first implementation at the state level. Prior to implementation throughout the state, it will be field tested at the local level through the pilot project in District 12.

In Fall 2003, CBC implementation guidelines addressing substance abuse and children's mental health were disseminated to the district and regional offices. The guidelines outline key steps that should be taken by district Substance Abuse and Mental Health Program Offices to maximize success in coordination and integration of substance abuse and children's mental health services with implementation of private-based community-based care. The Substance Abuse Program Office is participating in selected CBC Readiness Reviews at the district level to identify successes and areas needing improvement.

Additionally, in Summer 2003, the Florida Senate conducted a Senate Interim Project to evaluate coordination and integration of substance abuse services with Child Welfare and CBC. The purpose of the project is to advise the department and Legislature about the current situation, and to identify opportunities for improvement in situations where parental substance abuse is a contributing factor to child abuse and neglect. On-site data collection was conducted through individual and staff interviews, as well as individual record reviews, in the Suncoast Region and in District 2. The report was released in November 2003. Findings and recommendations will determine some of the FY 2004-05 priority strategies to improve prevention of abuse and neglect and family retention or reunification for families with substance abuse involvement.

Cross-Training

The Substance Abuse Program in Jacksonville funded and piloted a revision of the Child Welfare League of America's Cross Training - Resource Workbook and Trainer's Manual for Substance Abuse and Child Welfare Staff. Core training in substance abuse for child protection staff was revised and is now part of the required pre-service training. Additionally, the Substance Abuse Program worked with the Family Safety Professional Development Center to revise the *Substance Abuse and Child Welfare Trainers' Guide, Advance Training*. This training course was piloted in Jacksonville in March 2002 and was generally offered bimonthly during 2003.

Strategic Directions for Improving Child Welfare Service Integration

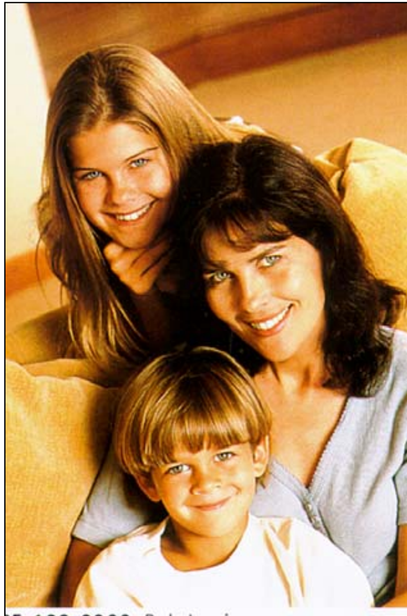
In conjunction with the Child Welfare/Community-Based Care Office, the Substance Abuse and Mental Health Programs will be working on the following strategies through FY 2005-2006:

- Expand the highly effective dependency drug court program;
- Expand the number of Substance Abuse Family Intervention Specialists (FIS) to improve the identification of parents/caretakers in need of substance abuse services who are involved with child protective services; and
- Develop a statewide best practice model for Collaborative Casework and a Florida Toolkit based on the strategies developed by the workgroup formed to implement the technical assistance project from the National Center for Substance Abuse and Child Welfare.

Temporary Assistance to Needy Families (TANF)

The TANF Substance Abuse and Mental Health (SAMH) Program is unique in that it provides services targeted for children, adults and their families through both the Substance Abuse and Mental Health Program Offices. The publicly-funded substance abuse and mental health system of care can best be described as two parallel systems that serves persons with substance abuse-related disorders and persons with mental illnesses through the provision of assessment, case management and treatment services. The two systems participate in ongoing collaboration with other state programs and agencies and community based providers including faith-based providers to further advance their responsiveness and accessibility for Florida's citizens.

The TANF SAMH program has re-established its Central Office infrastructure. A team approach and a support system were created through monthly telephone conferences with district and regional TANF Specialists. Central Office staff conducted several site visits throughout the state to provide technical assistance and support. In addition, monthly surplus/deficit reports are gathered and reviewed on a continuous basis in order to identify spending patterns, program direction and possible gaps in service delivery.



During FY 2002-2003, TANF mental health dollars served 3,704 children and 6,155 adults. This represents 3,178 additional individuals served during the fiscal year. Case management, in-home/on-site, individual and group outpatient were the most utilized services. During FY 2002-2003, TANF substance abuse dollars served 1,205 children and 6,208 adults, representing a total of 7,413 individuals served. Case management, Intervention, and Individual and Group Outpatient were the most utilized services. Also during FY 2002-2003, of the 9,859 served by mental health dollars and 7,413 served by substance abuse dollars, 52 percent and 77.9 percent respectively were family diverted from the welfare roll. This coincides with one of the main objectives of this federal program.

One current objective of the TANF Program is to integrate individuals served into the continuum of care established by the Substance Abuse and Mental Health Program Offices in their efforts to expand services for very young children by promoting early intervention services. This will include improvement and expansion of early intervention services for children presenting risk factors for out-of home placement, family safety involvement and welfare dependency. Activities specific to mental health services include:

- Identification of the social, emotional and behavioral needs of children within the mental health system of care;
- Creation of a coordinated system for early identification of mental health needs for children age birth to five through the process of screening, assessment and referral within the districts/region; and
- Building a training infrastructure for Infant Mental Health to include three levels: Level 1-Training for frontline caregivers; Level 2-Training for families and professionals caring for children in organizations and eventually to law enforcement and the judicial systems; and Level 3-Ongoing continuing education opportunities for specialized advanced training for currently practicing mental health professionals.

Early Intervention activities specific to substance abuse include integrating and coordinating efforts with Child Welfare/Community-Based Care to:

- Provide substance abuse screening and assessment services for parents and children designed to increase family stability. This will be accomplished by linking parents and children to substance abuse services, primary health care, prenatal and postnatal care, hospital inpatient care and other social services;
- Provide therapeutic services for children, in the context of a parent or a relative caregiver's substance abuse treatment program, to prevent future substance abuse and/or maladaptive behaviors;

- Establish prevention/early intervention programs for children involved with the child welfare system who come from families with a history of substance abuse;
- Train parents and relative caregivers to recognize symptoms and behaviors specific to substance abuse and misuse to prevent future substance abuse disorders; and
- Target domestic/family violence issues and the lack of appropriate and safe parenting skills that can foster behaviors that may lead to individuals who abuse and misuse substances.

These activities and services will be provided for the children either on-site or through linkages with other appropriate and qualified community service and faith-based providers. It is important to note that parental substance abuse is a major contributing factor in situations of child abuse and neglect and is one of the key barriers to family reunification. This alone would increase the risk of harm to children, thus increasing the need for state involvement and payment of services to ensure the protection of children.

Another objective of TANF SAMH Program will be to develop a mechanism of outreach to persons receiving substance abuse and mental health treatment regarding parenting services for TANF Individuals. The Mental Health and Substance Abuse Program Offices currently provide outreach services through a formal program for both individuals and their communities. Outreach services for individuals are those of encouragement, education and engagement for prospective individuals who show an indication of substance abuse and/or mental health disorder. Outreach expansion will include identification of individuals presenting risk factors for parenting services.

TANF Funding Issues

The Substance Abuse and Mental Health Programs were appropriated $22,737,500 for fiscal year 2003-2004. TANF funding permits the department to purchase critical treatment capacity for individuals receiving other forms of governmental assistance. Reductions in this critical funding would place added an burden on other forms of public assistance. Individuals with substance abuse needs would experience significant waiting periods for services and would continue to have difficulty finding/maintaining employment and achieving stability within their families. These individuals would also be at greater risk for entering the criminal justice system or accessing health care services due to their continued substance abuse/dependence.

Strategic Directions for SAMH TANF Program

The Substance Abuse and Mental Health Program Offices will be working collaboratively on several initiatives through FY 2005-2006:

- Develop “best practice” models for early mental health intervention services for children under the age of five;
- Incorporate national TANF goals included in the federal reauthorization bill with an emphasis on reducing out-of-wedlock births and promoting stability within the family, particularly with regard to marriage;

- Identify the priority needs for substance abuse services among TANF recipients;
- Enhance the front-end identification of TANF recipients, adults and children, who are in need of mental health and substance abuse services; and
- Develop performance measurement mechanisms to identify and improve the rate of family reunification among TANF recipients who are involved with the child welfare system.

Chapter 7: Financial Management

State, Local and Federal Funds

The primary sources of funding for Substance Abuse and Mental Health (SAMH) Services are state appropriated general revenue and state trust funds, federally allocated block grants and categorical grants, Medicaid funds and local matching funds. These major sources of funding are discussed below.

General Revenue and State Trust Funds

General revenue and state trust funds are legislatively appropriated at levels necessary to meet state expenditure requirements related to three primary areas of responsibility for SAMH services:

1. Federal mental health and substance abuse block grants require that state expenditures must at least match previous years' expenditures. The mandated level of minimum spending is termed "Maintenance of Effort" (MOE) which specifies that spending must remain at a level that is not less than the average of the two previous years;
2. Participation in the Medicaid Program requires that the state provide a required matching share of financial participation for SAMH Medicaid funded services; and
3. The Legislature appropriates general revenue and state trust fund dollars to fund specific SAMH initiatives.

Table 6 depicts the mental health funding appropriated by the Legislature for FY 2003-2004 according to major program areas.

Table 6: Mental Health Funding for FY 2003-2004

	Program Management and Compliance	Adult Mental Health	Children's Mental Health	Mental Health Treatment Facilities	Violent Sexual Predator Program	Total
General Revenue	$7,237,946	$210,044,495	$64,773,594	$163,031,215	$23,281,128	$468,368,378
Alcohol, Drug Abuse & Mental Health Trust Fund	$456,687	$20,480,914	$9,382,756	$0	$0	$30,320,357
Tobacco Settlement Trust Fund	$212,367	$8,872,633	$612,772	$0	$0	$9,697,772
Federal Grants Trust Fund	$1,228,225	$22,130,319	$14,079,894	$0	$0	$37,438,438
Operations & Maintenance Trust Fund	$0	$3,131,228	$0	$87,160,890	$0	$90,292,118
Grants & Donations Trust Fund	$0	$1,099,807	$5,313,192	$0	$0	$6,412,999
Administrative Trust Fund	$218,184	$0	$0	$32,480,194	$0	$32,698,378
Total	$9,353,409	$265,759,396	$94,162,208	$282,672,299	$23,281,128	$675,228,440

Federal block grant funds also support children's mental health services. The children's set-aside requires state expenditures for both federal block grant and state funds for a system of integrated services for children with a serious emotional disturbance as of federal fiscal year 1995 and each subsequent year at a level not less than an amount equal to the amount for FY 1994.

Mental Health Block Grant - (FFY 2003)

The Community Mental Health Services Block Grant supports Florida's community mental health system of care through the allocation of federal funds. These funds are awarded to all states and territories based on a complicated formula using population data and certain criteria. The block grant program is a federal initiative administered under the auspices of the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS). Funds are awarded based on a successful application submitted to CMHS by September 1st annually.

The block grant requires the establishment and support of a State Mental Health Planning and Advisory Council. The purpose of the Council is prescribed in Public Law 102-321. The Council is charged with the following duties:

- Reviewing the state plan provided to the Council by the state for submission as part of the federal community mental health services block grant application;
- Advocating for adults with a serious mental illnesses and children with a serious emotional disturbances or mental illnesses; and
- Monitoring and evaluating the allocation and adequacy of mental health services within Florida.

The MOE process is a major requirement of block grant funding and is a requirement that states will not supplant state funding with federal funding. To ensure states meet this requirement, the states must document that they have maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the previous two-year period. States must report actual expenditures rather than the approved operating budget for the two years upon which the MOE is based. Failure to comply with federal MOE requirements places the funds at risk, with the potential for a dollar penalty for every dollar shortfall below the MOE requirement.

Federal block grant funds may not be used for inpatient care. Funds may be used for most other community mental health services. Florida uses its block grant funding to support the following services: assertive community treatment teams, assessment, case management, crisis stabilization, crisis support, day/night activities (day treatment), intervention, outpatient, in-home and on-site, residential care, respite care, sheltered employment, supported employment and supported housing. A portion of the block grant may be used for administrative purposes.

Substance Abuse Funding for FY 2003-2004

In FY 2003-2004 the Substance Abuse Program Office was appropriated $189 million for children and adult substance abuse services and program management. The table below depicts state and federal funding for children's substance abuse services, adult substance abuse services and administration for FY 2003-2004.

Table 7: Substance Abuse Services Funding for Fiscal Year 2003-2004

	Program Management and Compliance Substance Abuse	Child Substance Abuse	Adult Substance Abuse	Total
General Revenue	$2,152,971	$20,898,730	$16,443,059	$39,494,760
Other State Funds		$15,137,907	$8,118,178	$23,256,085
Total State Funds	$2,152,971	$36,036,637	$24,561,237	$62,750,845
Federal Trust Funds				
ADAMH TF (SAPT BG)	$1,872,219	$34,865,172	$74,320,692	$111,058,083
TANF (FGTF)		$640,000	$14,097,500	$14,737,500
Other Federal Funds	$357,419	$0	$233,980	$591,399
Total Federal Funds	$2,229,638	$35,505,172	$88,652,172	$126,386,982
Total	$4,382,609	$71,541,809	$113,213,409	$189,137,827

In FY 2003-2004 the Substance Abuse Program Office received $9 million in lump sum funding to expand detoxification and treatment services and statewide prevention activities.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The Substance Abuse Prevention and Treatment (SAPT) Block Grant award of $95,064,189 (FFY 2003) is a major source of funding for prevention and treatment services in Florida, comprising half of the Substance Abuse Program's budget. As with the Mental Health Block Grant, a major requirement of the Substance Abuse Prevention and Treatment Block Grant award is the MOE. This requires that the state maintain expenditures for community substance abuse services at a level that is not less than the average level of such expenditures for the previous two-year period. Failure to comply places the Substance Abuse Prevention and Treatment Block Grant funds at risk. In state Fiscal Years 2000 and 2001 the Substance Abuse Program exceeded MOE requirements. For state Fiscal Year 2002, the Substance Abuse Program experienced a MOE shortfall of $341,121, primarily resulting from funding reductions incurred during the 2001 special legislative session. The Program is in the process of analyzing potential MOE shortfalls for state Fiscal Year 2003.

The Substance Abuse Prevention and Treatment Block Grant contains numerous provisions regarding target populations and specialized services. These provisions, which are detailed below, have a direct bearing on the budgeting, contracting and tracking of Substance Abuse Prevention and Treatment Block Grant expenditures:

- The state must expend not less than 35 percent of the award on treatment activities regarding alcohol and not less than 35 percent on treatment regarding drugs;

- The state must expend not less than 20 percent of the award on primary prevention programs for individuals who do not require treatment for substance abuse;
- The state must expend an amount on services and activities designed specifically for women with dependent children and pregnant women that is not less than the amount expended in FFY1994;
- The state must expend at least five percent of the Substance Abuse Prevention and Treatment award on HIV Early Intervention services for individuals who are being treated for substance abuse, and services must be provided at the site where the treatment is being provided;
- The state cannot expend more than five percent of the Substance Abuse Prevention and Treatment award on administration of the grant;
- The Substance Abuse Prevention and Treatment Block Grant requires that the expenditure of state funds in any state fiscal year be not less than the average of state expenditures in the prior two fiscal years; and
- Some of the mandates from the Substance Abuse Prevention and Treatment Block Grant include outreach services to persons who use intravenous drugs and services to persons with tuberculosis. Although not funded directly by the Substance Abuse Prevention and Treatment Block Grant, these groups have been designated by the Substance Abuse Program Office as individuals who are high priorities for services, both through outreach to enhance identification of those in need and reduced waiting periods for substance abuse and support services.

Budget Allocation Methodology

Section 394.908, F.S., stipulates how substance abuse and mental health funds are to be allocated to the department's districts. The Legislature recognized that over the years the allocation of funds to districts became inequitable. This was due, in large part, to the population shifts that occurred throughout the state over the past twenty years. Additionally, when federal block grants were created under the Omnibus Reconciliation Act of 1981, communities that had been successful in garnering direct Federal grants now received those funds under the block grant program. These were not always the most populated areas of the state. Beginning in July 1997, the Legislature determined that equity would be achieved over time by appropriating 75 percent of additional funding beyond the 1996-97 FY base appropriation to those districts below the statewide equity average.

The equity formula prescribed in statute requires estimates of the number of people needing mental health and substance abuse services, respectively. The estimated size of the target population is divided into the appropriations for the respective target population, establishing as statewide equity average. Seventy-five percent of new appropriations for a particular target population is allocated only to those districts that are below the statewide equity average. Twenty-five percent is allocated to all districts based upon the estimates of the number of people in need of services. Funds identified

in the General Appropriations Act (GAA) may be earmarked for district or program specific allocations. The following section details the specific methodologies used in allocating funds in accordance with the equity requirements of Florida Statutes.

Mental Health Allocations

Adult Mental Health

In 1999, the department began the process of closing G. Pierce Wood (GPW) Memorial Hospital. To accomplish the closure, additional funds were appropriated to provide services and supports in the community. The new funding for community services, combined with the former funding base, resulted in an estimated per prevalence rate of $1,225. This level of funding was determined to be the minimum necessary to provide for a service package that would appropriately meet the needs of persons with severe and persistent mental illnesses. The $1,225 per prevalence funding is considered the benchmark goal for the districts not included in the GPW catchment area (District 8, 14, 15, Suncoast). The goal of the Mental Health Program is to achieve equity across all districts by narrowing the gap between the benchmark of $1,225 and the existing per prevalence funding in those non-GPW districts.

Table 8: Adult Mental Health Services Funding Equity (FY 2003-2004)

District	District Budget	Target Population	Allocation Per Target Population
1	$8,775,610	12,585	$697.31
2	$8,771,837	13,440	$652.67
3	$6,711,043	10,468	$641.10
4	$13,171,172	22,845	$576.55
7	$23,010,210	39,994	$575.34
8	$20,229,800	16,090	$1,257.29
9	$13,974,478	21,244	$657.81
10	$22,086,239	32,253	$684.78
11	$29,731,752	46,259	$642.72
12	$6,480,214	9,301	$696.72
13	$8,384,646	13,547	$618.93
14	$12,830,590	10,926	$1,174.32
15	$11,831,026	8,441	$1,401.61
SC	$61,932,854	54,841	$1,129.32
Total/Average	**$247,921,471**	**312,234**	**$794.02**

Allocation per person is represented as an average across the districts and region. Total funding amounts do not equal those in Table 6 due to funds allocated to control and headquarters.

New funds that are not specifically targeted in the appropriations act to named districts are allocated to non-GPW districts to bring the current benchmark rate closer to the funding to the benchmark rate in the districts within the GPW catchment area.

Section 394.908 (8), F.S., contains a special funding provisions that apply strictly to FY 2003-2004. First, the department must ensure that each district or region will receive funding that does not go below the final operating budget for FY 2002-03 for each district or region. Further, all new funds received in excess to the FY 2002-03 levels will be allocated in accordance with the provisions of the General Appropriations Act.

Children's Mental Health

Recurring funds are distributed based on each district's previous year operating budget. As with the adult funding requirements, the provisions of s. 394.908 (8), F.S., stipulate that the allocations for each district/region for FY 2003-2004 must be made in accordance with the General Appropriations Act. A current goal is to bring districts/region closer to the benchmark level of $448.88. The improved equity funding for emergency stabilization services and community-based outpatient services in each district/region would ensure that, regardless of the location, any child with serious emotional disturbances/emotional disturbances will have access to quality mental health treatment.

Table 9: Children's Mental Health Services Funding Equity (FY 2003-2004)

District	District Budget	Target Population	Allocation Per Target Population
1	$2,394,473	6,771	$353.64
2	$1,986,297	6,805	$291.89
3	$1,729,795	5,311	$325.70
4	$3,478,985	12,922	$269.23
7	$6,600,012	21,422	$308.10
8	$2,857,964	7,832	$364.91
9	$4,592,905	10,614	$432.72
10	$4,795,154	16,632	$288.31
11	$8,765,015	25,295	$346.51
12	$898,210	4,450	$201.84
13	$2,131,553	6,778	$314.48
14	$1,871,149	6,228	$300.44
15	$1,942,287	4,327	$448.88
SC	$8,270,444	27,000	$306.31
Total/ Average	**$52,314,243**	**162,387**	**$322.16**

**** Allocation per person is represented as an average across the districts and region. Total funding amounts do not equal those in Table 6 due to funds allocated to control and headquarters.***

Substance Abuse

Substance abuse funding for FY 2003-2004 has been appropriated and allocated with the special funding provisions contained in section 394.908 (8), F.S. All new funding received in excess of FY 2002-2003 recurring appropriations was allocated according to provisions of the General Appropriations Act, ensuring that no district or region received an allocation of recurring funds for FY 2003-2004 that was less than its initial approved operating budget containing lump sum appropriations or reductions in unfunded budget for FY 2002-2003.

Substance Abuse Allocations - Children

Allocations of new funds for residential and aftercare services are made to districts using the formula as prescribed in Section 394.908, F.S.

Table 10: Child Substance Abuse Services Funding Equity (FY 2003-2004)

District	District Budget	Target Population	Allocation Per Target Population
1	$3,178,339	16,404	$193.75
2	$3,209,529	14,878	$215.72
3	$2,132,541	10,875	$196.10
4	$5,114,092	29,318	$174.44
7	$8,289,909	37,689	$219.96
8	$3,564,012	19,875	$179.32
9	$4,125,141	24,496	$168.40
10	$5,776,338	32,554	$177.44
11	$8,585,398	53,445	$160.64
12	$2,268,962	11,239	$201.88
13	$3,273,521	16,586	$197.37
14	$2,846,997	11,928	$238.68
15	$2,363,166	11,605	$203.63
SC	$12,065,458	62,267	$193.77
Total	**$66,793,403**	**353,159**	**$189.13**

**** Allocation per person is represented as an average across the districts and region. Total funding amounts do not equal those in Table 7 due to funds allocated to control and headquarters.***

- Twenty-five percent is allocated based on population projections for the January 2001 census estimates.
- The Florida Youth Substance Abuse Survey 2000, completed January 2000, provided prevalence data about youth alcohol and drug use. The number of students, ten to 17-years-old, who reported use of alcohol or other drugs three or more times in the past month, are targeted as youth in need of treatment services. A concurrent special analysis provides a methodology for adjusting in-school substance abuse prevalence for students who drop out of school in each county. Prevalence rates for school and youth who drop out by county are applied to the

2003 census estimates. Seventy-five percent is allocated to districts that are below equity.

- Outreach and intervention services allocations are made to those districts with a high rate of deaths of individuals that are heroin related. Actual district allocations are based on a district's proportionate number of deaths of persons that are heroin related.
- Youth substance abuse prevention projects were awarded on an open competitive basis statewide to the highest ranking applicants responding to an Intent to Negotiate request for research-based replication and validation projects.

Substance Abuse - Adults

Allocations of new funds for residential and aftercare services are made to districts using the formula prescribed in Section 394.908, F.S.

- Twenty-five percent is allocated based on population projections for the 2003 census estimates.
- The National Household Survey on Drug Abuse for three age groups (18-24; 25-34; and 35-over) are used to estimate the number of adults in need of substance abuse services in each district. This number is then applied to the 2003 census estimates. Seventy-five percent is allocated to districts that are below equity.

Table 11: Adult Substance Abuse Services Funding Equity (FY 2003-2004)

District	District Budget	Target Population	Allocation Per Target Population
1	$4,688,243	32,903	$142.49
2	$4,837,778	36,831	$131.35
3	$3,918,825	29,949	$130.85
4	$7,711,723	57,796	$133.43
7	$12,834,909	101,788	$126.09
8	$4,641,987	43,245	$107.34
9	$6,063,187	54,834	$110.57
10	$9,297,012	79,561	$116.85
11	$19,215,475	118,268	$162.47
12	$5,927,951	24,862	$238.43
13	$4,455,725	36,728	$121.32
14	$3,738,283	29,432	$127.01
15	$2,859,649	22,371	$127.83
SC	$17,073,759	141,746	$120.45
Total	**$107,264,506**	**810,314**	**$132.37**

**** Allocation per person is represented as an average across the districts and region. Total funding amounts do not equal those in Table 7 due to funds allocated to control and headquarters.***

Medicaid – Substance Abuse and Mental Health

Medicaid's Community Mental Health Program, which provides a range of evaluation, treatment planning, rehabilitative and therapeutic services for Medicaid recipients with mental illnesses or substance abuse problems, was initiated in 1983. At that time, both Medicaid and Florida's mental health program were part of the Department of Health and Rehabilitative Services. Design of the Medicaid Community Mental Health Program has evolved largely through a close cooperative relationship between the current department's Substance Abuse and Mental Health Programs and AHCA.

Medicaid accounts for more than half of the funding for publicly-purchased mental health and substance abuse services in Florida. AHCA oversees the certification of providers and state expenditure of Medicaid funds. To become a certified Medicaid provider, a community-based agency must receive appropriate licensure under AHCA (mental health) or the department (substance abuse) and must be under contract with the department to provide mental health or substance abuse services.

One significant feature of the Medicaid Community Mental Health Program has been its evolving funding methodologies. Initially, the Medicaid Community Mental Health Program drew its general revenue funding from periodic transfers of funds from the department's mental health program to support the state share of Medicaid costs. In the early 1990s this practice was halted and Medicaid state match funds were subsequently requested by the AHCA through the Medicaid Social Services Estimating Conference. At that time, approximately $12 million in general revenue budget was transferred from the department's base to AHCA's base budget. Also during this period, Florida Medicaid established separate Targeted Case Management Programs for adults and children. These programs provide planning, linking to resources and advocacy for persons with serious mental illnesses. Departmental districts are charged with certifying that contractors and case managers meet standards for this program. In the mid 1990s, $9 million dollars was transferred in general revenue from the department's base budget to AHCA's base budget to support this program. Additionally, Medicaid has established a prepaid capitated mental health program in Districts 6 and 14 in mid-1996, in accordance with proviso language in the appropriations bill. This initiative established a prepaid, capitated behavioral health program in this area. The department worked closely with AHCA in the design and implementation of the project, which has resulted in contained costs and improved access for Medicaid recipients.

In 1996 Medicaid Program began a utilization management program. The department works closely with AHCA in managing the utilization of Medicaid through a contract with a private utilization management company. AHCA also funds utilization management staff positions in the district offices that perform some aspects of the utilization management work in conjunction with the private company. A number of Medicaid initiatives have been designed to deal with specific departmental target groups. In the early 1990s the department and AHCA established the Intensive Therapeutic On-site Service that provides for a range of services delivered in the child's home or school setting. In 1994 the Specialized Therapeutic Foster Care Service was established. This provides for a foster home with specially trained foster parents and support from

mental health professionals as an alternative to costly residential settings. This program is financed through general revenue transfers from the department to AHCA of approximately $10 million each year. Behavioral Health Overlay Services were initiated for the Department of Juvenile Justice in 1998 and for the department's Family Safety Program in 2000. This arrangement provides for a uniform rate to provide behavioral health interventions for children in residential facilities. In 2000 the Comprehensive Behavioral Assessment service was implemented. This service ensures a prompt and thorough behavioral assessment for children in shelter status.

The department is working with AHCA on a number of initiatives involving Medicaid, including the development of joint contracting and service purchasing through networks, establishment of new funding methodologies such as case rates or capitation and institution of new codes for billable Medicaid services for substance abuse.

Medicaid/Match Issues

The department, in conjunction with AHCA, is performing analyses to determine the potential value of permitting crisis stabilization units and residential programs that are not subject to the federal Institution for Mental Diseases (IMD) prohibition to participate in the Medicaid program. This would entail certification of local or state funds as match for federal financial participation in these programs.

Residential Service in Institutions for Mental Diseases (IMDs)

Federal law permits federal financial participation in IMDs for persons under 21 years. The 2000 General Appropriations Act contains proviso language that authorizes AHCA to obtain a Healthcare Finance Administration (HCFA) waiver to pay for mental health psychiatric residential services in IMDs. The department transfers $15 million in general revenue to AHCA as match for the program. The initiation of the IMD program has been of considerable assistance in meeting the unmet needs of dependent children who are Medicaid eligible. However, there remains a large number of low-income children who need this service and whose parents cannot manage the catastrophic cost of residential psychiatric care, which averages approximately $350 per day.

Increasing Selected Medicaid Fees for Service

In the fourth quarter of FY 1999-2000, a budget amendment was approved authorizing the transfer of $1.6 million in general revenue from the Alcohol, Drug Abuse and Mental Health (ADM) budget to AHCA in order to provide state match for increases in selected Medicaid fees. This fee increase was necessary because fees for Medicaid's Community Mental Health Program had not been increased since 1982, and most were reduced in 1996. Consequently, increases in reasonable costs outpaced the ability of providers to deliver quality services to Medicaid recipients at these rates. In 2000, an additional $6 million in general revenue transfers were made from the department's operating budget to support the fee increases. There have been no further fee increases since the 1999-2000 adjustment.

Projected Medicaid Expenditures for Mental Health for State Fiscal Year 2002-03*:

- Adult Community Mental Health- $56,029,468
- Adult Targeted Case Management- $33,460,135
- Children's Community Mental Health- $137,417,675
- Children's Targeted Case Management- $33,138,265
- Children's Therapy Services - $28,840,592
- Prepaid Mental Health Plans - $24,900,159
- Total Projected Expenditures - $313,786,295*

**These expenditures are projected until final certified forwards are paid. These projections do not include Medicaid expenditures for inpatient care in general hospitals for persons with mental illness diagnoses or inpatient and rehabilitative services provided through several prepaid behavioral health plans and health maintenance organizations (HMOs) capitated for behavioral health.*

Medicaid Fee-for-Service/Substance Abuse - $10,094,415 (FY 2001-2002)

Medicaid funding accounts for approximately five percent of the Substance Abuse Program budget. There are several reasons for this: 1) limitations on eligible services for individuals who abuse substance without an accompanying mental health diagnosis; 2) Institution for Mental Disease (IMD) exclusions and loss of eligibility after an individual's admission to long-term residential care; 3) implementation of Temporary Assistance to Needy Families (TANF) funding; and 4) reluctance of some providers to incur infrastructure costs and potential liabilities associated with Medicaid billings. However, maximizing federal revenue for eligible services to eligible participants must continue to be a critical financial management strategy. In collaboration with AHCA and the Florida Alcohol and Drug Abuse Association (FADAA), the department is identifying strategies to improve Medicaid support of substance abuse services. Under Florida's Medicaid Community Mental Health Services Program, Medicaid-eligible recipients with a primary diagnosis of substance abuse may receive a wide array of community-based interventions through an enrolled provider. Florida's substance abuse community referral system needs to improve the identification of Medicaid individuals who have substance abuse problems.

Substance Abuse and Mental Health Medicaid Initiatives

The department has been collaborating with AHCA to identify possible strategies to improve the provision of substance abuse and mental health services for eligible Medicaid enrollees. Although the current deficient in the Medicaid budge will present

significant challenges, the strategies that the two agencies are committed to pursuing for state FY 2003 through 2005 include:

- Examining the adequacy of current Medicaid funding to support substance abuse services to families in child welfare, TANF and school violence programs;
- Developing a bundled rate for all services that methadone programs provide for individuals, including general administration and take-home medication. This has been accomplished and will be reviewed to determine its effectiveness;
- Adding a new code to establish community detoxification as a billable Medicaid service, to reduce current expenditures for inpatient services and encourage treatment in less restrictive and less costly settings;
- Determining the percentage of individuals with substance abuse needs who are Medicaid eligible to evaluate the impact of using the department's general revenue funds to draw down federal Medicaid dollars for Targeted Case Management. Currently, only mental health general revenue is used. Targeted case management cannot be billed for individuals who have solely substance abuse needs;
- Assessing the potential for: 1) treatment approaches which maximize use of existing codes such as Intensive Therapeutic On-Site Services & Individual Therapy; 2) adding new codes for services such as "Aftercare" or "Intensive Outpatient Services;"; and 3) billing mental health codes;
- Implementing changes to Behavioral Health Overlay Services regulations to allow billing of Targeted Case Management performed by provider staff during the last 60 days before an individual's discharge. This will enable continuation of the established relationship between the individual and the counselor or case manager;
- Increasing referrals of individuals for Medicaid;
- Allowing children with a substance abuse or substance dependence only diagnosis to be eligible for Intensive Therapeutic Onsite Services; Home and Community-Based Rehabilitative Services and Targeted Case Management. The current Medicaid program excludes a substance abuse only diagnosis for these services limited to children;
- Implementing recommendations to determine very young children eligible for community mental health services;
- Modifying the Individual Therapy Code to read "Therapy" and allowing the provision of family therapy services under this code; and
- Effective 7/01/2004, the "Community Mental Health Services" handbook will be revised to include a methadone reimbursement code. Discussions with AHCA will continue regarding potential future revisions to be more inclusive of substance abuse treatment and mental health psychosocial rehabilitation services.

Medicaid and Revenue Maximization Initiative

In December 2003, AHCA received a grant award of $200,000 from the Robert Wood Johnson Foundation to develop strategies for expanding Medicaid service coverage for individuals needing substance abuse treatment. AHCA, the department and FADAA will jointly develop the strategies to address the following issues:

- ***Maximization of Medicaid***
  - Expansion of eligible benefits
  - Certification of general revenue and local match
  - Expansion of provider networks

- ***Implementation of a Joint Management System***
  - Establishment of teams to address systems design, procurement, and management
  - Establishment of a pilot to model single managing entity concept

Many of the strategies will be developed in accordance with the requirements of Chapter 2003-279, Laws of Florida, (formerly S.B. 2404) the Florida Drug Control Strategy and the Technical Assistance Collaborative, Inc., blueprint "Reforming and Enriching Florida's Services". AHCA must consider the containment of the growth in Medicaid expenditures when developing strategies under this grant award. The Robert Wood Johnson Foundation project will run through April 2005 and will seek to achieve the following:

- Integration of project recommendations into the existing AHCA and department policies;
- Pilot alternative funding mechanisms other than unit cost contracting;
- Development of comprehensive, community-based substance abuse service delivery mechanisms;
- Development of outcomes and measurements in accordance with the requirements of the Medicaid Federal Waiver, specifically pertaining to quality and performance standards;
- Development of numerical targets to:
  - Increase federal Medicaid participation;
  - Eliminate the waiting list in the pilot area (Suncoast Region); and
  - Increase individuals' utilization of less costly services.

Florida will be receiving technical assistance from the Center for Health Care Strategies, Inc., and the Technical Assistance Collaborative, Inc., and will interface with other Robert Wood Johnson Foundation project states to identify optimal purchasing and service models. Florida will also be seeking technical assistance from states that have developed model Medicaid continuums of care and contract purchasing systems.

Local Match

Chapter 394, F.S., requires that community mental health and alcohol programs be funded in part by local matching funds on a 75/25 state-to-local ratio. Chapter 65E-14, Florida Administrative Code (FAC), specifies what types of funds or contributions may count toward satisfying the local match requirement. Briefly, these include local government funds, in-kind contributions, fees, and program income.

Chapter 394, Part IV, F.S., contains "The Community Alcohol, Drug Abuse and Mental Health Services Act" (s.394.65 through s.394.907). Under s.394.67(13), local matching funds are defined as, "funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate and bequests and funds received from community drives or any other sources."

Section 394.76(3)b, F.S., exempts from the local match requirement: 1) residential and case management services that are funded as part of a deinstitutionalization project; 2) portions of general revenue generated through Medicaid reimbursement; and 3) general revenue transferred from the department into SAMH appropriations categories to match federal funds earned from Medicaid services that previously did not require a local match prior to transfer to the SAMH services budgets. This section also provides that only community alcohol and mental health services, not drug abuse services, shall require match. This is a vestige from when there were separate alcohol and drug abuse services appropriations.

The local matching process begins with the appropriation of SAMH funds to the department and the subsequent allocation of funds to the districts and ultimately through contracts to providers. The departmental contracts with providers identify state funds that require local match and specify the required local match amount. Providers are required to develop and submit operating budgets that detail the sources and amounts of funding to be used to satisfy the local matching requirements.

The provider is solely responsible for going to local governments to request funding. There are no regulations which address which local government funding source (city, county, special tax district, etc.) is responsible for providing funds. Additionally, there are no regulations that address the situation in which local governments refuse to provide funds.

Following the end of the contract year, the required annual financial and compliance audit verifies, among other items, that the requisite amount of local matching funds were obtained and expended. If the local match requirements have not been satisfied, the provider may be required to return the unmatched portion of state funds to the state.

The total required local match contribution for substance abuse and mental health for FY 2001-2002 was approximately $71 million. Of that amount, the counties and district/region community-based agencies provided more than $109 million in cash and in-kind matching funds. The actual match exceeded the required match primarily due to

time-limited funding for special projects and services at the local levels and establishment of specific councils and taxing authorities to fund substance abuse and mental health services. These match amounts are subject to considerable fluctuation as local funding initiatives are initiated or eliminated due to changing political and community support and the availability of local funding.

Table 12: Summary of Local Match by District (FY 2001-2002)

Districts	Total Match Required In Contracts	Actual Match Provided All Counties/District	Total Cash Match	Total In-Kind Match
01	$3,545,581	$4,661,198	$3,312,851	$1,348,347
02	$2,732,728	$3,400,709	$2,650,987	$749,722
03	$2,770,836	$4,766,507	$4,766,507	$0
04	$7,230,685	$9,810,837	$9,649,918	$160,919
SC	$13,785,942	$13,785,942	$13,785,942	$0
07	$7,035,399	$21,620,809	$18,075,811	$3,544,998
08	$5,073,671	$8,052,260	$5,593,589	$2,458,671
09	$4,520,483	$13,681,783	$11,162,354	$2,519,429
10	$5,455,190	$5,455,190	$5,455,190	$0
11	$9,002,460	$10,756,950	$10,756,950	$0
12	$2,849,761	$2,849,761	$2,836,038	$13,723
13	$3,128,658	$6,246,711	$6,227,766	$18,945
14	$1,620,618	$2,036,514	$1,582,533	$453,981
15	$2,399,490	$2,401,605	$2,013,877	$387,728
Total	**$71,151,502**	**$109,526,776**	**$97,870,313**	**$11,656,463**

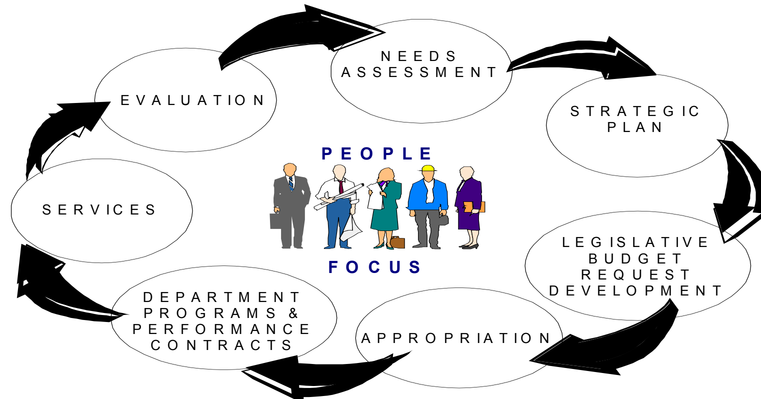
Substance Abuse Mental Health Performance Contracting System

The department relies extensively on its established network of community based providers. It works with its provider partners who operate programs under performance contracts as an integral part of performance based program service provision. All direct individual service contracts entered into by the department contain a set of performance measures, standards, terms and methodologies by which the performance of the contract provider may be evaluated. This system accomplishes the following: verifies that the funds expended by the department for contractual services benefit the citizens of Florida and promotes the achievement of the department's Long Range Program Plan outcomes. Additionally, it promotes efficient use of funds through identification and reduction of ineffective services, provides quantitative information regarding the effectiveness of service delivery and assists the department in determining the modifications needed in future contracts.

Performance contracting is an integral part of the department's planning, budgeting, and evaluation system. Performance contracts specify that a quantifiable level of performance be achieved by the provider for a particular performance measure.

Measures of performance include outputs (direct counts of program activities), and outcomes (results of program activities in the lives of those served). For example: a 95 percent performance measure may be written as 95 percent of the children served under this contract will have no findings of maltreatment.

The figure below illustrates how performance contracting fits into the planning, budgeting and evaluation cycle.



Changes to the Financial Rule, 65E-14, Florida Administrative Code (FAC)

The department began implementation of the system of unit cost performance contracting in 1996 but did not begin the revision process to the accompanying Financial Rule, 65E-14, FAC, until rule development workshops were held beginning in August 2001.

Additional development meetings were held throughout the following months and well into 2002 so that specific rule provisions could be clarified with staff and Program Directors. A Circulated Notice of Rule Promulgation Package was developed and input and approval was solicited from all fourteen districts and the headquarters offices.

Throughout the process, a working relationship between stakeholders, who have historically viewed the contracting process as over complicated and overly bureaucratic, and the department was fostered to encourage progress that reflected itself in significantly strengthened and improved language being incorporated into proposed changes. Significant among the changes in the financial rule were welcomed provisions that allowed for contractors to have increased flexibility in invoicing for individual cost centers, greater accountability by adding language for additional independent audit requirements, requiring reporting of all revenues and expenditures, clarifying local match requirements, placing current accounting principles, standards, systems and controls in the rule, and requiring data used on requests for payment be consistent with the electronic data system.

Additional technical changes to the contracting system are envisioned over time. Future amendments to the financial rule will be promulgated in consultation with stakeholders.

Future Goals for the SAMH Contracting System

Further enhancements to the contracting system were made in 2003 with the Secretary's assignment of direct line authority to the Program Directors over the SAMH contract managers. This delegation eliminated possible bottlenecks in the SAMH contract system administration that allowed for a greater line of authority and policy directives.

Future goals that the department will include exploration of moving the contracting system from a unit cost system to one based on a fee-for-service or a prospective payment mechanism. These goals also include expanding Medicaid pre-paid uniform rate programs from pilot programs to a statewide program, and obtaining Medicaid reimbursement for selected SAMH services that were historically funded by state general revenue sources and for selected services that were not historically funded in Florida.

The fiscal constraints involved in this process do not envision any other than a revenue neutral system. In other words, this services expansion should not cost Florida taxpayers more than it does presently.

Chapter 8: Strengthening Accountability

In accordance with Secretary Regier's fourth goal to "strengthen accountability", the Substance Abuse and Mental Health Program Offices have developed a strategy to "increase quality of service interventions and improve the system of fiscal accountability." The strategy supports the evolution of the present fragmented service delivery system into organized networks, the redesigning and implementing of a uniform monitoring process to support quality services, and the transformation of the substance abuse and mental health services information system into one that supports system decision making. These strategies are based on making available the most reliable information possible on system performance, service utilization, and quality of interventions.

This chapter contains four major projects, related action steps and anticipated deadlines that are designed to implement the above departmental goal and the strategies of the Substance Abuse and Mental Health (SAMH) Program Offices. The first project deals with the redesign and implementation of contract monitoring tools and protocols; the second project pertains to compliance with the Health Insurance Portability and Accountability Act (HIPAA) standards; the third project contains action steps to improve the performance measurement system; and the fourth project pertains to transformation of existing data system into a decision making model. The final portion of the chapter addresses statewide performance results for FY 2002-2003.

Strategic Course(s) of Action:

1. Redesign and Implement Uniform Monitoring Tools and Develop Mechanism for Monitoring Quality

   - On July 1, 2003, the SAMH Program Offices promulgated a revised financial rule, 65E-14, F.A.C., to ensure greater accountability of SAMH providers, as well as to promote operational standardization in the areas of finance and administration among providers statewide. Several training sessions were provided in June 2003 to district staff, SAMH providers and other interested stakeholders, in an effort to promote the understanding and standardization of these rule provisions across the state. Subsequent to these training sessions, based on feedback and input from district staff and SAMH providers, the Program Office filed an additional rule amendment to clarify and streamline many operational aspects of the rule. These changes became effective in November 2003.

   - Chapter 2003-279, Laws of Florida (LOF), formerly known as SB 2404, requires the department to accept accreditation and independent audit reviews in lieu of monitoring for substance abuse and mental health providers and to promulgate administrative rules that outline monitoring standards that are above what is contained in accreditation standards. In October 2003, the SAMH Program

Offices released monitoring tools that assess contract compliance with current administrative program rules as well as general administrative and fiscal areas addressed in contractual agreements. In compliance with the provisions of SB 2404, the monitoring tools and protocols address duplication with accrediting bodies. As state and federal laws are amended or promulgated, the SAMH Program Offices will complete analyses of accreditation standards and amend monitoring tools and protocols as necessary.

- Chapter 2003-279, LOF, also requires the department to accept independent audit reviews for all providers in lieu of the department's monitoring of their financial operations. This poses an obstacle because audit reports are submitted to the department months after contracts have expired, rendering potential repayment of funds cumbersome. Another challenge in accepting independent audits in lieu of department monitoring is the lack of consistency among independent auditors in the areas that are covered during their reviews. To resolve these two issues, the Program Office plans to implement three year contracts with providers in FY 2004-2005 and, through contract or rule, include requirements for auditors to review specific aspects of SAMH contracts, which the SAMH Program Offices deem necessary, to ensure a high level of accountability.

- A statewide training was provided to district monitoring staff in October 2003 on the implementation of SB 2404 initiatives relative to provider contract compliance monitoring. The central SAMH Program Offices staff will provide future training and technical assistance to district staff on an on-going basis reflecting new monitoring requirements.

- Beginning July 2004, district program staff, in conjunction with district contract performance units, will be required to submit monitoring plans to the SAMH Program Offices that outline monitoring schedules for providers for a period of three years. Because Chapter 2003-279, LOF, places new limitations on the frequency of on-site visits, which vary for each program, such planning is necessary to ensure the successful implementation of these provisions. The SAMH Program Offices will track district monitoring through quarterly reports submitted by district Program Offices summarizing monitoring activities for that quarter. The central SAMH Program Office will provide training and technical assistance to district staff in the areas of monitoring methods, protocols and evaluation. A three tiered approach to monitoring will be implemented to include contract compliance monitoring, monitoring of program specific administrative rules and statutes and clinical monitoring. The central SAMH Program Office will carefully monitor district progress in the application of these tools and protocols through technical assistance, site visits, zone meetings and conference calls.

2. Comply with HIPAA Standards

   HIPAA requires the department to comply with: (a) privacy standards (45 CFR Parts 160 and 164) by April 14, 2003; (b) electronic transactions and code sets standards (45 CFR Parts 160 and 162) by October 16, 2003; and (c) security standards (45 CFR Part 142) by April 20, 2005. To meet these requirements, the department completed and implemented a HIPAA Project Plan in December 2001, which targets the following milestones.

   - April 2003: completed the development and statewide implementation of HIPAA privacy standards, including identification of privacy officer and associated functions, development of HIPAA policies and procedures, and staff training and certification;

   - July 2003: completed the statewide implementation of HIPAA standards for code sets, including modification of existing data systems to that contain secure and controlled access to confidential information;

   - December 2003: The department is expected to obtain a legal opinion about whether or not contracted providers should comply with HIPAA electronic transaction standards if they submit service events that are used by the department as the basis for verification and payment of their invoices. A SAMH policy document based on this legal opinion is expected by January 31, 2004;

   - April 2004: The department is expected to complete the HIPAA privacy requirements for noticing individuals served in state mental health facilities about their rights and privileges to know how their protected health information may be used and disclosed; and

   - April 2005: The department is expected to complete the development and statewide implementation of the HIPAA security standards, including remediation and closing of the gaps related to record maintenance, use and re-use of computer equipment, data back-up and storage, integrity and audit controls, encryption and decryption of electronic data, and automatic logoff and authentication methods.

3. Improve the Performance Measurement System

   The SAMH Program Offices will continue to use the Data Improvement Workgroup (DIWG) members as the main input vehicle for stakeholders' input to identify and use appropriate performance indicators and measures as accountability tools to drive system changes in the following areas:

   - <u>Accountability for best practices</u> to assess the degree to which the service delivery system follows evidence-based practices for delivering care at all levels.

Various source documents, such as strategic plans, performance partnership grants, statutes, rules and regulations, accreditation standards, and publications and research studies sponsored by various national organizations (e.g., the National Association of State Mental Health Program Directors – NASMHPD and the National Association of State Alcohol and Drug Abuse Directors – NASADAD) will be used as the framework for identifying and defining key systemic performance indicators and measures associated with various evidence-based practices;

- Accountability for individual outcomes that can be used at the local level as part of the provider's quality assurance process to assess changes that occur for individual individuals as a result of delivering care. Key source documents, such as individual service plans and treatment plans, may be used as the framework for defining key performance indicators associated with individual's needs and how these needs are being met at the local level;

- Accountability for system performance this will include key performance indicators and measures to assess the system of care compliance with strategic and organizational objectives at the state, district and local levels. Various source documents, such as contracts, statutes, rules and regulations, strategic plans, and other systemic policies and procedures, will be used as the framework for defining key performance indicators and measures associated with system performance. The General Appropriations Act (GAA) performance measures are examples of system performance indicators.

In addition, the SAMH Program Offices have begun holding performance measurement stakeholder meetings to identify nationally recognized measures that may be adopted by Florida. This process includes initial meetings with various SAMH stakeholders, including districts, providers, advocacy groups, state institution representatives, and Legislative staff. Furthermore, an attempt is being made to integrate performance measures required by a variety of funding sources, accreditation bodies, and state and federal government entities.

Pending the development of these new performance measures, the department has a contract with FMHI to conduct an operations research study to analyze existing data pertaining to relationships between GAA performance outcomes, individual characteristics, and types of services provided. Data needed for this research are still being collected and analyzed for publication by June 30, 2004. The understanding gained through these analyses will result in improved ways of contracting for services, developing performance standards, and setting more realistic performance targets. Over the long-term, an understanding of these relationships will allow risk-adjustment of outcomes or payments based on various risk factors involved.

4. Transform the Data System into a Decision Making Model

   - Chapter 2003-279, LOF, requires the department and AHCA to establish or develop data management and reporting systems that (a) promote efficient use of data by the service delivery system; (b) address the management and clinical care needs of the service providers and managing entities; and (c) provide information needed by the department for required state and federal reporting.

   - Section 394.9082, F.S., requires the department and AHCA to develop service delivery strategies that will improve the coordination, integration, and management of the delivery of substance abuse and mental health treatment services to persons with emotional, mental, or addictive disorders. One of the goals of this legislation is to improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes.

   - Section 394.77, F.S., requires the department to establish a uniform management information system and fiscal accounting system for use by providers of community substance abuse and mental health services.

   The following are action steps taken by the SAMH Program Offices in response to this legislation and other state data requirements:

   a) COGNOS Software During FY 2001-2002, SAMH Program Offices implemented web-based data analysis and reporting tools that use COGNOS software products. This software permits "data mining" that is capable of analyzing and reporting tabular and graphic data from multiple databases simultaneously via the Internet. This software, which has only been available to departmental staff, will be deployed statewide and will be directly accessible to staff in provider agencies by July 1, 2004. This will greatly improve the accessibility and dissemination of SAMH data for planning, monitoring, and other purposes as required by s.394.9082, F.S.

   b) ONE Family SAMH System During FY 2002-2003, the department successfully developed and piloted web-enabled application software in District 1 contracted provider agencies to reflect HIPAA standards as well as the s.394.9082, F.S., and Chapter 2003-279, LOF, data requirements. This application software system, known as ONE Family SAMH, provides not only provider-level data, but also individual-level data related to socio-demographic and clinical characteristics of persons served, the types and amounts of services received, and the outcomes of these services. This system, which will be deployed statewide in FY 2004-05 will replace the existing SAMH systems (i.e., ADMDW and MHSA), is also designed to integrate data from other database systems including, but not limited to, the following:

- Florida Accounting Information Resource (FLAIR), which provides data on approved operating budgets, as well as revenues and expenditures related to substance abuse and mental health services;
- Florida Medicaid Management Information System (FMMIS), which provides data on Medicaid eligibility status and Medicaid paid claims;
- Florida Online Recipient Integrated Data Access (FLORIDA), which provides information on TANF eligibility status for persons who need cash assistance;
- Home SafeNet, which provides data on children and families served in the state welfare system; and
- ADM Contract Database, which provides data on provider capacity, contracted service units and unit costs (Exhibit A), and contracted performance measures and targets (Exhibit D);

c) Financial Management Database System In September 2003, in response to s.394.77, F.S., the SAMH Program Offices completed the development of a financial management database system. This automated system will allow staff in the central and district offices to use a uniform process to allocate the approved operating budgets by district and contract, track contract amendments and invoice payments, and monitor surpluses and deficits for contracted services. This system was tested and prototyped in October and November 2003 by contract managers and fiscal staff in Districts 4, 11 and 14, and was deployed statewide in December 2003. The long range plan is to redesign this system in FY 2004-2005 by integrating the ADM contract database using web-enabled application software;

d) Waiting List The SAMH Program Offices, in collaboration with the Office of Adult Program services and the Office of Information Systems, are developing the requirement specifications to add a waiting list data module in ONE Family SAMH, which will be used statewide to monitor the status of persons on waiting lists for various services, including those waiting to be discharged from or admitted to state mental health facilities or to community provider agencies. This data module will be tested and piloted in FY 2003-2004 for statewide implementation in FY 2004-2005;

e) Functional Assessment Instruments Currently, there is no uniform clinical instrument to assess the levels of functioning for adults served in the mental health program. In FY 2002-2003, the central Mental Health Program Office organized a task force, including clinical staff from various organizations, to conduct a nationwide survey of existing functional assessment instruments and to recommend those that are appropriate for persons served in the mental health program. In September 2003, this task force recommended the use of Functional Assessment Rating Scale (FARS) and Modified Global Assessment of Functioning Scale (GAF-M). The department expects to complete a detailed implementation plan in February 2004, which will describe action steps and strategies to pilot these instruments in FY 2004-2005;

f) Prevention Data The central Substance Abuse Program Office contracted with the University of Miami to develop a web-enabled Performance-Based Prevention System (PBPS). The department expects to start the statewide implementation of this system in FY 2004-2005, including the development of its interface with ONE Family SAMH;

g) TANF Eligibility Data Currently, only data pertaining to TANF eligibility for cash assistance, which are collected by the Economic Self-Sufficient (ESS) Program Office and maintained in the FLORIDA system, are accessible to SAMH Program Office staff via the ONE Family SAMH system. The SAMH Program Offices are developing a database system to collect data on persons who are eligible for TANF services other than cash assistance, e.g., family diversion. This database will be piloted in FY 2003-2004 for statewide implementation in FY 2004-2005, including the development of its interface with ONE Family SAMH System;

h) ASAM Data The substance abuse service providers use the American Society of Addiction Medicine (ASAM) instrument to determine the individuals' levels of care at the time of an individual's admission, throughout his/her treatment and at his/her time of discharge. This process is currently done manually and data collected cannot be easily analyzed and reported. The central Program Office has already developed the requirement specifications to automate this process by adding the ASAM data module into ONE Family SAMH System in FY 2004-2005;

i) Medicaid Eligibility Data The SAMH Program Offices have signed an agreement with AHCA to receive daily extract of data pertaining to SAMH individuals who are Medicaid eligible. As a result of this agreement, SAMH providers will have online capability to determine the Medicaid eligibility status of their individuals, and SAMH Program Offices will be able to match these data with corresponding records in ONE Family SAMH in order to identify SAMH service events that are Medicaid compensable, i.e., SAMH services that are Medicaid billable and are provided to Medicaid eligible individuals. The central SAMH Program Offices have already completed the requirement specifications to pilot this process in FY 2003-2004 for statewide implementation in FY 2004-2005; and

j) Community Needs Assessment Data A workgroup including staff in the districts, state mental health treatment facilities and central Program Office are developing the requirement specifications, which will be used to consolidate and automate information related to Form 7000 and Form 7001 admission and discharge forms. The plan is to complete the programming activities, including testing and prototyping, by June 30, 2004. This data module will be linked to the Waiting List data module, which will be piloted and implemented in ONE Family SAMH during FY 2004-2005.

Performance Measurement

The Substance Abuse and Mental Health Program Offices recognize that several of the performance measures that are legislatively mandated may not be appropriate for use at the individual contract level. In consultation with our major stakeholders, the department plans to explore drivers of service delivery that would more appropriately be applied at the individual contract level. Concurrently, the department will continue to review all performance measures in determining how best to measure successful performance of a provider. All activities related to performance measures will adhere to legislatively mandated outcome measures. The mental health and substance abuse performance outcomes for FY 2002-2003 are outlined below. The arrows reflect the desired level of change in performance, either an increase or decrease, based on the phrasing of the GAA measure.

Children's Mental Health Performance

Table 13 below shows the performance results for children's mental health services in FY 2002-2003.

Table 13: Children's Mental Health GAA Outcome Measures for FY 2002-03

Target Population	Performance Outcome Measure	State Standard	Actual Statewide Outcome
Children with serious emotional disturbance (SED)	a. Annual number of days serious emotionally disturbed (SED) children (excluding those in juvenile justice facilities) spend in the community	344 ↑	348
	b. Percent who improve their level of functioning	TBD Baseline only.	65%
Children with Emotional Disturbances (ED)	a. Annual number of days emotionally disturbed (ED) children (excluding those in juvenile justice facilities) spend in the community	358 ↑	357
	b. Percent who improve their level of functioning	TBD Baseline only.	62%
Juvenile Incompetent to Proceed	a. Percent of children with mental illness restored to competency and recommended to proceed with a judicial hearing	90%↑	TBD
	b. Percent of children with mental retardation restored to competency and recommended to proceed with a judicial hearing	68%↑	TBD

Adult Mental Health Performance

The table below indicates performance outcomes for FY 2002-2003.

Table 14: Adult Mental Health GAA Outcome Measures for FY 2002-2003

Target Population	Performance Outcome Measure	State Standard	Actual Statewide Outcome
Adults with Serious and Persistent Mental Illness in the Community (SPMI)	a. Average annual number of days spent in the community (not in institutions or other facilities)	350 ↑	346
	b. Average annual days worked for pay	40 ↑	29
Adults in Mental Health Crisis	a. Median length of stay in CSU/Inpatient services	TBD Baseline only.	3.0
Adults with Forensic Involvement	a. Percent of persons who violate their conditional release under chapter 916, Florida Statutes, and are recommitted	2% ↓	1.36%
	b. Average annual number of days spent in the community (not in institutions or other facilities)	263 ↑	248
Adult Mental Health Treatment Facilities	a. Percent of civil commitment patients per Chapter 394, F.S., who experience symptom relief	TBD	NA
	b. Percent of adults who are not guilty by reason of insanity (s.916.3217, F.S.) who experience symptom relief	TBD	NA
	c. Average number of days to restore competency for adults in forensic commitment	TBD	NA

Children's Substance Abuse

The table below represents statewide performance levels for FY 2002-2003. On a statewide basis, providers exceeded performance expectations for treatment completion. The follow-up measure continues to be problematic, however, the most recent survey results exceed the state standard. Measurement of pre/post-treatment commitment rates is currently being coordinated with the Department of Juvenile Justice.

Table 15: Children's Substance Abuse GAA Outcome Measures for FY 2002-2003

Target Population	Performance Outcome Measure	State Standard	Actual Statewide Outcome
Children with Substance Abuse Problems	a. Percent of children who complete treatment	72% ↑	76%
	b. Percent of children who are drug free at 12 months following completion of treatment	52% ↑	55.6%
	c. Percent of children under the supervision of the state receiving substance abuse treatment who are not committed to the Department of Juvenile Justice during the 12 months following treatment completion	85% ↑	67%
Children At Risk of Substance Abuse	a. Percent of children who receive targeted prevention services who are not admitted to substance abuse services at the 12 months after completion of prevention services	95% ↑	96.3%

Adult Substance Abuse Performance

The table below represents statewide performance levels for FY 2002-2003. On a statewide basis, providers exceeded performance expectations for employment. The child welfare measure continues to be problematic; however, the Substance Abuse Program is coordinating a state-sample record review in conjunction with Child Welfare and CBC to obtain the necessary data. Measurement of pre/post-treatment arrest rates is currently being coordinated with the Department of Law Enforcement.

Table 16: Adult Substance Abuse GAA Outcome Measures for FY 2002-2003

Target Population	Outcome Measure	State Standard	Actual Statewide Outcome
Adults with Substance Abuse Problems	a. Percent of adults who are drug free at 12 months following completion of treatment.	54% ↑	68%
	b. Percent of adults employed upon discharge from treatment services	68% ↑	72%
	c. Percent of adults who complete treatment	69% ↑	71%
	d. Percent of adults in child welfare protective supervision who have case plans requiring substance-abuse treatment who received treatment	55% ↑	See note.
	e. Percent change in the number of individuals with arrests within six months following discharge compared to number with arrests within six months prior to admission	50% ↑	70%

Note: The child welfare/substance abuse performance measure is currently being captured through a statewide survey sample of protective services' records. Results are anticipated by February 1, 2004.

Chapter 9: Development of District Plans

Overview

As a key part of the state's planning process, each district/region developed a comprehensive plan with broadly inclusive local participation. The district/region plans were automated in an uniformed reporting format to facilitate a common organizational approach that would allow the achievement of comparable results. Key elements from the 14 district/region plans are summarized in this chapter.

The district plans are divided into five chapters, each aligned with the main chapters of the state substance abuse and mental health services plan:

Chapter 1: Executive Guidelines and Legislative Initiatives- This chapter provides an overview of significant trends, conditions, and other issues in the district/region, summarizes provider profiles, and identifies purchased and licensed capacities. It also addresses specific statutory requirements regarding target populations, service delivery, and financial resources availability.

Chapter 2: Mental Health Program Strategies- The department developed a series of goals to improve service provision and outcomes of persons served, enhance opportunities for stakeholder collaboration, and refine its workforce and operational structure to improve efficiency over the next five years. The Mental Health Program developed a series of strategies in alignment with the department's goals. Each district/region was required to identify their courses of action to implement these mental health strategies at the local level through FY 2005-2006.

Chapter 3: Substance Abuse Program Strategies- The department developed a series of goals to improve service provision and outcomes of persons served, enhance opportunities for stakeholder collaboration, and refine its workforce and operational structure to improve efficiency over the next five years. The Substance Abuse Program developed a series of strategies in alignment with the department's goals. Each district/region was required to identify their courses of action to implement these substance abuse strategies at the local level through FY 2005-2006.

Chapter 4: Collaborative Strategies and Initiatives- This chapter provides information on Chapter 2003-279, L.O.F., specific to the development of managing entities, co-occurring Services, Temporary Assistance to Needy Families, and coordination of substance abuse and mental health service provision for persons involved with child welfare. Each district/region provides a description of collaborative initiatives and plans for enhancing collaboration with other departmental programs and community-based agencies.

Chapter 5: Performance Measurement, Contract Monitoring, Data Systems and Financial Management- This chapter provides information on Contracting Methods, Allocation of Funds, Fiscal Accountability, and district/provider performance relative to the General Appropriations Act Output/Outcome Measures.

Stakeholder Input

Throughout the planning process, district and regional substance abuse and mental health staff solicited input from a variety of local stakeholders including associations, alliances, advocacy groups, local government, community-based providers, law enforcement, community MHSA professionals, and schools. Each district/region was required to delineate the extent of stakeholder involvement in planning and service initiatives. Prior to finalizing their plans the districts and region were required, at a minimum, to review input from local governments, planning councils (if applicable), and alliances.

At the local level, stakeholder input is accomplished through a variety of methods. ***Table 17*** displays the various approaches used by districts to solicit stakeholder input. The headings in the columns represent the various methods/approaches used by the districts; the rows headings represent the stakeholders. The percentages in the boxes represent the percent of the districts that used the method/approach to solicit stakeholder input. The method/approach employed varied across districts.

Table 17: Different Approaches Used to Solicit Stakeholder Input Utilization By Districts

	Public Forum/Town Meetings	MHSA Conference	Survey	DCF District Planning Meeting	Other Types of Input
MHSA Associations	50%	50%	35%	57%	28%
Community Alliances	64%	42%	35%	92%	35%
Individual Advocacy Groups	64%	35%	42%	78%	57%
Service Providers	64%	50%	57%	85%	57%
DCF Program Staff	71%	50%	50%	78%	64%
Community MHSA Professionals	64%	35%	21%	71%	57%
Local Schools	71%	28%	35%	71%	50%
Dept. Juvenile Justice	71%	35%	42%	71%	35%
Local Government	71%	35%	14%	64%	42%
Law Enforcement	71%	35%	14%	64%	35%
Other	42%	.07%	28%	.07%	.07%
TOTALS	**63.9%**	**35.9%**	**33.9%**	**66.4%**	**41.8%**

Across the 11 stakeholder groups above, the most common method of district solicitation for stakeholder input was the district planning meetings (66.4 percent). Another popular method was public forum/town meetings (63.9 percent). SAMH

conferences and survey methods were used approximately 34-36 percent of the time while alternative methods (listed as other types of input above) were used 41.8 percent of the time.

District Plans

The following key issues were identified as significantly impacting the demand for services, utilization of services, service models and financial resources. Several issues are also identified as “unmet needs” at the community level and are addressed in various chapters of the state plan.

Local Conditions and Trends

- An increase in the number of medical doctors prescribing pain medications, then abruptly discontinuing services, has increased the demand for methadone and detoxification services.

- Drug court for first-time offenders continues to increase the demand for state and county funded residential services. Juvenile drug courts are under-funded and inadequately staffed to meet the growing needs. Many of the drug court programs throughout Florida were initially funded by federal grants. Upon expiration of the grants’ terms the burden of continuing services falls on the state and local communities.

- Rising prescription drug abuse problems exist across the state. Substance abuse providers are reporting a significant increase in the number of new individuals seeking help for prescription drug abuse.

- Abuse of oxycodone and club drugs has had a significant impact on the number of youth referred for treatment.

- Districts report a trend in increased use of self-directed care and recovery models, with emphasis on reducing the stigma associated with individuals with mental illnesses.

- The number of individuals served in the districts is growing and changing, and is increasingly becoming more culturally diverse. There are more service demands for individuals who are older, more medically complex or who have dual service needs. There are greater service demands for children and infants with mental health needs. Additionally, more individuals with brain injury are seeking services from the districts.

- There are escalating costs for providing mental health services. Insurance rates, workers’ compensation and health benefit costs are rising. Lack of competitive salaries and benefits are increasing turnover of staff. Pharmaceutical expenditures and transportation costs are escalating. Individuals are finding free mental health

counseling to be less available. There is an expressed need for more equitable distribution of funding based on population growth.

- The administrative trends reported include: problems accessing the social security and Medicaid systems for benefits for people the department served; limited program office staff to keep up with increases in the individuals being served, service providers, and the number of contracts requiring monitoring.

- Movement toward community-based care has placed more emphasis on mental health services for child welfare recipients and increased staff turnover because of salary competition from the private sector.

Primary Services Needs Overview

- Place greater emphasis on aftercare and case management within the continuum of care to reduce the risk of individuals' relapses.
- Additional adult and adolescent residential treatment beds are needed to eliminate waiting lists.
- Maximization of Medicaid substance abuse services in the areas of case management (intensive and targeted) and for individuals with co-occurring substance abuse and mental health needs.
- There is a need to additional funding to expand drug courts and to provide necessary resources.
- There is a need to develop array of specialized services to homeless individuals and older adults.
- The districts are experiencing escalating costs in providing mental health services for children and adults. A particular concern is lack of sufficient funding for individuals who are not eligible for Medicaid benefits.
- Increased funding is needed for the Indigent Drug Program and medication assistance programs. Providers, especially those providing co-occurring services, need access to indigent drug dollars to provide psychotropic medications for individuals with substance abuse and mental health co-occurring needs.
- The districts have the capacity to serve some individuals with co-occurring needs (Mental Health/Substance Abuse). There is a far greater demand for services than what is currently available. Additional training is needed at the provider level to address the needs of these individuals.
- Additional case management services are recommended. Included in these are expansion of FACT Teams, intensive case management services and targeted case management. There also needs to be increased funding to accommodate eligible individuals who do not receive SSI and Medicaid.
- The districts report a greater need for a variety of residential options, including short-term residential treatment beds to serve the needs of individuals in crisis, residential treatment facilities, specialized therapeutic foster care services, supported housing,

therapeutic group homes, forensic residential services and residential services for those with co-occurring substance abuse and mental health needs.

- Specialized therapeutic intervention services should be implemented or enhanced to serve a diverse group of persons with various mental health needs. Recommendations include expansion of community based competency restoration for adults and juveniles, access to behavioral therapy or Dialectical Behavior Therapy, services for individuals with traumatic brain injuries/organic brain syndrome, implementation and expansion of mental health courts, expansion of school-based treatment, early identification of infant and children mental health needs, and additional caregiver training and caregiver respite services.

District Highlights (Special Projects and/or Pilots)

The department continues implementation of several existing pilots while responding to new initiatives created through legislation:

- District 8 and the Suncoast Region piloted the first coordinated and integrated response to address the problems of co-occurring substance abuse and mental health needs by a combining a crisis stabilization unit and a addiction receiving facility for the treatment of adolescents. These demonstration models are currently being evaluated by the Florida Mental Health Institute with a final report submitted to the Legislature no later than December 31, 2003.

- District 11 was awarded a Criminal Justice Drug Abuse Treatment Systems Grant to create a new research center within the University of Miami Center for Treatment Research on Adolescent Drug Abuse.

- District 4 will work with community agencies to establish a managing entity for substance abuse services directed to child welfare recipients in Districts 4 and 12. The entity will be "accountable" for the coordination of these services. This was a Legislative mandate through S. B. 2404.

- Behavioral Health Initiative - In District 1, pursuant to s.394.9082, F.S., the district has contracted with a managing entity utilizing a capitation similar to the method used by Medicaid. This is the same managing entity administering the Medicaid carve-out funds. This allows the managing entity to align financial systems and clinical services and focus on the individual needs of the service participant, and his or her family or support system. The contract includes all substance abuse treatment services to facilitate an integrated and holistic approach to the delivery of services to individuals and families. This contracting approach also better integrates behavioral health services for Medicaid and non-Medicaid recipients and allows flexibility in the planning and delivery of needed services.

  To support the focus on the individual service participant, support the new contracting system and to better assess individual and financial outcomes, District 1 developed and implemented the Pilot Integrated Data System (PIDS). PIDS integrates the previous separate Mental Health and Substance Abuse data systems

and finance and contractual systems into a user-friendly system that provides relevant and immediate information to clinicians, quality improvement managers, finance managers, contract managers and others. The PIDS system was developed in tandem with OneFamily, which provides extensive reporting capabilities and integration with other databases such as Medicaid and TANF. The new system is cost-effective to operate and has demonstrated substantial cost and timesaving to the providers and other system users. One Family is a type of computer architecture inside of which there are many small programs than can be built to meet specific requests.

- Florida Algorithm (FALGO) - In 2001 the Florida Legislature passed Specific Appropriation 381, which contains proviso language calling for the department and AHCA to adopt and systematically implement an evidence-based medication algorithm for the treatment of individuals with schizophrenia and related illnesses. The proviso language requires the implementation and evaluation of this evidence-based algorithm in the community mental health system. To comply with this directive the Institute for Health and Human Services Research at Florida State University and the department's Mental Health Program Office are working collaboratively to develop an implementation process.

  FALGO involves the implementation of evidenced-based medication algorithms for treatment of persons with thought and mood symptoms associated with mental illnesses. FALGO is a step-by-step medication and treatment approach that reflects the current state of knowledge on effective and appropriate care, as well as clinical consensus judgments when knowledge is lacking. The algorithm supplies a guideline for all aspects of treatment. However, physicians and other staff are empowered to divert from guidelines whenever it is thought to be more beneficial for the person served.

- System Redesign - An essential part of the behavioral health system redesign in District 8 is the move toward a recovery-oriented service system In support of these principles of recovery, self-determination, peer directed care and community inclusion, the service array in District 8 has evolved over the past two years to significantly reduce the use of facility-based programs and to increase the use of supportive living and FACT programs to provide community-based treatment and support. In addition, the district has implemented several recovery-oriented, person-centered projects. These projects encourage community integration and connections to foster individuals' recovery and provide employment and peer supports. These projects include Peer-to-Peer and Family-to-Provider education, community mentor or ComPeer, Recovery Teams and Personal Outcomes Measures interviewers. The latter employs people in recovery to assist the district in measuring recovery outcomes and quality of life for people with severe, persistent mental illnesses.

- Self- Directed Care (FloridaSDC) – Florida SDC is an approach to providing publicly funded behavioral health care services wherein the individual is granted a high

degree of self-determination in choosing services and providers necessary for recovery from mental illness. This program provides mental health treatment and support services for adults who have a serious mental illness while allowing the individual to control the public mental health funds allotted for his/her treatment and to directly purchase the services from their vendor of choice.

- In District 4, the FloridaSDC Program has reached full capacity. Additionally, the department, in partnership with the Florida SDC advisory board, is in the initial planning stages of expanding the program into District 8 for adults and initiating a small pilot within District 4 using family-directed care concepts for children and youth. The program has received national attention from experts in the field of self-determination for people with disabilities and has also received a national award. Other states are very interested in using the FloridaSDC model as the blueprint for similar programs for adults with mental illnesses and the program is partnering with the FALGO project to help educate individuals about medications.

Appendices

Achieving the Promise

Florida's Strategies

in Response to the President's

New Freedom Commission Report on Mental Health

Appendix A

January 2004

Appendix A – Florida's Strategies in Response to the President's New Freedom Commission Report on Mental Health

Commission Goal: Americans Understand That Mental Health is Essential to Overall Health

National strategies include:

Advancing and implementing a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

In accordance with this national strategy, the Mental Health Program Office is implementing a statewide initiative to reduce stigma and discrimination made possible by a technical assistance grant from the Substance Abuse Mental Health Services Administration (SAMHSA). Florida is one of eight states to pilot the "Eliminating Barriers Initiative (EBI)", a national campaign to fight stigma and discrimination. With the aid of the grant from SAMHSA, the Mental Health Program Office has developed a strategic marketing plan that addresses stigma and discrimination through a multi-media campaign. The goals of this effort are to build public support for the principle of recovery, raise awareness, and reduce discrimination.

The Mental Health Program Office is partnering with the Governor and the Office of Drug Control Policy through the Florida Task Force on Suicide Prevention to achieve the goal of reducing the overall incidence of suicide by Florida's citizens by one-third (from 13.64 per 100,000 in 1998 to approximately 9 per 100,000 in 2005). The Task Force was created to assess Florida's current suicide prevention activities and recommend future initiatives. These recommendations include advancing the science of suicide prevention; integrating efforts across agencies and organizations; mounting a public information campaign; training caregivers and community leaders; limiting access to expeditious means of suicide by increasing awareness and responses; developing a responsive health care system; and broadening support for suicide prevention at all levels of state government. Task Force efforts are currently underway to address all of these recommendations as outlined in "Preventing Suicide in Florida", a strategy paper that can be viewed at:

http://www.myflorida.com/myflorida/government/governmentinitiatives/drugcontrol/suicide_prev.html.

Addressing mental health with the same urgency as physical health.

The Mental Health Program Office is addressing this area by working to improve access to behavioral health care services in primary health care. Additionally, the Program Office is increasing community capacity for short-term residential

treatment and acute care services to provide a quick and effective response to individuals suffering from the results of trauma and crisis. Access to behavioral health was identified as an important element to the state's CHIP program, Florida KidCare. The Behavioral Health Network (Bnet) was created for children enrolled in Florida KidCare who have intensive behavioral health needs. The program requires close coordination with Children's Medical Services (CMS) who coordinate their physical health needs. Working agreements are being negotiated between the department and the Department of Health to ensure that mental health is a covered service under Early Intervention Services for Infants and Toddlers, Part "C." Florida also has created a behavioral health screening tool to assist physicians in screening for substance abuse and mental health needs as part of the Medicaid "Well Child Check-up".

The Mental Health Program Office is working in cooperation with the Department of Health, Florida Council for Community Mental Health and Florida Association of Community Health to develop an interagency agreement template that could be used by the federally qualified health care centers and community mental health centers to develop cooperative arrangements to provide non-duplicative behavioral services. This is especially important in rural areas where behavioral services are not otherwise available.

Commission Goal: Mental Health Care is Consumer and Family Driven

National Strategies include:

Developing an individualized plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance.

Currently, Florida's publicly funded mental health system requires that each individual receiving services must have an individualized plan of care. Traditionally, the community mental health case manager writes this plan. However, the focus of care must shift to a recovery-based model that considers the individual as the center of his or her recovery plan. To move in this direction, the Mental Health Program Office will rewrite the current statutory rules that guide case management planning, as well as retrain all adult and child case managers. The concept of recovery is already being reinforced within several of Florida's mental health treatment facilities, where they employ a model of "Role Recovery" adapted from Boston Center for Psychiatric Rehabilitation. The Mental Health Program Office plans to expand the principles and strategies from this model to the community mental health system. Additionally, one district in Florida, District 8, is piloting using structured interviews to complete "Personal Outcome Measures," a tool that involves the individual in evaluating how he or she is progressing towards recovery. These measures are taken from The Council, an international quality improvement organization.

Involving consumers and families in orienting the mental health system toward recovery.

Mental health services that are recovery-oriented need input from individuals living with serious mental illnesses. Advocates frequently say to policymakers "Nothing about us without us." In this vein, the Mental Health Program Office plans to hire a Peer Advocacy Coordinator when a salaried position can be secured. This person will assist in rewriting policy and promoting recovery-based, person-centered system planning. Fully implementing the model of self-directed care for adults and family directed for children mentioned previously also assists the department in reaching this goal. The Mental Health Program works collaboratively with the State Mental Health Planning Council and many other advocacy groups that support a system that enhances recovery by providing the individualized supports necessary to help individuals realize their full potential.

Specific strategies in Florida include a focus on evidenced-based practices which support a recovery based model that views the individual as the center of his or her recovery plan of care. Initiatives include efforts to improve individuals' access to appropriate medications and best practice clinical management such as with the use of medication algorithms; redirecting community funding to support psychiatric rehabilitation and evidence-based practices; increasing the capacity for community-based short-term residential treatment and acute care; fully implementing a self-directed care model throughout the service delivery system, reducing the number of days individuals stay in state mental health treatment facilities and children's residential treatment centers and working with multiple community organizations to achieve these strategies. This subsequently increases the number of days individuals live in the community.

Aligning relevant federal programs to improve access and accountability for mental health services.

Although this goal is being addressed on a federal level, the Mental Health Program Office is strengthening partnerships through joint projects with the Department of Education's Vocational Rehabilitation to improve access to employment opportunities; the Department of Housing and Urban Development (HUD) to improve access to housing; the Social Security Administration to improve the length of time it takes to reinstate benefits; and the Agency for Health Care Administration's Medicaid office on several policy and accountability initiatives. Additionally, the Program Office is working with the Sheriff's Association, through the Partners in Crisis Coalition, to develop a bulk-purchasing program for use by the jails, and by expanding Crisis Intervention Team (CIT) training for local law enforcement agencies. Expanding mental health courts, specifically designed to serve misdemeanant and felony offenders who have mental

illnesses, will also serve to improve access to care and enhance coordination.

Creating a comprehensive State Mental Health Plan.

The department actively works with other agencies, community stakeholders, and the people it serves to develop a comprehensive plan every three years. The Substance Abuse and Mental Health Corporation, established by the 2003 Legislature, has been charged with the responsibility of reviewing and assessing the status of the publicly-funded substance abuse and mental health service system and for making recommendations for strategies to improve the performance of the system.

In order to enhance coordination of care the Deputy Secretary for Substance Abuse and Mental Health will convene a quarterly communications forum. This forum will provide a venue for organizations and state agencies to share current initiatives and issues in the areas of substance abuse and metal health. The first meeting will be held in February 2004.

Protecting and enhancing the rights of people with mental illnesses.

The State Mental Health Planning Council is mandated under federal law to conduct three major functions. These include: 1) monitoring the adequacy of the publicly funded mental health service system; 2) advocating for both adults and children with mental illnesses; and 3) reviewing the mental health block grant application. The Planning Council has developed active committees that serve as a voice for adults and children with mental health needs and their families. Additionally, many members of the Planning Council represent local and statewide advocacy organizations that are on the cutting edge of developing innovative programs.

Both community programs and mental heath treatment facilities have processes in place to provide persons receiving treatment access to advocacy and the redress of grievances. Each program has consumer advocacy staff, grievance committees and clearly defined procedures to address individual complaints. In addition, individuals who receive services are active participants on advisory committees.

Increasing participation of people served by the system in policy and planning development is of ongoing importance and will continuously be emphasized. Inviting individuals to participate in task groups organized by the Mental Health Program Office and throughout the service delivery system will remain a key strategy in protecting and enhancing the rights of people with mental illnesses and their families.

The Statewide Advocacy Council (SAC) is authorized by section 402.165, F.S. This Council represents the interests of individual who are served by state agencies that provide services for individuals or families and serves as an independent, third-party mechanism for protecting the constitutional and human rights of individuals served by the department or by any state agency.

Commission Goal: Disparities in Mental Health Services are Eliminated

National strategies include:

Improving access to quality care that is culturally competent.

The Mental Health Program Office recognizes that access to quality culturally competent care is of the utmost importance. The Program Office is assessing the need for statewide training. Certain areas of the state, such as south Florida, are currently employing culturally competent strategies in their service delivery system, both in promoting service availability and in delivery of services. Lessons learned will aid in expansion of training. Best practices will be endorsed and replicated throughout the state.

Improving access to the quality of care in rural and geographically remote areas.

The Mental Health Program Office is developing a plan to improve individuals' access to behavioral health care services in primary health care settings in rural areas by working collaboratively with the Department of Health and other partners to attain this goal. Tele-medicine will be considered as a part of the plan if feasible. Additionally, there is a need to increase the availability of community based short-term residential treatment and acute care to ensure that services are available to individuals in every county, including very remote areas of the state.

Commission Goal: Early Mental Health Screening, Assessment and Referral to Services are Common Practice

National strategies include:

Promoting the mental health of young children.

The goal of expanding mental health services to very young children to prevent serious mental health problems is of primary importance to the department and is a targeted focus described within this plan. Likewise, the department is promoting early intervention services for individuals receiving Temporary Assistance for Needy Families (TANF). A vital initiative that will be completed in 2004 is the integration of mental health care with the child welfare system to provide ready access and quality services for children and their families. In addition, the Program Office has just completed an Infant Mental Health Pilot project in three sites,

Miami, Sarasota, and Pensacola. These pilots served children aged birth to three years with emotional disturbances who were involved with the child welfare system. As a result of positive outcomes (no children who completed the programs were reported as abused), the program has been expanded to five additional sites with a goal of statewide implementation by 2005.

Improving and expanding school mental health programs.

In addition to the completion of the integration of children's mental health with the child welfare system, the department will work with the Department of Education to address suicide prevention strategies. The Mental Health Program contracts with children's mental health providers for mental health overlay services in schools. These include individual and group services for children with emotional disturbances and their families. A strong link exists between the Multi-Agency Network for Students with Severe Emotional Disturbance (SED-NET) and children's Mental Health Program staff, both at the state and local level. This collaboration ensures the identification and development of strategies to improve outcomes for children.

Screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies.

The department recognizes that identification of persons with co-occurring needs is a priority issue and is developing a statewide plan designed to promote early detection through screening and education. In accordance with Chapter 394, F.S., the Substance Abuse and Mental Health Program Offices have established two demonstration projects to develop crisis stabilization units/addictions receiving facilities (CSU/ARF) for children in crisis. This will allow mental health and substance abuse needs of children to be addressed in an integrated and holistic manner. This issue was addressed in detail in Chapter 6, Collaborative Initiatives.

Screening for mental disorders in primary health care across the lifespan and connecting to treatment and supports.

It is widely understood that the majority of people seeking mental health care first talk with their primary physicians about their concerns. It is vital that quality mental health care be as accessible as possible and that general practitioners have training that allows them to recognize mental health issues across the lifespan. The department is working collaboratively with the Department of Health to improve individuals' access to behavioral health care services in primary health care settings. For children, a behavioral component is included in the Medicaid Child Health Check-Up with the Behavioral Health and Developmental

Screening Form that identifies substance abuse and mental health risk factors.

Commission Goal: Excellent Mental Health Care is Delivered and Research is Accelerated

National strategies include:

Accelerating research to promote recovery and resilience, and to ultimately cure and prevent mental illnesses.

The contracted evaluation of pilot projects across the state by various universities allows meaningful comparisons of different methods of treatment and service delivery. This information is valuable in designing a seamless, effective system of care and for modification of systems that do not produce the desired results. The interactive data system in the Florida medication algorithm project (FALGO) will allow research based on the data collected. The statewide introduction of the Functional Assessment Rating Scale (FARS) with adults, and continued use of the Children's Functional Assessment Rating Scale (CFARS) with children, will allow meaningful comparisons of individuals across treatment settings on multiple dimensions and provide data for comparisons of medication regimes, treatment methods and settings.

Advancing evidence-based practices using dissemination and demonstration projects and creating a public-private partnership to guide their implementation.

Florida recognizes the significance of emerging evidence-based practices and has continued to create new innovative partnerships for the implementation of medication algorithms (FALGO), assertive community treatment, and supported employment. Florida will continue to advance the effort of bridging the gap between science and practice in the areas of Multi-Systemic Therapy (MST), Therapeutic Foster Care (TFC), wrap-around services, infant mental health, parent/family education, and trauma informed care by creating public-private partnerships to guide the implementation of these evidence-based practices. Collaboration will continue with the National Association of Mental Health Program Directors Evidence-Based Practice Center, state universities and advocacy organizations to promote, disseminate and train providers in innovative methods.

The Florida Self-Directed Care Pilot Project (FlordiaSDC) in District 4 is an approach to providing publicly-funded behavioral health care services in which individuals are granted a high degree of self-determination in choosing services and providers necessary for their recovery from mental illnesses.

Improving and expanding the workforce providing evidence-based mental health

services and supports.

The Mental Health Program Office has partnered with the Center for Prevention and Early Intervention Policy, Florida State University, to expand the number of clinicians trained in diagnostic techniques with children ages birth to five years. The Mental Health Program Office has also supported training for our providers through the National Technical Assistance Center for state mental health planning. The state mental health treatment facilities provide staff training in crisis prevention techniques aimed at incorporating the principles of trauma informed care into an initiative to reduce the use of seclusion and restraints. In collaboration with the Florida Developmental Disabilities Council, Inc., the Department provided a training regarding supported employment issues, including best practices and financial work incentives using the Ticket-to-Work program and other benefits offered by the Social Security Administration. Florida Assertive Community Treatment (FACT) trainings in relevant areas such as supported employment, Dialectical Behavior Therapy (DBT), assessment and individualized treatment planning, co-occurring recognition and treatment, and substance abuse all within a recovery model framework, will continue to be provided throughout the state.

Developing the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma and acute care.

The Mental Health Program Office has sought out partnerships with state universities in Florida to promote research to practice initiatives. The Program Office will strengthen those partnerships to increase research in understudied areas of mental health. Initial research collaboratives have included the Florida medication algorithm (FALGO) project for standardized medication practices, and the evaluation of the Florida Self-Directed Care (Florida SDC) pilot.

Commission Goal: Technology is Used to Access Mental Health Care and Information

National strategies include:

Using health technology and telemedicine to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

An additional component of the Mental Health Program Office's efforts to improve access to behavioral health care services in primary health care settings is exploring the use of telemedicine technology, especially for individuals living in rural areas. A workgroup comprised of mental health facility staff, Program Office staff and information system staff is developing and implementing a secure, web-based program to share

community needs assessment (C.N.A.) information with hospital treatment staff, community providers and district staff in order to anticipate needs and insure that placements are available for individuals who are ready for a less structured environment. The C.N.A. is expected to be operational in 2004. The adult forensic mental health system Internet website provides information to forensic system stakeholders and their families. The Living Environment Activities Preference (L.E.A.P) website has been developed by one of the state mental health treatment facilities to provide facility service team members and residents access to information regarding residential placement and services statewide. Plans are underway to introduce this promising practice in each of the state's civil and forensic mental health treatment facilities.

Developing and implementing integrated electronic health record and personal health information systems.

The department will improve its data system by transforming it into a system decision-making model that will provide immediate feedback to the system users, who can then use it for quality improvement activities. The state mental health treatment facilities have developed and implemented an electronic medical record system for tracking resident files. This system allows for improved documentation, facilitates communication between disciplines and provides real-time information necessary for helping make treatment decisions.

Appendix B - Substance Abuse Best Practice Award Winners 2003

The following programs received Best Practice Awards at the 2003 Florida Alcohol and Drug Abuse Association (FADAA) Annual Conference in August 2003 for exemplary or promising substance abuse programs and services:

Grand Prize: The Village South, Miami: Companeros en Recuperacion (Partners or Companions in Recovery)

Treatment Programs:

- First Place: The Starting Place, Hollywood: Juvenile Drug Court: Cannabis Youth Treatment Track
- Second Place: River Region Human Services, Inc., Jacksonville: In-Jail Substance Dependency Treatment Program
- Third Place: First Step of Sarasota, inc., Sarasota: Mothers & Infants Program

Prevention Programs:

- First Place: Drug Abuse Comprehensive Coordinating Office, Inc., Tampa: Family Centered Substance Abuse Services Prevention
- Second Place: The Center for Drug-Free Living, Inc., Orange, Osceola and Brevard Counties: Village House Program
- Third Place: Drug-Free Youth in Town (DFYIT), Miami: DFYIT

Intervention Programs:

- First Place: Serenity House of Volusia, Inc., Daytona Beach: Interdisciplinary Managed Care (IMC)

Best Rural Program:

- Tri-County Human Services, Inc., (TCHS), Dept. of Children & Families Districts 13 and 14: Triad Women's Project

Best Innovative Program:

- DISC Village, Inc., Operation PAR, Inc., Coastal Behavioral Healthcare, Inc., Human Services Association, Inc., Tallahassee, Orlando, Sarasota and St. Petersburg: Community Assessment and Intervention Centers

Best Promising Practices:

- ACT Corporation, Daytona Beach: Jail Diversion

- Broward Addictions Recovery Center (BARC) & Broward County Elderly and Veterans Services Division (EVSD), Ft. Lauderdale: Mature Adult Program
- The Center For Drug Free Living, Inc., Orlando: Women's and Children's Program
- Home Detox, Inc., Venice: Home Detox, Inc.
- Lifestream Behavioral Center, Inc., Leesburg: Crossroads II
- Manatee County Girls Club, Inc. D/B?A Just for Girls, Bradenton: Positive Action Living (PAL) Programs for Youth
- Manatee Glens Corporation, Bradenton: The Access Center
- Non-Violence Project USA, Miami: Non-Violence Project
- Operation PAR, Inc., Pinellas Park: Interfaith Advisory Committee
- Southwest Florida Addiction Services, Inc., Ft. Myers: TLC Occupational Therapy Program
- Stewart-Marchman Center, Inc., Daytona Beach: Residential Adolescent Program (RAP) Continuing Care
- Tri-County Human Services, Inc., Lakeland: Prevention Services Program

Appendix C - Stakeholder Input

Throughout the planning process, district Substance Abuse and Mental Health (SAMH) staff sought input from a broad group of local stakeholders, including individuals, organizations and agencies interested in substance abuse and mental health services. District stakeholders include groups such as associations, alliances and advocacy groups, local government entities, individuals with serious mental illnesses and their families, parents of children and youth with serious emotional disturbances, substance abuse and mental health providers, law enforcement, community mental health and substance abuse professionals and school representatives. The SAMH central Program Offices expanded the district plan format to include the additional requirements contained in Section 394.4574, F.S. This legislation pertains to the department's responsibilities for each mental health resident who resides in an assisted living facility that holds a limited mental health license (LMH-ALFs). The intent of consolidating these two plans was to strengthen the alignment between the district SAMH plans and the annual district LMH-ALF plans by combining the two stakeholder processes and the plan elements.

The State Substance Abuse and Mental Health Program Offices conducted two forums to solicit input from stakeholders in the development of this plan, both held on October 23, 2003. The first meeting was held with the State Mental Health Planning Council. The Council is comprised of consumers, family members and representatives from each of thirteen districts and one region of the Department of Children & Families. The Councils membership includes representation from advocacy groups and state agencies including: the state Departments of Education; Community Affairs; Corrections; Elder Affairs; Juvenile Justice; Agency for Health Care Administration; the Mental Health Associations of Florida; Florida Council for Community Mental Health; the Statewide Advocacy Council and members who represent children and adolescents with mental health problems, including the Federation of Families for Children's Mental Health. The Council is charged with assessing the adequacy of the State's public mental health service delivery system. The following represent the Council's input for improving the mental health system of care:

- Increase consumer operated services to promote recovery;
- Increase funding for wrap-around services for children and adolescents including funding for meaningful educational activities and socialization opportunities;
- Improve essential early intervention and prevention services for children and their families;
- Achieve funding for intervention and treatment services for children in the juvenile justice system that may help reduce the likelihood of further delinquent acts;
- Enhance the indigent psychiatric medication program;
- Promote mental health and physical health parity;
- Promote access to affordable independent housing for adults with serious mental illnesses;
- Increase staffing at the mental health central office to enhance the lives of adults and children with mental health needs;

- Enhance community treatment, rehabilitation and support for individuals being discharged from the Department of Corrections and other facilities;
- Monitor the implementation of recently passed legislation, Chapter 2003-279 Laws of Florida (formerly Senate 2404), with assistance from the Council.

Also on October 23, 2003, the State Substance Abuse and Mental Health Program Offices held a second meeting with key statewide public and private sector stakeholders to obtain feedback on the plan. Representation included key stakeholders from the following organizations: Mental Health Association of Okaloosa/Walton County; Florida Advocacy Center for Persons with Disabilities; Mental Health Association in Florida, Inc.; the law firm of Holland & Knight, LLP; Florida Psychiatric Society; Florida Coalition for Children; National Depressive and Manic Depressive Association; Florida Mental Health Institute, University of South Florida; Office of the State Courts Administrator; the Department of Education and individual advocates.

The stakeholders attending the forum in person or by phone were provided with an overview of the major strategies of the Mental Health and Substance Abuse Programs. The participants responded favorably to the overview. In addition to the question and answer session, the following represents additional input by individuals attending:

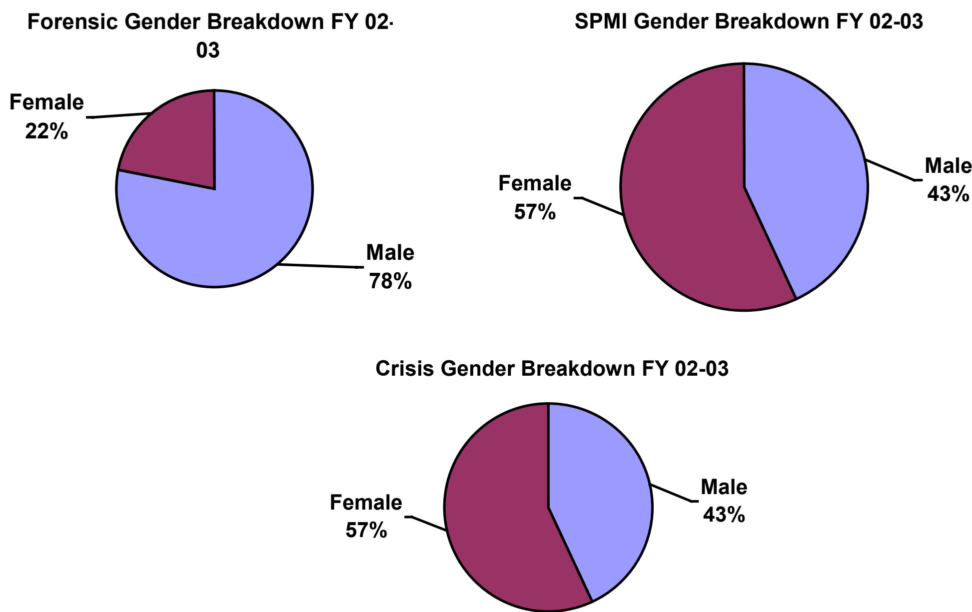
- Expand drug courts;
- Maintain and promote open access to atypical psychotropic medications;
- Increase funding for the West Florida Community Care Center, including resources for medical needs of the aging population served by this facility;
- Provide funding for housing for people being discharged from hospitals or jails;
- Streamline funding resources to reduce confusion and improve efficiencies;
- Increase involvement and support of the educational system to promote treatment and reduce incarceration of children;
- Include specific language in the plan that discusses the utilization of Assisted Living Facilities (ALF) licensed for mental health;
- Provide an adequate and appropriate array of services for persons living in ALFs, including addressing their clinical and psycho-social needs; and
- Increase funding for ALFs, allowing them to compete for department rate agreement funding.

All of the issues raised and strategies recommended by the stakeholders were considered for incorporation into the appropriate chapters of this plan.

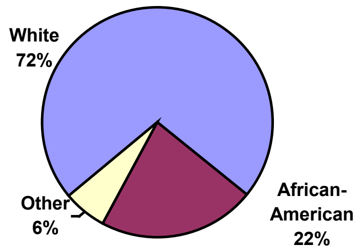
Appendix D – Mental Health Persons Served

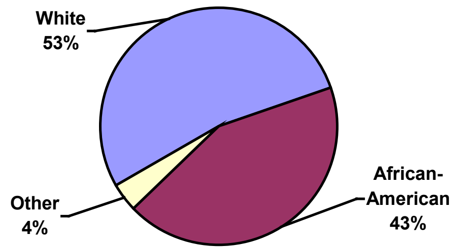
Demographic Information for Adults Served - FY 2002-2003

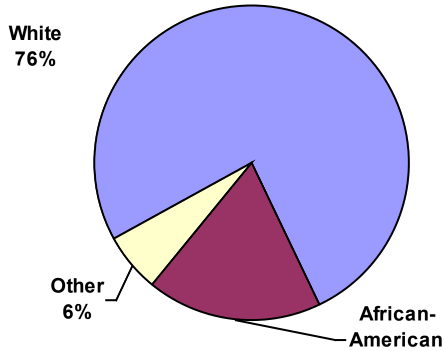
The statistical profile of adults served in community during FY 2002-2003 indicates that the majority of these individuals are persons with SPMI (53 percent), female (57 percent), black (73 percent), other than Hispanic (83 percent), and younger adults between 18 and 54 years old (95 percent). The charts below provides the demographic distribution of persons served in each of the three adult community mental health target populations by gender, race, ethnicity, age group and diagnosis.



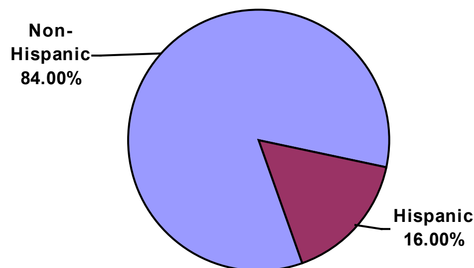
Gender: The charts above show the percentages of the 151,991 adults enrolled and served in community by gender within each target population group during FY 2002-03. As seen in these charts, males are the majority only in the forensic target population group (78 percent). This percentage is significantly lower in the other two groups (43 percent).

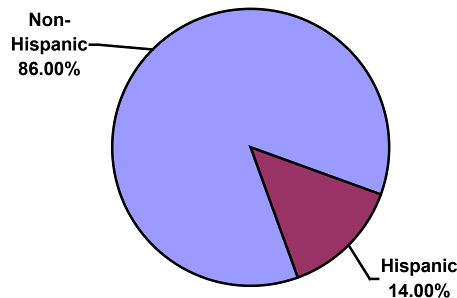


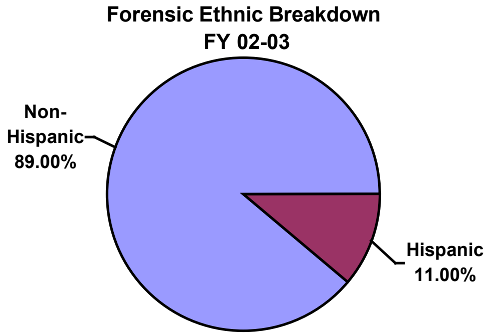




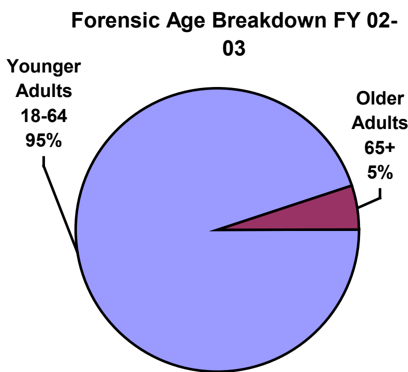
Race: The charts above provide the percentages of the 151,991 adults enrolled and served in community by race within each target population group during FY 2002-2003. As seen in these charts, the majority of the persons served in each population group are whites, with those in crisis target population having the highest percentage (76 percent). Further, the forensic target population group has the highest percentage of African-Americans (43 percent) as compared to percentages of African-Americans in the other groups.

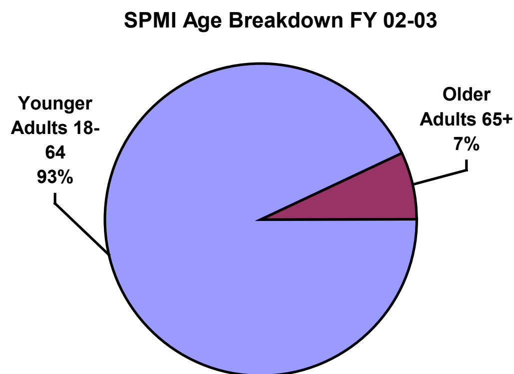


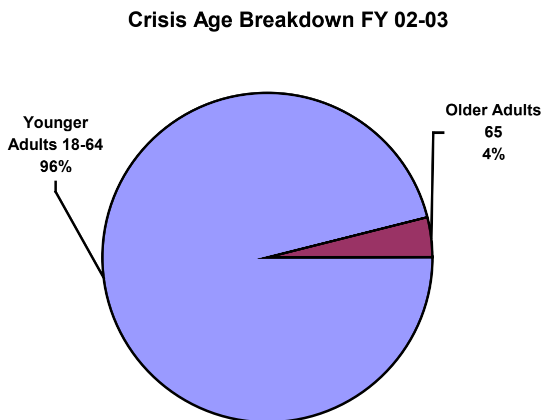




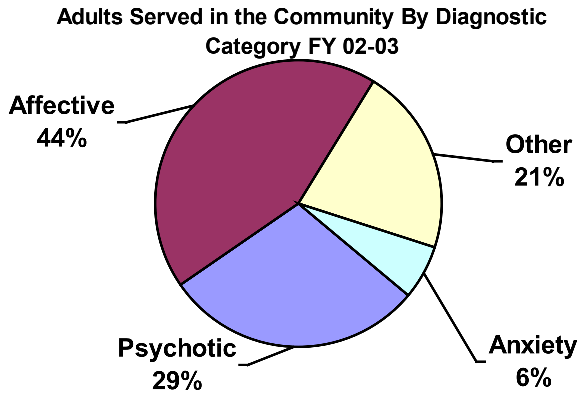
Ethnicity: The charts above provide the percentages of the 151,991 adults enrolled and served in community by ethnicity within each target population group during FY 2002-2003. As seen in these charts, the majority of the persons served in each population group are non-Hispanic, with the crisis target population group having the highest percentage (89 percent). Further, the percentage of Hispanic person is higher in the SPMI target population group (16 percent) as compared to the other two target population groups.







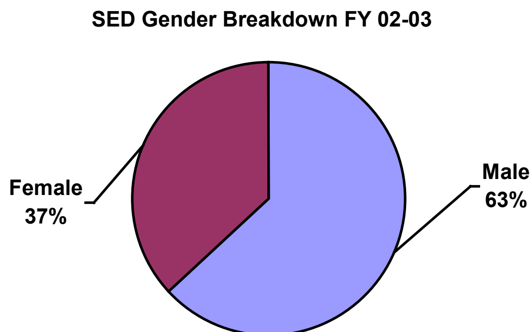
Age: The charts above provide the distribution of the 151,991 adults served in community by age group within each target population during FY 2002-2003. As shown in these charts, the vast majority of persons served are younger adults between 18 and 54 years old. The percentage of older adults varies by target population from 4 percent in the crisis group to 7 percent in the SPMI group.

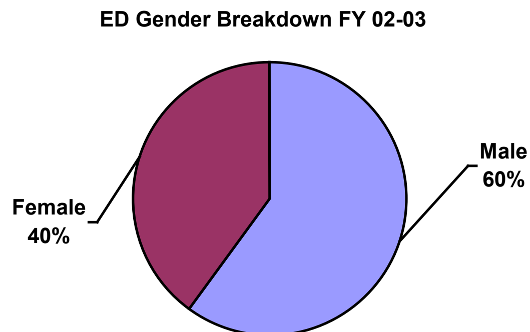


Diagnosis: The chart above provides the distribution of the 160,991 adults served in community by diagnosis group within each target population during FY 2002-2003.

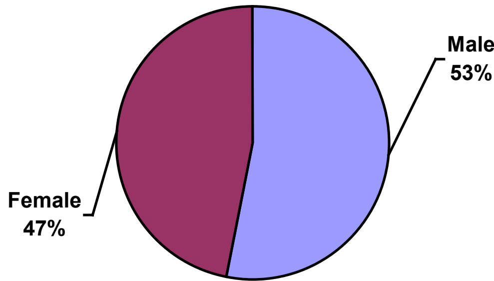
Children's Demographic Information

The statistical profile of children served in community during FY 2002-2003 indicates that the majority of these individuals are children with SED (62 percent), white (59 percent), male (61 percent), non-Hispanic (83 percent), between 4 and 12 years old (54 percent). The charts below provides the demographic distribution of persons served in each of the three children community mental health target populations by gender, race, ethnicity, age group and diagnostic category..

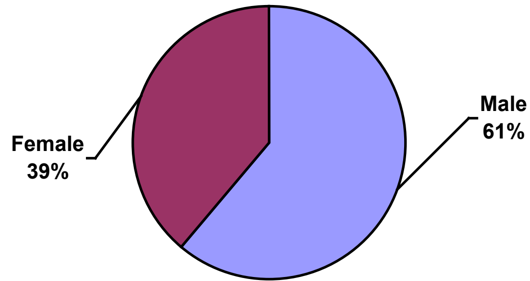




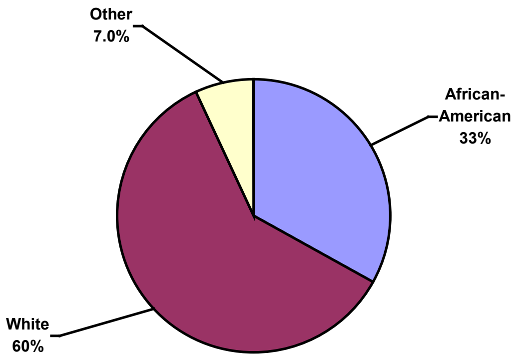
At Risk Gender Breakdown FY 02-03



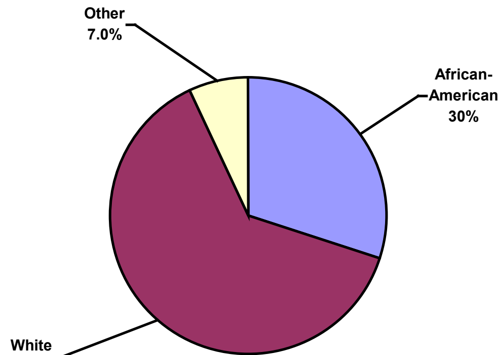
All Gender Breakdown FY 02-03



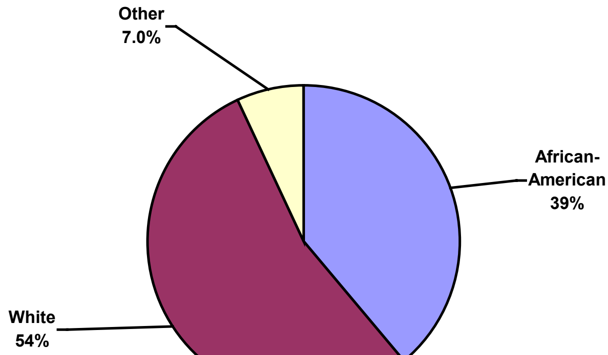
Gender: The charts above show that most of the 85,616 children served in community during FY 2002-2003 are males (61 percent), with the At Risk target population having the lowest percentage of males (53 percent).



SED Race Breakdown FY 02-03

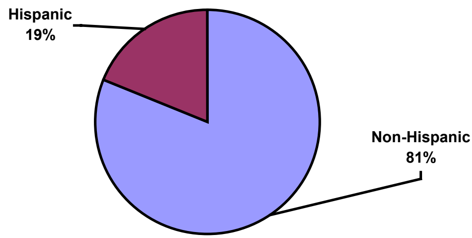


ED Race Breakdown FY 02-03

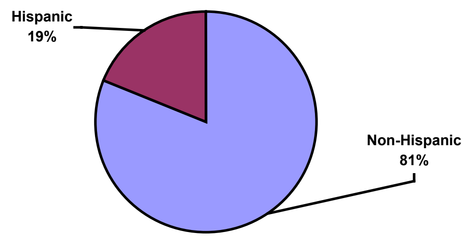


At Risk Race Breakdown FY 02-03

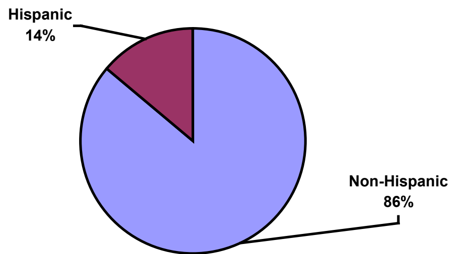
Race: The charts above show that whites (59 percent) constitute the majority of the 85,616 children served in each of the three community target populations during FY 2002-2003. As seen in these charts, however, this percentage varies by target population group from 54 percent in the At Risk group to 63 percent in the ED group.



SED Ethnicity Breakdown FY 02-03

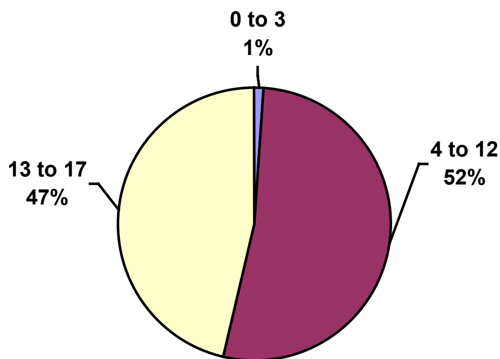


ED Ethnicity Breakdown FY 02-03

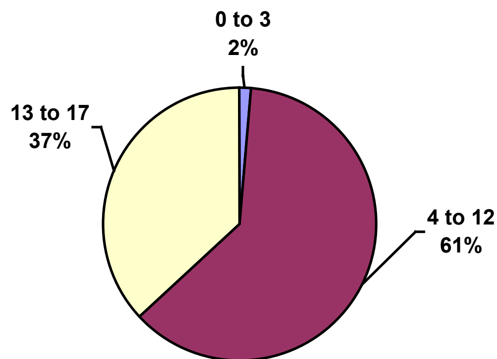


At Risk Ethnicity Breakdown FY 02-03

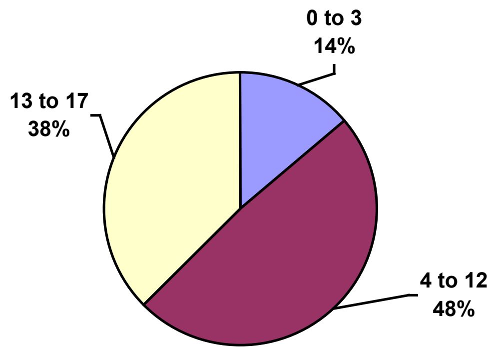
Ethnicity: Although 83 percent of the 85,616 children served in community during FY 2002-2003 are non-Hispanic, the charts below show that the At Risk group has the lowest percentage of Hispanic persons (14 percent) as compared to the other two groups with 19 percent.



SED Age Breakdown FY 02-03



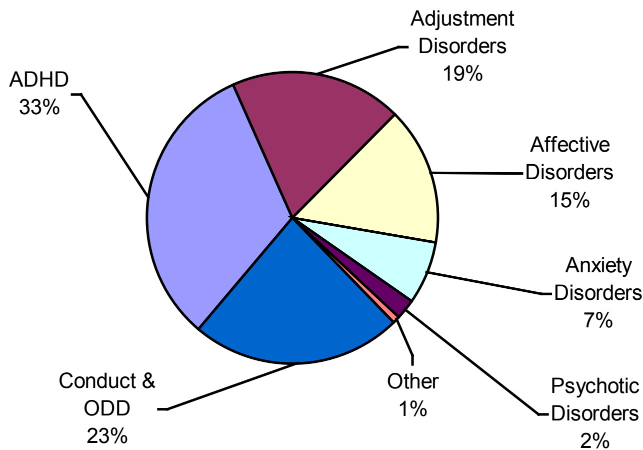
ED Age Breakdown FY 02-03

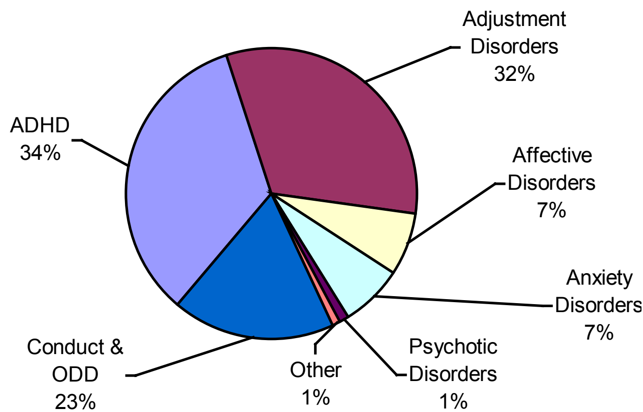


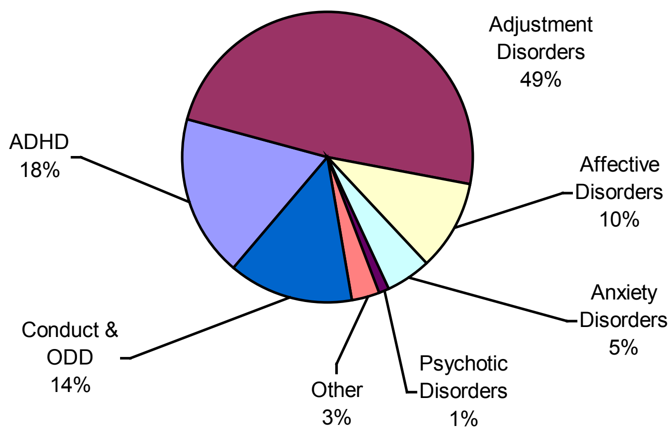
At Risk Age Breakdown FY 02-03

Age: The majority of the 85,616 children served in community during FY 2002-2003 are between 4 and 12 years old (54 percent). However, as seen in the charts above, this percentage varies by target population group from 48 percent in the At Risk group to 61 percent in the ED target population group. Further, the charts show that the At Risk group has the highest percentage of infants under 4 years old (14 percent).

SED Served in the Community By Diagnostic Category FY 02-03





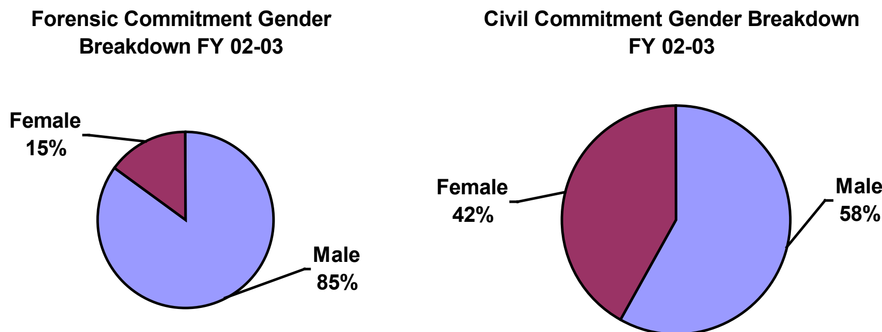


Diagnosis: The chart above provides the distribution of the 85,616 children served in community by diagnosis group within each target population during FY 2002-2003.

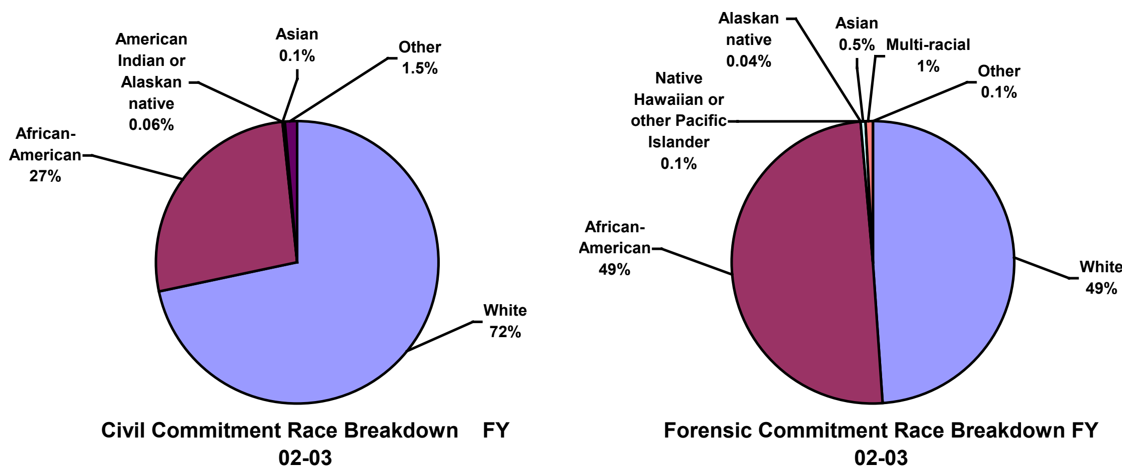
State Treatment Facilities Demographics FY 2002-2003

The statistical profile of persons served in state mental health treatment facilities during FY 2002-2003 indicates that the majority of these individuals are white (58 percent), male (74 percent), and non-Hispanic (94 percent), and under 64 years old (94 percent). The charts below provides the demographic distribution of persons served in each of the two state mental health treatment facilities target populations by gender, race, ethnicity, age group and diagnostic category.

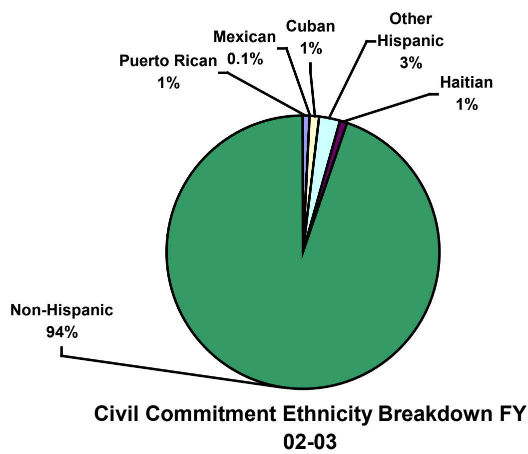
Gender: The following charts show that although most of the 3,890 persons served in state hospitals during FY 2002-2003 are males, the percentage of males is significantly higher in forensic population (85 percent) than civil population (58 percent).



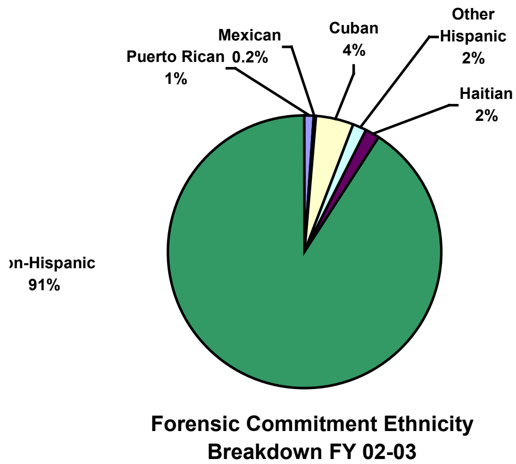
Race: As seen in the charts below, the vast majority of the civil population (72 percent) are whites, whereas the percentage of non-whites (51 percent) is slightly higher in the forensic population.



Ethnicity: As seen in the charts below, more than 90 percent of the persons served in state mental health treatment facilities are non-Hispanic for both civil and forensic population. However, the charts also show, that the percentage of Hispanic persons is slightly lower in civil population (six percent) than in forensic population (nine percent).



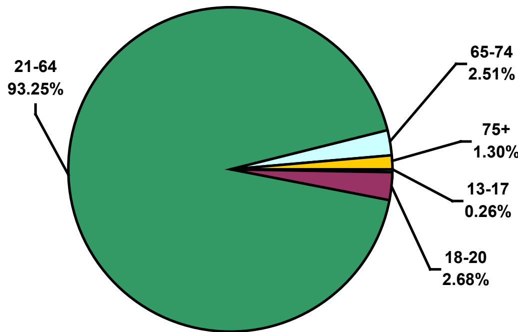
Civil Commitment Ethnicity Breakdown FY 02-03



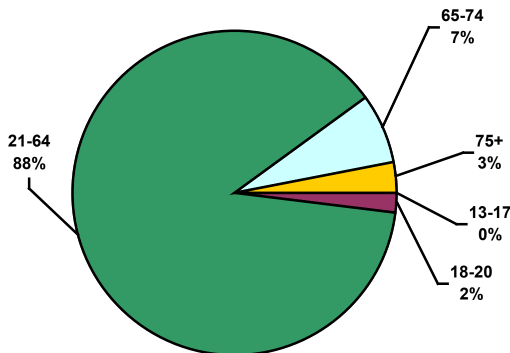
Forensic Commitment Ethnicity Breakdown FY 02-03

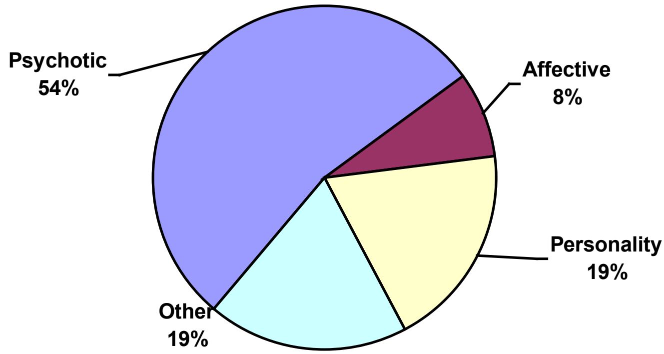
Age: The charts below show that the forensic population is relatively younger than the civil population. As seen in these charts, 93 percent of the forensic population is under 65 years old, as compared to 88 percent for civil population.

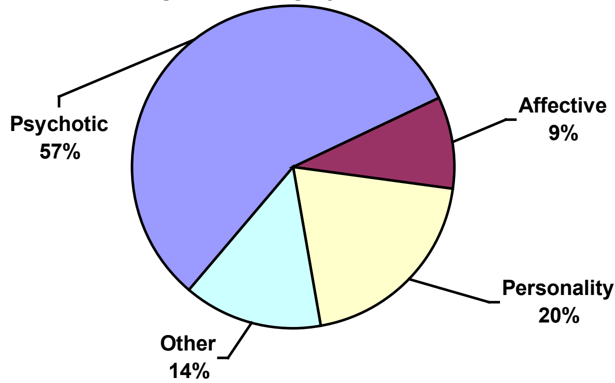
Forensic Commitment Age Breakdown FY 02-03



Civil Commitment Age Breakdown FY 02-03







Diagnosis: The above charts provide the breakdown by diagnosis groups for adults served in the state treatment facilities for civil and forensic commitment for FY 2002-2003.

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