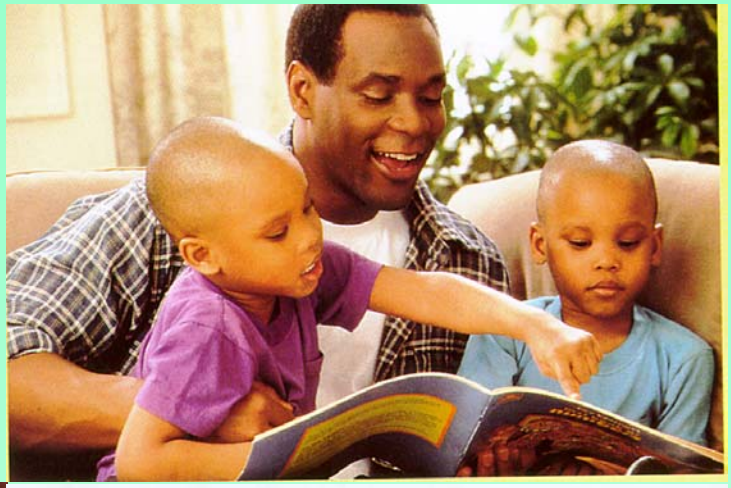

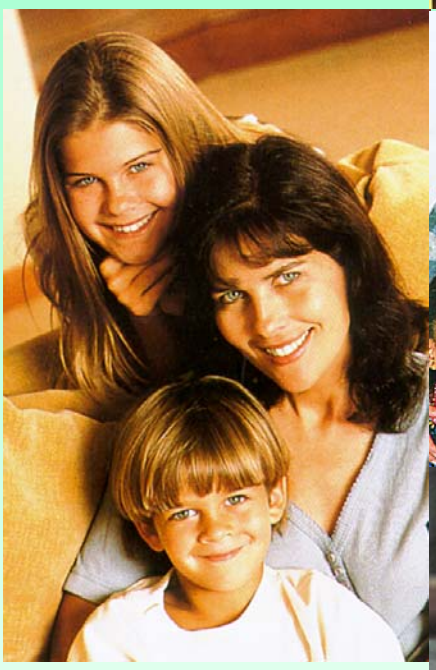

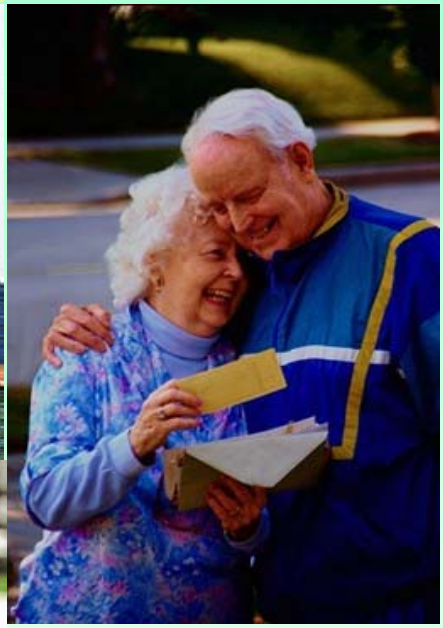

Mental Health and Substance Abuse Services Annual Update January 1, 2003

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

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: 2000-2003
Report Due Date:	January 1, 2003
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 1 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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CF 1610, Oct 96 (Replaces HRS Form 1610 which may be used)

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Overview

Mental Health and Substance Abuse State Plan

The 2000 Florida Legislature, by amending section 394.75, F.S., restructured the process by which the state's publicly-funded mental health and substance abuse service systems are planned, designed and implemented. Every three years, beginning in 2001, the Department, in consultation with the Medicaid program in the Agency for Health Care Administration, is required to prepare 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. The initial plan covering a three-year period was submitted to the Governor and the Legislature in 2001. The plan is to be updated and submitted to the Legislature annually.

The updated plan has statewide data and a review of current district plans to assess the status of the strategic directions identified in the master plan. The plan update is intended to provide succinct, up-to-date information on Florida's publicly-funded substance abuse and mental health system of care. It does not duplicate the detailed information contained in the original master plan entitled, "State Mental Health and Substance Abuse Plan: 2000-2003," but rather summarizes the major issues and provides a status report on the stages of implementation for the strategic courses of action.

For each of these strategic areas, we have identified progress on areas where actions were taken during the past two years. As the master plan covers a three-year cycle, there will not necessarily be activities described for every strategy in this report. We have provided information about continued courses of action for the third year of the plan as well as any evolving issues that may have necessitated a new course of action.

Executive Guidance and Legislative Initiatives

Mental Health and Substance Abuse Commission

The Florida Commission on Mental Health and Substance Abuse was created in 1999 to review the overall management of the state's mental health and substance abuse system. Twenty-three commissioners from throughout Florida were appointed by the Governor and Legislature to broadly represent key mental health and substance abuse constituencies. The final commission and workgroup reports were delivered in early January 2001. The commission recommendations included:

- The creation of a statewide leadership entity, located in the Governor's Office, composed of leaders from Florida's human services, and coordinated with the Office of Drug Control. This leadership entity was charged with the development of a statewide strategy for mental health and substance abuse services, information systems, and a wide-ranging mental health and substance abuse education and prevention campaign.
- Redefining the role, structure and function of the specialty mental health and substance abuse system based in the Department of Children and Families (DCF) for adults with severe and persistent mental illness. This redefined system would be founded on science-based standards of care, with single points of accountability for continuity of care, flexibility in funding and management, and local control based on statewide leadership and benchmark standards.
- The development or strengthening of jail diversion strategies for persons at risk of incarceration as a result of mental illness or addictive disorders, as well as the provision of adequate resources for appropriate treatment for incarcerated persons.
- The provision of adequate emergency services throughout the state and improved access to services and the provision of ongoing care that is appropriate for age and culture. The needs of specific groups (e.g., older adult, trauma victims, homeless persons, and persons with co-occurring mental and addictive disorders) identified as being inadequately served by the current system should also be addressed.

The Department has addressed the above last three items in this state plan. The table below provides a crosswalk of the Department's actions that address these recommendations.

Table of Commission Recommendations and Departmental Actions

Commission Recommendations	Departmental Actions
System of Care Improvements – Individuals with Severe and Persistent Mental Illness	• Implementing the behavioral health service delivery strategies (Districts 1 & 8) • Implemented the Self-Directed Care (SDC) choice pilot in District 4 for adults with serious mental illness • Developed two additional provider networks in the Suncoast Region and District 11 • Expanded the behavioral health specialty care network (BNET) for children
Jail Diversion Strategies	• Strengthened crisis intervention team training for law enforcement • Strengthened community partnerships • Completed an analysis of Florida's forensic system • Expanded and improved forensic programs
Emergency Services	• Completed an analysis of the acute care system through the Behavioral Health Services Integration Workgroup
Needs of Specific Groups	• Implemented two crisis stabilization unit/addiction receiving facility demonstration models for children with co-occurring substance abuse and mental health disorders • Conducted a Multi State Workshop through the Center for Substance Abuse Prevention for identifying promising approaches in working with older adults with substance abuse problems • Completed an assessment of mental health and substance abuse treatment services across various systems regarding youth involved with the Juvenile Justice System through the Behavioral Health Integration Workgroup. • Established a single point of access (SPOA) in each geographic area of the state to assist Family Services Counselors in accessing mental health services for children in foster care. • Improved early intervention services for very young children and their families.

Section 394.9083, F.S.

Chapter 2001-191, Laws of Florida, was the initial legislative response to the recommendations of the Florida Commission on Mental Health and Substance Abuse. This legislation revised Chapter 394, F.S., in four significant areas:

- Piloting of two behavioral health management strategies in conjunction with the Agency for Health Care Administration (AHCA).

- Accepting provider agency accreditation in lieu of on-site licensure inspection and duplicative programmatic and administrative monitoring.
- Piloting an integrated children's crisis stabilization unit (mental health) and children's addiction receiving facility (substance abuse).
- Developing a statewide Behavioral Services Integration Workgroup.

Pilot Behavioral Health Service Delivery

The passage of Chapter 2001-191, Laws of Florida, permitted the Department and AHCA to establish two behavioral health service delivery strategies. These strategies are testing methods and techniques for coordinating, integrating, and managing the delivery of mental health services and substance abuse treatment services for persons with emotional, mental, or addictive disorders. The law also required the development of a managing entity for each service delivery strategy and an independent entity to evaluate both service delivery strategies. Districts 1 and 8 were chosen for implementing these strategies. The Florida Mental Health Institute was required by legislation to complete the independent evaluation.

The Department of Children and Families, in consultation with the Agency for Health Care Administration, is required to amend the master state plan to describe each service delivery strategy referenced in the legislation. The requirement is addressed in this section.

District 1

- **Operational Design**

  The District 1 pilot is designed to complement the Medicaid Prepaid Mental Health Plan ("Carve-out") pilot operational in District/Area 1 (Escambia, Santa Rosa, Okaloosa, and Walton counties). District 1 contracts with the Managing Entity (ME) for the Carve-out to better integrate Medicaid, state Mental Health and Substance Abuse, and other financial resources via the design and implementation of new contracting and financing methods.

  The District has made great progress in the implementation of the legislation. The Phase 1 Contract with the Managing Entity for the Medicaid Prepaid Behavioral Health Plan was executed July 1, 2002, and pays a prepaid rate for a specified benefit package of services. This method of contracting is highly compatible with the Medicaid contract and allows for maximum flexibility in the delivery of clinical and support services to clients, while ensuring a high level of accountability.

  The district developed the Pilot Integrated Data System (PIDS) as an integral component in the new contracting methodology. The PIDS system provides a simplified database that integrates program and financial information regarding the delivery of service to individual clients. Program and related financial data can be aggregated at any level for program and financial analysis. The PIDS system has merged with the Unity One system to provide a comprehensive data system with extremely powerful reporting capabilities. District 1 is currently developing an "integrated" outcome measurement system that will allow for a comprehensive analysis of client outcomes and associated services and costs, at both the client specific level and aggregate level. The district is planning for the "Integrated Outcome Management System" (IOMS) to be operational January 2003. The IMOS system will be a

powerful tool with clinical, quality improvement, financial planning and management, and research implications.

In collaboration with the community based care provider, the dependency court system and other community partners, the District 1 Mental Health and Substance Abuse Program Office is also involved with the integration of child welfare and behavioral health services. This collaboration should result in a stronger "front end" system which will assure the timely delivery of appropriate holistic services to families involved with the child welfare system.

The district is field testing systemic approaches to reduce waiting lists for long-term care, including West Florida Community Care Center. These include concepts like a "virtual" institution, and other non-traditional approaches to long-term treatment.

The District Client Advocacy program was initiated effective July 1, 2002, to assist clients in self-advocacy in receiving necessary services. These services are provided by the Mental Health Associations and are totally independent of the Managing Entity. The Mental Health Associations have also been contracted to expand family education services throughout the district.

- **Counties or Service Districts**

  The pilot is operational in the Department's District 1 and AHCA Area 1 that encompasses Escambia, Santa Rosa, Okaloosa, and Walton counties.

- **Expected Outcomes**

  - Dramatic improvements in the reporting and use of critical management, financial, clinical, and client data that is HIPPA compliant. Completion date: July 1, 2003.

  - Better integration of funding to reduce the programmatic effects of "stovepipe" funding and to enhance the development of "seamless" program delivery. Completion date: July 1, 2004.
  - Increased client access to needed services. Completion date: July 1, 2004.
  - Increased individualization of client services. Completion date: July 1, 2004.
  - Improved contracting and financing of client services. Completion date: July 1, 2004.

- **Development of Substance Abuse Service Protocols**

  The Managing Entity (ME) and network providers are researching and implementing evidence-based practice models of service delivery.

- **Credentialing Requirements for Substance Abuse Services**

  The Department is implementing an improved method of quality improvement that reduces redundancy, better utilizes available data and improves focused monitoring. Additionally, all major network providers will be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) by July 2003.

- **Development of New Service Models for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders**

  The District Mental Health and Substance Abuse Program Offices have adopted the "Minkoff" model of delivering services to individuals with co-occurring mental health and substance abuse disorders. The District 1 model of integrated service providers has fostered a greater focus on clients with co-occurring disorders.

- **Development of Service Models Specific to Child Welfare System and to Abused and Neglected Children and Families**

  The managing entity for this pilot is also the Department's District 1 Community Based Care (CBC) provider. Much effort and planning by CBC, the district program office, the Judicial system, and other stakeholders has been put into the development of a holistic, family focused assessment, timely intervention, and service systems. The service needs of the various family members, as well as the child, will be provided in an integrated and well-coordinated manner to effect the best outcomes for the child and family, while ensuring child safety. The district will develop a "front end" intervention system supervised by the court that provides timely assessment of all family members and immediate intervention and services as needed. Children and adults needing more intensive services may be involved in services as varied as residential treatment, specialized women's addictions services or dependency drug court - all accessed through a single portal. Completion date: July 1, 2003

District 8

- **Operational Design**

  The Managing Entity plan for District 8 involves competitive procurement of an Administrative Services Organization (ASO) to perform management functions for Alcohol, Drug Abuse and Mental Health (ADM) funded services. This ASO will be jointly procured and funded by the Department and AHCA. The district will not use the 10 percent of the funding for mental health and substance abuse treatment for the ASO as allowed by the legislation. Instead approximately $500,000 that was allocated for system development has been made available for the district for this purpose, with an additional amount, approximately $200,000, expected to come from Medicaid administration trust funds. The community stakeholders, including providers, are opposed to the use of the district's treatment funds for the administrative functions of an ASO, so the availability of these additional funds to the district has been instrumental in getting full backing on the project from stakeholders and provider agencies.

  To further facilitate streamlined management and coordination of services, the major mental health and substance abuse providers have incorporated and are in the process of developing

a provider network in which membership will be offered to all Department and Medicaid behavioral healthcare providers. Specialty services that are not covered in the resulting provider mix will be sought and added to the network. The network will operate as a coordinated and integrated unit with formalized linkages to other systems utilized by consumers. An advisory group comprised of a variety of community stakeholders has been developed to provide oversight of the project.

Over the past two years, the overall service system in District 8, for adults as well as children, has moved from one that relied heavily on outmoded, restrictive and expensive residential models of care to one in which a broad array of services are individualized, community-based, and recovery-oriented.

A situational analysis was completed by Florida State University to examine District 8 in comparison to two best practice models found elsewhere in the country. This provided benchmarks and direction for a system redesign. In support of these best practices, the district has significantly changed the focus from facilities-based services to integrated, community-based services and supports over the past two years. In addition, a number of consumer-based initiatives have been launched via contracts with the National Alliance for the Mentally Ill.

In an effort to maximize leveraging of federal dollars, part of the District 8 strategy is to apply for one or several Medicaid waivers through the Center for Medicaid Services. The strategies call for an actuarial base approach to rate setting for capitation rather than using historical expenditures. Successful implementation of such a waiver will allow the Department to better use general revenue to expand services for children and to incorporate Medicaid funded recovery services in a managed system of care. The Department has contracted with Florida State University to research the feasibility and assist with design of the waivers.

- **Counties or Service Districts**

  The counties involved in this service delivery strategy include all of DCF District 8 including Lee, Collier, Charlotte, Hendry and Glades. The Medicaid Area 8 includes all the above counties, as well as two additional counties, Sarasota and DeSoto, which will not be involved in this strategy.

- **Expected Outcomes**

  Because the overall driving philosophy of the system redesign is recovery, the district is piloting the use of personal outcome measures in consumer-directed behavioral health, developed by the Council on Quality and Leadership in Supports for People with Disabilities. The premise is that outcome measures for a recovery-based service system are not the same as for traditional mental health programs because the recovery-based programs, such as Florida Assertive Community Treatment (FACT) and Supportive Housing, are based on rehabilitation principles rather than clinical models. Personal outcome measures are indicators of the individual's quality of life, and apply to the whole person across service settings. Services and supports, including those that are recovery-oriented and person-centered, are seen as the means to an end, not ends in and of themselves. The actual attainment of personal outcomes is the ultimate goal.

The project will entail gathering information via structured interviews with individuals served. Interviewers are people with a mental illness or family members who have been trained by the council and who are employed via a contract with the National Alliance for the Mentally Ill. Use of the data gathered from the project will provide the district with information on which to build upon strengths and address weaknesses as a system. It will allow for planning to be data driven while also being sensitive to individuals' preferences. Additional outcomes expected include:

- Improved assessment of needs.
- Improved access to Medicaid behavioral health services in the district.
- Improved clinical outcomes for people served.
- Improved integration of care with community based care contractors.
- Prevention of duplicative services.
- Decreased fragmentation of the service delivery system.
- Improved accountability for individual providers and the system as a whole.
- Expansion of recovery-based services.

◆ **Timeframes**

The following are expected timeframes for the District 8 system redesign project:

• Identification of service components	December 1, 2002
• Let Request for Proposals (RFP) for ASO	March 1, 2003
• Award ASO	April 1, 2003
• Research Medicaid Utilization	April 1, 2003
• Develop clinical pathways	April 1, 2003
• Define benefit eligibility	July 1, 2003
• Design/apply for Medicaid Waiver	July 1, 2003
• Develop provider network	July 1, 2003
• Implement use of Unity One data system	July 1, 2003
• Develop health literacy process	September 1, 2003
• Implement medication algorithm	September 1, 2003

◆ **Development of Substance Abuse Service Protocols**

As part of the system redesign effort, the Department has contracted with Florida State University to assist the district and providers develop protocols and clinical pathways to address the needs of people. Based upon their recommendations, the Department will purchase a pathway package that has been validated and successfully used elsewhere. This will be completed by April 1, 2003.

◆ **Credentialing Requirements for Substance Abuse Services**

The Request for Proposal that is developed through the contract with Florida State University will address this issue. It is expected that, in this service model, the ASO will provide guidelines and oversight of provider credentialing.

- **Development of New Service Models for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders**

  The district is currently participating in a Children's Crisis Stabilization Unit/Juvenile Addiction Receiving Facility (CCSU/JARF) pilot project that demonstrates blending of mental health and substance abuse funding into a "single door" short-term, acute care facility. This allows for improved accessibility to and coordination of services, while providing reduced costs as compared to the traditional separate CSU and ARF facilities. This model, if deemed successful by independent evaluation, may then be replicated and expanded to adult units.

  For the adult population, the district is blending substance abuse and mental health funds into a contract for a supported living program for people with co-occurring disorders. Increasingly, the district is moving away from the abstinence model to a harm reduction model, which realistically assumes that relapse is a part of recovery. People under this model will not be prematurely discharged from treatment as occurred in the past under the old model.

- **Development of Service Models Specific to Child Welfare System**

  The community-based care (CBC) contract for the district has not yet been awarded. The district program office participates in the planning for community-based care, and the CBC coordinator participates in the mental health/substance abuse system redesign effort. Every attempt is made to plan for both the CBC and the ASO with consideration as to how each will interact with the other. To assist with coordination between the ASO and CBC efforts, the CBC provider will be appointed to the ASO advisory committee. In District 8, the majority of the providers that will be involved in community-based care for child welfare will also be part of the mental health/substance abuse (MH/SA) provider network.

- **Service Provision to Abused and Neglected Children and Families**

  District 8 has contracted with Florida Gulf Coast University to function as the single point of access (SPOA) for coordination of behavioral health services for Family Safety children. This contract is jointly funded and administered by the district Family Safety and the district Alcohol, Drug Abuse and Mental Health (ADM) program offices. Master's level clinicians are responsible for referrals and tracking completion of Comprehensive Behavioral Health Assessments and Qualified Evaluator Assessments. The SPOA also provides various educational forums for providers and Family Safety staff to ensure that roles are understood and the system is well coordinated. Further, the SPOA completes a case plan review for quality assurance with ten percent of the total case plans in each quarter. These reviews have generated data that is used for quality improvement activities with providers and Family Safety staff. In addition, the data is used to identify gaps in services in its contract planning process.

  Since the ASO is intended to be the single point of access for all mental health and substance abuse services in the district, the current SPOA functions will ultimately be assumed by the ASO when it is implemented. The creation of a single point of access for both adult and

children's services via the ASO, will allow for timely access of a wide variety of services for both the children and the adults involved in the Family Safety system.

The district has implemented the use of the Family Intervention Specialist (FIS) to address the needs of child welfare recipients. Substance abuse professionals are out-posted to several sites in the district in which Family Safety staff is stationed. Referrals come from this staff to the FIS, who then connects individuals and families to substance abuse services and tracks progress. The FIS also accepts referrals from Dependency Drug Courts. The FIS model is used in three of the five counties in District 8, with plans to expand to all five during Fiscal Year 2003/04.

- **FMHI Evaluation**

Under contract with the Department of Children and Families (DCF) and in accordance with the requirements of s. 394.9082, F.S., the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida, is conducting an ongoing formative evaluation of financing strategies for the public mental health and substance abuse system. New financing strategies are being tested in two demonstration sites: DCF District 1, including Escambia, Okaloosa, Santa Rosa and Walton counties, and DCF District 8, including Charlotte, Collier, Glades, Hendry and Lee counties. FMHI's role is to help identify the most effective methods and techniques used to manage, integrate, and deliver behavioral health services as specified in the legislation. FMHI is required to submit annual status reports that briefly describe the Florida residents being served in the demonstration sites, summarize the activities that have occurred during the past 12 months, describe the progress achieved, and delineate problems and obstacles that may inhibit future progress in response to the legislation. The first report was submitted January 1, 2003.

- **Self-Directed Care**

In addition to the pilots in districts 1 and 8, the Department has implemented the Adult Mental Health Self-Directed Care (AMHSDC) Program pilot in District 4. The program became operational October 14, 2002, which was within a year of release of the final Self-Directed Care Task Force Report. Florida State University School of Social Work is serving as the administrative services organization and Florida Mental Health Institute is serving as the independent evaluator. AMHSDC has been implemented as a parallel service delivery system to the current case management service delivery system. Participants, their significant others and service providers are educated on the processes of recovery from mental illness and the central role that individual self-determination and self-direction must play as the individual travels the road to recovery. The program will use the Unity One data management system and work with other state initiatives (system redesign pilots in D1 and D8) to maximize resources. To date, interested participants have reserved approximately one-fourth of the slots in the program. AMHSDC has been well received by advocates (local, state, and national), by service recipients and their significant others, and by ADM contracted providers.

- **Additional Network Development**

Although not part of the requirements of Section 394.9083, F.S., two other provider networks have been developed.

Suncoast Region - Central Florida Behavioral Health Network Pilot Project

The Central Florida Behavioral Health Network (CFBHN) is a substance abuse and mental health provider-sponsored network serving the Suncoast Region and District 14, a catchment area which includes 20 percent of the state's population. The network was established in 1997 with the Department's District 6 program office administrative support and funding. The Department currently contracts with CFBHN to serve more than 8,000 clients from target populations and programs: Temporary Assistance to Needy Families (TANF), juvenile drug court, HIV, heroin and cocaine at-risk populations, family safety intervention and reunification, children's mental health, substance abuse aftercare and the dual diagnosis system's development initiative. The network maintains systems for cost accounting and client services reporting under these contracts.

The Department intends to expand its contracts with CFBHN to achieve the following:

- Define client pathways and a service system under prospective payment for a diverse client population in a large geographic area served by multiple, independent agencies.
- Explore the blending of Medicaid, federal block grant, and state general revenue funding at the network level, maximizing the use of local match, to establish community-based systems of care offering a range of services targeted to individual client needs (will serve as a prototype for Medicaid substance abuse clients).
- Establish access to care standards and systems which are responsive to local stakeholders such as the community-based care organizations, juvenile and adult courts, hospital emergency rooms, and public schools.
- Begin to define prospective payment rates for various levels of client severity by further development of the network's client data base to permit case-mix analysis.
- Document for possible replication the infrastructure necessary for a regional provider-sponsored network serving a large, diverse population to manage state and federal funds, in a manner which achieves state-defined targets for costs, quality improvement, and client outcomes.
- Determine alternatives for the information technology resources and expertise required to support an independent provider sponsored network.
- Develop a service system design for clients with co-occurring disorders (co-existing mental and substance use disorders).
- Establish strategies to ensure integration of substance abuse and mental health services to families involved in the child welfare system.

District 11 Managed Care Initiatives

District 11 also developed a managed care initiative during the year 2002. The District 11 Department of Children & Families, advertised the Request for Proposal (RFP) #11-03-KD001 on November 20, 2002, for an Administrative Services Organization/Agency to manage Behavioral Health Services (Substance Abuse) in Miami-Dade & Monroe counties. The sealed proposals in response to the RFP were received in December 2002.

The administrative agency will be responsible for the administration/management and the provision of Substance Abuse Behavioral Health Services through qualified direct service subcontractors (providers). Related Adult & Children Substance Abuse Behavioral Health Services include: Assessment, Outpatient, Day/Night, Residential Level-2 & Level-4 for Adults and Residential Level-1 (Substance Abuse Residential Treatment-SART) for Adolescent males/females. Other responsibilities of the Administrative Services Organization include but are not limited to the following:

- Ensuring continuity of care through networks of care (health & primary care) and integrated comprehensive services, which will include specialty providers, i.e. sexual abuse treatment, and deaf services.

- Subcontracting substance abuse behavioral health services with agencies that are accredited or working toward accreditation through acceptable accrediting bodies in order to promote best practices and the highest quality of care in contracted substance abuse and mental health services through the achievement of national accreditation.

- Data management.

- Providing client driven services with performance outcome measures

- Conducting Quality Assurance Reviews, which will include Peer Review to ensure that quality services are being delivered to clients, and to ensure continuity of care. The Quality Assurance and Peer Review will include, but is not limited to the American Society of Addiction Medicine (ASAM), as well as State Integrated Substance Abuse Reports (SISAR) validation, reviewing and updating policies and procedures, clinical operations and performance outcome measures.

- Accepting guidance and recommendations from the Alcohol, Drug Abuse and Mental Health Planning Council and District 11 Program Office.

- Partnering with county governments in Miami-Dade and Monroe counties, domestic violence providers, dependency and drug courts, and national managed care organizations.

- Assuming management and funding of the service array presently provided by Concept House, Inc., through the currently funded Administrative Services Organization.

District 11 continues to manage the centralized intake system to track and manage substance-abuse clients in Miami-Dade County by the following activities:

- The district is identifying clients with behavioral health (substance abuse) treatment needs by various entities, including the court system, hospital crisis and detoxification units, and via self-referral. Clients receive substance abuse assessments through one of the district's contracted providers. Based on the assessment, clinically appropriate treatment referrals are made. If the recommendation is residential treatment, the client's assessment is inputted into a shared network database (Treatment Automated Referral System [TARS]) and the client is placed on the district waitlist for residential treatment. The District Utilization Management (UM) system maintains a daily list of all vacancies with the contracted providers and places waitlist clients. Clients are matched with agencies providing the needed services. Clients identified in target populations are prioritized. This system maximizes client placements by using all available resources.

- The district is continuing to pilot the modified rate agreement with one contracted provider (Here's Help). The pilot has been successful, as the provider has been able to provide services in the different levels of care with more flexibility in numbers of clients. The provider has successfully demonstrated self-management of the allotted budget and has provided services to clients in all levels of care. In addition, this flexibility has allowed the provider to move clients across the different services and levels of care in a clinically appropriate manner without the restrictions of limited funds in specific services. This system enhancement will be expanded through the Administrative Services Organization. District 11 will continue to use FMHI to have a consultant work with the district and the provider community to establish case rates that would be piloted through the Administrative Services Organization.

Accreditation, Licensure and Monitoring Activities

As a result of the passage of Chapter 2001-191, Laws of Florida, the Department of Children and Families and the Agency for Health Care Administration (AHCA) are now required to accept, in lieu of conducting on-site licensure reviews, the accreditation survey report of an accredited substance abuse provider. The Department, through its district/regional offices, will conduct full licensure reviews once every three years. However, non-accredited substance abuse provider agencies will still be licensed annually. In this regard, substance abuse providers will be required to annually submit an application for licensure and submit licensure fees. The three-year cycle only applies if the substance abuse provider maintains its accreditation. The local district/regional offices will still be permitted to conduct monitoring reviews of providers with cause at any time.

AHCA developed procedures to implement Chapter 2001-191, Laws of Florida, effective September 6, 2001. Prior to that date each licensed mental health residential facility received an annual re-licensing survey. After September 6, 2001, accredited facilities have been or will be surveyed in the 12 to 24 month period after the beginning of their accreditation period. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitative Facilities (CARF) generally accredit facilities for a three-year period. However, a shorter accreditation period is granted if the accrediting organization feels it is warranted.

The Department is working on reducing duplication in administrative and program monitoring of accredited providers. In this regard, the Department is reviewing and comparing accreditation

standards, administrative rule standards, audit standards, and departmental operating procedures to identify overlapping areas relative to required provider monitoring. Overlapping areas are being considered for elimination, notwithstanding consideration of accreditation deficiencies, contract corrective actions or qualified audit opinions. The Department still has considerable work to be done in the following areas: 1) the administrative monitoring process must be modified to comply with all substance abuse and mental health rules - proposed completion - March 2003; 2) districts must be thoroughly trained in implementation - proposed completion - March 2003; and 3) rules must be initiated to address program area gaps not covered through accreditation - proposed filing - June 2003.

Required Reports

Subsection 394.741(7), F.S., requires the Department and the 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 Department surveyed other states to determine what states were doing relative to licensing and monitoring substance abuse and mental health providers. The Department's district/regional offices were also surveyed to determine costs of licensure and monitoring. The state's administrative rules (standards) were compared with standards promulgated by accrediting organizations to determine where duplication may exist. In addition, anecdotal information was provided by various respondents. The information generated from these surveys was used to respond to the Legislature's mandate to report on the "viability" issue referenced above. These reports are being submitted to the Legislature through a separate document.

Crisis Stabilization Unit/Addiction Receiving Facility Demonstration Models

Chapter 394, F.S., authorizes the Department of Children and Families, in consultation with the Agency for Health Care Administration (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 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 CSU/ARF model this year. The Suncoast Region, Department and AHCA staffs are monitoring the initiation of this model and progress so far is positive.

- The Department and FMHI are developing an evaluation model to determine the effectiveness of service integration within the demonstration models. The evaluation is required by statute to be completed by December 31, 2003. Ruth Cooper Center and Coastal Recovery Center will be 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 clients served and related performance outcomes; and
  - feasibility of continuing or expanding the demonstration models.

Behavioral Health Services Integration Workgroup

The Behavioral Health Services Integration Workgroup was authorized by s. 394.9083, F.S., for the purpose of assessing the barriers to the effective and efficient integration of mental health and substance abuse treatment services across various service systems and to propose solutions to those barriers. The workgroup was also charged with ensuring that plans for mental health and substance abuse treatment services, which are also required by statute, consider solutions of the Integration Workgroup.

In accordance with the statute, the Secretary of the Department of Children and Families invited the participation of the departments of Juvenile Justice, Health, Corrections, Elder Affairs, and Education; the Office of Drug Control Policy; the Agency for Health Care Administration; and representatives from county jail systems, homeless coalitions, county government; public and private Baker Act receiving facilities; assisted living facilities serving behavioral health clients; providers of behavioral health services and child protection services; and consumers of behavioral health services and their families. In addition, a listing of other interested parties was created in order to provide these parties with ongoing information about the workgroup's activities.

Areas of particular focus during Fiscal Year 2002-03 include:

- access to emergency behavioral health services;
- promising practices for provision of behavioral health services to youth returning to the community from juvenile justice programs;
- interface between the publicly-financed mental health and substance abuse system and assisted living facilities (ALFs);
- inventory of early identification and intervention policies and strategies employed by the departments of Education and Children and Families; and
- strategy assessments for improving integration of behavioral and primary health care services.

Below is a description of activities completed:

Evaluation of Emergency Services System

The Behavioral Health Services Integration Workgroup identified emergency behavioral health response systems as a priority area and an ideal area for study because of the intersection of various systems of care responding to needs of people in need of emergency or acute care services. A subcommittee was established within the Behavioral Health Services Integration Workgroup to focus on emergency services. The subcommittee developed a set of questions targeted for focus groups that were identified by a survey of the subcommittee. The result of their work identified barriers to service, types of services needed, data collection, and financial constraints, if any, and suggested solutions. A total of 12 barriers were identified with the most frequently reported barrier being accessing sub-acute or immediate aftercare for mental health and substance abuse conditions. Access to post discharge services is a problem in both residential and outpatient settings. All respondents identified mobile crisis services as an essential component in a well functioning acute care system. A total of 10 service needs were identified. The subcommittee identified 14 solutions to the barriers with the most frequently reported being access to comprehensive assessments at the initial point of screening. The subcommittee recommended the full text of the report be distributed to members of the Behavioral Health Services Integration Workgroup for further review and recommendations.

The Louis de la Parte Florida Mental Health Institute (FMHI) is performing studies and data collection in support of the workgroup's activities.

Evaluation of Juvenile Justice Services

An assessment of mental health and substance abuse treatment services across various systems regarding youth involved with the juvenile justice system was completed by Louis de la Parte Florida Mental Health Institute. This report, the product of the Behavioral Health Services Integration Workgroup, revealed four strong, promising service integration practices in the state of Florida. Comprehensive collaborative structures were in place in St. Lucie, Broward, Martin and Orange counties.

Common themes among these four successfully operating systems are:

- Community leadership by those who can and do make a difference.
- Single points of entry with multiple referral paths.
- Case management services are largely or completely separate from therapy and service delivery.
- Case review mechanisms facilitated family and youth input, accountability and problem solving.
- Collaborative and coordinated service delivery.
- Strategic use of financial and community resources.

Chapter 2002-248, Laws of Florida - Supportive Housing

Chapter 2002-248, Laws of Florida, directs the Secretary of the Department of Children and Families to establish a workgroup to review issues associated with publicly-funded supportive

housing/living arrangements. "The workgroup shall address development of administrative rules regarding:

- the definition of supportive housing services;
- individual's health and safety (resident's rights, concerns and standards); and
- the use of subsidies funded by the Department of Children and Family Services."

The Department's implementation of Chapter 2002-248, Laws of Florida, included the following:

- Convening a workgroup composed of legislatively required agencies and other parties;
- Conducting workgroup meetings on September 6, October 8, October 22 and November 22, 2002; and
- Submitting the workgroup's recommendations to the Legislature as part of the Master Plan.

The complete Workgroup Report On Supportive Housing, Chapter 2002-248, Laws of Florida, is included in this plan as Appendix A. The workgroup recommendations for the Department to consider are listed in priority order:

- Submit a legislative budget request for an appropriation to fund supportive housing.
- Analyze each district/region's current general revenue funds to identify opportunities to redirect funds to rental subsidies and services for non-Medicaid eligible individuals.
- Designate new federal mental health block grant funds for supportive housing.
- Coordinate with Medicaid to ensure supportive housing services can be billed to Medicaid.
- Continue to expand activities to promote the development of affordable housing coalitions that include members of this workgroup with an emphasis on targeting rural and low-income counties.

Florida Drug Control Strategy

In 1999, Florida advanced on its fight against illegal drug use by creating and implementing a Florida Drug Control Strategy. In September of 1999, after intense study of the problem, the Governor published a strategy to reduce illegal drug use by 50 percent by 2005. The strategy used a three-prong 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 us 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.

Goals and Objectives

Goal 1: Protect Florida's youth from substance abuse.

Objective 1: Educate children, parents, and other youth mentors to help Florida's young people reject illegal drugs and underage alcohol and tobacco use.
Objective 2: Provide Florida's youth with research-based substance abuse programs.
Objective 3: Encourage and assist the development of community coalitions in preventing substance abuse.
Objective 4: Create drug-free schools and environments that promote zero-tolerance for substance abuse where Florida's youth can be free from the risks of drugs, alcohol, and tobacco.
Objective 5: Work with the media, community structures, sports organizations, businesses, and faith groups to encourage young people to reject substance abuse.

Goal 2: Reduce the demand for drugs in Florida.

Objective 1: Educate Floridians as to the dangers of illegal drugs.
Objective 2: Provide effective treatment to Floridians that need it.
Objective 3: Provide research-based substance abuse prevention programs.
Objective 4: Expand drug-free workplace programs that emphasize drug prevention, education, testing, and intervention.
Objective 5: *Support community coalitions that take a stand against drug abuse; expand their reach to blanket all of Florida's counties.*

Goal 3: Reduce the supply of drugs in Florida.

Objective 1: Strengthen law enforcement with adequate laws, resources, training, and coordination – across jurisdictional boundaries and throughout the criminal justice system - to stop the trafficking of drugs.
Objective 2: Coordinate federal, state, and local law enforcement efforts toward the common objectives of decreasing the supply of illegal drugs and dismantling drug trafficking organizations.
Objective 3: Improve and expand information systems that provide law enforcement officials with the tools to effectively counter drug trafficking.
Objective 4: Disrupt criminal money laundering operations and seize and forfeit criminal assets.
Objective 5: *Reduce the illegal diversion of prescription drugs.*

Goal 4: Reduce the human suffering, moral degradation, and social, health, and economic costs of illegal drug use in Florida.

Objective 1: Heighten the public's awareness as to: the realities of drug abuse; its pervasiveness throughout every element of society; the nature of addiction as an illness; and, the intent to help those suffering from illegal drug use to recover and become contributing members of society.
Objective 2: Expand Florida's drug court system to break the nexus between drugs and crime, thereby lowering the recidivism and relapse rates.

Objective 3: Create a system of substance abuse screening, assessment, intervention, and treatment of individuals and families involved in Florida's child protection system.

Objective 4: Support and promote the professional development of those who work with substance abusers.

Objective 5: Expand research and technology initiatives that promise to lower the incidence of drug abuse, lessen the supply of illegal drugs, and reduce the health and social cost of drug abuse.

Performance Measures (to be accomplished by the end of 2005)

- Reduce drug abuse in Florida to 4 percent or less.

Assessment: This most important measure is on target. Latest National Household Survey on Drug Abuse indicates Florida's current use rate 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 1 percent or less;*
  - *Ecstasy, GHB, Ketamine, and other 'club drugs' to 3 percent or less;*
  - *All drugs to 8 percent or less;*
  - *Tobacco use to 14 percent or less, illegal sales to 8 percent or less; and*
  - *Alcohol use to 20 percent or less, illegal sales to 8 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 effect 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. Although youth and young adults tend to use drugs – often in experimentation – at higher rates than the population at large, our ultimate target must be to get their numbers as low as possible.

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

Assessment: Recently implemented standardized measurement has shown 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 a drug-free workplace.

- 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.

- *Reduce heroin, cocaine, and prescription overdose deaths by 50 percent.*

Assessment: After almost tripling between 1995 and 1998, heroin deaths flattened in 1999 and 2000 before rising again in 2001 by 30 percent. Cocaine deaths are down two percent since 1998 after rising steeply in the previous five years. Prescription drug overdose deaths, a category unmeasured before 2000, showed epidemic-like growth rates until the last six months of 2001, when GHB and Oxycodone related deaths decreased 60 percent and 14 percent from the preceding six months.

- 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. – indicate that where successful prevention, treatment, and law enforcement efforts have come together, associated costs of substance abuse are going down.

- 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 is 150-200 metric tons annually and heroin at three metric tons. Seizures (in both the transit and arrival zones) and deterrence bring those amounts down (as well as for all other illegal drug use). Seizures in 1999, 2000, and 2001 have been 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.

Italicized print indicates new or revised goals/objectives and performance measures since 1999 strategy.

Source: Florida Drug Control Strategy 1999-2005 Part 1, Section 2: A Restatement of Goals, Objectives and Performance Measures (Update)

Florida Drug Control Summit 2002

On April 30, 2002, Governor Bush and First Lady Columba Bush hosted the 4th Annual Florida Drug Control Summit sponsored by the Office of Drug Control. There were almost 400 leaders representing professionals from the field of drug treatment, prevention, and law enforcement. John Walters, Director of the Office of National Drug Control Policy and Jim Towey, Director of the White House Office of Faith Based & Community Initiatives, addressed the summit and congratulated Florida for its strides under Governor Bush in reducing substance abuse and outlined national strategies for combating drug use. The latest *National Household Survey on Drug Abuse*, sponsored by the Substance Abuse and Mental Health Services Administration, reported that Florida's drug use had dropped to 5.5 percent, a significant drop from last year's 6.8 percent and much closer to the Governor's goal of 4.0 percent for 2005.

The 4th 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 up 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: Expanding the Base
- Treatment: Research, Practice, & Resources
- Prevention: Family Perspectives
- Prevention: Community and School Perspectives
- Law Enforcement: Interdicting Drugs
- Law Enforcement: Prosecuting Drug Trafficking Organizations

Treatment: Expanding the Base

The session "Treatment: Expanding the Base" covered three main topic areas: (1) treatment services; (2) system integration and coordination; and (3) special populations. The comments and recommendations from the treatment session are as follows:

- Treatment Services
    - Faith-based services have greatly helped "fill in the gap" for necessary treatment and support services. There is a need for voluntary standards and training for faith-based service providers. We need to adjust the strategy to coordinate Florida's faith-based efforts with the White House Office of Faith-Based and Community Initiatives.
    - Treatment capacity expansion in recent years, including drug courts, services for women/children, etc., has helped significantly. We need to examine how well our expansion is keeping pace with per capita growth in Florida's population.
    - Restoration of in-prison treatment capacity will provide added options for drug court judges and necessary treatment services to precede newly-funded correctional transitional services.
    - We need to expand drug courts and specialized treatment services for individuals in rural communities.

- Systems Integration and Coordination
    - Progress on Child Welfare/Substance Abuse linkage.
    - Expand capacity for treating persons with co-occurring disorders.
    - Mentoring in private sector (by businesses/individuals) for clients upon re-entry into the community would help for jobs, housing, and other areas.

- Streamlining standardization consistency across state agencies is strongly desired. Good progress with Governor's Streamlining Initiative.

◆ Special Populations

- Strengthen linkages for persons with HIV and infectious diseases.
- Specialized outreach services for older Americans.
- Persons with disabilities – need to educate providers and physicians to better diagnose disabilities and strategies for serving these clients.
- Strengthen relationship with recovery community to help with advocacy.
- Local successful initiatives.

Treatment: Research, Practice, & Resources

The breakout session for Treatment: Research, Practice, & Resources reported on three major areas: (1) quality improvements and best practices; (2) special populations; and (3) resources. The comments and recommendations from the session are as follows:

◆ Quality Improvements and Best Practices

- Enhance technology transfer efforts, including:
  - Increased resources for technical assistance, technology transfer.
  - Specific goals and benchmarks in strategy.
  - Increased resources for training and clinical supervision.
  - Continue to improve statewide outcome measures and benchmarks.

◆ Special Populations

- Co-occurring disorders
- Elderly
- Individuals addicted to painkillers
- Recommendations:
  - Create an epidemiology workgroup to better forecast trends
  - Develop specialized treatment protocols (individuals addicted to painkillers)

◆ Resources

- Provide leadership on elimination of Medicaid Institute for Mental Disease (IMD) exclusion.
- Specific benchmarks for increasing treatment resources in strategy.
- Expand drug court model to serve more people in the criminal justice system.
- Recommit to support for Department of Corrections treatment services (in-prison and community-based).

Prevention: Family Perspectives

The breakout session for Prevention: Family Perspectives focused on five main areas: (1) marketing; (2) recruitment; (3) dissemination of information; (4) incentives; and (5) the

development of an economic model for prevention. The comments and recommendations from the session are listed below:

- Conduct a unit cost study for prevention that is reflective of the current use of evidence-based programs (since these programs tend to be more costly). Follow the study through the development of an economic model for prevention that will be used in Florida for reimbursement of services.
- Develop and implement a sustained, hard-hitting social marketing campaign for families. Give parents targeted bites of developmentally and culturally appropriate recommendations as a call to action.
- Provide incentives for supporting prevention efforts through:
  - Incentives for businesses who give time off for attendance at prevention events/classes; and
  - Rewards and status for businesses.
- Provide information from the state level about program models, promising and "best practices," i.e., how to involve churches, community centers, community leaders and how to best train parents/families.
- Support and recruit parents as leaders, spokespersons, outreach workers and prevention educators for other parents, i.e., through Parent Corps, Parent College, Abriendo Puertas model.

Prevention: Community and School Perspectives

The breakout session for Prevention: Community and School Perspectives focused on enhancing and supporting anti-drug coalitions. The comments and recommendations from the session are presented below:

- Develop a list of possible actions that will increase the number and quality of community anti-drug coalitions in Florida.
  - Improve community readiness.
  - Improve identification of priorities.
  - Improve targeting of services and programs.
  - Improve local prevention resource assessment.
  - Improve assessment of community prevention effort.

- Recommendations for Short-Term Action
  - Define coalitions assuring the involvement of schools, community organizations, faith-based organizations, public health, federal, state and local government, businesses and workers, parents and youth.
  - Support the formation of a statewide council of local coalitions with representation on the Governor's Drug Policy Advisory Council.
  - Create dedicated state funding equal to a coalition coordinator in each county to tend to basic coalition functions: $50,000 x 67 = $3.35 million (+ state coordination capacity).
  - Provide training and technical support and resources to local coalitions on the identification of barriers to reducing local drug use, coalition building, and data driven planning.

- Provide information resources and technical support that assures coalitions have adequate local data to make valid planning decisions and to demonstrate effectiveness (also tie accountability to funding).

◆ Recommendations for Long-Term Action

- Develop infrastructure to assist and support local coalitions in ongoing marketing efforts to communicate local goals and objectives.
- Develop legislation charging communities to create prevention coalitions and provide technical assistance through the legislative language.

Law Enforcement: Interdicting Drugs

The breakout session for Law Enforcement: Interdicting Drugs focused on three major areas: (1) the integration and focus of law enforcement efforts; (2) methods to improve intelligence; and (3) statewide drug courts. The comments and recommendations are as follows:

◆ Integration and Focus of Law Enforcement

- Increase funding to support the focused and integrated efforts of the Violent Crime and Drug Control Council (VCDCC) at increased level ($4.5 million).
- Continue to fund the National Guard to support state and local participation for counter-drug efforts in Florida.
- Finalize implementation of seaport security standards at Florida's 14 deepwater ports.

◆ Improve Intelligence

- DrugNet Intelligence system developed and deployed
  - Sheriffs and chiefs workgroup formed to help increase usage and marketing.
  - Tie funding of the *Florida Violent Crime and Drug Control Council (VCDCC)* and the *Florida High Intensity Drug Trafficking Areas (HIDTA)* to participation in DrugNet.
- Connect three Florida HIDTAs and Puerto Rico HIDTA to Florida DrugNet.
- Continue to target money-laundering organizations.

◆ Statewide Drug Courts

- Training for law enforcement on drug courts - drug courts to produce roll call video for training new and existing officers.
- Institutionalize funding source for drug courts.

◆ Recommendations

- Request Florida be designated as statewide High Intensity Financial Crime Area.
- Consistent with objective to leverage technology and applied research, recommend statewide implementation of CrimeTrax for all felony narcotics offenders on supervised release.
- Continue to seek HIDTA funding to help on interdiction efforts such as Operation RiverWalk.

Law Enforcement: Prosecuting Drug Trafficking Organizations

The breakout session for Law Enforcement: Prosecuting Drug Trafficking Organizations focused three major areas: (1) sharing of intelligence; (2) substantial assistance agreements; and (3) court system. The comments and recommendations are as follows:

- Strategic Plan
  - A successful strategic plan must be based on good intelligence, which requires the sharing of intelligence through existing data bases, which are currently being underutilized.
  - Successful strategic plans involve "flipping" lower level drug defendants and using their cooperation and testimony to identify, apprehend and prosecute higher level operatives in the drug trafficking organizations through substantial assistance agreements.
  - A successful strategic plan must involve a determination of whether to proceed in federal court or in state court, based on a thorough analysis of the advantages and disadvantages of each.
  - Asset forfeiture and RICO proceedings are not being fully used in the war on drugs. Smaller law enforcement agencies in particular are unable to fully use these tools because of the cost of legal representation. Some form of statewide support should be considered for such agencies.

- Substantial Assistance Agreements
  - Ordinarily, it is advantageous to reduce substantial assistance agreements to writing.
  - Despite substantial assistance, normally some period of incarceration should be required.

- Recommendation
  - It is frustrating to law enforcement and harmful to communities when drug traffickers are allowed to post low bonds. The pre-trial detention statute should be revised to authorize judges to detain drug traffickers without bond under certain circumstances.

Governor's Streamlining Initiative

Following the 2001 Florida Drug Summit, Governor Bush requested the Department of Children and Families (DCF), Department of Corrections (FDC), and Department of Juvenile Justice (DJJ) to streamline several administrative functions across state agencies that administer substance abuse services funding to improve efficiency and reduce duplication. In conjunction with the Office of Drug Control, the Department of Children and Families convened a workgroup to:

- Develop a policy statement to ensure consistent, coordinated delivery and management of publicly-funded substance abuse services.
- Develop a single administrative rule to govern all substance abuse service provision.
- Initiate joint monitoring of contracted substance abuse providers/programs to improve coordination, reduce duplication of effort, and ensure consistency of standards used for evaluating compliance regarding licensure, programmatic, and contract requirements.

- Develop uniform performance measures and criteria for evaluating the efficiency and effectiveness of publicly-funded substance abuse services.

Accomplishments to date are as follows:

- 65D-30, F.A.C., has been revised to maximize consistency and reduce regulatory requirements for substance abuse programs and services funded and/or monitored by DJJ, FDC, and DCF.
- DCF, DJJ, and FDC conducted joint licensure/programmatic reviews of DISC Village, Inc., a provider in District 2 and Operation PAR, a provider in the Suncoast Region in January 2002.
- DCF is accepting full accreditation reports in lieu of on-site licensure reviews per Chapter 2001-191, Laws of Florida.
- DCF, DJJ, and FDC are collaborating on developing four common measures regarding (1) number of clients served; (2) discharge status (outcome); (3) recommitment rate (to DJJ); and (4) recidivism (arrest and/or commitment to FDC).
- DCF has developed a preliminary schedule of reviews that cover substance abuse licensure and contract monitoring internally. Our next step is to coordinate this schedule with DJJ and FDC. We anticipate that joint reviews will be at 100 percent by the end of the current fiscal year.

Substance Abuse

Trends and Conditions

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 admissions to Florida's prisons are for drug offenses. More than half of the clients 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 Florida 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, and increased emphasis within prevention programs on the dangers of using ecstasy, heroin and oxycodone.

The Substance Abuse Program Office estimates that there are 791,333 adults in Florida with substance abuse problems in need of treatment services and an additional 1.5 million adults that are at-risk for developing substance abuse problems. The Substance Abuse Program is currently serving 15 percent of adults in need of substance abuse services.

Significant Trends in Use

A 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, methamphetamines, heroin, cocaine, and rohypnol.

Ketamine, a veterinary tranquilizer, is currently one of the most popular drugs among youth. In the RAVE and club scene, the substance is often sold under the name of "special K" and is known as "K", "KitKat", "VitaminK", and "Ket". This desire for Ketamine has resulted in an increase in animal hospital burglaries. Ketamine users usually take the liquid mixture and bake it until it turns into a flaky white powder like cocaine. Vials usually contain about 10 cubic centimeters worth of Ketamine and sell for $50 to $70. Because it lowers the heart rate, larger doses can lead to oxygen starvation to the brain and muscles. An overdose can also cause the heart to stop. A bill was passed in the 1999 legislative session and signed into law by the Governor adding Ketamine to the list of controlled substances.

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, announcement by disc jockeys, and word of mouth, affecting age groups 12-35, the highest concentration being those in their late 20's. 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.

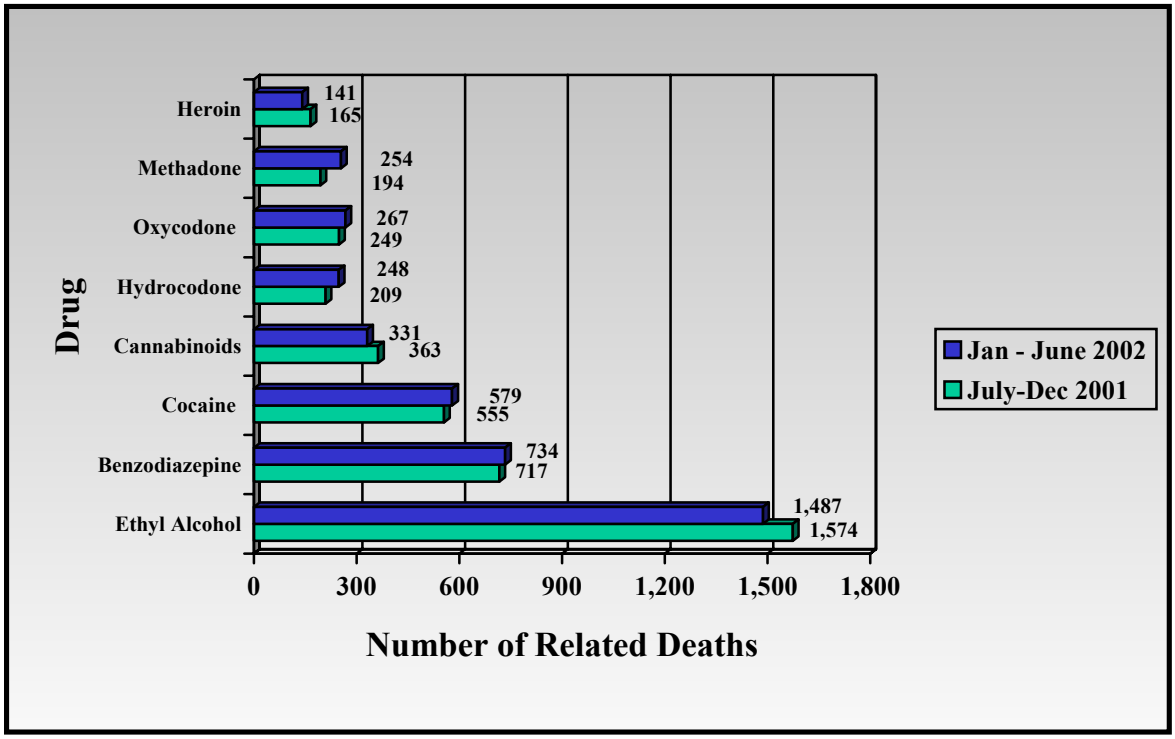
The Florida Department of Law Enforcement is actively monitoring the use of two research chemicals, AMT and Foxy, which are reportedly being diverted for recreational use. Both drugs are unscheduled and uncontrolled in Florida but are potentially dangerous psychoactive chemicals. The recreational use of research chemicals is of great concern as there is little to no information on this class of drugs regarding addiction or overdose potential, allergic reactions or possible long-term health problems. Research chemicals often have undergone virtually no human or animal toxicity studies.

Foxy or Methoxy Foxy is a psychoactive tryptamine that has dramatically different effects on users. Users often report strong feelings of energy or "buzzing" that can last from 10-14 hours. According to use reports in drug chat rooms and websites, many users have negative side affects from the drug, including extreme anxiety, diarrhea and nausea. Oral doses of Foxy are most common; however, the drug can be snorted or smoked. Foxy is generally found as a white or tan powder. Purple or green color pills with a spider or alien emblem have been noted in reports.

Drug-Related Deaths

Drug-related deaths continue to be problematic. There was a seven percent increase in cocaine-related deaths in 2001 when compared with data collected in 2000. Additionally, there was a 30 percent increase in deaths caused by heroin overdoses for 2001 when compared to 2000, which primarily are attributed to significant increases in Palm Beach and Broward counties. During 2001, Florida experienced a 71 percent increase in Methadone-related deaths when compared with 2000. Deaths with hydrocodone or oxycodone present in the body were also higher in 2001 than in 2000. Since these drugs were not tracked separately in 2000, a 45 percent increase occurred in the presence of hydrocodone or oxycodone during 2001. Methylated amphetamines deaths, MDMA, also known as Ecstasy, caused 31 deaths in 2001. Over a recent three-year period, 174 youth and young adults died from using club drugs. It is important to note, however, that the Florida Youth Survey in 2002 noted a slight decline in Ecstasy use among 6th to 12th grade youth. Two percent of the youth surveyed in 2002 indicated use of Ecstasy within the last 30 days, down from 2.8 percent in 2001.

12 Month Comparison of Drug-Related Deaths



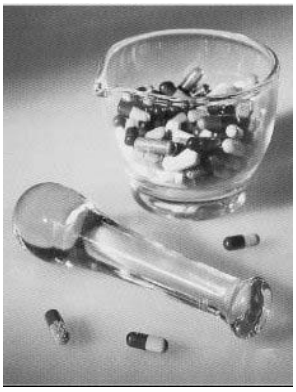
* Data derived from the Florida Department of Law Enforcement's *2002 Interim Report of Drugs - Identified in Decease Persons by Florida Medical Examiners*, November 2002.

Florida Youth Substance Abuse Survey

The Florida Youth Substance Abuse Survey is a collaborative effort among the Florida departments of Health, Education, Children and Families, Juvenile Justice, and the Governor's Office of Drug Control. It is modeled after the "Communities That Care" survey, and assesses various risk and protective factors for substance abuse, in addition to substance abuse prevalence. The survey was first administered to Florida's middle and high school students during the 1999-2000 school year, and is repeated annually.

The initial Florida Youth Survey administration involved county-level sampling of approximately 125,000 students in the Spring of 2000. Students were administered one of two surveys: The Florida Youth Substance Abuse Survey (FYSAS), or the Florida Youth Tobacco Survey (FYTS). Data was generated for counties and DCF districts in addition to the state of Florida. The 2001 Florida Youth Survey effort involved a statewide sampling only, that included approximately 27,000 students. Schools were chosen at random throughout the state, and classrooms within the selected schools were also chosen at random for participation. Students were administered either the FYSAS, the FYTS, or the Youth Risk Behavior Survey. In 2002, a county-level sampling was again conducted, involving nearly 130,000 students taking either the FYSAS or the FYTS. Subsequent annual administrations will continue to alternate between county-level sampling

using the two main surveys, and statewide sampling using all three surveys. Thus, county-specific data will be available bi-annually.



Among the major findings of the 2002 survey:

- Alcohol, cigarettes, and marijuana remain the most commonly used drugs among youth. Prevalence rates for other drugs are substantially lower.
- Binge drinking is more prevalent than tobacco, marijuana or other illicit drug use.
- Cigarette use among Florida students declined sharply from 18.4 percent in 2000 to 11.4 percent in 2002.
- Current marijuana use decreased from 19.8 percent to 17.2 percent among high school students, and from 7.9 percent to 5.9 percent among middle school students over the past two years.
- As a result of the large reduction in cigarette use, more high school students reported current use of marijuana than cigarettes for the first time in 2002.
- Past-30-day use of ***any illicit drug other than marijuana*** declined from 9.3 percent in 2000 to 7.5 percent in 2002.
- None of the drugs with available trend comparisons show a meaningful increase in use.

There is an estimated 330,984 youth in Florida who are in need of treatment services due to substance abuse or dependence. The Substance Abuse Program is currently serving 23 percent of youth in need of services. An additional 400,000 youth are at-risk for substance abuse due to risk factors such as poor school performance, low self-esteem, family dysfunction, emotional/mental health problems, and peer use.

Controlling Prescription Drug Abuse

Prescription drug abuse and OxyContin abuse have increased at an alarming rate in Florida. The Florida Medical Examiners' *2000 Report of the Drugs Identified in Deceased Persons* identified 957 cases of deaths in which oxycodone or hydrocodone was present in the body or cause of death. In comparison, cocaine was related to 1,105 deaths and heroin related to 328 deaths.[1] Another disturbing yet recent trend in the abuse of prescription medication is the abuse of methadone. In 2001, 357 individuals died with methadone present at the time of death. That was a 71 percent increase in methadone-related deaths over calendar year 2000. An additional 31 percent rise (254 deaths) in these deaths was recorded in the first six months of 2002, compared to the last six months of 2001. Under Governor Bush's leadership and the Florida Legislature, the Florida Board of Medicine, the Department of Health, the Department of Children and Families, the Office of Drug Control, the Florida Department of Law Enforcement, the Attorney General, and the Department of Elder Affairs have collaborated to develop strategies that would impact this tragic situation.

During the 2002 legislative session, Senator Locke Burt sponsored legislation that would help reduce illegal activity associated with prescription drug abuse. That legislation would have extended criminal penalties in this area, created serial numbers for prescription pads, and created

[1] Florida Department of Law Enforcement, Office of Statewide Intelligence, *Overview of Prescription Drug Abuse & The Oxycodone Problem in Florida, August 2001*. p. 3.

a central registry for prescriptions of these substances, without compromising patient confidentiality. Similar legislation is likely to be filed for the 2003 session.

In December of 2002, the Substance Abuse Program Office and the Department of Health, in collaboration with the Board of Medicine and health practitioner associations throughout Florida, conducted a mass mailing to practitioners throughout Florida alerting them to the concerns with methadone related deaths and providing recommendations for patient management and information sharing. Additionally, the Florida Association for the Treatment of Opioid Dependence has convened its member agencies to implement practices that could help manage patients who are obtaining methadone in other health care settings and diverting it to the street.

The Office of Drug Control is planning a one day summit on January 22, 2003, in Tallahassee, to address the dangers of and solutions to prescription drug abuse.

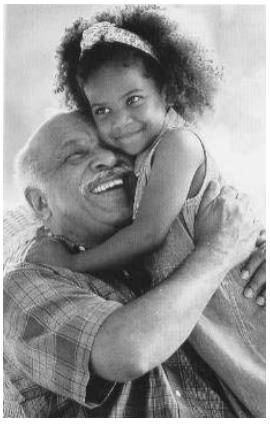
Buprenorphine

A new federal regulation regarding the use of the drug buprenorphine by physicians to treat addiction to opioids was adopted. The medication should be available by April 2003. The regulation would permit physicians to prescribe the drug from their private practices and require physicians to be certified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and receive minimal training in order to participate. As of November 2002, 57 physicians had applied for certification and 23 had been approved. The Substance Abuse Program will contact those physicians to help ensure linkages to appropriate detoxification and treatment services for their patients.

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 life style 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 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.



Provision of services to this population is complicated by a number of barriers. For instance, it is estimated that nationally there are at least 200,000 women in nursing homes who have alcohol problems. According to this same CASA report, women are more likely to be hospitalized for substance abuse problems than for heart attacks. 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 the older population. 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.

Problems facing the substance abuse and mental health service systems range from no public funding for community services for older people, poorly trained front-line care providers, an inadequate number of trained and skilled clinical gerontological professionals, and unrecognized special needs of older people due to a lack of monitoring of existing facilities.

Through the Center for Substance Abuse Prevention a Multi State Workshop was established that involved Florida's Department of Children and Families Substance Abuse and Mental Health Program Offices, Department of Elder Affairs, Florida Alcohol and Drug Abuse Association (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 outcome of the workgroup for Florida was the following vision:

- Facilitate collaboration between Florida's substance abuse, mental health, aging services, medical professionals and law enforcement agencies by establishing better communication, expanded and combined state plans, partnership agreements, cross training and collaborative legislative budget requests.
- Expand training to include medical professionals.
- Expand current data collection.
- Expand Medicaid waiver coverage.
- Establish policies based on data, best practices, and model programs, statutory, departmental policies and procedural amendments.
- Expand substance abuse prevention and treatment funding for services.
- Expand public education awareness.
- Develop ideal infrastructure.

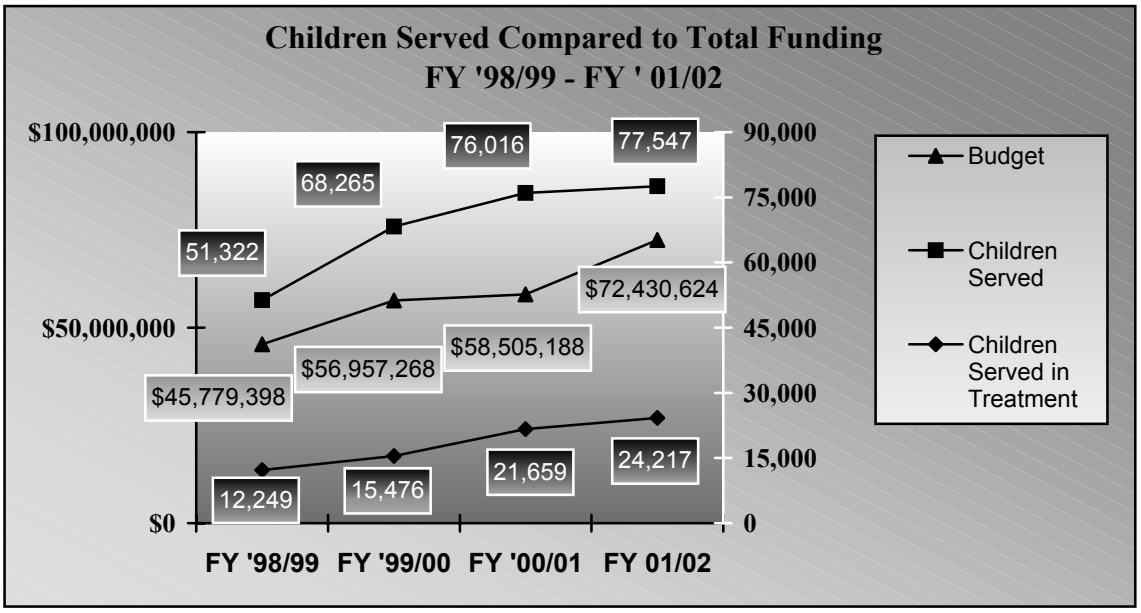
The workgroup also identified possible outcomes for the projected fiscal years that included new interagency agreements and state plans, multi-program legislative budget requests, standardized statewide data collection, and pharmaceutical funding initiatives.

The Department of Children and Families and the Department of Elder Affairs have made a commitment to work with the Center for Substance Abuse Prevention to develop strategies for preventing substance abuse among the older adults through enhanced interagency coordination and the training of health care professionals.

Clients Served and Budget

Children

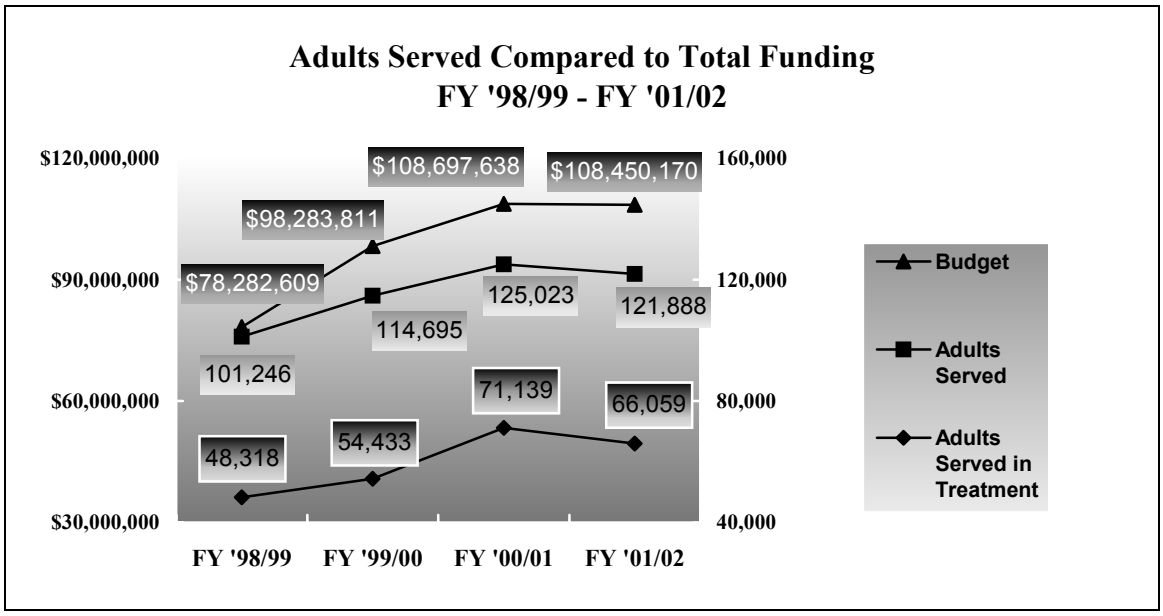
Over the past four fiscal years, the Substance Abuse Program has received a 58 percent increase in funding for children's substance abuse services; a significant portion of the increased funding has come through federal block grant increases and the award of a prevention grant from the Center for Substance Abuse Prevention. The state contributes funding at a rate slightly higher than 1:1 for children's substance abuse services, when compared to federal funding. The Substance Abuse Program used the funding increases to add detoxification and treatment capacity throughout the state and to strengthen service infrastructure. The result has been a significant increase in the number of children served in prevention and treatment programs.



* A consistent methodology was used in the above table for identifying children served in treatment across the four fiscal years. The numbers shown for children served in treatment in the 2002 Plan Update were lower due to the use of a different methodology.

Adults

Over the past four fiscal years, the Substance Abuse Program has received a 39 percent increase in funding for adult substance abuse services; a significant portion of the increased funding has come through a $20 million increase in federal block grant funds and an $8.5 million increase in state funding. The state contributes funding at a rate of 1:3 for adult substance abuse services, when compared to federal funding. The Substance Abuse Program used the funding increases to add detoxification and treatment capacity throughout the state and to strengthen service infrastructure. There has been a significant increase in the number of adults served in prevention and treatment programs in the past three years.



Fiscal Year 2002-2003 Funding

In Fiscal Year 2001-2002 the Substance Abuse Program Office received an additional $6.4 million to implement several prevention initiatives including Prevention Partnership Grants. Grants were awarded to providers through a competitive process mid-year and Fiscal Year 2002-2003 represents the first full year of operation for the Prevention Partnership Grant programs. Funding for the remaining program/service areas remained stable relative to FY 2000-2001. The special legislative session in November 2001 impacted the Substance Abuse Program through a reduction in funding for services and administration expenses. The reductions resulted in the elimination of 11 FTE positions responsible for governmental oversight activities, a net reduction of 16 percent of program staff statewide. There are now 59 positions remaining statewide to administer more than $175 million in contracted funds.

Substance Abuse Services Funding for Fiscal Year 2002-2003

	PROGRAM MANAGEMENT AND COMPLIANCE SUBSTANCE ABUSE	CHILD SUBSTANCE ABUSE	ADULT SUBSTANCE ABUSE	TOTAL
GENERAL REVENUE	**$2,054,389**	**$23,251,230**	**$19,525,104**	**$44,830,723**
OTHER STATE FUNDS	**$11,859**	**$15,915,565**	**$7,347,178**	**$23,274,602**
TOTAL STATE FUNDS	**$2,066,248**	**$39,166,795**	**$26,872,282**	**$68,105,325**
FEDERAL TRUST FUNDS				
ADAMH TF (SAPT BG)	**$1,510,322**	**$29,619,003**	**$65,058,908**	**$96,188,233**
TANF (FGTF)		**$640,000**	**$16,047,500**	**$16,687,500**
Other Federal Funds	**$706,880**	**$3,004,826**	**$471,480**	**$4,183,186**
TOTAL FEDERAL FUNDS	**$2,217,202**	**$33,263,829**	**$81,577,888**	**$117,058,919**
TOTAL	**$4,283,450**	**$72,430,624**	**$108,450,170**	**$185,164,244**

Federal Block Grant Technical Review

In May 2002, consultants from Johnson, Bassin and Shaw under contract with the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), in Washington, D.C., conducted a Core Technical Review. The review measures state progress and compliance with the requirements of the Substance Abuse Prevention and Treatment Block Grant. The findings are used to provide SAMHSA, CSAT and the states with a framework for effective technical assistance, technology transfer, and new policy initiatives.

Some problems and issues that were identified by the consultants with regard to contract requirements, monitoring, training and accounting for Substance Abuse Prevention and Treatment (SAPT) Block Grant activities are being addressed in FY 2002-2003. Contracts now include a new contract exhibit for the SAPT Block Grant requirements and new monitoring procedures and protocols are being tested and implemented by the DCF contracts division. The contract requirements include specific directions for data management that will allow tracking of specific SAPT Block Grant activities and fiscal reconciliation for required financial set-asides. The monitoring reports will now be posted to the Intranet and will be available to DCF Substance Abuse Program Office and administrative staff in the districts and in the central office thus correcting another problem identified by the reviewers. Florida also implemented a training plan to address deficiencies in district and provider knowledge with regard to the specific SAPT Block Grant requirements. The training began on December 2, 2002, and includes training on the new contract, data management, and monitoring provisions. The training is expected to reach 50 district monitoring, contract and program staff in the 13 districts and the Suncoast Region and an estimated 150 substance abuse provider staff. The training is scheduled for completion by the end of February 2003. These initiatives were recognized by the reviewers but were not identified as deficiencies in the final report.

With regard to the annual federal A-133 audit requirements, the reviewers were concerned that districts did not have adequate staff to review all of the A-133 audit reports. These are federal requirements for auditing certain federal funds and programs on an annual basis. They also noted that the reports were not available to central office staff. These concerns were shared with the Department's Contracts Unit, who is seeking remedies.

Lastly, the reviewers recommended and the state agreed to an analysis of Florida's services for pregnant women and women with dependent children as per the SAPT Block Grant requirements. This would be accomplished through a technical review arranged by CSAT and its contracting agent Johnson, Bassin and Shaw. The review would involve gathering information on the quality and scope of specialized services at 49 agencies with programs serving this population with the support of SAPT Block Grant funds. The arrangements for this review are still pending.

Medicaid - Substance Abuse

Medicaid funding accounts for less than five percent of the Substance Abuse Program budget. There are several reasons for this, including limitations on eligible services for substance abusers without an accompanying mental health diagnosis, Institution for Mental Disease (IMD) exclusions and loss of eligibility after admission to long-term residential care, implementation of

TANF funding, and 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 the Agency for Health Care Administration (AHCA) and the Florida Alcohol and Drug Abuse Association, the Department is identifying strategies to improve Medicaid support of substance abuse services. If funding permits, AHCA plans to develop procedure codes for outpatient detoxification services and bundled rates for methadone services. Procedure codes for detoxification services should help reduce hospital inpatient expenditures for detoxification while using federal funds to support these services. Bundled rates for methadone services should actually reduce current Medicaid expenditures for these services.

Strengthening the System for Licensure

Licensure of substance abuse facilities provides the foundation for the delivery of high quality services and ensures that there are adequate provisions in place to protect the health, safety and well being of clients. It is essential that the licensure system, provided for under Chapter 397, F.S., be strengthened to ensure the continuing integrity of the service system. Since direct service delivery is privatized licensure permits the Department the necessary control over standards of care, ensuring that services are delivered by qualified professionals in safe and appropriate environments.

Historically, the Department has relied on temporary Other Personal Services (OPS) positions to "fill in the gaps" since full-time equivalent (FTE) positions have not been authorized at necessary levels to handle licensing functions. There is a critical need to replace the OPS positions with FTE positions to ensure retention of qualified professionals. The Substance Abuse Program Office is also developing other initiatives to strengthen the licensure system. Staff is identifying the necessary elements for a centralized database that will enhance the management of licensure and permit the evaluation of licensure practices and provider performance.

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

Administrative rules under Chapter 65D-30, F.A.C., Substance Abuse Services, are being amended to update requirements and streamline the process of conducting licensure reviews in accordance with accreditation requirements under Chapter 2001-191, Laws of Florida, and the Governor's streamlining initiative regarding licensure and monitoring of substance abuse facilities. The rule is currently being reviewed and should be adopted by March 2003. The major focuses of the revisions are:

- Eliminating duplicative requirements and allowing greater flexibility with regard to service provision for providers.
- Removal of unnecessary requirements, making the rule less prescriptive.
- Including areas of exemption for the Department of Corrections and Department of Juvenile Justice as permitted under Chapter 397, F.S.

Substance Abuse Strategic Directions

The Substance Abuse Program Office has identified significant strategies designed to improve services and outcomes for children and adults affected by substance abuse. The program is

currently expanding the use of evidence-based models of care, especially with respect to prevention services for youth. Other priorities include the expansion of juvenile and adult drug court programs, aftercare, follow-up, and intra- and interagency service collaboration. These strategic directions and progress to date are outlined below.

Children's Substance Abuse Prevention, Evaluation, and Treatment

Issue Summary:

In support of the Florida Drug Control Strategy's goal of reducing substance abuse in Florida by 50 percent, the Substance Abuse Program dedicated significant resources toward increasing the availability of evidence-based prevention programs for youth. The Department, in conjunction with several internal and external stakeholder groups, developed a comprehensive prevention plan that emphasizes integration and collaboration among prevention service entities and the use of sound prevention practices. In its efforts to improve information dissemination regarding best practices, the Substance Abuse Program prevention web site is accessible through the state's primary site: ***MyFlorida.Com***.

Strategic Course of Action 2000-2003:

- Expand the use of evidence-based prevention programs for Florida's youth and their families.
- Develop a multi-agency statewide substance abuse prevention plan.
- Continue to collaborate on the annual administration of the Florida Youth Survey.
- Implement the Substance Abuse Prevention web site authorized in Chapter 397, F.S.
- Implement and test model systems of care for children's treatment services in districts 7 and 9, as authorized in Chapter 397, F.S.
- Support the expansion of drug courts (including delinquency and dependency) by providing access to evaluation and treatment services.
- Develop and expand aftercare program services and 12-month follow-up methodology.
- Support an alternative funding source for the Child and Adolescent Substance Abuse Trust Fund upon repeal of the alcohol beverage surcharge.

Progress to date:

Prevention

The 2001 Florida Legislature appropriated a $6.4 million increase in the federal Substance Abuse Prevention and Treatment Block Grant to bolster the state's prevention effort. Activities supported by these funds include local grants for the Prevention Partnership Grants (section 397.99, Florida Statutes) and the Drug-Free Communities Mini-Grant Program (based on the intentions of section 397.998, Florida Statutes) as well as other critical initiatives. All activities

and initiatives related to this appropriation are coordinated with the Governor's Office of Drug Control to assure progress toward the objectives to the *Florida Drug Control Strategy*.

Other activities of the 2002 Prevention Appropriation include:

- Establishing the North Florida Prevention Initiative to build community anti-drug coalitions in the 34 county region of north Florida. This effort is coordinated with the law enforcement initiatives in these counties through the Governor's Office of Drug Control.
- Incorporating drug prevention concepts into the Florida Comprehensive Assessment Test (FCAT).
- Updating the prevention data reporting system.
- Providing technical assistance to local service providers, schools and coalitions.

These activities grow out of foundational efforts developed over the last four years. The Florida Youth Initiative (FYI) demonstrated the effective implementation of "evidence-based" prevention programs by local organizations. The Florida Youth Substance Abuse Survey provided a baseline measure of youth drug use and related risk and protective factors at the county level. The *Florida Prevention System*, developed by the FYI Advisory Council, continues to function as the prevention component of the *Florida Drug Control Strategy*. The annual statewide prevention conference is coordinated by the Governor's Office of Drug Control, co-sponsored by five state agencies and serves as a conduit for gauging the state of Florida's prevention effort from a community perspective.

Implementation of 2001 Prevention Initiative

The Florida Legislature, under the leadership of Representative Sandra L. Murman, created the Substance Abuse Prevention Partnership Grant program and provided $4.5 million to fund projects and practices that have been proven effective in reducing youth substance abuse. The Department of Children and Families, Substance Abuse Program has awarded 44 Prevention Partnership Grants through a competitive application process. These grants were awarded only to schools or community-based organizations in partnership with schools.

Thirty-eight Prevention Partnership Grant projects replicate substance abuse prevention programs that have been rigorously tested, using scientific methods and control groups, and found to be effective in reducing youth drug use or related risk factors. An additional six grants are designed to validate the effectiveness of promising, locally developed, prevention strategies. These projects will target over 46,000 high-risk elementary, middle and high school youth over a two and a half-year period. Additionally, the projects will train over 9,000 parents and teachers to recognize the danger signs for substance abuse and effective techniques for successful intervention. Prevention activities will continue through June 2004. Twenty-six counties throughout the state will benefit from these grants.

The Department based grant award criteria on the most current prevention methods. First, successful applicants used data from the 2000 Florida Youth Substance Abuse Survey to determine local prevention priorities and select the best programs. Over 62,000 6th to 12th grade students from 95 percent of Florida's school districts completed the 2000 Florida Youth

Substance Abuse Survey. This survey estimated the prevalence rates of alcohol and other drugs and the risk and protective factors that are contributing to this prevalence.

Secondly, the Center for Substance Abuse Prevention (CSAP) identified substance abuse prevention programs that effect particular risk factors when properly implemented. Consequently, each applicant was able to match the key risk factors of its target population with the data contained in the 2000 Florida Youth Substance Abuse Survey. Based on this information, particular CSAP prevention programs and strategies were selected that were tailored to the risk factors of the population, which they were proposing to serve.

Building Coalitions

In August 2002 the Department, in cooperation with the Governor's Office of Drug Control, executed four contracts to build community anti-drug coalitions across the northern tier of the state. These contracts support outreach activities to help communities establish new coalitions or support existing coalitions with training, technical assistance and materials. Operations are centered in Pensacola, Tallahassee, Gainesville and Jacksonville. This is closely coordinated with the Coalition Network Project of the Governor's Office of Drug Control, a project funded by the Office of Drug Control with the Florida Alcohol and Drug Abuse Association.

North Florida Prevention Initiative					
District 1	District 2		District 3		District 4
Escambia Okaloosa Santa Rosa Walton	Bay Calhoun Franklin Gadsden Gulf Holmes Jackson	Jefferson Leon Liberty Madison Taylor Wakulla Washington	Alachua Bradford Columbia Dixie Gilchrist Hamilton	Lafayette Levy Putnam Suwannee Union	Baker Clay Duval Nassau St. Johns

The North Florida Prevention Initiative was enhanced in December 2002 with the execution of a contract with Florida State University to manage the statewide Community Anti-Drug Coalition Mini-Grant Program. Beginning in 2003, FSU will provide coalitions with access to $400,000 for critical training, technical assistance and materials.

Florida Youth Initiative

As of November 2002, the Florida Youth Initiative operates 28 evidence-based projects across the state. Twenty-two projects replicate programs that have been scientifically tested and found to be effective. Six projects are locally developed and are being tested through FYI to determine their prevention effectiveness. In the first two and a half years of operation, these programs have served over 9,000 Florida youth. The special funding for these test projects will end by June 30, 2003. Because of their documented success, some of the projects will be picked up for continued funding from another source. The Department hopes to assist additional successful projects continue.

An important product of the FYI effort has been the publication of manuals for local prevention programs that previously had no systematic and up-to-date manual. The production of manuals for all of the prevention efforts evaluated in the FYI effort has improved these programs' chances of eventually reaching the status of "best practice" or "evidence-based program."

Evaluate Evidence-Based Projects

FYI contracts with the University of Miami's Comprehensive Drug Research Center (CDRC) for the evaluation of the local projects. CDRC develops program-specific evaluation plans, provides evaluation technical assistance and receives and stores outcome and process data. The data is used to determine the effectiveness of each project and the initiative in general and to assess the fidelity of implementation of the science-based program model. A final report of the FYI project will be produced by June 2003. The Comprehensive Drug Research Center also has oversight of the Performance Based Prevention System, a pilot data collection and reporting system that has enjoyed success in five other states.

The publication of process and outcome evaluations of each local FYI project will doubtless provide incentive to service providers and funding agencies to promulgate evidence-based programs. These evaluations already indicate that programs based on sound scientific principles can be easily replicated in Florida resulting in substantial reductions in alcohol, tobacco and other drug (ATOD) use and related risk factors.

Expand Use of Evidence-Based Prevention Programs

Over the last four years the Department made great progress in transitioning its prevention services to reflect recent scientific advances in effective programming. The Florida Youth Initiative has been the hub of this effort. This year the Department will expand this effort in two ways. First, the Substance Abuse Program will target training and technical assistance activities to faith-based organizations to assure they are prepared to compete effectively for funding related to substance abuse prevention. Secondly, the Substance Abuse Program will apply to the Center for Substance Abuse Prevention for a $750,000 State Incentive Grant Enhancement. The purpose of this grant is to expand the focus of the State Incentive Grant program to new target populations and to promote improvement in the collection and use of data. If awarded, the new grant will focus on prevention for the 18-25 year old population.

Improved Interagency Coordination

The Department promotes interagency coordination in two ways. It coordinates the Interagency Florida Youth Substance Abuse Survey Team. Representatives from the departments of Children and Families, Education, Health, Juvenile Justice and the Governor's Office of Drug Control meet regularly to plan the administration of the survey and develop the county and state survey reports. In the spring of 2002, this coordination resulted in the co-administration of both the Florida Youth Tobacco Survey and the Florida Youth Substance Abuse Survey by over 120,000 youth in 64 counties. Results will be used by local entities of each department and by the agencies to target prevention resources.

The Department also takes a leadership role in the ongoing planning of the annual Statewide Prevention Conference. Five state agencies are co-sponsors of the conference. This is the premier event for bringing the latest best practices to Florida's community prevention organizations and celebrating current prevention efforts. Additionally, more than 1,000 youth and adult participants in the 2002 conference provided input to the Governor's Office of Drug Control about the status of local prevention efforts. This input will be incorporated into the planning of the Department.

Multi-Agency Statewide Substance Abuse Prevention Plans

The *Florida Prevention System: A Vision for the Prevention Component of the Florida Drug Control Strategy* was published in June 2001. The development of the plan was coordinated through the advisory council of the Florida Youth Initiative. The Florida Prevention System continues to be the state's guide for building an effective and comprehensive substance abuse prevention effort.

Florida Comprehensive Assessment Test (FCAT)

The Department has a letter of agreement with the Department of Health and Department of Education for a partnership to develop written alcohol and other drug-use, tobacco-use and violence prevention and education passages for inclusion in the preparation and test materials of the Florida Comprehensive Assessment Test (FCAT). This is a statewide activity of the 2000-01 General Appropriations Act, Specific Appropriation 340. The primary goal is to increase the awareness of the dangers of substance use/abuse among 3rd – 10th grade students.

The Department executed a contract with the University of South Florida to develop substance abuse prevention materials to be included in the student preparation and testing materials for the FCAT for the 2003-2004 school year. This information will be used to help ensure Florida's compliance with the Florida Prevention System within the Florida Drug Control Strategy.

Continuation of Substance Abuse Prevention Staff

The Substance Abuse Program Office is requesting replacement of Federal Grants Trust Fund budget with Alcohol, Drug Abuse and Mental Health Trust Fund budget to continue four career service positions in the central program office. These positions are currently funded under a cooperative agreement with the Federal Center for Substance Abuse Prevention for a State Incentive Grant that will terminate in July 2003. These staff provide necessary oversight for the transition of block grant prevention services to science-based prevention programs.

Substance Abuse Prevention Web Site

Chapter 397, F.S., mandated that the Substance Abuse Program develop a substance abuse prevention web site. The site was recently developed and can be found on the Substance Abuse and Mental Health web site at:

http://www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/sa/index.html

This site contains information on the Statewide Prevention Conference; Florida Youth Initiative; the Florida Prevention System; Prevention Partnership Grants; Florida Youth Substance Abuse Survey; Red Ribbon Week and links (for youth, college students, adults, parents, professionals, teachers, national organizations and information).

Treatment

Treatment Services Expansion

For Fiscal Year 2002-2003 the Florida Legislature appropriated an additional $2.8 million for children's substance abuse services to target critical expansion of residential and non-residential treatment services. Service capacity expansion focused on drug court treatment programs ($584,258) and Human Immunodeficiency Virus (HIV) education, counseling and testing ($149,730) for youth. The remainder of the funding increase was distributed pursuant to the statutory requirements for equity to focus on the enhancement of treatment services.

Adult Substance Abuse Prevention, Evaluation, and Treatment

Issue Summary:

More than half of the adults served by the Substance Abuse Program in Florida have some level of involvement with the criminal justice system. Many parents, whose children are under the custody and/or supervision of the state due to abuse or neglect, have significant substance abuse problems that contribute to family instability and domestic violence. This has created a strong need for collaboration between the Substance Abuse Program and Family Safety Program (child welfare) to develop a system for the identification of need and linkage to appropriate substance abuse services, with the ultimate goal of preserving the family.

Drug courts have evolved as an effective alternative to incarceration for individuals with substance abuse problems. The state is expanding the availability of these services and has experienced participation on the part of offenders in recent years. The Substance Abuse Program Office is also working diligently to identify, develop and implement effective treatment strategies for opioid addicts and women with dependent children, specifically those receiving other forms of public assistance from the state.

Strategic Course of Action 2000-2003:

- Integrate substance abuse services with Family Safety for families engaged in both systems through the implementation of family intervention specialists, expanded treatment capacity for pregnant and post-partum women and women and children, and other strategies identified in the joint departmental policy paper.
- Support the expansion of drug courts by providing access to evaluation and treatment services.
- Expand residential and aftercare program services and 12-month follow-up methodology. Continue to implement the Substance Abuse/Mental Health TANF program for WAGES participants and families at risk of entering the welfare system by providing substance abuse services that will assist them in maintaining gainful employment.
- Begin to develop statewide research to practice consortium in conjunction with the Florida Mental Health Institute and the Florida Alcohol and Drug Abuse Association.

Progress to Date:

Child Welfare Initiative - Family Safety

In 2000, Florida's Department of Children and Families (DCF) 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 to families involved in the child welfare system. A consensus was reached that both systems would commit to the following joint goals:

1. To protect and ensure the safety of children.
2. To prevent and remediate 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.
4. To support families in recovery.

The policy framework further identified 13 critical issues with specific recommendations, organized under seven domains, for improving Florida's coordination and integration of Substance Abuse and Family Safety services.

Success in Developing and Implementing the Integration Strategy

The 1999 federal Substance Abuse Prevention and Treatment (SAPT) Block Grant increase of $27 million facilitated critical funding in the amount of $17.8 million for treatment services for adults and families involved with Family Safety. From FY 1998-1999 to FY 2001-2002, the number of adult Family Safety referrals who received substance abuse treatment services, on an annual basis, increased by 45 percent. Over 17,000 adults directly referred by Family Safety received treatment services during this four-year period.

Throughout the state, many models of coordinated service delivery have been developed. The dependency drug court program in Pensacola was one strategy that had demonstrated effective outcomes with substance abusing parents whose children were under protective supervision or in foster care. This court program targeted families who had previously been under protective supervision; its success spawned interest in replication. As of December 2002 there were 12 dependency drug court programs in Florida, and four more planned for implementation in 2003.

Another successful strategy included appropriation of new funding for 35 Family Intervention Specialists, contracted to substance abuse treatment providers and co-located in Family Safety offices. These staff assess parents and other family members identified by child protection investigators for the need for substance abuse treatment. They facilitate entry to treatment and ensure linkage between the two provider systems during the treatment process. Their goal is to improve identification of the need for substance abuse treatment, maximize 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. In FY 2001-02 there were 4,561 active adult clients that had been referred by Family Safety for substance abuse services.

The Substance Abuse Program contracted with the Ounce of Prevention to fund services and provide programmatic and administrative technical assistance to enhance performance outcomes for three intervention and treatment programs, using different program models (Safe Port in Key West, Spectrum in Miami, Mothers in Crisis in Tallahassee). The programs targeted substance abusing women and their families who were at risk of, or involved in, the child protection system. Additionally, in June 2002, two technical assistance publications were produced under the contract to support substance abuse service providers in developing and enhancing services specific to the target group: 1) *Lessons Learned: Serving Pregnant and Parenting Women in Substance Abuse Treatment Programs* and, 2) *Substance Abuse Treatment Programs, Serving Pregnant and Parenting Women, A Replication Manual*. These publications are available on the Department's web site.

Cross-Training

The Substance Abuse Program funded 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*. District 4 conducted the pilot cross-trainings. 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 is available to districts on request.

Fetal Alcohol Syndrome

A statewide fetal alcohol syndrome workgroup was formed with the initial collaboration of the Substance Abuse Program and the Florida Department of Health. A Fetal Alcohol Syndrome (FAS) hearing was conducted in Clearwater, Florida by the National Fetal Alcohol 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. Key members of the U.S. Senate and the Substance Abuse and Mental Health Services Administration (SAMHSA) are currently reviewing transcripts from the proceedings and video from the hearing. Release is pending.

An FAS Resource Guide for Florida professionals and involved families is under development by the Substance Abuse Program and the Florida Department of Health. It is targeted for completion by June 2003. Draft Guidelines for Interagency Collaboration for Working with Substance-Exposed Newborns were developed through the Building Linkages for Healthy Families Workgroup. Guidelines have been disseminated for review and final approval has been targeted for early 2003.

Expansion of Florida's Drug Court System

Florida's drug court has become the centerpiece of the state's attempt to impede the drug-crime-arrest-incarceration cycle. The effective partnerships among the drug court judge, the public defender's and state attorney's office, law enforcement, and community-based treatment

providers has given addicted, non-violent offenders the opportunity to establish a solid track record for getting clean of drugs and staying both drug and crime free in subsequent years. Since July 1998 to November 2002, the number of drug courts have nearly tripled, from 26 to 73, with ten additional drug courts in the planning stage for 2003 *(see Table 1)*.

Table 1

Florida Drug Courts
July 1998 to November 2002

Court	Initial July 1998	Current November 2002	Projected 2003	Percent Increase
Adult	16	39	42	162%
Juvenile	9	22	25	178%
Dependency	1	12	16	1500%

The drug court program has been a tremendous success. Admissions in 2001 were 12,006, a 53 percent increase over admissions in 2000. The number of offenders graduating from the program in 2001 was 4,751, representing a 247 percent increase over the number of graduates in 2000.

Table 2

Admissions & Graduates from Florida' Drug Court Program
2000 and 2001

2000 Admissions	2000 Graduates	2001 Admissions	2001 Graduates
7,830	1,367	12,006	4,751

The Department of Children and Families has a significant role in providing access to treatment services in communities with drug courts. Nearly two out of three clients served by the Department are involved in the community criminal or juvenile justice system.

Methadone and Addictions Medicines

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

- The regulations require all methadone programs approved to provide methadone services prior to March 19, 2001, to be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a condition of continued operation. Methadone programs must now meet new federal opioid treatment standards promulgated under section 8.12 of the regulations and must become accredited by one of four accrediting bodies by May 2003.
- 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 private 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.

- The new treatment standards allow physicians greater flexibility in managing patient care.

Women's Services

The Substance Abuse service delivery system is designed to assist individuals and families to respond to addiction problems at the most optimum level. One of the many special populations served throughout Florida are pregnant women and women with dependent children. Some of these women and their children, receiving state-supported services, are also involved in the Family Safety system. Successful completion of treatment substance free is one of the critical strategies for prevention of child abuse and neglect. Pregnant injecting substance abusers, then pregnant substance abusers are the highest priority population for receiving services supported through federal Substance Abuse Prevention and Treatment Block Grant funds. The block grant requires that unique needs of this population be accommodated within the programs where they receive services. These services include: primary care, prenatal care, gender-specific services, transportation, child care, outreach, screening, testing, counseling for HIV/TB and referral services. Some of the key issues and activities currently underway include:

- The Substance Abuse Program Office remains actively involved in collaborative efforts with the Department of Health's Healthy Start Program to address issues relating to pregnant women who use alcohol and other drugs.
- The Substance Abuse Program Office is still an active member of the Fetal Alcohol Interagency Action Group which brings together state and provider agencies as well as other stakeholders to discuss and plan ways to identify, prevent and improve services to pregnant women who may be at risk for having children with Fetal Alcohol Syndrome or Fetal Alcohol Effects.
- The Substance Abuse Program Office is currently involved in a collaborative effort with the Department of Health to produce a resource manual on Fetal Alcohol Syndrome.
- The Substance Abuse Program Office is actively working with the Florida Department of Health, the Florida Alcohol and Drug Abuse Association and the Fetal Alcohol Interagency Action Group to plan a major conference on Fetal Alcohol Syndrome in June 2003.
- The Substance Abuse Program Office has completed a survey of all statewide women's treatment providers to more adequately determine the extent to which SAPT block grant funds are being used to provide required services to pregnant women in the state of Florida. The surveys have recently been received and the data is currently under analysis.

Substance Abuse and Mental Health Temporary Assistance to Needy Families (SAMH TANF)

The Substance Abuse and Mental Health (SAMH) Temporary Assistance to Needy Families (TANF) Program provides screening, assessment, case management, and treatment services to persons who are having employment and family instability due to mental illness and/or substance abuse impairment. On a local level, the SAMH TANF program is a collaborative effort between the Economic Self-Sufficiency Program Office (ESS) the regional workforce boards and their designees, the ADM district offices, and the treatment service providers. Contracted SAMH TANF staff provide initial mental health/substance abuse screenings and ongoing case

management for clients at one-stop centers throughout the state. The program provides assistance to eligible families so the children may be cared for in their own homes or in the homes of relatives while the parents participate in residential treatment programs. The provision allows the participant to retain the WAGES program cash assistance for up to 150 days while in residential treatment. TANF funds also support services to families in the child protection system.

The Department of Children and Families' Substance Abuse and Mental Health Program Offices have contracted with Florida State University for the purpose of re-establishing infrastructure to support the district and regional SAMH TANF Specialists. The central office SAMH TANF team consists of two Medical Health Care Program Analysts and a Staff Assistant, whose duties encompass:

- the implementation of newly created policies, procedures, guidelines and direction related to the SAMH TANF Program;
- statewide training, technical assistance and ongoing support for SAMH TANF planning, budgeting and legislation;
- coordination with the Florida Council for Community Mental Health (FCCMH), the Florida Alcohol and Drug Abuse Association (FADAA), the Office of Economic Self-Sufficiency as well as the Department's MH/SA Program Supervisors regarding the SAMH TANF planning initiatives;
- assurance that services support the involvement of consumers, families and other concerned citizens, and;
- to provide oversight to ensure that services support at least the first two of four TANF goals.

The TANF SAMH program provided substance abuse treatment services to 5,655 adults and 1,107 children in FY 2001-2002. Some of the outcomes for this population include:

- 68.7 percent of TANF adults were employed upon discharge from treatment.
- 64.2 percent of TANF adults successfully completed treatment.
- 76.9 percent of TANF children successfully completed treatment.

TANF Funding Issues

The Substance Abuse and Mental Health programs were appropriated $24,737,500 in Fiscal Year 2001-2002 to provide TANF services. The Substance Abuse and Mental Health programs received $24,687,500 in TANF funding for Fiscal Year 2002-2003, of which $16.6 million was non-recurring substance abuse funding. The Substance Abuse Program Office has submitted a legislative budget request for FY 2003-2004 to replace $14.7 million with recurring funding to ensure continuation of critical substance abuse treatment services to TANF clients and their families.

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 burden on other forms of public assistance; individuals with substance abuse problems would experience significant waiting periods for needed services and continue to have difficulties 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.

It is important to note that parental substance abuse is a major contributing factor in cases of child abuse and neglect and is one of the key barriers to family reunification. This alone will increase the risk of harm to children, thus increasing the need for state involvement and payment of services to insure the protection of children.

Implementation of Evidence-Based Practice

Peer Review

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 5 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 substance abuse treatment providers to have quality assurance plans.

In order to meet the federal requirement, the Department contracted with the University of Miami 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 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. The mission of the project was to move Florida's drug abuse treatment system towards excellence in client services.

The University of Miami (UM) was selected to be the contractor for the project because of its extensive research background and accomplishments in the area of addiction. The University of Miami is the *Florida Node* for the National Institute on Drug Abuse's (NIDA) Clinical Trails Network (CTN). The major emphasis of the CTN is on research and technology transfer. 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 Alcohol and Drug Abuse Association (FADAA) as subcontractor to UM. 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 received input from stakeholders.

Phase II was implemented in January 2002 and will end in December 2002.

The accomplishments for Phase II are as follows:

- Revised the peer review protocols and data collection instruments developed in Phase I;
- Beta tested the protocols in July 2002;
- Developed the peer review training manual;
- Trained ten peer review consultants;
- Evaluated the peer review training;
- Pilot tested the peer review protocols at two provider sites;
- Completed evaluation of the peer review process;
- Modified the protocols and data collection instruments based on evaluations; and
- Developed the strategy for Phase III.

The peer review process developed in Phase II is a model for other states to follow.

Best Practices

The 2002 Substance Abuse Best Practice Awards program was a competitive application process that was open to all licensed substance abuse prevention and treatment providers. 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. Following is a list of the 2002 winners in each category.

Grand Prize: The Village, Miami: Families in Transition

Treatment Programs:

- First Place: Here's Help, Miami: Substance Abuse Treatment Program
- Second Place: Tri-County Human Services, Bartow: JASA In-Jail Outpatient Program
- Third Place: ACT, Inc., Daytona Beach: Drug Court Program

Intervention Programs:

- First Place: Coastal Behavioral Healthcare, Sarasota: Programa Hispano
- Second Place: Broward Partnership for the Homeless, Ft. Lauderdale: Homeless Assistance Center

Prevention Programs:

- First Place: Memorial Healthcare System, Inc., Miramar: After-School Program
- Second Place: New Horizons Mental Health, Miami: Youth Substance Abuse Prevention Bureau

Innovative Programs:

- First Place: Catholic Charities, Miami: New Beginnings for the Dually Diagnosed

Best Promising Programs:

- ACT, Inc., Daytona Beach: Co-occurring Disorder Treatment Center
- First Call for Help, Ft. Lauderdale: INFOline Service
- First Step, Sarasota: Choices Substance Abuse Treatment Program
- Hanley-Hazelden Center, West Palm Beach: Center for Women's Recovery
- Helpline, Inc., Key West: Teenline Crisis Hotline
- Management Consulting Services, Altamonte Springs: Consulting Services
- Manatee County Girl's Club, Bradenton: Positive Action Living Program for Youth
- Myakka City Community Center: Choices Youth Prevention Program and Work Ethics Program
- People Builders, Palm Harbor: Ambulatory Detoxification Program
- Southwest Florida Addiction Services, Fort Myers: LIFE Family Intervention Program
- STEPS, Apopka: Intensive Aftercare Program

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 25th Annual Substance Abuse Conference held in Orlando in August 2002.

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 area of substance abuse treatment and prevention research. The Consortium consists of policymakers, practitioners, researchers, and consumers who are interested in improving substance abuse treatment services in Florida through better linkage across disciplines. The Consortium is sponsored by the Florida Department of Children and Families (DCF), the Florida Alcohol and Drug Abuse Association (FADAA), and the Suncoast Practice and Research Collaborative (SPARC)/Tampa PIC project at the University of South Florida, Florida Mental Health Institute (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 in Florida 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 four times over the past two years in different locations in Florida. The last meeting was held in Tampa on February 20, 2002. The Consortium is scheduled to meet 2-3 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. One product of the Consortium has been the compilation of a Statewide Research Compendium, which provides a catalogue of all substance abuse research in Florida that is sponsored by federal agencies or by foundations.

Potential Activities for 2003

Ongoing Meetings of the Consortium

The Florida Research to Practice Consortium will meet from 2-3 times in 2003 to develop work plan activities, develop program initiatives, and share information regarding current research and practice trends. One meeting each year has been held during the FADAA Annual Training Conference in Orlando, Florida.

Information Sharing

Compile and catalogue information regarding several ongoing co-occurring initiatives in Florida, including those described at the February Consortium meeting in Tampa (Community Action Grant, FADAA and Florida Council working groups). Key information may include mission statement, current and future activities, products, work plan, and evaluation efforts. This review may also include analysis of gaps and areas of potential overlap or support among existing initiatives.

Survey substance abuse programs (and possibly mental health programs) regarding current practices related to co-occurring disorders. Examples of survey areas may include the types of interventions or curricula that are currently being used in treatment programs, screening/assessment approaches, subpopulations that may need specialized interventions (e.g., women with histories of abuse), gaps in services, and perceived needs for technical assistance/training or programmatic innovations. The courts may also be surveyed in these same areas.

Federal agencies (e.g., CSAT) could be contacted to inquire about co-occurring initiatives that are currently being funded, and any program descriptions or materials that are available from these sites. The Addiction Technology Transfer Centers (ATTCs) might also be surveyed to see what materials are available (e.g., training curricula, treatment curricula, on-line continuing education courses, resource materials) related to co-occurring disorders.

Identification of Research Opportunities

Opportunities should be provided at each Consortium meeting to provide linkages between researchers and practitioners (e.g., related to co-occurring disorders). A workshop at the Annual FADAA Training Conference could focus on connecting researchers and practitioners who are interested in pursuing substance abuse treatment research. A preliminary panel/session could

focus on general issues related to engagement of practitioners in research, followed by breakout groups focused on specific topic areas of interest (e.g., co-occurring disorders, adolescent treatment, gender-sensitive treatment).

Technology Transfer and Implementation

The Consortium could identify an evidence-based practice (e.g., stage-wise treatment of co-occurring disorders, assessment approaches, and medication guidelines) and promote implementation of this practice in Florida. Targeted practice areas might be those identified by the Consortium or through a survey of research, practice, and policy communities in Florida. The new Florida/Alabama Southern Coast ATTC might be engaged in efforts to implement this evidence-based practice approach.

Examination of Public Policy/"Systems Change" Issues

Sponsor policy "forum" activities to examine issues such as financing, licensure/certification, and practice standards related to co-occurring disorders treatment.

Clinical Trial Networks

To date, the efficacy of new treatments for drug addiction has been demonstrated primarily in specialized research settings, with somewhat restricted patient 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. The first is to 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 patient populations. The second is to transfer the research results to physicians, providers, and their patients 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 5-10 community treatment programs (CTPs) that will bring to both the node and the network a variety of treatment settings and patient populations. The Florida Node includes urban and semi-rural areas, and treats a diverse population. The node has considerable expertise in adolescent family treatment, treatment for HIV/AIDS populations, aggressive engagement of drug abusers into treatment, and microanalysis of family therapy clinical process. The five CTPs in the node provide services to over 70,000 patients yearly, with a combined budget of over $1 million, accounting for 22 percent of the state drug abuse treatment.

The third sets of concepts developed by the nodes of the CTN have been submitted to NIDA. Among the 17 concepts is the Florida Node's proposal, Brief Strategic Family Therapy (BSFT). In the first phase of the review process, the BSFT concept was ranked 6th among the seventeen proposals and received very favorable comments. Florida's concept was presented at the national Steering Committee meeting in Denver, Colorado, in July 2001, and will go on to the next stage of concept review.

Professional Development and Training

Under authority of Section 397.321, F.S., the Department of Children and Families' Substance Abuse Program Office contracts with private providers for substance abuse prevention education, training and treatment referrals. The Substance Abuse Program Office provides $307,904 from Substance Abuse Treatment Block Grant money 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 substance abuse clearinghouse.

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 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; 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 curriculum 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 minority populations. FADAA includes State and National model programs designed to meet the needs of a multicultural substance abuse program to be presented at the conference.

The development of a program manual to provide future raining for the Marchman Act, Chapter 397, F.S., "Involuntary Admission Procedures," is currently underway. This essential training will provide professionals in the field of substance abuse, corrections and education with the necessary information regarding the procedure and legal procedures for involuntary admission into substance abuse treatment in the state of Florida.

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 plenaries 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 and 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 ATTC

Substance abuse represents the nation's number one health problem and causes more deaths, illnesses and disabilities than any other preventable health condition. The **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 consumer 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.

With a wealth of knowledge and experience in the field of technology transfer in evidence-based addiction treatment practices, the ATTC network is poised to join forces with NIDA to assist in the accomplishment of the second half of the CTN mission, the transfer of research results to physicians, providers, and their patients. Utilizing traditional and innovative training and technical assistance strategies, the ATTC Network is best equipped to move new knowledge into the field in meaningful and lasting ways.

Florida is fortunate to have a NIDA Clinical Trials Node. The University of Miami, School of Medicine has the research lead, with the participation of several community-based treatment programs (CTPs) located throughout Florida. The Southern Coast ATTC and NIDA Clinical Trial Node met to develop a concept paper in which several interesting issues emerged. Examples of some of those issues to be addressed are as follows:

- Help demystify and facilitate understanding of the research-to-practice process, addressing such questions as: Why does it take so long to move research to practice?
- Be more specialized in providing technical assistance with respect to resources available in the agencies.
- Participate in the Clinical Consultation Workgroup of FADAA, University of Miami, and the Florida Department of Children and Families as they embark on a new peer review process that is founded in the use of research-based interventions.
- Facilitate the use of the manual that is already produced through NIDA and CSAT (TIPS), as well as the NIDA CTN protocols.

- As resources allow, conduct a pilot study of technology transfer methodologies to determine the most effective means of training and sustaining the use of a particular practice/protocol.

Other Key Training Initiatives

- *Substance Abuse Prevention and Treatment (SATP) Block Grant* – The Substance Abuse Program Office is conducting regional training for field staff on block grant management, planning, and performance requirements. The primary goals of these training workshops are to orient new staff to the federal requirements, identify district/region specific issues, and provide a forum for staff input into the planning process.
- *Contracts* – In anticipation of the adoption of the new financial rule, 65E-14, F.A.C., and implementation of systems/procedures for HIPAA compliance, the Substance Abuse and Mental Health Program Offices are developing contract training materials to be used for regional workshops beginning in mid-year 2003.
- *Administrative Rule 65D-30, F.A.C.* – The Substance Abuse Program Office will conduct regional training workshops for district/region licensing and monitoring staff on the major provisions in 65D-30, F.A.C., beginning in mid-year 2003.
- *Performance Improvement/Technical Assistance* – The Substance Abuse and Mental Health Program Offices provide annual performance improvement training for district/region staff and community-based providers on data submission, data management, and performance standards. These training events have facilitated significant improvements in data reporting rates and accuracy over the past three fiscal years.
- *Child Welfare* – The Substance Abuse Program Office, in conjunction with Family Safety, conducts a number of annual training workshops for district/region staff and community-based providers. Training included the topic of fetal alcohol syndrome, and a statewide meeting of family intervention specialists. The Substance Abuse Program will also be presenting several workshops at the statewide Community-Based Care Conference on February 26-28, 2003, in Tampa.
- *Human Immunodeficiency Virus (HIV)* - The University of Miami recently conducted a two-day training in Miami for provider staff working in the forty HIV Early Intervention programs. The substance abuse specialists in the district offices also attended. The training covered federal and state requirements, and a variety of topics surrounding HIV issues. A training manual was produced for and provided for attendees.

Mental Health

Trends and Conditions

Not since the 1966 Community Mental Health Act has the needs of persons diagnosed with mental illness been so much in the national forefront. The seminal 1999 Surgeon General's report on Mental Health explained to the nation the efficacy of providing treatment and supports. Now with President Bush's interest in assisting persons with disabilities this focus has continued. Within the state the demand for services is exceeding the resources and the organizational changes are challenging the capacity of the workforce. The national economic downturn requires that the department, providers and communities to seek new solutions. The challenge is to preserve what is effective and be willing to change practices when evidence points to a better way.

Internal Trends and Conditions

The organizational structure and managerial demands of the department are shifting. One of the major changes is the shift from small districts to a larger regional structure as exemplified by the creation of the Suncoast Region. Staff must now cover broader geographical areas and interact with more local government entities and provider organizations. The span of control is as large as some states resulting in the need for increased competence and efficiencies.

Not only is the department changing the composition of organizational entities, it is also changing the way it does business. In most cases, direct service delivery will no longer be provided by departmental staff. Operations is moving from in-house delivery to contractual arrangements. Managers must change their orientation from supervision and a day to day focus to that of competent mangers of service systems.

Community mental health services have from inception been provided through contracts. However, as the expectations for high quality services increase, with a focus on performance measures and outcomes, and as the array of services expands, it is now apparent that staff responsible for mental health contracts must have excellent skills in public purchasing as well as strong understanding of mental health clinical and system of care requirements. As the Family Safety community-based care program becomes operational throughout the state, the mental health program must ensure that the requirements in the mental health contracts are aligned with community-based care expectations to achieve the outcomes for families. The same type of alignment must be achieved with substance abuse.

The Mental Health Program Offices must be adequately staffed and trained to be able to appropriately work with the system of care. The districts are responsible for the procurement of effective clinical and rehabilitative services. The staff must have the expertise to provide programmatic guidance and monitoring. As the Department continues to improve performance based contracting, case rates and capitation methods of payments, it is imperative that the focus of contracting monitoring expand from the counting of units of service to a focus on access, timely response to needs, family supports, self-directed recovery and personal outcomes.

This re-direction of focus will require staff with expertise in these areas. The Suncoast Region is to some extent the prototype of future regional staffing. However, currently 56 percent of the 27 total staff in the Suncoast region are other personnel services (OPS). The OPS category is not an

appropriate staffing mechanism for the expertise and continuity necessary to maintain and manage systems of care. Throughout the state there are 66 OPS positions critical to the operation of mental health. Consideration should be given to converting these positions to state positions. This action would help stabilize the mental health workforce.

Both nationally and in Florida, states are experiencing a shortage of persons willing to work at the direct care level or even professionally with the population of persons with mental illness. Wages are often low, and the responsibilities are much higher than in other low-salaried positions. Service providers throughout the country are finding that existing staff and newly hired personnel do not have the necessary competencies to implement the new evidence-based practices. States are looking at manpower development and other options to increase the communities' capacity to provide quality services.

Additionally, families need our support. The President's New Freedom Commission on Mental Health cites the annual prevalence figures translate into millions of adults and children disabled by mental illness. *The disability toll can be quantified in a way that cannot be ignored:* when compared with all other diseases (such as cancer and heart disease), mental illness ranks *first* in terms of causing disability in the United States, Canada, and Western Europe, according to a study by the World Health Organization (WHO, 2001). In the U.S., the economy's loss of productivity from mental illness amounts to $63 billion annually (DHHS, 1999). Yet the illness is sometimes invisible to the untrained eye and unfortunately still misunderstood. Stigma is one of the greatest barriers to effective treatment and recovery. Families often find themselves the only source of support for their children, including adult children. The burden can break even the strongest families.

Many parents of children with emotional disturbances also have a severe and persistent mental illness. The mental health service system must be much more responsive to the parenting supports needed by these persons as well as assisting in maintaining relationships to the greatest degree possible. The Department must continue to work with organizations such as the Federation of Families, NAMI, and other mental health organizations to build stronger families.

Services for adults diagnosed with severe and persistent mental illness are also becoming more community based and holistic in approach. Florida is adhering to the national direction of providing evidence-based practices and addressing the necessary personal supports that are essential to recovery. Last year, the Department closed one of its major state mental health hospitals, G. Pierce Wood, in Arcadia, resulting in a loss of 350 state hospital beds. The successful closure of this hospital was possible due to additional services that were established in the catchment area formerly served by this hospital. This 18-county hospital catchment area built a more expansive set of services that focused on acute care and short-term residential programs to promote both individual and community safety, and created a new array of community support options to improve the ability of individuals with severe and persistent mental illness to recover and live safely in the community. The demand for supports for these individuals, especially persons coming to our attention through the criminal justice system, exceeds the capacity to serve.

External Trends

Over the last few years, the communities of Florida have become more concerned about the need for mental health services. In the Orlando area, a group entitled "Partners in Crisis," formed to express their desire to improve services for persons with mental illness. This group includes sheriffs and other interested parties and is especially concerned about the number of persons with

mental illness currently in county jails. Additionally, judges have raised issues about the increasing numbers of persons with mental illness coming through the courts. The Department's experience with increasing demand for forensic hospital admissions underscores these issues and points to the need for a more comprehensive service system in Florida.

The Florida Commission on Mental Health and Substance Abuse issued a report in January 2001 that included in its recommendations that the state expand services to persons who are disabled due to mental illness and develop a program to provide for continuity of care for these individuals across several life domains. Other stakeholder groups are also influential. These groups include the Mental Health Association, the Florida Center for Advocacy for Persons with Disabilities, the State Advocacy Council, State of Florida Mental Health Planning Council, the Florida Council for Community Mental Health and others. Another significant recent trend is the desire expressed by consumers for the state to develop a new service approach known as "self-directed care." This approach would provide more choice, giving the consumer a greater voice in the services and supports that are provided. As a result of the advocacy by consumers and their families, a pilot program for self-directed care is being implemented in District 4.

Over the years Medicaid has assumed a key role in funding community mental health services. Currently over fifty percent of the services are paid directly by Medicaid. More and more of the mental health general revenue has been transferred to Medicaid to provide the federal match. These public policies have resulted in obtaining higher levels of federal reimbursement which is commendable. Unfortunately, they have had some unintended negative consequences. Diversion of the scarce state mental health dollars to support federal match leaves fewer resources to provide critical services not reimbursable by Medicaid or to serve individuals not eligible for Medicaid coverage. Concerns have been raised by parents that they can no longer access residential care due to the funding shift to Medicaid. Without Medicaid, adults cannot access necessary medication and professional treatment. Individuals with Medicare are also without coverage for pharmaceuticals. These individuals often become more ill resulting in uncompensated care in hospitals or in state funded crisis beds or hospitals.

Actions taken by Medicaid have a profound impact on the program and services received by persons with mental illness. Increasingly, Medicaid has been required to implement actions to contain costs. Developing managed care options is one way to address cost containment. Nationally, states are turning away from the traditional capitation model used in the 1990s and are developing hybrids in which the states have a higher degree of control and which limits the possibility of profits leaving the state instead of being reinvested into services. States such as Michigan and Pennsylvania have given their existing systems of care the first opportunity to operate the managed care programs. Section 394.9082, F.S., provided the Department and Medicaid an opportunity to demonstrate ways to manage costs and blend services to improve access and care. Two projects are being implemented this year, one in District 1 and one in District 8.

The President's New Freedom Initiative and the Commission on Mental Health

President George W. Bush has declared his support for people with mental and physical disabilities, pledging to "tear down" barriers to equality that face many of the 54 million Americans with disabilities. On February 1, 2001, President Bush announced *The President's New Freedom Initiative.* In so doing, 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 into daily community life.

The President signed an Executive Order on June 18, 2001, supporting community-based services and programs for individuals with disabilities. This Executive Order directs key federal agencies to work together and with states to ensure full compliance with the Supreme Court's ruling in the Olmstead case (1999) and the Americans with Disabilities Act of 1990. In response to the Executive order, the Center for Mental Health Services established a National Coalition to Promote Community-Based Care and awarded Florida (and all states who applied) a small grant of $20,000 to facilitate necessary partnerships with key stakeholders and service delivery systems and build coalitions to promote community-based care. The Mental Health Program Office has been using this money to assist in its statewide supported housing initiative in partnership with the University of South Florida.

One component of the President's plan to promote full access to community life is the establishment of *The President's New Freedom Commission on Mental Health* on April 29, 2002. The Commission's task is to study the United States mental health service delivery system, including both the private and public sector providers. The Commission will then advise the President on methods to improve the system so that adults with serious mental illness and children with serious emotional disturbances can live, work, learn, and participate fully in their communities. This President's Commission is the first comprehensive study of the nation's public and private mental health service delivery systems in nearly 25 years and is to be completed in April, 2003. An interim report from the Commission was submitted to the President in October 2002.

The interim report indicates that the mental health system is in need of reform to diminish fragmentation and promote recovery. The Commission identified barriers to quality care and recovery. Some relate directly to the service delivery system itself, such as fragmentation and gaps in care for children, adults and older adults. Others reward dependency such as through a mix of inadequate rehabilitation and disincentives to work. Still others reflect a failure to make mental health a national priority. In its next phase of work, the Commission will be addressing ways to break down these barriers to recovery.

One such barrier identified by the President himself is the stigma associated with mental illness. The Mental Health Program Office is pleased that Florida has been selected (along with seven other states) by the federal Department of Health and Human Services and the Center for Mental Health Services to participate in a three-year project designed to assist states, through public education and information campaigns, in reducing the discrimination and social stigma commonly experienced by children and adults with mental illness. The planning for this project is scheduled to begin in January 2003.

Health Insurance Portability and Accountability Act (HIPAA)

The national Health Insurance Portability and Accountability Act (HIPAA) legislation will also have a major impact on health and mental health services in the states. The major provisions of HIPAA as they currently exist are:

- Standardization of financial transactions for all health providers. A standard transaction format will be used for any billing. This will change the way the mental health office receives data from providers as well as how they will be transmitting billing information to other

payors, such as insurance companies, Medicaid and Medicare. Medicaid will be reducing the number of valid service codes.

- Establishment of new standards for the privacy of client information and consent standards for its release. This includes records access by the patient and control of the release of their records to other individuals. A major impact is a change in the consent forms currently being used.

- Establishment of national standards for the transmission and security of data files. This will affect providers, the Department and other payors, including Medicaid. There are new tougher standards for who can have access to client information.

Early Intervention and Family Support

The recent studies in brain development of infants and young children have had a major impact on our understanding of social and emotional development. The National Research and the Institute of Medicine published a compilation of information on the importance of early childhood development entitled "From Neurons to Neighborhoods" (2000). This book clearly shows that addressing the social and emotional needs of very young children is essential. Children's early development is dependent upon the health and well being of their families. Unfortunately many children suffer the impact of untreated mental health and substance abuse disorders of their parents and exposure to both family and neighborhood violence. These children, often burdened with multiple risk factors, are very likely to develop serious emotional and behavioral problems in the future. The current knowledge of the impact of trauma and the above factors indicate that mental health interventions must be available to young children and their families.

Families are becoming organized as a result of several initiatives across the state. The National Alliance for the Mentally Ill (NAMI) Florida began targeting families of young children in 2000. Their services have included creation of training materials and distribution of information specifically for parents of young children with serious emotional disturbance. At the same time, Florida Institute for Family Involvement (FIFI), the Florida chapter of the Federation of Families has made a concentrated effort to establish local chapters across the state. It is expected that this united voice of families will continue to grow.

Clients Served

During FY 2002-2003, Florida's program of services for persons with mental disorders continues to provide treatment and supportive services for children and adults in the legislatively established target populations. The target populations are: children with serious emotional disturbance (SED), children with emotional disturbance (ED), children at risk of mental health problems, adults with serious and persistent mental illness (SPMI), adults in crisis, and adults in community forensic status.

Clients Served by Community Mental Health Providers in FY 2001-02

	Children's Mental Health				Adult Mental Health			
District	SED	ED	At-Risk of MH Problems	Unduplicated Total Kids	SPMI	In Crisis	Community Forensic	Unduplicated Total Adults
1	2,567	1,492	250	4,309	4,856	4,360	63	9,279
2	2,551	1,610	84	4,245	4,201	3,244	107	7,552
3	2,673	778	68	3,519	3,270	1,971	75	5,316
4	4,030	1,907	139	6,076	5,577	3,920	225	9,722
7	6,023	2,557	410	8,990	4,638	16,068	104	20,810
8	1,615	1,249	190	3,054	2,475	3,290	62	5,827
9	1,709	1,049	107	2,865	2,097	1,668	30	3,795
10	3,181	1,532	447	5,160	6,823	3,273	77	10,173
11	9,390	4,402	275	14,067	11,677	8,647	259	20,583
12	2,082	858	116	3,056	2,190	1,663	100	3,953
13	2,346	1,170	79	3,595	2,731	3,088	69	5,888
14	1,933	2,259	387	4,579	3,953	3,809	52	7,814
15	2,129	948	89	3,166	1,334	2,533	35	3,902
23	8,021	4,257	758	13,036	20,623	6,526	541	27,690
Statewide*	48,785	25,667	3,351	*77,803	75,298	62,995	1,717	*140,010

* Statewide represents an unduplicated count of clients, not a cumulative total of district served numbers. This is due to some clients being served in more than one district.

Fiscal Year 2002-2003 Funding

The table below depicts Fiscal Year 2002-2003 funding for mental health services.

Mental Health Services Funding for Fiscal Year 2002-2003

	ADULT COMMUNITY MENTAL HEALTH	STATE MENTAL HEALTH TREATMENT FACILITIES (ADULTS)	CHILDREN'S COMMUNITY MENTAL HEALTH	PROGRAM MANAGEMENT & COMPLIANCE	TOTAL
GENERAL REVENUE	**$212,498,742**	**$192,540,780**	**$66,899,000**	**$7,098,586**	**$479,037,108**
OTHER STATE FUNDS	**$13,103,668**	**$68,073,923**	**$5,925,964**	**$429,198**	**$87,532,753**
FEDERAL TRUST FUNDS					
ADAMH TF (MH BG)	**$19,480,914**		**$9,382,756**	**$450,849**	**$29,314,519**
TANF (FGTF)	**$8,000,000**				**$8,000,000**
Other Federal Grants TF	**$14,212,869**		**$13,945,227**	**$2,049,441**	**$30,207,537**
TOTAL FED TRUST FUNDS	**$41,693,783**		**$23,327,983**	**$2,500,290**	**$67,522,056**
TOTAL	**$267,296,193**	**$260,614,703**	**$96,152,947**	**$10,028,074**	**$634,091,917**

Mental Health Strategic Directions

Improving the System of Care for Persons with Mental Health Disorders

Issue Summary:

In order to manage serious chronic conditions of all types, the more advanced health care organizations are realizing the need for a systems-based design to address the interactions of cost and clinical quality drivers over the entire course of care and throughout all the components of care. It is within this interaction of costs and quality that efficiency and effectiveness can be achieved. Continuity of care is the central feature of this system. All the components are linked into an integrated whole, eliminating duplication of care, administrative costs, and unnecessary practices and procedures. This continuity must exist at every stage in the array of services from diagnosis, acute care, psychiatric rehabilitation, counseling, and family and individual supports. Strategies to develop a well-designed system of care must align structure to support the system, skills to enable successful implementation, and a receptive culture to encourage (and not deter) the system's development and operation. The Mental Health program estimates that the transition from a component-based fragmented set of services to a system of care could take over three years.

Vision

- The Mental Health Program Office worked with its many stakeholders to construct a vision of the system of care that is the product of an ongoing exchange of ideas, interests, and concerns about the current system of care. Community partners and local officials, individuals, family members and Department staff jointly crafted this vision to guide the design of a more efficient, responsive and effective system. The vision encompasses:
  - Integration across service components.
  - Easy access to care.
  - Resources focused on the most vulnerable persons.
  - Service responsiveness determined by individuals' needs rather than financial reimbursement codes.
  - Instituting evidence-based practices.
  - Development of provider networks.

Strategic Course of Action 2000-2003:

- Improve both the service array and quality of services for children who live with their families or relatives.
  - Expand services for children with serious emotional disturbances who live with their families or relatives. Work with the Agency for Health Care Administration, Children's Medical Services, and the Legislature to expand the Child Health Insurance Program for

children with serious emotional disturbances and improve in-home services, family supports and wrap-around programs for this population.

- Review the system of care currently in place for the Child Health Insurance Program to ensure that it addresses the needs of the children and families and provides appropriate linkages with the regular Healthy Kids Program and the other components of the service system.

- Use provider networks to coordinate and integrate care. This strategy has already been discussed in the subsection entitled, "Pilot Behavioral Health Service Delivery."

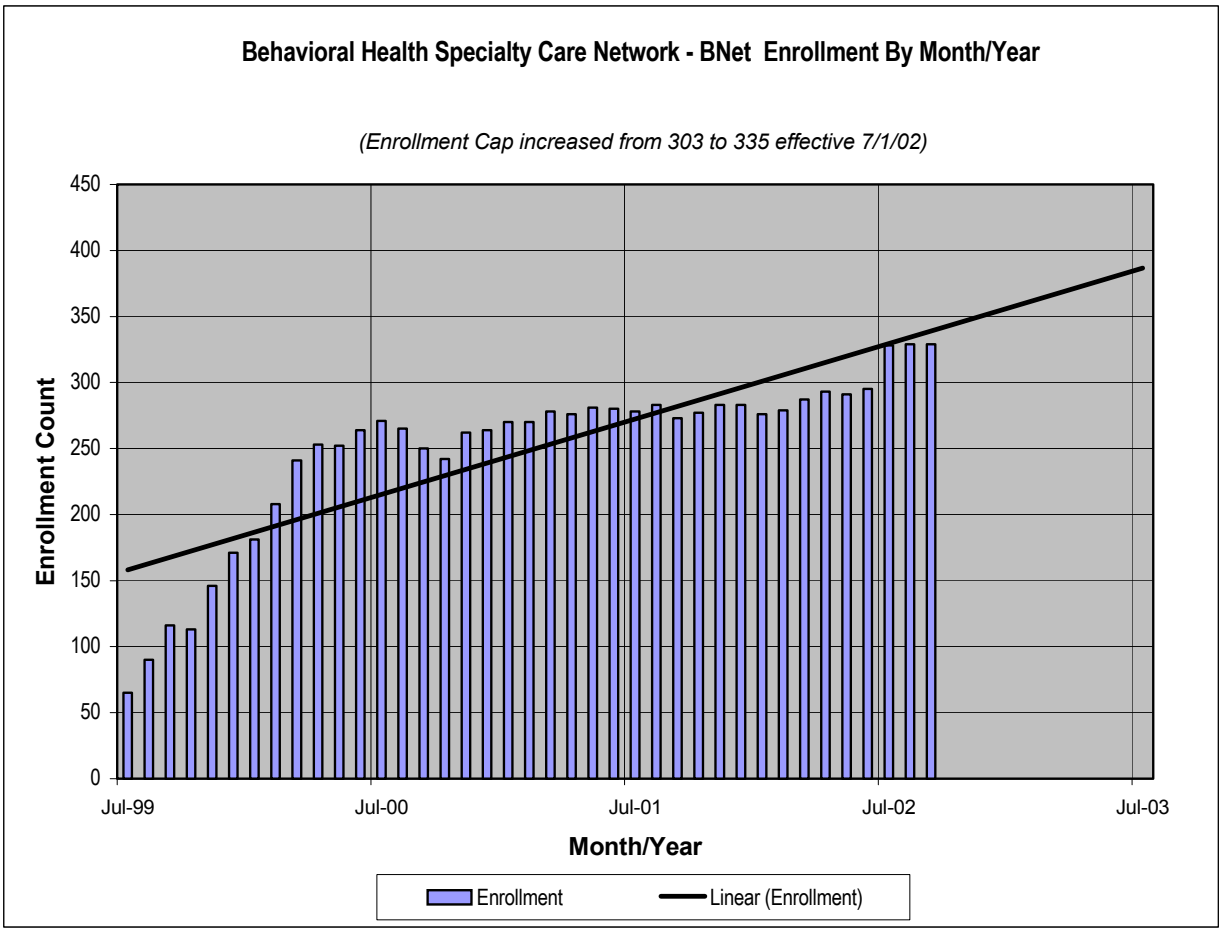
Progress To Date:

- **Behavioral Health Specialty Care Network (BNet)**

  During the 1998 session, the Florida Legislature enacted the Florida KidCare Act, the authorization for the state's Child Health Insurance Program under Title XXI. One provision of the legislation created the authority for the Department to develop and administer the Behavioral Health Specialty Care Network, known as "BNet". BNet provides behavioral health services for low-income children with severe mental health or substance abuse problems whose families have no health insurance for them and therefore are eligible for and become enrolled in KidCare.

  The BNet benefit package is comparable to the mental health and substance abuse services covered in Florida's Medicaid plan. In addition to that range of services, the BNet projects are able to recommend and offer individualized treatment services, known as alternative services, that support children with high-level needs and enable families and schools to keep these children out of more restrictive levels of care. Alternative services include individualized wraparound services, intensive case management, respite, family support, and other individualized services and supports.

  In 2001, the Department and AHCA jointly contracted with FMHI to conduct an evaluation of the district level implementation of BNet. The evaluation report published in July 2001 found that, while there was a high degree of satisfaction among both parent and district interviewees regarding service comprehensiveness and quality, findings were mixed regarding the use of flexible wraparound" services. The evaluation report recommended providing additional technical assistance in the effective use of individualized services.



Continued Course of Action:

- Continuing to track and provide technical assistance to service providers in the use of individualized wraparound services for children and their families served by the BNet program.
- To continue to address those findings, the Central Office BNet staff conducts regional training sessions with the contracted BNet providers to provide on-site technical assistance reviews that focus on enhancing the use of alternative services. BNet staff also tracks the use of alternative services through monthly provider reports.
- Services have been expanded through BNet to serve children with serious emotional disturbance and/or substance abuse problems who are living with their families.
- For FY 2002-03, an additional 32 slots have been added to bring the total number to 335.
- Implementing the pilot systems of care described in this report under the subsection entitled, "Pilot Behavioral Health Service Delivery."

- Developing a service delivery design with Medicaid to maximize federal reimbursement and promote integration of care.

Integration of Children's Mental Health Services for Families Served by the Family Safety Program

Issue Summary:

- Children subjected to abuse or neglect and removed from their families are at high risk of emotional and behavioral problems. Because of their high incidence of mental health problems, these children need to receive professional assessment and timely, quality treatment at levels appropriate to the severity of their conditions.

Strategic Course of Action 2000-2003:

- Analyze the unmet needs and existing interfaces between Family Safety and Children's Mental Health offices to determine where there are opportunities for better integration of services.
- Develop operating procedure, CFOP 155-10, that more fully integrate services for the children and families both programs serve.
- Re-design the Children's Mental Health system of care to ensure that children in the custody of the Department access quality mental health services consistent with the children's needs and within the mandatory timelines imposed by statutes and the courts.
- Expand the Specialized Therapeutic Foster Care Program and successfully implemented Behavioral Health Overlay Services.

Progress to Date:

- The Mental Health and Family Safety programs, in conjunction with the districts, reviewed existing practices and determined a more structured approach should be used statewide in the delivery of mental health services for children in the Department's custody. Together, the two programs drafted a uniform procedure intended to ensure more fully integrated services for children in the Department's custody who are served by both programs.
- The new Operating Procedure, CFOP 155-10, - Mental Health Services for Children in the Custody of the Department - was promulgated on August 7, 2002.
- CFOP 155-10 has fully implemented section 39.407, F.S., which provides specific requirements for placement of children in the Department's custody into the more restrictive residential mental health treatment levels and for frequent impartial reviews of their need for continued stay. These requirements include a suitability assessment of the child by a qualified evaluator, a Florida-licensed psychiatrist or psychologist under a contract through the Medicaid program and who has no conflict of interest with a residential treatment program. The procedures give guidelines for Family Safety to use in making an initial determination of whether the child should be referred for such an evaluation.

- The procedures give specific instructions on the respective roles of Family Safety, Children's Mental Health and the single point of access throughout the process of referral, assessment, placement, treatment and discharge of the child from a treatment program. The procedures assign responsibilities for making the statutorily required reports to the court within the mandatory timelines imposed by statutes and the courts.
- A key component of the new system design is the establishment of a single point of access (SPOA) in each geographic area of the state to assist Family Services counselors in accessing mental health services for children in foster care. The SPOA has been fully implemented in each of the districts/region. These individuals provide a smoother gateway to mental health assessments and services and ensure that service providers are being responsive to the special needs of these children, especially regarding their permanency goals.
- To better evaluate whether children in the Department's custody are receiving the mental health services they need, the Mental Health Program Office has designed an automated statewide database to track assessed needs, the resulting referrals for mental health services, and the subsequent services provided. Every child in shelter care is eligible for and must be provided a Medicaid-funded comprehensive behavioral health assessment. These assessments provide in-depth, detailed information about the child's emotional, social, behavioral, and developmental functioning within the home, school, and community, including direct observation of the child in those settings. The assessments are used to provide recommendations to accomplish permanency planning and to help develop an individualized, strength-based case plan. The single-point of access tracks the progress of referrals for these assessments and for services and provides regular reports to both the Family Safety and Mental Health district program offices.
- Two programs designed specifically for children in the state's custody and funded through the Medicaid program are:
  - **Behavioral Health Overlay Services** are mental health and substance abuse services designed to meet the treatment needs of children placed in Family Safety's residential group care facilities. The intent of these services is to improve a child's mental status, emotional and social adjustment, and support the child in the current setting to avoid a more intensive level of care. Children's Mental Health, Family Safety, and the Agency for Health Care Administration have developed provider designation procedures to facilitate a methodology for planned program development statewide. During FY 2001-2002, there were 3,822 children/youth who received Behavioral Health Overlay Services.
  - **Specialized Therapeutic Foster Care** is a therapeutic program that provides intensive, effective, community-based mental health treatment to children in the care and custody of the state. Specially trained foster parents are available 24 hours a day to provide therapeutic interventions for children with severe emotional and behavioral problems who would otherwise need to be placed into much more expensive and restrictive residential treatment programs. During FY 2001-2002 there were 734 children served in Level I homes and 526 served in Level II homes, for a total of 1,260 children served.
- **Statewide Inpatient Psychiatric Program (SIPP)** serves Medicaid eligible high-risk youth who have been determined to require psychiatric inpatient residential services to appropriately address their complex mental health needs. The Florida Legislature authorized the Agency for Health Care Administration to request a federal waiver and amend the state Medicaid plan to provide a statewide inpatient psychiatric program (SIPP) for Medicaid-eligible children in need of such services. The SIPP initiative was implemented January 1, 2002, with providers selected through a request for proposal process in each of the

Department's districts/region. Children with Medicaid coverage, who have a serious emotional disturbance and meet criteria for placement into this intensive level of treatment, may be prior authorized by AHCA for such treatment. Implementation of this program provides this service for Medicaid-eligible children, including both children in the Department's custody and those living with their families. There are 395 SIPP beds available for Medicaid-eligible children. It also frees up some residential treatment funding in the existing general revenue budget that may be used to serve additional non-Medicaid eligible children living with their families who need this level of treatment.

- **Therapeutic Group Care (TGC)** are intensive community-based mental health services provided in a foster care setting for children in the care and custody of the state who have emotional disturbances, and who meet certain clinical eligibility criteria. TGC services provide placement options for children and youth ready to step-down from more restrictive residential placements and for those who require more intensive community-based services to avoid placement in a more restrictive setting. Treatment includes psychiatric, psychological, behavioral and psychosocial services. There are 167 Targeted Group Care beds. During fiscal year 2001-2002, 310 children were served in the Targeted Group Care program.

Continued Course of Action:

- The Department has begun to implement a formal Quality Review process of the single point of access within each district/region. The review will be conducted in each district during 2002-2003.
- The Mental Health Program will work with Community Based Care to ensure integration of services as the Department privatizes Child Welfare Services.
  - Participating in joint quality assurance reviews of and provide technical assistance to CBC lead agencies in the integration of children's mental health services with the child welfare services they provide.
  - Expand the use of the comprehensive behavioral health assessment to all children served by the CBC lead agencies and placed in out of home care.
  - Participating in regularly scheduled meetings and conference calls between CBC lead agencies and Department level CBC staff.
  - Developing new strategies in family and systems integration and presenting these at state and national level conferences.
  - Meeting monthly with CBC Department staff to identify and address areas that will enhance service coordination to the children and their families that the CBC lead agencies serve.

Closure of G. Pierce Wood State Hospital and Define the Role of State Hospitals

Issue Summary:

The 2000 Legislature determined that the G. Pierce Wood (GPW) State Hospital would close on April 1, 2002. The hospital phase-down took place gradually with admissions stopping on July 1, 2001. The Department worked with stakeholder planning teams and developed a three-pronged planning process for the closure around the content areas of facility utilization, community

development, and G. Pierce Wood closure. The hospital completed all patient transfer and discharges ahead of schedule on February 8, 2002.

Strategic Course of Action 2000-2003:

- Used 50 vacancies at South Florida State Hospital.
- Convert 100 Florida State Hospital civil beds to serve persons placed under Chapter 916, F.S.
- Improve utilization management statewide to assure admissions are appropriate and discharges are prompt.
- Re-align hospital catchment areas.
- Close 50 beds at Northeast Florida State Hospital.
- Introduce additional short-term residential treatment beds in GPW area.
- Expand assertive community treatment team services in the GPW area.
- Introduce additional residential beds in the GPW area.
- Secure job placements for GPW employees.
- Reduce GPW census.
- Maintain a safe environment at GPW by monitoring "significant reportable harmful events".
- Reduce GPW staff positions according to schedule.
- Develop a comprehensive discharge process for persons moving from the hospitals to the community and a database to follow their progress.
- Implement at least 69 short-term residential beds before admissions are diverted to other hospitals.
- Develop additional crisis stabilization capacity, residential capacity, and other supports in the catchment area.

Progress to Date:

- Residents transferred from Florida State Hospital have filled the 50 vacancies at South Florida State Hospital.
- 100 additional civil beds at Florida State Hospital were converted to accommodate forensic "step-down" clients for a total of 250 beds.
- A utilization management system assuring appropriate admissions and prompt discharges was designed with a reporting format. A database was developed to track indicators and set targets for bed use.
- The hospital catchment areas were re-aligned in July 2001 and again adjusted to move District 14 to South Florida State Hospital.
- The number of beds at Northeast Florida State Hospital was reduced by 59 to a total of 543 beds.
- An additional 107.5 short-term residential beds (community-based) were created in the G. Pierce Wood area by November 2001.

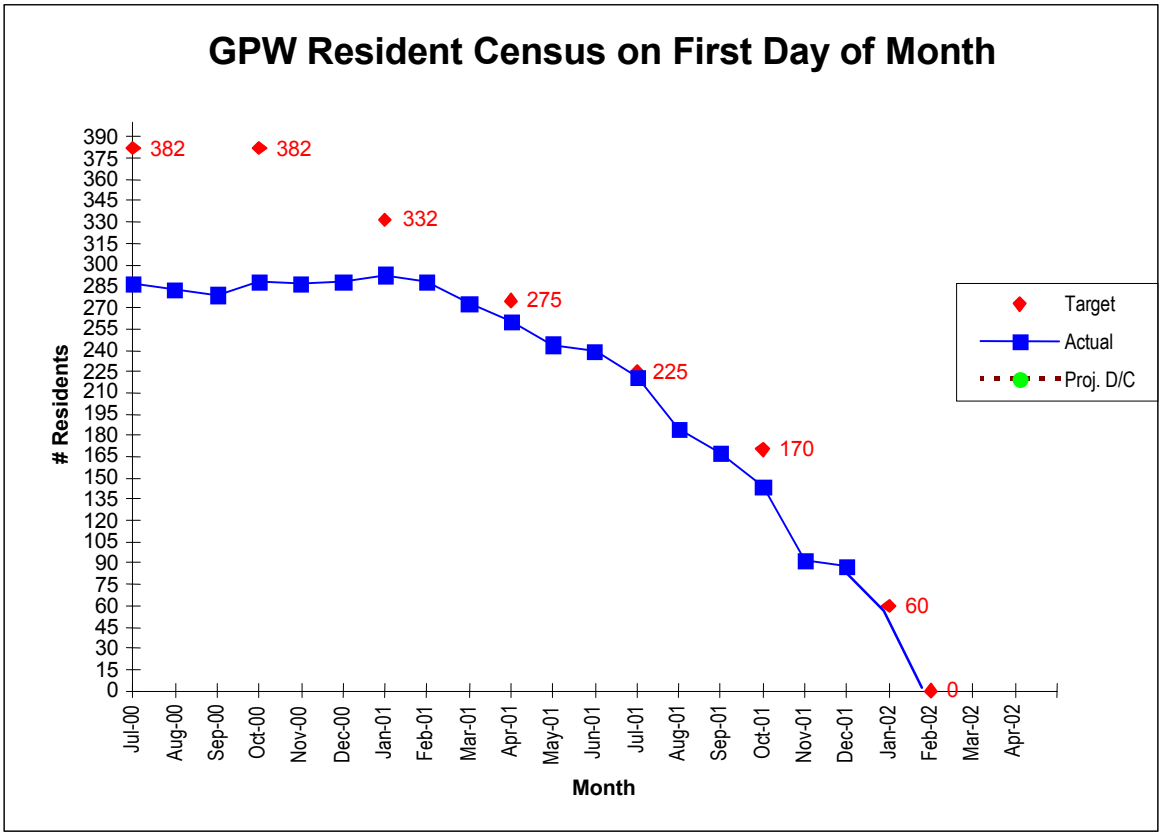
- Assertive community treatment team services were expanded in the GPW area from five teams to 11, with the capacity to serve up to 1,100 individuals with severe and persistent mental illness. All 11 teams are fully operational, with one of them designated as a forensic team in the Sun Coast Region.
- Additional community capacity was created to accommodate persons being discharged from the hospital and to divert persons in the community from being hospitalized. The following activities were accomplished:
  - Developed 168 community residential beds;
  - Increased crisis stabilization beds by 34.5 percent;
  - Increased capacity of supported living and in-home supports to serve 467 individuals;
  - Increased housing assistance capacity to serve an additional 185 persons; and
  - Increased the capacity of system of care by adding community support services, such as supported employment, case management, medication management, and physician services. The following table provides a summary of expanded services in the GPW catchment area. Please note, the table includes only new services and does not show the previously established service capacity.
- The system redesign initiative in the former GPW catchment area resulted in an increased capacity and more effective community integration for persons served by the publicly-funded mental health system. Major expansion occurred in the development of acute care and sub-acute care as well as in supported housing/supported living. Highlights of expanded services in districts included in the former GPW catchment area are shown in the following table.

Summary of Expanded Services in

Former G. Pierce Wood State Hospital Catchment Area

Service Type	Additional Beds/Served	Counties Served
Acute Care – Crisis Stabilization Unit (CSU)	34.5	Pinellas, Pasco, Sarasota, Hillsborough, Lee, Collier, Charlotte, Hendry/Glades, Polk, St. Lucie
Sub-Acute Care - Short-term Residential Treatment Facility (SRT)	107.5	Pinellas, Hillsborough, Manatee, Lee, Collier, Charlotte, Polk, St. Lucie
Mobile Crisis Teams (3 new teams & enhance 2 existing teams)	----	Lee, Collier, Hendry/Glades, Charlotte, Polk, Highlands, Hardee
Group Homes	56	Pasco, Hillsborough, Lee, Collier, Charlotte, St. Lucie
Supervised Apartments	14	Polk, Highlands, Hardee, Martin, Okeechobee
Adult Foster Care	77	Sarasota, DeSoto, Pinellas, Pasco, Hillsborough
Specialized Housing	11	Manatee, Sarasota
Supported Living/In Home Supports	467	Pinellas, Hillsborough, Manatee, Pasco, Sarasota, DeSoto, Lee, Collier, Charlotte, Hendry/Glades, Martin, Okeechobee, Indian River, St. Lucie
Housing Assistance	185	Lee, Collier, Charlotte, Hendry/Glades
Drop In Center (Expand existing Centers and add 1 Center)	----	Pinellas, Hillsborough, Pasco, Sarasota, DeSoto, Lee, Collier, Charlotte, Polk, Highlands, Hardee, Martin
Substance Abuse (includes Dually Diagnosed)	10	Hillsborough, Highlands, Avon Park
Family Emergency Treatment Center	----	Pinellas, Polk, Highlands, Hardee
FACT [6 new teams (1 forensic) & enhance existing teams]	----	Pinellas, Hillsborough, Collier, Charlotte, Polk, Highlands, Hardee, Martin, Okeechobee
Medication Management (IDP) & Physician Services	---	Pinellas, Hillsborough, Pasco, Sarasota, DeSoto, Manatee, Lee, Collier, Charlotte, Hendry/Glade
Sheltered Employment Supported Employment	----	Pinellas, Sarasota, Lee, Collier, Charlotte, Polk, Highlands, Hardee, St. Lucie, Martin, Indian River, Okeechobee
Mental Health Court	20 slots	Lee
Geriatric Services	----	Lee, Collier
Forensic Services	----	Hillsborough, Pinellas, Polk, Highlands, Hardee
Day Treatment	----	Polk, Highlands, Hardee
NAMI: Family Resource Specialist Peer to Peer Compeer Family to Provider Personal Outcome Measures	----	Lee, Hendry/Glades, Collier, Charlotte
Outpatient – Individual and Group	——	Martin, St. Lucie, Indian River, Okeechobee
Case Management	----	Lee, Hendry/Glades, Collier, Charlotte, Polk, Highlands, Hardee
Contingency Funds for needed additional services as identified over time including Behavioral Programming & Psychotherapy	----	Pinellas, Hillsborough, Pasco, DeSoto, Sarasota, Manatee, Hardee, Polk, Highlands

- For GPW employees, job placement activities were established. Activities included job fairs, establishing a one-stop center on campus, posting job advertisements from area newspapers, conducting face-to-face interviews with employees to determine who needed help in transitioning successfully, and providing classes to improve interviewing and job hunting skills and résumé development. As a result of the varied and creative job placement activities, 638 employees found employment. The majority were placed with the Department of Juvenile Justice, the Sexually Violent Predator Program, the Economic Self Sufficiency Program, Gulf Coast Center, Mental Health providers, and other DCF programs, state agencies, and private/public sectors. This represents over half (65.6%) of the FTE population. On February 28, 2002, 135 employees were laid off.
- Resident census for GPW has remained below the established targets throughout the closure process. The following graph shows the actual hospital census and the projected (targeted) census from July 2000 to the hospital's closure. The hospital completed all patient transfers and discharges on February 8, 2002. A total of 90 residents were transferred to other Florida state hospitals with the remainder discharged to the community.



- A safe environment at GPW was monitored through "significant reportable harmful events" reports. These events remained below the targets established for the closure process with the exception of two months. During those two months, staff investigated the issues and followed up with corrective action plans. There were no significant harmful events reported during the final two months of the closure.

- GPW staff positions were reduced according to schedule.
- The Mental Health Program Office developed a comprehensive discharge process for persons moving from the hospitals to the community and a database to follow their progress.
- The Mental Health Program Office in conjunction with key stakeholders from the planning teams developed an integrated discharge process for transitioning people from the G. Pierce Wood Hospital to the community. This process included those activities prior to discharge/transfer as well as continuity of care activities after the person was discharged or transferred. The process clarified roles and responsibilities of hospital and community staff, and facilitated a successful discharge and community integration. The process identified tasks with associated timeframes for completion that placed greater responsibilities on community providers. While the integrated discharge process initially was developed for persons being discharged from GPW, it has been expanded to the catchment area served by Atlantic Shores (South Florida State Hospital).
- The Mental Health Program Office developed a discharge tracking database to follow the progress of each person discharged to ensure linkages were maintained between the hospital and the community providers. Weekly conference calls were held between the hospital, districts and the Mental Health Program Office to facilitate a smooth transition to the community and to identify barriers and facilitate successful discharges. Further, the Mental Health Program Office hired one high-level staff person to oversee the closure activities of GPW and the associated community development activities. This position worked in consultation with Mental Health Program Office staff who were assigned to assist in the hospital's closure and subsequent community activities.
- Through June 30, 2002, residents discharged into the community received follow-up visits at least weekly by The Outreach Program (TOP) for three months to monitor their progress and work with community case managers to alter services when appropriate to better meet client needs. TOP coordinated the transfer of the management of client services to community case managers. The Central Office staff continues to track and monitor client progress. Tracking was facilitated through the submission of monthly reports from the districts/region, including follow-up calls if necessary, regarding specific clients who needed closer monitoring and assistance to promote success within the community. Quarterly reports are submitted for a more comprehensive tracking and monitoring of all clients.

Continued Course of Action for GPW Closure:

- $29.3 million in recurring dollars continues to support the expanded services for those individuals discharged into the former GPW catchment area.
- An additional $18 million was appropriated to annualize services that were phased in during FY 2001-2002.
- The persons discharged from GPW after January 2001 will be tracked quarterly,
- Analysis will be completed of persons placed in state hospitals who were at GPW during the closure period.

Define the Role of State Mental Health Treatment Facilities

Issue Summary:

There are five state mental health treatment facilities (also known as mental health institutions/state hospitals) operated by the Department of Children and Families in Florida.

Facility	Operating Bed Capacity	
	Civil	**Forensic**
Florida State Hospital	486	500
Northeast Florida State Hospital	553	0
North Florida Evaluation and Treatment Center	0	217
South Florida Evaluation and Treatment Center	0	200
South Florida State Hospital/ASH	325	0
TOTAL	1,364	917

An increasing number of individuals with forensic commitment are being transferred from forensic facilities in to the civil population because they no longer require the security of a forensic placement. These beds have been designated as step-down beds. Of the total 1,364 civil beds, 388 are designated as forensic step-down beds, which includes 256 at Florida State Hospital, 72 at Northeast Florida State Hospital and 60 at South Florida State Hospital/Atlantic Shores.

The role of the state mental health treatment facilities is to serve individuals with severe and persistent mental illness who require a blend of treatment, rehabilitation and support services. It is necessary for all aspects of the facilities – policies, administration, clinical practice and direct care – to be coordinated and focused. This focus is based on the belief that with appropriate services, individuals with a mental illness can learn to manage their symptoms, overcome or adapt to their illness and develop or recover functional skills. Participation in these programs should enable them to realize significant improvements in their quality of life and facilitate return to their community, or to proceed through the judicial process, as early as possible.

Continued Course of Action:

- Complete an analysis of persons placed in state hospitals from GPW at closure and later from the GPW catchment area.
- Complete an analysis of persons with traumatic brain injury, medical complexities, and the elderly to determine appropriateness of placements.
- Complete bed and community resource comparative analysis with other states.
- Review the success of Short Term Residential Treatment Programs.
- Develop state hospital role definition and service delivery plan for inclusion in January 2004 plan.

Implement Evidence-Based Practices for the Most Vulnerable Persons with Mental Health Disorders

Issue Summary:

The United States Surgeon General's Report on Mental Health indicates there is a range of well-documented efficacy treatments for most mental disorders. These evidence-based treatments have proven to be more effective than treatments for cancer and heart disease. Scientific research on the brain and behavior has developed at an extraordinary pace. A range of effective treatment for most mental and behavioral disorders that occur across the life span have been introduced. Two broad types of intervention include psychosocial treatments and psychopharmacologic treatments. Often these interventions are most effective when combined. Evidence-based and best practices services for adults include Assertive Community Treatment (ACT) supported employment, supported housing, and consumer-directed services. Services proven effective for children include individualized wraparound approaches to service planning and delivery, with in-home services and family supports.

Strategic Course of Action 2000-2003:

- Establish ACT teams, strength-based case management, supported employment, transportation, access to medication and housing in the community for adults with severe and persistent mental illness. The following actions will be taken:
  - Continue with the implementation of the ACT Teams. Fully staff the Mental Health Program Office to provide the necessary supports to the ACT teams and continue with the FACT training and technical assistance. Establish benchmarks and monthly reporting mechanisms to track progress.
  - Improve case management through a partnership with Medicaid regarding targeted case management, rule modification, training and technical assistance. Continue to develop independent case management options.
  - Refine the cooperative agreements with the office of Vocational Rehabilitation Services at the Department of Education to strengthen the supported employment approach. Focus 50 percent of the time of one staff person in the program office to develop and implement supported employment initiatives. Look for opportunities to obtain grant support for pilots, training, and conferences to change practice and expectations regarding work.
  - Determine how the Mental Health program can take advantage of opportunities available through the "Ticket to Work" federal legislation and recommend policy and legislative action for 2003.
  - Develop a plan to implement supportive housing over the next three years.
    - Determining and implementing strategies to improve access to affordable, integrated community housing.
    - Determining what current services could be modified to provide the necessary supports as well as how the state could better use Medicaid funding for this important service for persons with mental illness.

- Support consumer-operated programs such as Drop-In Centers. Increase employment of consumers as role models and recovery counselors in the provision of recovery-based community services.
- Work with Medicaid, the Transportation Disadvantaged Program and other agencies to develop transportation options.
- Expand the Indigent Drug Program to increase the use of evidence-based practices and to provide better access to more effective medications for non-Medicaid eligible persons.

Progress to Date:

- **Florida Assertive Community Treatment (FACT) Teams**

The FACT initiative represents a departure from Florida's traditional adult community mental health service delivery system. It replicates the "Program of Assertive Community Treatment" (PACT) model developed in 1972 in Wisconsin for providing comprehensive community-based treatment for persons with severe and persistent mental illness. PACT assumes total responsibility for the treatment, rehabilitation and support of persons who have limited functional skills in major activities of daily living. These persons have not been successfully served in the traditional service delivery system and are at high risk of repeated psychiatric hospital admissions, prolonged inpatient psychiatric hospitalization, or repeated crisis stabilization unit use because of their severe symptoms. Over time, the PACT model has proven to decrease hospitalization time and to facilitate community living and psychosocial rehabilitation for service recipients.

As of June 30, 2002, a total of 31 FACT teams have been funded. Districts 1, 2, 3, 9, 10, 12, and 13 each have one team. Districts 4, 14 and 15 each have two teams. Districts 7 and 11 each have three teams and the Suncoast Region and District 8 have four or more teams. Of the 31 teams, a total of 16 are in the former GPW catchment area.

The Mental Health Program is fully staffed to support the FACT initiative, providing policy and program development, contractual and budget oversight, coordination of the competitive bidding process, monitoring/oversight of program implementation, and technical assistance. Since the inception of the FACT initiative, training has been provided to all but seven teams. Plans are being developed to provide a new approach for training of teams through collaboration with district offices as well as developing in-state capacity for training through the more experienced FACT teams.

As of October 31, 2002, there are two teams that are not operational as a result of competitive bid protests and subsequent administrative hearings. The two teams will be located in districts 4 and 11 when the protest process has been completed. The Department prevailed in the recommended final order issued by the Division of Administrative Hearings. A period of 30 days is established for any appeal that may come from the final order, resulting in a delay of implementing the two new teams until early next calendar year.

The following reporting requirements continue for FACT teams:

- *Monthly Progress Report:* Information on census numbers, demographic data, living and employment situations, staff training activity and staffing levels. In addition, this report identifies the time spent in direct service contacts with service recipients.
- *Monthly Enrollment Report:* Detailed log of individuals who have been or currently are engaged and/or enrolled in FACT, including any persons who discontinued receiving FACT services.

- *Monthly Enhancement Report:* Expenditure of funds by individuals for either housing or medication needs in order for them to maintain themselves in the community.

Teams are monitored on a monthly basis to determine how they are doing statewide in meeting the target census. The following graph measures current team enrollments, engagements and total served against statewide target as of June 30, 2002. The total number served includes both individuals who are engaged and enrolled.

During November 2001, providers were selected to operate six additional FACT teams in the former GPW catchment area. Teams were implemented approximate to the following schedule:

- January 2002:
  - 1 team in District 8 serving Collier County.
  - 1 team in Suncoast Region serving Hillsborough and Pinellas counties and specializing in serving a forensic population.
- March 2002:
  - 1 team in District 15 serving Martin and Okeechobee counties.
  - 1 team in Suncoast Region serving Pinellas County.
- April 2002:
  - 1 team in District 8 serving Charlotte County.
  - 1 team in Suncoast Region serving Hillsborough County.

◆ Case Management Services

The redesign of case management services is proceeding with the completion of Chapter 2001-191, Laws of Florida, accreditation standards review activities. This review has provided a comprehensive examination of contemporary accreditation-based approaches and standards. During this period, the Mental Health Program Office has also examined emergent recovery and nationally recognized evidence-based practices that will be the foundation of a comprehensive redesign of the roles of case managers and related operational financial incentives.

One of the primary roles of evidence-based systems of care delivery will be the creation of a responsive and accountable 24-hour, 7 day a week case management service. Within this redesign, one of the salient features will be greatly increased frequency and quality of the coordination of medical and pharmaceutical services with the ongoing community services and supports offered to persons. Inherent in these changes will be more of a team approach to the provision of coordinated care capable of addressing the multiple needs of each person in an individualized yet comprehensive manner.

◆ Supported Employment

The unemployment rate among adults with serious and persistent mental disorders continues to hover at 90 percent (National Institute on Disability and Rehabilitation Research). To address this need, the following supported employment strategies have been initiated:

- The Mental Health Program Office, in collaboration with the Office of Vocational Rehabilitation Services at the Department of Education, developed a cooperative agreement to strengthen agency efforts in developing supported employment initiatives.

This agreement allows the Department to ascertain a 4:1 match from the Department of Education through a contract with them. Currently, forty mental health providers across the state have taken advantage of this agreement and at least ten others have expressed interest in doing so this coming fiscal year.

- The Florida Developmental Disabilities Council, Inc., awarded funds to develop statewide supported employment programs focusing on individuals with the dual-diagnosis of developmental disabilities and mental illness. This contract has been completed. It funded a very well-received one-day workshop in Tampa 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. A manual on how to implement a supported employment program and user-friendly pamphlets regarding benefit planning were also produced and distributed statewide. The advisory committee that assisted in the completion of this project is very interested in continuing this work and fortifying progress by combining efforts with other statewide employment groups.

- Last year, four Ticket-to-Work training seminars were offered in Tallahassee, Jacksonville, Fort Lauderdale, and Tampa to educate consumers and providers on program components, both for individuals receiving services and for providers wanting to be designated as "employee network providers."

◆ Supportive Living/Housing

- Nationally, there are two major avenues of change that must be accomplished in order to substantially increase opportunities for disabled persons to live in their chosen communities. Although inter-related, each of these two areas are so complex that they are identified as separate avenues in order to attain projects of manageable size, scope and complexity. These two avenues for essential change are: (1) affordability of integrated, scattered site community housing units; and (2) the adoption of a systemic philosophy of rehabilitation, recovery and the empowerment that is inherent in acting in accordance with distinctly higher expectations for personal choices, responsibilities and natural consequences.

  - As a limited response to the need for monthly rent subsidies, some districts have provided "support funds" that are flexible, client-related funds used to assist clients in living more independently by paying for rent, deposits and other needed services.

  - Some districts and providers have begun to more closely work with their local housing authorities in order to access whatever units may become available.

- Evolving strategies and actions to implement such recovery-oriented systems of community care include the following:

  - The Department has contracted with the Florida Mental Health Institute (FMHI) to secure the services of nationally prominent consultants to assist in the areas of supported living, supportive housing and Olmstead related services planning.

  - The Department's consultant has drafted a guideline for supportive housing. The product concurrently speaks to the roles of service providers, housing landlords, service recipients, families and others in facilitating an individual's ability to successfully reside in affordable, integrated and permanent housing of their choice.

- The Department is conducting a public workshop on the key aspects of supportive housing, including definition and applicability, safety, health and rights, and the use of financial subsidies for housing.
- The Department, with the Medicaid Office, is substantially redesigning the array of services funded by Medicaid. This effort will involve deleting "program-based" services and implementing individualized recovery-oriented services that are founded upon accountable service definitions, and standards of provision that are founded upon national evidence-based practices, competencies and processes.
- As these changes continue, administrative rules for both community services and financial billing procedures and incentives will be concurrently reviewed to reflect the recovery model of care.
- The program office has linked with Florida's preeminent affordable housing groups, commissions, homelessness and other disability advocacy groups in forming a coalition to collectively address the need for affordable housing units for households with extremely low incomes. In turn, this coalition has become engaged in Florida's Real Choice Partnerships Project, the state's ADA or Olmstead planning project designed to reduce barriers to ADA implementation throughout Florida. In furtherance of these efforts, this group has linked with the Shimberg Center at the University of Florida which is the state's center for housing related research and need planning data.

◆ Consumer-Directed Services

The Department funds drop-in centers throughout Florida as opportunities for natural social and community supports for individuals, friends, and family members. While these centers are consumer-operated programs, most of them have some level of professional support. Additionally, training on the "clubhouse model", a program designed to assist people with mental illness to achieve social, financial and vocational goals, was sponsored by the Department and the Florida Mental Health Institute and was held in Fort Myers during November 2001. The executive director of International Center for Clubhouse Development presented information on benefits and standards of clubhouse programs. Participants included individuals, family members, National Alliance for the Mentally Ill (NAMI) members, mental health professionals, and providers.

District plans identified the following services:

- The Suncoast Region funds three consumer-operated Drop-In Centers in Sarasota and DeSoto counties (providing employment and support services), a large consumer-operated Drop-In Center in Hillsborough County (planning to provide Fast Track Supported Employment services pending available funding), and consumer-operated Drop-In Centers in Pasco, Pinellas, and Manatee counties (one being a clubhouse model).
- District 8 funds three drop-in centers with $30,000 that are operated by Charlotte Community Mental Health, David Lawrence Center and Ruth Cooper Center. "Warm lines" have been implemented at the drop-in centers.
- District 9 funds two drop-in centers and has another funded by United for the Mentally Ill for persons with a severe and persistent mental illness.
  - Amigos is in West Palm Beach and provides consumer operated social/recreational, peer support groups, and referral services for 150 (unduplicated) persons annually.

- The Peer Place is in northern Palm Beach County and provides consumer operated social/recreational, peer support groups, and referral services for 4440 (unduplicated) persons annually.
- Joe's Place is in the southern Palm Beach County on the grounds of South County Mental Health Center and provides social/recreational activities.

- District 14 funds centers in Polk, Hardee and Highlands counties with $133,000.
- District 15 funds three centers for $62,264, which are operated by the Mental Health Association.

Continued Course of Action:

- The Mental Health Program Office will continue to support the operation of the 31 existing FACT teams. The program office will continue to provide technical assistance to the teams and the districts on operational and policy issues. Additionally, the program office will continue to monitor the teams for compliance with the PACT model upon which the FACT initiative was based. The program office will continue to collect and analyze data concerning FACT activities and make these available to the House and Senate staff upon request.
- The Mental Health Program Office will continue to support the development of strength-based case management. Currently, the program office staff are reviewing each of the mental health laws and rules compared to each of the major accrediting organizations guidelines, as required in Chapter 2001-191, Laws of Florida. The intent of this review is to avoid duplication of monitoring efforts. The program office, in conjunction with the Contract Performance Units, will continue to monitor those services that are not covered by national accreditation standards. Subsequent to completion of the review, the Mental Health Program Office will initiate rule revisions with priority given to such services as strength-based case management. All case management related issues will continue to be coordinated with the Medicaid program for their potential impact on Medicaid's targeted case management program.
- The Mental Health Program Office will pursue funding for at least two demonstration projects that would demonstrate the quality of life benefits of supported employment for persons with a mental illness.
- The Mental Health Program Office is exploring the development of cost-sharing strategies and identifying opportunities to leverage state dollars with federal and other non-state resources, perhaps through a home and community based waiver that focuses on supported employment and extends across departments. Currently, the Department is working with the Agency for Health Care Administration to revise billing procedure codes and definitions for those codes. It is hoped that work adjustment can be included under the Rehabilitation Option. This would allow providers to provide the post-skills training support (follow-along services) necessary to promote successful transition into the work force.
- The Mental Health Program Office has applied for a "State Implementation of Evidence-Based Practices" grant from SAMHSA. The proposal would develop a supported employment model for transitioning youth (ages 16-21). If awarded, the Department will work cooperatively with the University of South Florida, Florida Mental Health Institute, to develop an evidence-based model that can be replicated throughout the state and is based on national best practices.
- This year, the Department was awarded a "Real Choice" Grant from SAMHSA, Center for Mental Health Services, for statewide coalitions to promote community based care related to

the *Olmstead* decision. Through this grant, and in cooperation with the University of South Florida's Mental Health Institute, the Department will coordinate at least one more statewide conference regarding benefits available to people with mental health disabilities who choose to work. The grant is also supporting the Department's efforts to coordinate supported housing initiatives across programs and departments. A Supported Housing Coalition has been organized and has begun its planning stages.

- The Mental Health Program Office continues to contract with the Florida Mental Health Institute to finalize the development of the statewide housing plan. The program office also continues to offer training opportunities and technical assistance, both directly and through our relationship with the Florida Mental Health Institute. Whenever possible, supported housing/living activities will expand from the former G. Pierce Wood catchment area to other parts of the state. Upon completion of the state housing plan, the program office will work with the Florida Mental Health Institute to disseminate guidelines for district staff to use to work with their local housing authorities and providers on different ways to implement supported housing/living.
- The program office, in conjunction with the state's Real Choice Partnership, numerous other housing and disability entities, and state housing finance officials, are actively meeting to discuss the economic barriers to affordable housing for disabled persons living on SSI and SSDI payments. Individuals and households living at this extremely low-income level simply cannot afford fair market rate priced housing in their communities. SSI and SSDI recipients' entire monthly income would be consumed by the monthly cost of fair market rent priced housing alone. In contrast, the HUD guidelines only permit housing costs that are less than 40% of a household's monthly income.
- In addition to housing's economic affordability and availability issues, the Mental Health Program Office is also working to define and implement evidence-based practices for supportive housing services and rent cost subsidies for persons with a serious mental illness. These voluntary services and supports, as well as limited rental cost assistance subsidies, are often needed and sought after by individuals who are choosing to live in integrated, scattered site homes in their respective communities. The focus of supportive housing is to help individuals live in their communities enjoying the same cultural opportunities, surroundings, risks, rewards, experiences and associations enjoyed by persons without disabilities.

Interface with the Criminal Justice System

Issue Summary:

The Department provides services to adults with a severe and persistent mental illness who are involved with the criminal justice system. They are provided in the community to individuals as a diversion to incarceration and to individuals with court-ordered conditional release plans, pursuant to Chapter 916, F.S. Services are also provided in institutional settings to individuals committed to the Department as "incompetent to proceed" to trial or "not guilty by reason of insanity" (pursuant to Chapter 916, F.S.) The Department provides assessment and treatment services to restore the competency of juveniles committed to the Department as "incompetent to proceed" to trial due to mental illness. The Department also screens and evaluates all sex offenders being released from incarceration and provides a secure confinement and treatment facility for adults court ordered into the Department's custody under the Jimmy Ryce Act.

Strategic Course of Action 2000-2003:

- Maintain cooperative agreements between the justice system and local mental health systems, for defining strategies and community alternatives for diverting individuals out of jail and the criminal justice system.
- Provide training to Florida's law enforcement officers, using the Memphis Police Department's Crisis Intervention Team Program.
- Promote the development of community partnerships between criminal justice, law enforcement, advocacy groups and mental health providers.
- Pursue funding for programs in the community that will serve as an alternative to incarceration and placement in state treatment facilities.
- Review best practices among the three forensic facilities for competency restoration and for preparing individuals for successful return to the community.
- Continue tracking and funding services to individuals on court-ordered conditional release status (pursuant to Chapter 916, F.S.) to meet their mental health needs and provide for public safety.
- Continue to implement the Juvenile Incompetent to Proceed Program.
- Continue to implement and expand the Sexually Violent Predator Program.

Progress to Date:

- Districts have coordinated and are regularly attending meetings with local stakeholders to improve communication and develop cooperative agreements.
- Eight districts have participated in providing Crisis Intervention Team training for law enforcement officers in their area and three additional districts are in the process of coordinating training to occur in the near future.
- To promote the development of community partnerships, districts are participating in meetings such as "Partners in Crisis", "Public Safety Coordinating Councils", and various other mental health work groups and task forces.
- Mental Health courts are now operating in five counties in five districts, and courts in other counties are exploring the development of this program.
- As an alternative to incarceration, some districts are using FACT as a diversion resource and for screening of forensic individuals ready to be discharged.
- The Suncoast Region has established a Community Competency Restoration Program offering competency restoration training to individuals in jail and in the community on conditional release. This innovative program allows the region to offer the courts an alternative to forensic hospitalization for non-violent incompetent to proceed individuals. Similar programs are planned for three additional districts.
- Two new FACT teams have been established to work with individuals in the forensic system, one in the Suncoast Region and another in the Miami area.
- The Department submitted a $4.9 million legislative budget request for FY 2003-04 for community forensic services. This request includes funding to contract for 23 Forensic

Mental Health Specialist positions, one Short Term Residential Treatment Facility (SRT) and one Residential Treatment Facility Group Home (RTF) each in districts 10 and 11, and Community Competency Restoration Programs in districts 2, 10, and 11. This funding will allow individuals to receive services in the community and provide alternatives to incarceration and placement in a state treatment facility.

- A $7.5 million budget amendment allocation was distributed to the non-GPW catchment area districts in October 2002 to provide current year funding for residential services, case management, community support and outpatient services. This funding will enable individuals to receive services in the community and provide alternatives to incarceration and placement in a state treatment facility, as well as provide services for individuals returning to the community on conditional release.
- Nationally recognized consultants were hired to analyze Florida's forensic system (community and state treatment facilities). The final report was completed and distributed to all district administrators, district program supervisors and hospital administrators in August 2002. The report contains recommendations for improving efficiency in competency restoration, discharge preparedness and utilization of our state treatment facilities, as well as recommendations for reducing commitments, increasing diversions and improving efficiency in moving individuals through the court system. The districts and state treatment facilities have updated their action plans and implemented changes to impact the forensic waiting list by incorporating recommendations from our consultants.
- The statewide average number of days to restore individuals to competency improved by 11 days in FY 2001-02 when compared to FY 2000-01. This is a reduction of 22 days since FY 1998-99, while at the same time the number of discharges of individuals competent to proceed has increased by 36 percent
- The percent of individuals, who returned to court within 30 days following restoration of competency, has increased from 68 percent in FY 2000-01 to 79 percent in FY 2001-02. This improvement is even more significant since discharges of individuals competent to proceed increased by 7.5 percent in FY 2001-02.
- Every district/region is increasing the percentage of individuals returned to court within 30 days of restoration to competency. Seven of 14 districts/regions are meeting or exceeding the 2001 calendar year statewide average of 76 percent returned within 30 days.
- The civil hospitals are providing the Mental Health Program Office with bimonthly reports on the release status of forensic individuals in civil step-down programs. This information is shared with the district forensic coordinators in an effort to assist in the early identification of individuals approaching discharge readiness.
- The Mental Health Program Office has developed a comprehensive statewide database and is collecting information on individuals on court ordered conditional release. Each district/region has developed a process for the tracking of individuals on conditional release from their area.
- The Mental Health Program Office is using a computer generated simulation model to determine the impact of various actions on the forensic waiting list. The simulation model continues to be instrumental in guiding action plan decisions.
- In June 2002, Florida State Hospital - Forensic added two female beds, North Florida Evaluation and Treatment Center added one male bed, Florida State Hospital - Civil made available five geriatric and one dually diagnosed beds, and Northeast Florida State Hospital

added 15 additional forensic step-down beds. This capacity was added with no additional resources.

- In July 2002, Northeast Florida State Hospital opened 25 additional forensic step-down beds, increasing their total step-down capacity to 72.
- Florida State Hospital opened 24 additional secure forensic beds in October 2002.
- The number of individuals committed to the Department, pursuant to Chapter 916, F.S., in FY 2001-02 remained about the same when compared to FY 2000-01 commitment numbers. However, individuals committed for the first quarter of FY 2002-03 are up by approximately 22 percent when compared to the same quarter last year.
- The Juvenile Incompetent to Proceed (JITP) Program serves mentally ill and mentally retarded children, who are charged with felonies, but do not have the ability to participate in a legal proceeding. The court orders the child to either a community or secure setting for competency restoration training services to enable the child to understand the charges against them and the court proceedings. Community competency restoration services include case management and competency training. Secure residential services include mental health treatment, behavior management programming, intensive competency restoration training, individual and group counseling and such other medical, social, education and rehabilitative services required to restore the child's competency.
- The state contracts with Twin Oaks Juvenile Development Inc. for secure competency restoration services. The secure program is located in Hosford, Florida. Starting on January 1, 2003, they will also hold the contract for the community competency restoration services.
- The Juvenile Incompetent to Proceed Program is experiencing a significant increase in the number of juveniles ordered by the juvenile courts into the secure and community program. These increases have forced a waiting list for competency restoration services.
- There are currently 84 juveniles receiving community competency restoration services. The waiting list is currently at 53.
- There are 48 residential beds available to serve juveniles requiring the security of a residential facility. There are eight juveniles awaiting residential placement, with an anticipated wait of 45 days.
- Prior to January 1, 1999, there was no Sexually Violent Predator Program (SVPP), no staff, and no facility. SVPP, with its partner agencies, has brought the program from legislation to a complete program that screens and evaluates all sex offenders being released from incarceration, that provides a secure confinement and treatment facility, and has a current population of approximately 400 persons court-ordered into Department custody under the Jimmy Ryce Act.
- 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. Continued construction at FCCC will provide secure beds for up to 530 residents by July 2003.

Continued Course of Action:

- The Mental Health Program Office will continue to encourage districts to develop partnerships with stakeholders and to work cooperatively in implementing strategies for the early diversion of appropriate individuals charged with a property crime or other non-violent offense.
- As recommended by our forensic consultants, the Mental Health Program Office will encourage each district to identify and carefully examine individuals in their area that repeatedly cycle through the criminal justice and mental health systems. These individuals collectively use a disproportionately large amount of resources across mental health, substance abuse, social service, and criminal justice systems. The tracking of these individuals as they move from their initial contact with law enforcement, to jail, through the court system, into a forensic hospital and back to jail and the community can be beneficial in identifying gaps in the system and barriers to treatment. Information obtained from this examination can be used to make program changes and improve services in an effort to break the cycle.
- The Mental Health Program Office will continue to encourage districts to monitor forensic individuals hospitalized in forensic facilities and civil step-down programs, to promote increased involvement of forensic coordinators and case managers in early identification of individuals appropriate for community placement and in the discharge planning for these individuals.
- The Department will consider recommending changes to Chapter 916, F.S., such as:
  - Clarifying that the Department's responsibility, to maintain a sufficient number of facility beds in order to meet need, is dependent upon adequate funding;
  - Allowing restriction of communication with outside parties when an individual requests that he/she not receive communications;
  - Clarifying the circumstances when information from a clinical record may be released without the consent of a client or legal guardian;
  - Modifying the commitment requirements to reflect the language used in civil commitments and to agree with case law; and
  - Specifying the court's time limit to transport an individual recommended as ready to return to court or the community, and that the individual will be discharged and a recommitment order must be issued to readmit the individual to a forensic facility.

Florida's Mental Health "Baker Act"

Issue Summary:

Under the provisions of Part I, Chapter 394, F. S., the "Baker Act," mental health services are provided to adults and children who are experiencing a mental health crisis. These services are offered in the community and, for adults, in the state mental health treatment facilities on either a voluntary or involuntary basis. The Baker Act governs mental health services, including voluntary admission, involuntary examination, and involuntary placement of individuals. Implemented in 1972, the law is designed to protect the rights and liberty interests of persons

with mental illnesses as well as to ensure public safety. Specific criteria must be met in order to conduct an involuntary examination and placement of individuals. Included in the criteria is that the person has a mental illness and is not able to survive alone or refuses to care for himself or exhibits a substantial likelihood that in the near future he will inflict serious bodily harm on himself or another person.

Strategic Course of Action 2000-2003:

- Increase Baker Act community resources to reduce utilization of hospital inpatient bed days for persons suffering from an acute psychiatric crisis.
- Increase the effectiveness and efficiency of the Baker Act in relation to process and procedures to better protect the rights of persons with a mental illness.
- Pursue funding for increasing crisis stabilization unit capacity including exploring increased Medicaid funding for eligible persons to divert them to hospital inpatient resources thus making available more crisis stabilization unit beds.
- Develop a system of care prototype for how a community-based crisis system should operate.
- Explore the feasibility of contracting with Louis de la Parte Florida Mental Health Institute to conduct a study of the effectiveness of mobile crisis response services and pursue additional funding if deemed appropriate.
- Address the findings of the Supreme Court Commission on Fairness in its December 1999 report.

Progress to Date:

- **Increase Community Mental Health Resources/Funding**

  The Department has submitted legislative budget requests for the following:

  - $998,000 for involuntary outpatient commitment services;
  - $4,953,730 for expanded forensic services; and
  - $1,001,100 for additional services for the sexually violent predators program.

- **Increase Effectiveness/Efficiency of Baker Act Procedures**

  - Statewide training on the rights of and due process for persons with a mental illness has been provided through a contract with the Florida Mental Health Institute. This training was offered in each district and provided to approximately 3,000 persons. Persons trained included nursing home staff, persons working with the elderly, public and private Baker Act receiving facility staff, hospital personnel, mental health professionals, law enforcement and judicial system staff, emergency room physicians, attorneys, advocates, case managers, Department staff, individuals and family members, and protective services workers. Training materials were developed and statewide training was conducted between January and May 2002. This training corresponds to the recommendations of the Supreme Court Commission on Fairness Report, December 1999.
  - The Mental Health Program Office also contracted with the Florida Mental Health Institute to revise the Baker Act Manual to reflect current practices and issues. The

manual is the reference guide used by providers, districts, law enforcement, the judicial system and physicians and hospitals when addressing issues related to services under the Baker Act.

- A Baker Act web-site has been developed and is expected to be operational in the next couple of months.
- The Mental Health Program Office plans to provide the above referenced training and revision of the Baker Act Manual in 2004.
- Acute care issues are a major focus of the Behavioral Health Services Integration Workgroup, authorized by section 394.9083, F.S. The Workgroup is a broad-based entity with representation from both the public and private sector of Florida's behavioral health services community. The Department has contracted with the Louis de la Parte Florida Mental Health Institute to conduct in-depth studies of issues, problems and best practices in acute care systems. This work consists of interviews and representative focus groups of acute care stakeholders in a number of communities throughout Florida.

◆ Develop Prototype for Crisis System of Care

The Department contracted with the Florida State University for a mental health needs assessment and an analysis of the District 8 acute care system with recommendations as to how the system may be improved. This needs assessment is completed with recommendations addressing hospital discharge, family education and self help, crisis response and management, community living supports, skill development, residential services and housing, assertive community treatment and case management, psychotherapy, medication management, and co-morbidity. As part of the Behavioral Health Services Integration Workgroup, an analysis of the acute care system has been completed.

◆ Involuntary Outpatient Commitment

During last legislative session, The Florida Sheriff's Association sought to amend Chapter 394, Part I, F.S., (the Baker Act), to add involuntary outpatient commitment procedures. The Florida Sheriff's Association has spearheaded this legislative proposal. The bill, SB 2030, did not pass for two reasons: 1) opposition by several groups and 2) the potential fiscal impact. Major opposition came from both judicial and public defenders due to the anticipated workload associated with the bill's passage. The Florida Sheriff's Association is pursuing this amendment again this legislative session.

Continued Course of Action:

◆ Increase Baker Act Community Mental Health Resources

The Mental Health Program Office will implement any new adult mental health programs or services received as part of the legislative budget request package. This will include funding to increase crisis stabilization unit bed capacity, as well as other mental health services.

◆ Increase Effectiveness/Efficiency of Baker Act Procedures

The Department will continue to support the Baker Act training activities and to provide policy direction, under the advice of legal counsel, to ensure that all training conducted and

educational materials distributed are consistent with current law and rule. The Mental Health Program Office will also provide input to the Secretary and the Legislature on any substantive Baker Act legislation being considered for the 2003 legislative session.

- **Increase Crisis Stabilization Unit Capacity**

  The Mental Health Program Office will continue its oversight of the implementation of the new crisis stabilization unit and short-term residential treatment capacity in the G. Pierce Wood catchment area. Also, the office will provide any requested information on the Department's legislative budget request for the expansion of crisis services for children and adults. The Department will expand adult and children's crisis stabilization unit capacity based on new legislative appropriations.

- **Develop Prototype for Crisis System of Care**

  In District 8, the Mental Health Program Office, in conjunction with the Agency for Health Care Administration, is exploring the Medicaid funding mechanism to support emergency outpatient services, such as mobile crisis response teams, as a specific service funded under Medicaid community mental health programs. This will help balance out over-reliance on general revenue emergency service funding in District 8. Additionally, the Mental Health Program Office will review and begin to implement within available resources the recommendations from the Behavioral Health Services Integration Workgroup on emergency services.

- **Involuntary Outpatient Commitment**

  The Department continues to analyze the proposed revisions to the involuntary outpatient commitment bill for both the programmatic and fiscal impact. We are reviewing involuntary outpatient commitment laws in the other states that have passed similar legislation. The Department continues to work closely with the Governor's Office and other mental health stakeholders on this issue.

Eligibility Determination

Issue Summary:

There are 16 mental health target populations defined by law. While the identification of target populations has vastly improved the understanding of who is served by the mental health system and has helped providers focus on those groups, it still does not provide sufficient direction to determine who should be eligible for what type of services. The Mental Health and Substance Abuse Commission Report (January 2001) recommended, and the Department concurs, that the state should concentrate its limited state and federal dollars on persons with critical needs who have no other means to access care.

For adults, the state should focus on persons whose mental illness results in substantial functional loss in areas of daily living and social competency. The Department also recommends that for children the focus should be children in the Family Safety program, children with publicly funded insurance (Medicaid and Title XXI), and children who have a serious emotional disturbance and are without health insurance or are underinsured.

Currently, persons can access contracted providers directly and the provider determines if the person fits one of the target populations and then determines what services should be provided. The services available are those contracted annually by the Department and are not necessarily directed by the special needs of the individual. Since the Department has narrowed who can be served, it is becoming increasingly necessary to establish an eligibility determination process for at least the most expensive packages of services.

Strategic Course of Action 2000-2003:

- Develop a method to establish eligibility based on level of need to include:
  - Determine assessment tools and procedures that more clearly define populations and that are sensitive enough to be used for eligibility determination.
  - Develop an operational strategy to complete eligibility determination.
  - Recommend priority populations for service.
- Determine a range of services and estimated costs by target populations to establish specific benefit packages for target populations.
  - Continue to refine the needs assessment to determine, in general, the range, frequency, and duration of services by target population.
- Recommend benefit packages for each target population.
- Seek funding for an actuarial study that would ascertain the gap between current rates and rates necessary to fund an adequate system of care that provides recovery-oriented services.
- Establish and test in District 8 a set of clinical guidelines that set objective criteria for type, level and duration of care.

Progress to Date:

- A study has been completed to determine the major gaps in service in District Eight benchmarked against other state's with delivery systems that provide a range of rehabilitative and recovery oriented services. This information is being used by a working group of stakeholders in the district to determine priorities for services expansion and reduction in establishing a redesigned system of care.

Continuing Course of Action:

- In December of 2002, the Department contracted with the Florida State University's Institute for Health and Human Services Research to conduct an actuarial study to estimate a set of model Medicaid capitation rates for each of the broad Medicaid eligibility groupings. The rates will be constructed to support a behavioral health care system that adequately addresses recovery and rehabilitation services as well as acute care and support for dependent and delinquent populations. The actuarial analysis will assess actual rates in reference states that are reputed to provide good systems of care. The actuary will also construct rates from a budgetary standpoint. That is, determine the size of Florida eligibility groups, the types and duration of services they need, reasonable costs for these types of services and capitation rates derived from these factors. Based upon these analyses the actuary would then recommend capitation rates for these eligibility groups in Florida. The University will also be

tasked with determining rates necessary to adequately serve indigent non-Medicaid eligible populations and to pay for non-Medicaid compensable services, such as room and board or job development.

- One aspect of eligibility is deciding what specific treatments and supports will be most effective for a person with a given mental health condition. During 2003 the Florida State University's Institute for Health and Human Services Research will be working with providers in the District 8 pilot behavioral health strategy under section 394.9082, F.S., to develop a set of clinical guidelines. These guidelines will set out best practices for treatment of and recovery from a variety of mental illness conditions. The guidelines will also set out clinical guidelines for admission, continued stay and discharge from discrete types of services. The purpose of these guidelines is to insure that the right service is provided in the right amount and for the right period of time. This work will contribute to the design of benefit packages.
- The Mental Health Program Office will review other states' eligibility packages and consider developing two levels of care: 1) Emergency Services and Short-term Treatment and 2) Program for persons with disabilities or at great risk for a disability.

Improve Clinical Practices

Issue Summary:

The Department is reviewing clinical guidelines and standards to determine which of these should be recommended for use in community and inpatient treatment settings. Additionally, the degree of discretion in adopting various practices and the variance allowable in those treatment settings must be discussed with stakeholders before recommendations are concluded.

Strategic Course of Action 2000-2003:

- Because medications are a critical element in treatment, it is essential that medication related practices become more consistent and ensure that treatment is the best possible medication of choice. Medication regimes should positively impact a course of treatment such as reducing symptoms of mental illness and enhance quality of life. At the same time, responsible practitioners should be able to demonstrate treatment efficacy and cost containment where appropriate. The Mental Health program is continuing to pilot the use of a new medication algorithm that should positively impact practice.
- The Mental Health program will try to expand the Indigent Drug Program for persons without adequate insurance who live in the community.
- The Mental Health program will develop strategies for the incorporation of clinical guidelines and pathways into all clinical practices.
- The Mental Health program will consider a requirement that providers be accredited by either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA) by year 2003. Waivers however, should be provided for small agencies if appropriate accreditation is not available. If providers are accredited, monitoring requirements should be modified to reduce duplication.

- The Department is providing or arranging for training for district and provider staff on a regular basis. Partnerships with the Florida Mental Health Institute, Florida State University, and other academic centers should be strengthened to increase training opportunities through local training centers (universities and community colleges) and through distance learning technologies.
- The Florida Administrative Code (rules) will be updated to address clinical and other treatment practices.

Progress to Date:

Medications

- A contract with the University of Florida, School of Medicine, Department of Psychiatry has been procured. The professional monitoring team has been trained regarding the Department's policy for use of psychotropic medications in state treatment facilities. Two pilot reviews were conducted as part of the training. All state mental health and developmental treatment facilities will be reviewed annually regarding use of psychotropic medications with constructive feedback to enhance quality of services at the facilities. This external monitoring was initiated in September 2002.

- Three competency-based training programs to teach raters of abnormal involuntary - movements as potential side effects of antipsychotic medications were completed in July 2002 by a nationally recognized consultant from the University of South Carolina. All state mental health and developmental disabilities' treatment facilities now have competency-based trained staff completing the Dyskinesia Identification System, Condensed User Scale (DISCUS), a standardized assessment tool used to monitor for tardive dyskinesia, a potentially serious and debilitating side effect of these medications. A total of 228 people were trained statewide as DISCUS raters. This included staff from several private providers and from one district office. The training program also introduced staff to the Monitoring of Side Effects Scale (MOSES) which is a tool used to monitor for side effects of all psychotropic medications. A total of 34 staff were trained during these workshops as trainers of DISCUS raters so that each treatment facility has the training materials and resources to ensure on-going training for staff at the facilities.

- To ensure that the state's public mental health system of care maintains contemporary psychotropic medication practices the Department has established a statewide Pharmacy and Therapeutics (P&T) Committee. This committee develops standards for psychotropic medication use in state mental health and developmental disabilities' facilities. It has clarified language in the procedure for use of psychotropic medications in state treatment facilities and identified types and frequency of drug regime reviews completed at the facilities. Committee planned agenda includes assessment of facilities' P&T Committees' data collection with a move toward standardization for trend analysis of like facilities and completion of medication utilization reviews for trend analysis and cost containment strategies.

Clinical Pathways and Medication Algorithm

- The Texas Algorithm for Treatment of Schizophrenia was adapted, modified and then initiated in Districts 1 and at Florida State Hospital. Florida's version of this set of tools is called the FALGO (Florida Algorithm). Use of algorithms is considered an evidence-based

practice that addresses medication management in a more effective and efficient manner. The Mental Health Program Office has begun to evaluate the effectiveness of this project using the Positive and Negative Symptoms Scale (PANSS). District 1 has implemented the schizophrenia algorithm. As new clients enter the system, the algorithm is initiated when a diagnosis of schizophrenia has been determined. In District 2, Florida State Hospital has expanded the use of the schizophrenia algorithm to all of the hospital's admission units with a plan to include the forensic units by February 2003. PANSS data is being collected and use of the data as an outcome measure is being examined. District 1 and Florida State Hospital plan to evaluate the merit of all the data being collected and standardize data collection.

- Additionally, the 2002 Appropriations Act proviso language directed the Department to work with pharmaceutical companies to fund grants to support the implementation of the algorithm. Florida State University will be the grant recipient. Also, the proviso language directed the Department to work with AHCA to expand the use of the algorithms to all sites accessing the state Indigent Drug Program (IDP). The Mental Health Program Office will phase-in these requirements over the next two to three years.

Indigent Drug Program

- As part of the FALGO implementation project mentioned above, an Indigent Drug Program grant is being developed to provide additional psychotropic medications based on a partnership with pharmaceutical companies. This grant will facilitate the promulgation and use of evidence-based algorithms in the community mental health system.

Accreditation

- Chapter 2001-191, Laws of Florida, required the Department to review its laws and rules compared to major accreditation organizations' requirements. The Mental Health Program Office has completed a detailed analysis of accreditation standards of JCAHO, CARF, and COA as they relate to statutes and rules. A draft matrix has been developed with assistance from the Agency for Health Care Administration and has been shared with the Florida Mental Health Council. The matrix demonstrates comparison between statutes, rules, and accreditation standards and duplication in monitoring. The outcome of this comparison is to focus the Department's monitoring on those areas not covered by accreditation standards. A secondary outcome will be to review existing rules for revisions that will reflect current clinical practices and consistency with the principles of psychiatric rehabilitation. Upon completion of this review, the Mental Health Program Office will initiate rule revisions for priority services within the mental health system of care.

Training

- The Mental Health Program Office, in conjunction with the Florida Mental Health Institute, successfully completed a training series entitled "New Models for Service Delivery". These programs were designed to assist providers and other behavioral health professionals with resources that promote social rehabilitation services/practices. The training included conferences on essential elements of a mental health service delivery system including Supported Living/Housing; Principles and Practices of a Rehabilitation Model; Supported Employment; the ClubHouse Model; Behavioral Management; and co-occurring Disorders. The training sessions were well attended by private providers, consumers, and family members. The information provided was well received and will be used to lay the foundation

for redesigning the community mental health delivery system toward contemporary national models.

- The Department has provided training sessions during 2002 on the use of DC: O-3 to prepare clinicians for evaluation of children between the ages of birth and five years of age who are coming into care. The DC: O-3 is a nationally recognized program designed for working with infants and toddlers. Comprehensive Behavioral Health Assessments have been expanded to include children ages zero to five.

Practice Guidelines, Standards, and Rules

- To provide clinical practice guidelines and standards for behavioral health services for children, the Department has promulgated Chapter 65E-11, Florida Administrative Code, Behavioral Health Services. The rule is in the process of being amended to change its name. This rule is applicable to the contracted providers of the Behavioral Health Specialty Care Network (BNet) services within Florida KidCare, the state's Child Health Insurance Program initiative.
- The Department completed a licensure rule, 65E-9, for residential treatment centers which is currently in the final review process. These facilities will be licensed by the Agency for Health Care Administration under Chapter 394, F.S. The rule will apply to all residential treatment centers, including therapeutic group homes, under contract with the Department to provide treatment services for children with an emotional disturbance or serious emotional disturbance. The rule includes standards for treatment and discharge planning, the use of restraints and seclusion, and the use of psychotropic medications.
- The Department is currently in the process of completing a rule for the Indigent Drug Program. The rule will establish policy on eligibility, provider requirements for participation in the program, and sanctions to be applied for failure to meet those requirements. This draft is scheduled to be completed in January 2003.

Continued Course of Action:

- The University of Florida will continue to review medication practices in the state treatment facilities and make recommendations to enhance quality of care.
- The statewide Pharmacy and Therapeutics Committee will evaluate the state treatment facilities' and Developmental Disabilities facilities' medication utilization review data for trend analysis and make recommendations for ensuring medication efficacy and cost containment.
- The Department, in partnership with Florida State University, will phase-in the use of the Florida Algorithm in community and hospital settings over the next three years, as well as collaborate with the University and pharmaceutical companies to expand the Indigent Drug Program.
- The Department will continue to review clinical training needs, and as funds become available, initiate specific training initiatives for District personnel and community providers. The Department would like to complete a statewide needs assessment in this area so that priorities can be determined. Such areas to be considered include treatment and programs for Co-occurring Disorders (Substance Abuse and Mental Illness) and treatment for Borderline Personality Disorder (e.g., Dialectical Behavioral Treatment).

- Using the results of the analysis of accreditation standards, the Mental Health Program Office will determine which critical standards of care and treatment are not covered through the accreditation processes and will draft new rules to address those standards, as well as to reflect current recovery-focused principles and practices. Monitoring tools will also be designed to eliminate duplications in monitoring of standards already required for community providers by their accrediting organization (e.g., JCAHO, CARF, COA).
- The Department will pursue promulgating rules for the Indigent Drug Program, the Out-of-home Care rule, and the licensure rule for residential treatment centers for children.

Prevention – Mental Health

Issue Summary:

Recent brain research indicates that quality care-giving during the first few years of life is critical to the development of the capacity for emotional and behavioral development. A healthy mother/baby relationship is necessary for the infant's neural patterns to develop in order to create a sense of trust and the ability to manage the environment. Without this attachment, research shows that infants may never develop the essential neurobiological structure necessary to control their emotions and behaviors in the future.

Biological and environmental factors can also contribute to the development of mental health and mental illness, and an accumulation of risk factors usually increases the likelihood of onset of a mental health disorder. Areas that may cause children to be particularly at risk of mental illness include having a parent with a mental illness, living with domestic violence, or being victims of abuse and neglect. Research indicates that prevention and early intervention strategies may be effective in reducing illness and disability in both mental and addictive disorders.

Strategic Course of Action 2000-2003:

- Identify and encourage providers to develop staff who have expertise with infants and young children.
- Work with the Agency for Health Care Administration to develop service for children ages birth through five.
- Assist in the development of public policies that support prevention and treatment of mental health for children ages birth through five.
- Meet with the Professional Development Center staff to identify training goals including screening, assessment, and early referrals of children ages birth through five.
- Develop strategies to identify the population of children who reside with parents who are mentally ill to ensure early identification of need.
- Target children in the dependency system that have parents with mental illness for early service intervention.
- Work with Family Safety to identify issues in working with a parent with mental illness.
- Develop a system response for situations when the parent must be hospitalized due to a mental illness or substance abuse problem.
- Provide screening for identified children of adults with mental illness for symptoms of emotional disturbance.

- Review current services available at domestic violence shelters and Family Safety shelters.
- Obtain educational information for the district offices to distribute to local providers targeting best practices in working with victims of physical violence/abuse.

Progress to Date:

- A workgroup comprised of staff from the Agency for Health Care Administration, the Department of Children and Families, the Florida Council for Community Mental Health and members of the provider community developed policy on the provision of community mental health services to children birth through five years of age. The policy was distributed as part of the Mental Health Coverage and Limitations Handbook (Chapter 2, Section 5) and became effective May 1, 2002. Florida's Medicaid program is the first in the nation to develop specific policy for children birth to five years of age. The Mental Health Coverage and Limitations Handbook outlines criteria for eligibility determination, assessment, service authorization, and sets requirements for children receiving mental health day treatment and intensive therapeutic on-site services.
- A query of the ADM Data Warehouse to identify the number and characteristics of very young children served by the children's mental health program revealed that approximately 5,962 children ages birth to five received Infant Mental Health Services during 2001-2002. A review of mental health services indicates that the highest billed Medicaid services provided for this population, in descending order of frequency, include Treatment Plan Reviews, Intensive Therapeutic On-Site Services (ITOS), Individual Therapy, and Case Management. All the districts reported providing mental health services and support to children under the age of five receiving Infant Mental Health treatment and supports.
- The Department has expanded capacity to provide Comprehensive Behavioral Health Assessments to children, ages birth to five, who are in foster care. Approximately 830 assessments were completed for this population between January 1, 2002, when tracking was initiated, through July 30, 2002. Statewide training has been provided to continue to expand our capacity to properly evaluate this target age group.
- The Department is coordinating a three-site pilot project targeting infant mental health. The pilots are designed to prevent future maladaptive emotional, social and behavioral development. The three-year pilots were initiated in 2000 with an appropriation of $250,000 and received continuation funding in 2001 and 2002. Three infant mental health sites have been established in Miami, Sarasota and Pensacola to target children under age five at high-risk for developmental delays due to harmful and damaging factors in the infant's environment. Florida State University is evaluating the pilots and will make recommendations for replication and expansion.
    - The Miami project is operating in conjunction with Judge Cindy Lederman's "Prevent Project." The project received national recognition by the National Center for Children in Poverty and also the Governor's Peace at Home Award for their efforts in combining infant mental health and Early Head Start.
    - The Child Development Center, in conjunction with the Family Safety Privatization Project, coordinates the Sarasota project. The Center's Vice-President of Community Based Services developed a crosswalk between the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The crosswalk was reviewed and approved by the Agency for Health Care

Administration and the Department of Children and Families. The crosswalk has also been endorsed by Zero to Three: National Center for Infants, Toddlers and Families.

- Lakeview Mental Health Center heads the Pensacola project, which serves rural communities around the Pensacola area. Services provided by this project are mainly home-based, which assist the child and their parent/caretaker in the child's living environment.

- Training is being offered around the state to address Florida's increasing need for clinicians trained in the use of the Diagnostic Classification of Mental Health and Developmental Disorders (DC: 0-3). The DC: 0-3 is a comprehensive, multi-axial framework for diagnosing emotional and developmental problems during the first three years of life. Medicaid's guidelines for community mental health services for children ages birth through five years encourages the use of the DC: 0-3 in determining the infant or child's ICD-9-CM diagnosis.

  - The Agency for Health Care Administration and the Florida Council for Community Mental Health sponsored training for Comprehensive Behavioral Health Assessors on the use of the DC: 0-3 in Orlando during August 2002.

  - Dr. Robert Harmon conducted a training on the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) in Miami in February 2002. Dr. Harmon is a nationally recognized expert in the area of infant mental health.

  - District 1 CMH/ADM has developed a districtwide training curriculum to provide a comprehensive base of training for professionals authorized to conduct assessments of children 0-5. In an ongoing cooperative effort with SEDNET and the Infant Mental Health project of Lakeview, CMH/ADM is facilitating a three-day training to 100 community mental health counselors and certified comprehensive assessment providers. Trainers include: Joy D. Osofsky, Ph.D. – a nationally recognized expert on the 0-5 population, Scott Benson, MD – Board Certified Child and Adolescent Psychiatrist and Pediatrician, Kim Haga, Ph.D. – Licensed Psychologist.

  - Palm Beach County/District 9 has a Children's Services Council (CSC) whose primary focus is the development of a Prevention System of Care, with strong focus on children ages 0-5.

Continued Course of Action:

- The Department currently requires the use of comprehensive behavioral health assessment for all children between the ages of five and 17 who are placed in shelter. The Department will continue to closely monitor the number of assessments provided for children in foster care from birth to five years of age. An ongoing analysis will be done to ensure we are moving toward meeting the need. Additional training will need to be coordinated with the Agency for Health Care Administration to continue to expand the number of individuals who are trained to provide services for this population.

- Additional training will be offered to clinicians across the state to provide in-depth education/practice in using the DC: 0-3 and to expand the cadre of clinicians using the DC: 0-3 as a tool in the completion of Comprehensive Behavioral Health Assessments.

- The Department will incorporate into existing mental health programs strategies to build stronger families. Some opportunities are as follows:
  - Promote relationship-based work with both parents in the Infant Mental Health pilots.
  - Develop means to assist persons with mental illness to maintain relationships with their families. One mechanism will include the Mental Health Program Office contracting with the National Alliance for the Mentally Ill for Family to Family training.
  - Assist parents with mental illness in appropriately addressing the needs of their children.
  - Provide family support and family counseling to families with children who have emotional disorders.

Collaborative Initiatives

Overview

The Mental Health and Substance Abuse Program Offices have developed collaborative initiatives in several program, performance, and financial management areas to maximize the efficient use of resources for those in need and to enhance the overall effectiveness of the systems of care. The programs are in the process of developing integrated services for clients with co-existing mental and substance use disorders. The primary aims of this initiative are to provide timely and appropriate services for clients through reduced duplication, blended funding streams, and coordinated case management.

The Mental Health and Substance Abuse Program Offices are also working together on the development of new models for system management that will focus on improving the way the state purchases services and manages service delivery at the district and regional levels. The programs are collaborating in the modification of the ADM data system in accordance with these management models and in response to federal data management guidelines regarding the storage and use of health services information. The Department, as a whole, is continuously striving to improve performance through enhanced data systems and analysis methods. This section of the report reviews FY 2001-2002 performance and provides a series of recommendations to improve performance measurement in the future.

Strategic Directions

The primary strategic directions that are being jointly addressed by the Mental Health and Substance Abuse Program Offices are outlined below.

Develop Methods to Provide Services for Persons with Co-occurring Disorders

Issue Summary:

Historically, clients with co-occurring disorders have been treated in parallel systems, i.e., having their mental health issues addressed through the mental health service system and having their substance abuse issues addressed separately through the substance abuse service system. This has led to many clients receiving duplicative services while others fall through the cracks. The Department recognizes the need for comprehensive, integrated services for persons with co-occurring disorders and has begun to develop service and funding models to fulfill this need. Pilot projects are underway in several districts to develop, implement, and evaluate models.

Strategic Course of Action 2000-2003:

- Development of a draft policy paper on co-occurring disorders.

- Joint support of the Mental Health and Substance Abuse Integrated Training Institute in cooperation with Florida State University.
- Fund and support of Florida Assertive Community Treatment Teams for individuals with severe mental illness, many of whom have co-occurring substance abuse disorders.
- Fund for a co-located, secure detoxification and crisis stabilization unit for the dually diagnosed in District 4, where the substance abuse provider is funding both substance abuse and mental health services.
- Acquisition of a post-doctoral research fellow on co-occurring disorders through the National Institute on Drug Abuse, in partnership with the Florida Mental Health Institute.

Progress to Date:

The Mental Health and Substance Abuse programs have been working jointly on a number of initiatives to improve mental health and substance abuse treatment services to persons with co-occurring disorders. The Mental Health and Substance Abuse Program Offices formed a workgroup to identify opportunities for improvement and new initiatives to integrate and strengthen the delivery of services to persons with co-occurring disorders. The following is a breakdown of other accomplishments to date.

- The Substance Abuse Program Office participates on the Florida Alcohol and Drug Abuse Association and Florida Council on Mental Health's Joint Committee on Co-occurring Disorders, which focus's on identifying barriers, and developing recommendations and action plans for and improving barriers to services for co-occurring disorders.
- The Substance Abuse Program Office has assisted in gaining funding for, and acquiring a post-doctoral research fellow (Dr. Chad Matthews, Ph.D.) on co-occurring disorders through the National Institute on Drug Abuse, in partnership with the Florida Mental Health Institute and the Mental Health Program Office. Dr. Matthews has taken lead in coordinating completion of the Co-occurring Disorders Policy Paper and is developing a work plan for its implementation.
- Funding for a collocated, secure detoxification and crisis stabilization unit for dually diagnosed persons in District 4 is continuing, where both substance abuse and mental health services are being funded by the substance abuse provider.
- Funding and support are still being provided for a pilot program for the collocated children's crisis stabilization unit/addictions receiving facility in District 8.
- Implementation continues for the present TANF initiative that assesses and addresses the needs of, and provides services to, individuals with both mental health and substance abuse problems in the community.
- Efforts are continuing between the Substance Abuse and Mental Health Program Offices in working closely with the Department of Health and Florida Healthy Kids, Inc., in implementing behavioral health provisions of the Title XXI Florida KidCare Program, which includes substance abuse and mental health benefits for 222,722 children.
- The Mental Health and Substance Abuse programs have initiated, in collaboration with the Agency for Health Care Administration, a survey of licensed mental health residential programs to determine the extent of programs providing integrated mental health and substance abuse services.

Licensure Requirements

The Substance Abuse and Mental Health Program Offices are currently developing licensure requirements and exemption allowances for mental health providers that serve persons with co-occurring disorders. Providers serving persons with primary mental health disorders that have a co-existing substance use disorder should be able to provide integrated services as part of their treatment protocol. For mental health agencies providing licensable substance abuse components, options for licensure under discussion include:

- Hire a qualified professional (pursuant to Chapter 397, F.S.) to provide substance abuse treatment services on-site, no separate substance abuse licensed required; or
- Contract with a licensed substance abuse agency to provide substance abuse services; or
- Obtain a substance abuse license for a licensable facility or program component.

Community Collaboration Efforts

The Substance Abuse Program Office is participating in the Tampa-Hillsborough Community Action Grant on Co-occurring Disorders Workgroup. The Community Action Grant is intended to provide technical assistance and community consensus building to implement effective services for co-occurring disorders in Hillsborough County. The workgroup has developed a strategic plan based on Dr. Kenneth Minkoff's Comprehensive Continuous Integrated System of Care (CCISC) Model.

Florida Assertive Community Treatment (FACT) Teams

The FACT initiative is uniquely designed to address persons with co-occurring mental health and substance abuse disorders. The staffing of a FACT team addresses the issue of co-occurring disorders by requiring that at least one staff of the team be trained in the treatment of substance abuse disorders. FACT teams provide comprehensive substance abuse services as one of 15 mandated services. Minimally, these services include individual and group interventions to assist persons:

- Identify substance use, effects, and patterns.
- Recognize the relationship between substance use and mental illness and psychotropic medications.
- Develop motivation for decreasing substance use.
- Develop coping skills and alternatives to reduce or minimize substance use.
- Achieve periods of abstinence and stability.

Program Management, Compliance and Performance Improvement

Issue Summary:

Unit-based contracting is the method adopted several years ago by the Mental Health and Substance Abuse programs to pay for community-based services, replacing the longstanding grant-in-aid funding mechanism. As a result, the Department is now able to account for services provided and funds expended, thereby improving the service delivery system. However, the current contracting system needs to address some drawbacks, including issues of efficiency, cost-effectiveness, and flexibility in meeting client needs, as recommended by several stakeholders, including provider agencies, the Office of Program Policy Analysis and Government Accountability (OPPAGA), and the Auditor General's Office.

The recommendations from these stakeholders include changes to Florida's mental health and substance abuse service delivery infrastructures to enhance integration of functions and reduce fragmentation in the system of care. One of these changes is to expand the use of alternative contracting strategies, such as case rate, administrative service organization (ASO), and provider service networks, for delivering behavioral health managed care. As a result of these recommendations, the Department is currently using District 1 and District 8 to pilot the case rate and the ASO strategies, respectively. Like many other states, Florida is not yet ready to use the capitation type of program.

There are also deficiencies in the Department's performance measurement system as noted by OPPAGA, including issues of appropriateness and relative importance of the measures.

There are also organizational issues that need to be addressed to improve the system of care. Chief among these improvements are:

- The roles and functions of the headquarters' program offices and the district program offices should be more clearly defined and differentiated.
- The interface between the potential capitation of Medicaid Behavioral Healthcare and the Community Based Care programs should be defined.
- The roles and responsibilities between central state hospital supervision and the program office responsibilities with the hospitals should be clarified.
- In order to ensure quality mental health services, to enhance protection of persons with severe and persistent mental illness and children who are seriously emotionally disturbed, and to improve the safety of the community, it is necessary to provide staff infrastructure at the district/region level. Conversion of Other Personal Services (OPS) to Career Service/Select Exempt should be the first step in this process.

Finally, legal issues remaining to be resolved include:

- Johnson Lawsuit: In 1987, six consumers at G. Pierce Wood (GPW) filed a federal class action lawsuit against the hospital administrator and the then-HRS secretary, alleging poor treatment and conditions at the hospital and the failure to timely discharge residents. In 1989,

the parties entered into a consent decree providing for extensive, detailed relief at the hospital.

In 1993, the parties agreed to "exit criteria," a set of standards that purported to measure compliance with the consent decree at the hospital and in community treatment facilities.

In March 1998, the Department of Justice intervened in the case. However, DOJ did not intervene to enforce the consent decree or exit criteria, but instead, the government raised new claims and sought new relief at the hospital and in community facilities in an effort to expand the scope and nature of community-based treatment. The federal district court held a five-week trial in August-September 2000.

On June 25, 2001, the district court ruled for the Department, finding that conditions and treatment at the hospital and in the Department's community mental health facilities in the GPW catchment area were constitutionally adequate. The ruling did not dissolve the consent decree or exit criteria.

- M.E. v. Bush is a federal class action complaint seeking declaratory and injunctive relief filed against the Departments of Children and Families, Juvenile Justice and the Agency for Health Care Administration by Legal Service of Miami and Holland and Knight in 1990. The complaint alleged the departments had not provided therapeutic services to children in the state's physical and/or legal custody.

  A settlement agreement was approved on September 17, 2001, by Judge K. Michael Moore, of the U.S. District Court for the Southern District of Florida, Miami Division.

- LeClair Lawsuit: The Office of the Attorney General (OAG) is currently litigating this lawsuit in Federal Court for the Department. A court date for oral arguments has been requested but has not yet been set by the judge. The OAG is seeking an end to the lawsuit and vacatur of the outdated consent decree HRSR 95-3. The Department has prepared a replacement operating procedure CFOP 95-6 and has instructed the state mental health and developmental disabilities facilities to begin implementation of 95-6 (or continue with 95-3 in areas that are more stringent than 95-6 until HRSR 95-3 is vacated).

  The Mental Health Program Office has developed a comprehensive training and reference manual to provide a structured framework for use of psychotropic medications in state treatment facilities. Training has been provided for all the facilities regarding implementation of the draft CFOP 95-6. The Department has contracted the University of Florida, School of Medicine, Department of Psychiatry to provide external review of the facilities to assess the process of implementation with a benchmark for the first year of implementation. The team also provides recommendations to facilitate full implementation of 95-6. This monitoring serves as a peer review process that provides consultation regarding psychotropic medication use within state facilities.

Strategic Course of Action 2000-2003:

- Reduce the number of cost centers to have broader categories.
- Developing a more accurate billing methodology that is more provider-friendly.

- Re-writing the patient fees portion of the contracting manual to be clearer.
- Developing a clear complementary benefit guide to indicate to providers what services are to be billed to Medicaid and what services should be paid for through the Department.
- Revising the contracting manual and the current model contracts.
- Incorporating alternative provider payment mechanisms such as case rates or bundled service packages.
- The Mental Health and Substance Abuse programs are developing a model of system management using an ASO or provider network and fully describing how this mechanism would operate.
    - The Mental Health and Substance Abuse programs will prepare cost estimates for services and will develop a plan for covering these costs.
    - The Mental Health and Substance Abuse programs will work with Medicaid to help develop a complementary contracting program.
    - The Department will work with individuals, providers, county government and other stakeholders in designing the ASO model or provider service network for system of care organization and management.
    - It is recommended that the pilot comprehensive system of care model described earlier and the ASO model or provider service network be implemented together in the former GPW catchment area.
- Review how performance measures are being applied at the individual contract level.
- Developing an algorithm for determining successful performance that will take into consideration the relative importance of all the measures to the specific target populations and cost centers to be covered by the contract. Statutory authority may be necessary to implement this strategy.
- Developing process measures that focus on the effectiveness of specific services or service packages and whether these services improve client stability and functioning.

Progress to Date:

Mental Health and Substance Abuse Financial Rule and Statute

Chapter 65E-14, Florida Administrative Code, is the Community Alcohol, Drug Abuse and Mental Health Financial rule, which implements the financial provisions of Part IV, Chapter 394, F.S. The Substance Abuse and Mental Health Program Offices are revising this rule, which provides the framework for the contracting manual and the model contracts. This revision process involves various stakeholders, including the Department staff, advocacy organizations, providers, and other interested parties, who provide their input in a series of forums, including statewide survey instruments and workgroup meetings.

After the Department's internal review and approval of the draft rule, public hearings will lead to completion of the rule revision process and its promulgation by June 30, 2003. The complexity of the current contracting system, particularly regarding regulatory oversight and accountability, requires a very methodical and detailed approach that significantly delayed the initial promulgation timeline.

The proposed financial rule revisions seek to:

- Increase provider flexibility in the determination of services to be delivered based upon client needs.
- Reduce complexity by simplifying the financial reporting requirements.
- Improve accountability by implementing performance contract billing procedures that uniquely identify clients served, services provided, service dates, and amounts paid to providers.
- Improve data reporting and enhance the monitoring of invoice payments to ensure that only authorized services are billed to the Department and accounted for properly.

The financial rule includes revisions to the cost center structure for mental health and substance abuse services, which will enhance the flexibility for planning and budgeting at the activity level. The revised rule is also more provider-friendly, as it simplifies and deletes unnecessary requirements, and includes a revision to the patient fee schedule consistent with law.

Auditor General's Report

The Auditor General completed an Operational Audit (Report No. 03-051) in November 2002 of the Mental Health and Substance Abuse Programs (MHSA). The focus of the audit was to review and evaluate Department policies and procedures related to MHSA provider contracts, billings, monitoring, and data systems controls. The review disclosed concerns with policies and practices for billing of provider contracts. The audit also found deficiencies in policies and procedures for controlling, maintaining and disseminating data in the Alcohol, Drug Abuse and Mental Health Data Warehouse (ADMDW). The Department has actively been pursuing improved performance in this area and has been in the process of implementing the recommended changes including:

- Developing and implementing performance contract billing procedures for non-TANF payments. The Department has initiated proposed revisions to Chapter 65E-14, F.A.C., Community Alcohol, Drug Abuse and Mental Health Services Financial Rules, to require the total number of units on the invoice, paid by the Department, match up, by contract, with client-and-event- specific electronic records submitted to the ADMDW. This total includes only units paid for by the Department, Medicaid or local matching funds that include patient fees and other revenues eligible as match. This rule is expected to be completed and fully promulgated by March 31, 2003, for an effective date of July 1, 2003.

- Additionally, the Department has taken the approach that providing district staff with additional tools to perform their assigned duties this will enhance compliance with contracting policies and procedures. These tools may include the addition of data queries, technical assistance from specialized units of the Department, and access to ongoing training. For example, the Department will conduct statewide training of district contract managers, district ADM program staffs, fiscal and contract management staff to address the revisions to Chapter 65E-14, F.A.C., which will include the contract invoicing process and monitoring providers' invoices and supporting documentation prior to authorizing payments for ADM services.

- The MHSA program offices will be using COGNOS cubes, a data retrieval software, to uniformly produce and distribute the Substance Abuse and Mental Health performance measure reports. The statewide deployment of these reports are available to district data

liaisons immediately after they are published each month. In response to the central tracking of ad hoc report requests, a staff member is now assigned the responsibility to be the office point of contact for all ad hoc data requests.

- The data warehouse is going to be revised to include the contract number, funding source and procedure codes to the service event record. These revisions not only will include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) procedure codes, but also will enable the Department to match the number of units reported on the invoices with the number of units reported in the ADM data warehouse service events. These revisions are being piloted in District 1 using a web-enabled application to be used in the future as a replacement for MHSA software.

- The data system will also be enhanced to improve its security control features to further limit the possibility of improper disclosure or use of programs and data.

Continued Course of Action:

Chapter 65E-14, F.A.C.

Chapter 65E-14, F.A.C., is in its final review and approval cycle. The Department anticipates publishing a final notice of adoption in the Florida Administrative Weekly by mid-January 2003. If all goes well, the rule will become final in March 2003 to be effective by July 1, 2003. The ADM Model Contracts will be revised to be consistent with the changes made in Chapter 65E-14, F.A.C., prior to July 1, 2003. Training for district and provider staff is being planned for April or May 2003.

Development of a Benefit Guide

The Mental Health and Substance Abuse offices have coordinated with the Department's legal counsel and contract administration office to develop revised language on Medicaid billing for inclusion in the ADM model contracts. Additionally, we have prepared a Medicaid/ADM crosswalk of each of the ADM cost centers compared to the Medicaid procedure codes. When Chapter 65E-14, F.A.C., is promulgated, the revised information will be distributed to ADM providers.

Work will continue on the development of benefit packages, projected for completion by March 2003. A necessary step in this process is the analysis that will compare the current service array in District 8 with a model system and identify where there are gaps in the current system. This information will then be used to help determine priorities for modifying current services and developing new services.

Compliance with HIPAA Standard Requirements

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as Public Law 104-191, requires each covered entity to comply with federal standard requirements for privacy, security, code sets and electronic transactions of protected health information. The compliance deadline for privacy standards is April 14, 2003. The initial compliance deadline for electronic transaction standards and code sets was October 16, 2002, but the U.S. Congress approved a one-year extension to October 16, 2003. The proposed security standards are still under review; December 31, 2002, is the expected date for the security rule promulgation.

Non-compliance with any standard requirement for security or electronic transaction could lead to civil monetary fine penalties of up to $25,000 per person for violations of each standard per year. Noncompliance with privacy standards includes both civil and criminal penalties of up to $250,000 per person and/or imprisonment of not more than ten years.

The following are the major milestones for implementing HIPAA standards within the Department:

Identification of HIPAA Covered Entities

- In March 2002, the Department's General Counsel issued a statement defining HIPAA covered entities within the Department as "any programs funded by Medicaid, in whole or in part, that provide or pay for medical care". This narrow definition appeared to include only Medicaid Kidcare, developmental disabilities, substance abuse and mental health.

- In September 2002, the DCF Secretary signed a decision memorandum declaring the entire Department as a HIPAA covered entity, instead of declaring each individual program office and institution within the agency as a covered entity. The following are some major benefits of this decision:

  - The need for only one HIPAA Privacy Officer responsible for developing one set of standard policies and procedures to ensure a unified and timely response to HIPAA privacy issues across all departmental entities.

  - No requirement for chain of trust partner agreements between departmental entities that exchange protected health information electronically.

  - A requirement for only one chain of trust partner agreement between the whole Department and any external agency that exchanges protected health information electronically with any departmental entity.

  - Minimum audit requirements for the disclosure of protected health information, as intradepartmental disclosures will not be subject to HIPAA auditing requirements.

  - Minimum impact associated with future changes to the HIPAA standard requirements for privacy, security, electronic transactions and code sets.

HIPAA Implementation Team and Project Plan

The Department's oversight structure, which is responsible for implementing HIPAA standards, is an interdisciplinary team of state employees, including an Executive Sponsor, a Project Manager, a Privacy Officer, a Security Officer, a Legal Counsel, a Business Area Facilitator, a Technical Area Facilitator, and a Training Officer. The central program office staff, who is responsible for ADM Policy Integration and Information Systems, also currently serves as the HIPAA Business Area Facilitator.

- The Department's HIPAA project plan includes several activities that are in various stages of completion as described below:

- Established points of contact in both central and district program offices and in state institutions and distributed the required materials for HIPAA orientation and awareness.

- Completed gap analysis surveys and identified major risks that need corrective actions.

- March 31, 2003, is the expected date for completion of all activities related to implementation of HIPAA requirements for privacy standards. Draft copies of staff training materials and standard policies and procedures are currently under review, with expected completion date of January 31, 2003.

- September 30, 2003, is the expected date for completion of all activities related to implementation of HIPAA requirements for electronic data transactions and code sets. Standards for most HIPAA code sets, including ICD-9 diagnosis codes, are already an integral part of the ADM data warehouse system.

- Responses to most frequently asked questions pertaining to legal interpretation and implementation of the various HIPAA standards are already available from the Department's Office of Legal Counsel. This includes the generic language related to privacy assurances in the Department's contracts with its various business associates.

◆ The following are steps already taken by the central program offices to ensure contracted providers' compliance with the various HIPAA standard requirements:

- Conducted data summits, including HIPAA workshops, as part of the annual conferences organized in August 2002 by the Florida Alcohol and Drug Abuse Association (FADAA) and in September 2002 by the Florida Council for Community Mental Health (FCCMH). These workshops provided contracted provider agencies with additional information needed to modify their own information systems.

- Continue to provide technical assistance, including training sessions and site visits, to both district and provider staff concerning security and confidentiality issues.

- Updated existing data collection policies and procedures, including system documentation and database application software, to reflect HIPAA requirements for code sets and security standards. The Department is currently conducting a study to establish encryption standards that meet the minimum HIPAA requirements.

- As part of the security requirements for fiscal year 2003-2004, contracted providers will be required to change the method of data submission by using Virtual Private Network (VPN) via T1 line, cable modem, or DSL, instead of using the keyfob dial-up via the Department's Routing Transport Service (RTS). The financial rule allows contracted providers to bill the Department for indirect administrative services, which include costs associated with data collection and submission.

- The financial cost of compliance with various HIPAA standards, especially those related to electronic transactions of individual health care claims for payment, is very large and is going to impact both the Department and contracted providers. Limitations in current financial resources will make it very difficult for the Department to adequately plan and meet the current compliance deadline of

- October 16, 2003.

Improving Data Analysis and Reporting Capabilities

Section 394.9082, F.S., requires the Department and the Agency for Health Care Administration (AHCA) to develop strategies that will improve the coordination, integration, and management of the mental health and substance abuse service delivery system. One of the strategic goals of this legislation is to improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes. The following are improvements needed in the current data systems in order to comply with this statutory requirement:

- Change the database platform from the current client-based application, i.e., the MH-SA software, to a web-enabled application, which the Department is piloting in District 1 during Fiscal Year 2002-2003 to replace the MH-SA software starting in Fiscal Year 2003-2004. The major benefits from statewide implementation of this web-enabled application are as follows:

  - Improved efficiency of the client service delivery due to immediate verification of clients' eligibility status. For example, the new system will establish a free and direct interface with other database systems, such as the Florida Medicaid Management Information System (FMMIS), the Florida Online Recipient Integrated Data Access (FLORIDA), and the Home Safe Net.

  - Improved effectiveness of client service delivery by providing online database access capability to direct service staff. For example, the new system will have both standard and ad hoc capabilities to analyze and report data needed at all levels for both clinical and management decisions.

  - Reduced costs due to maintenance of only one integrated database system instead of several different stand-alone database systems (e.g., one in each provider agency that may use different hardware, software, and database applications).

- Change the electronic data submission process from the current dial-up system using the Department's Routing Transport Service (RTS) to a system that uses a web-enabled file transfer protocol (web-FTP). The major benefits from implementing this change are as follows:

  - Improved standards associated with the security and confidentiality of protected health information as required by HIPAA.

  - Reduced costs associated with potential litigation and lawsuits, as well as large monetary fines and/or harsh criminal penalties, by implementing the required HIPAA security and privacy standards.

- Implement a web-enabled Online Analytical Processing (OLAP) system, which will enhance the Department's ability to analyze data and generate timely reports that are immediately accessible to users statewide. This new system, which is currently available to the Department's staff in both central and district offices, will be deployed and accessible statewide to all contracted provider agencies. The enhanced system will significantly improve

the rate at which reports are run and will allow for more in-depth examination of performance at the client, provider and state levels.

Currently, the Department is negotiating with the vendor of the OLAP system for licensing packages that will enable providers to have access to online reports using this analytical tool. The first phase will allow providers to access the data cubes for standard performance outcome measures. This access will be available via the Department's Intranet site, which both districts and contracted providers currently use to upload and download their data to and from the ADM data warehouse. The second phase will be to make the aggregated cubes available through the new web-enabled database system being piloted in District 1 for statewide implementation starting in Fiscal Year 2003-2004.

FY 2001-2002 Performance

The Mental Health and Substance Abuse 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, we plan to explore drivers of service delivery that would more appropriately be applied at the individual contract level. Concurrently, we 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 Department, as required by Florida Statute, completed its Annual Contract Performance Report in November 2002. A comprehensive review of 169 contracts (containing client-specific performance targets) indicated substantial compliance on the part of providers; nearly 95 percent of provider contracts met or exceeded performance requirements for FY 2001-2002. For the contracts that were identified as deficient, districts took corrective actions that resulted in reductions in contract amounts, non-renewal of contracts, or other sanctions.

Children's Mental Health Performance

The table below shows the performance results for children's mental health services in Fiscal Year 2001-2002. In both of the performance outcome measures, the actual statewide outcomes significantly met or exceeded the state standard.

Children's Mental Health

General Appropriations Act (GAA) Outcome Measures for FY 2001-02

Target Population	Performance Outcome Measure	State Standard	Actual Statewide Outcome
Children with Serious Emotional Disturbance (SED)	a. Projected annual days SED children (excluding those in juvenile justice facilities) spend in the community	341	347
Children with Emotional Disturbances (ED)	a. Projected annual days ED children (excluding those in juvenile justice facilities) spend in the community	353	357

The GAA also includes some children's mental health outcome measures intended only for collecting baseline data during FY 2001-02. The table below lists these measures, which had no

GAA targets and are not included in this report because they were not part of provider contracts during FY 2001-02.

FY 2001-02 GAA Children's Mental Health Outcome Measures for Baseline Collection Only

Target Group	Outcome Measure
Children with Serious Emotional Disturbance (SED)	Percent of improvement of the emotional condition or behavior of the child or adolescent evidenced by resolving the presented problem and symptoms of the serious emotional disturbance recorded in the initial assessment.
Children with Emotional Disturbances (ED)	Percent of improvement of the emotional condition or behavior of the child or adolescent evidenced by resolving the presented problem and symptoms of the serious emotional disturbance recorded in the initial assessment.

Adult Mental Health Performance

The table below indicates performance outcomes for FY 2001-2002.

Adult Mental Health GAA Outcome Measures for FY 2001-02

Target Population	Outcome Measure	State Standard	Actual Statewide Outcome
Adults with Serious and Persistent Mental Illness in the Community	a. Average annual number of days spent in the community (not in institutions or other facilities)	350	349
	b. Average annual days worked for pay	40	34
Adults in Mental Health Crisis	a. Percent not readmitted within 30 days of discharge from a CSU/Inpatient unit	97%	98%
Adults with Forensic Involvement	a. Average annual number of days spent in the community (not in institutions or other facilities)	310	251
	b. Percent of persons who violate their conditional release under chapter 916, Florida Statutes, and are recommitted	<2%	1.3%

Children's Substance Abuse

The table below represents statewide performance levels for FY 2001-2002. On a statewide basis, providers exceeded performance expectations for treatment completion. The follow-up measure continues to be problematic; recommendations regarding this measure are made at the end of this section. Measurement of pre/post-treatment commitment rates is currently being coordinated with the Florida Department of Juvenile Justice.

Children's Substance Abuse GAA Outcome Measures for FY 2001-02

Target Population	Outcome Measure	State Standard	Actual Statewide Outcome
Children with Substance Abuse Problems	a. Percent of children who complete treatment	72%	74%
	b. Percent of children who are drug free during the 12 months following completion of treatment	52%	N/A*
	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%	Data not yet available.
Children At Risk of Substance Abuse	a. Percent of children who receive targeted prevention services who are not admitted to substance abuse services during the 12 months after completion of prevention services	95%	95.3%

* The department is legally required to get consent from parents/guardians prior to interviewing children and was unable to get a sufficient sample of respondents. In the vast majority of cases, parents/guardians refused to allow their children to be interviewed for the follow-up study.

Adult Substance Abuse Performance

The table below represents statewide performance levels for FY 2001-2002. On a statewide basis, providers exceeded performance expectations for employment. The child welfare measure continues to be problematic; recommendations regarding this measure are made at the end of this section. Measurement of pre/post-treatment arrest rates is currently being coordinated with the Florida Department of Law Enforcement.

Adult Substance Abuse GAA Outcome Measures for FY 2001-02

Target Population	Outcome Measure	State Standard	Actual Statewide Outcome
Adults with Substance Abuse Problems	a. Percent of adults who are drug free during the 12 months following completion of treatment.	54%	65.4%
	b. Percent of adults employed upon discharge from treatment services	65%	72.9%
	c. Percent of clients who complete treatment	69%	68.4%
	d. Percent of adults in child welfare protective supervision who have case plans requiring substance-abuse treatment who are receiving treatment	53%	Data not available from Family Safety
	e. Percent change in the number of clients with arrests within 90 days following discharge compared to number with arrests within 90 days prior to admission	55%	Data being compiled through FDLE.

During the 2002 session the Florida Legislature adjusted the GAA measure for pre/post-treatment arrests to align with the federal requirement of 180 days prior to and following treatment. The new standard for this measure for FY 2002-2003 is a 50 percent change in the number of clients with arrests following completion of treatment.

Recommendations for Performance Measurement - Substance Abuse

Over the past five years, as the Department has executed performance-based program budgeting requirements, several difficulties have been identified in the process of setting performance standards. Each year the Department is held to a series of standards established in the General Appropriations Act (GAA). To ensure the attainment of these standards the Department establishes district-level targets through its Agency Business Plan process, based on the state standards for each measure and each district's prior year's performance. The districts, in turn, set performance expectations for providers for applicable measures through the contracting process.

Most of the GAA measures are written for state-level achievement and often do not translate well to the district and provider levels. For example, the pre/post-treatment measurement of arrests for substance abusers is a societal measure of the overall system's impact. Holding providers accountable for this measure provides perverse incentives by encouraging them to serve fewer criminal justice-involved clients (so that the measure would not apply to most clients). As an alternative for local level evaluation, providers should be measured against factors that they have control over and contribute to lower post-treatment arrest rates such as completion of treatment and employment upon discharge.

Performance measurement should be used at the state, district, and provider levels to not only facilitate results-oriented management and maintain accountability to external stakeholders, but to improve the overall quality of care for clients and their families. At each of these levels the performance focus should vary somewhat. At the state level, performance should demonstrate to external stakeholders that a program or system is positively impacting societal problems and costs as intended, such as improved self-sufficiency or less dependence on publicly funded services. Performance measurement should also permit state level administrators to identify services that are cost-effective without negatively affecting the quality of care. At the district or local level,

performance expectations should be geared toward local needs, allowing administrators to contract for and evaluate services according to identified priorities. The program offices and the DCF Mission Support and Performance Team are developing a review and approval process for districts to develop locally-appropriate measures for inclusion in contracts. Each district will be required to submit information on the methodology used for developing each measure to include target setting, validity and reliability statements, and a brief justification prior to inclusion in contracts.

Another significant problem associated with current performance standards is that they do not account for client case mix variations; the presenting needs, characteristics, and symptomologies of clients that vary considerably across programs and service modalities. Programs serving clients with more chronic, debilitating conditions should not be subjected to the same expectations for performance as programs serving clients with less debilitation and more functional capacity. The Mental Health and Substance Abuse Program Offices are currently working with the Florida Mental Health Institute and outside consulting entities to develop case mix methodologies to help develop appropriate performance targets.

In an effort to more appropriately measure the effectiveness and efficiency of public mental health and substance abuse services the Department is making the following recommendations:

- Align substance abuse performance measurement timeframes with federal block grant requirements. Since the federal Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) measures will become mandatory within the next two funding cycles, alignment ensures that providers are held to single standards for all measures. Failure to align will force the Department to duplicate its efforts for measuring separate state and federal standards. Recommended changes include:
  - Adjustment of the pre/post-treatment timeframes for arrests of adults with substance abuse problems from 90 days to 180 days to align with CSAT.
  - Adoption of CSAP prevention measures, at the district and provider levels, relative to perceived harm, intent to use, and attitudes toward substance use.
- Assign common definitions for recidivism and recommitment for joint measures shared with the Department of Corrections and the Department of Juvenile Justice.
- Allow for the development of unit cost measures that correspond to comparable units of service within budget activities, e.g., groupings of services that are purchased by the hour, half-day and full-day. Current requirements combine dissimilar units, which prevent the program offices from identifying a true picture of service costs.
- Eliminate measures that have been determined to be unattainable due to lack of resources or legal (confidentiality) impediments. These measures are outlined below.

  - ***Child Welfare Measure for Adults in Need of Substance Abuse Services***

    The department is currently developing client data systems within the child welfare and Mental Health and Substance Abuse program areas that will facilitate accurate identification of those clients accessing both systems of care, their presenting needs and services received. The department is currently forced to conduct hard-copy file reviews of Family Safety clients to identify individuals who had presenting needs for substance abuse services; the results are then checked against the ADM data warehouse to determine receipt of needed

services. This process is quite labor intensive and the department does not currently have the resources to conduct this survey on an annual basis. The department is recommending that the measure be deleted for FY 2002-2003 and reinstated in FY 2004-2005 when the data systems will allow for an automated, integrated evaluation of these clients.

- ***Substance Abuse Treatment Outcome 12 Months Following Completion of Treatment.***

  Beginning in Fiscal Year 1999-2000, the Substance Abuse program contracted with Florida State University to survey treatment completers six months following discharge from treatment to determine the extent of post-treatment abstinence. The surveys are based on self-admission of substance use and subjects require prior permission to be contacted for the survey. Addresses and telephone numbers updated at discharge are highly changeable in this survey population. The vast majority of survey principals who could be reached refused to cooperate, including most of those who had indicated prior consent (or parental consent) in writing following treatment. The fact that only volunteers provide survey input makes projection of survey results to the entire population highly questionable. Each year of the six-month follow-up survey, there were insufficient numbers of child/parental respondents to draw any conclusions from survey results.

  This fiscal year, the follow-up survey is directed to treatment completers 12 months following treatment, rather than 6 months after treatment completion. The veracity of treatment completers' demographic information is even more eroded by the additional half-year time lag between treatment completion and survey contact attempts. Contracted surveyors are having extreme difficulty in finding enough adult completers who are willing to participate in the survey. Finding enough parental respondents to provide meaningful survey results for children will not be possible.

  The annually reported survey is very expensive and labor-intensive, with extremely sparse results of questionable reliability. It is not feasible to collect survey results at district and provider levels. We suggest that this measure be discontinued, and that program performance outcomes be measured by more reliable methods based on electronically reported data, such as, "Percent who complete treatment."

- ***Prevention Measures***

  The Substance Abuse and Mental Health Services Administration, through the Center for Substance Abuse Prevention (CSAP) is currently developing a set of "core" measures for substance abuse prevention, including the number of times drugs were used in the last 30 days, attitudes towards drug use, perception of harmfulness of drug use, intention to use a drug in the future and age of first use of drugs. In the coming years, SAMHSA will ask states to begin reporting on these measures. DCF currently collects this information for the general youth population through the Florida Youth Substance Abuse Survey. Data collection strategies are being piloted to collect similar data at the program level through

the development of a web-based reporting system for substance abuse prevention activities.

Appendix A

Workgroup Report on Supportive Housing
Chapter 2002-248, Laws of Florida (SB 2254)

Completed November 27, 2002

I. Purpose

Chapter 2002-248, Laws of Florida, directs the Secretary of the Department of Children and Families to establish a workgroup to review issues associated with publicly funded supportive housing living arrangements.

"The workgroup shall address development of administrative rules regarding:

- The definition of supportive housing services;
- Individual's health and safety (resident's rights, concerns and standards); and
- The use of subsidies funded by the Department of Children and Family Services."

II. Workgroup Process

The Department's implementation of Chapter 2002-248, Laws of Florida, included the following:

- Convening a workgroup composed of legislatively required agencies and other parties. Please see Attachment I for workgroup participants.
- Conducting workgroup meetings on September 6, October 8, October 22 and November 22, 2002.
- Submitting the workgroup's recommendations to the Legislature as part of the Master Plan.

III. Background of Supportive Housing

Nationally, the most identified barrier to community integration of persons with disabilities is the lack of affordable and safe housing. Over the last twenty years assisting people to obtain affordable housing and supports has emerged as the primary approach to address this issue. For example, supportive housing issues can be found in the following national documents on mental health:

- U.S. Surgeon General's Report on Mental Health;
- U.S. Olmstead decision; and
- November 12-13th agenda for the President's New Freedoms Commission on Mental Health.

Affordable housing and supports is recognized as a key factor in obtaining successful and enduring outcomes for disabled persons. Multi-year federal demonstration supportive housing projects have shown that costs attributed to supporting housing are balanced against the accumulated public and societal costs of not providing this service. Federal laws and court decisions have mandated the integration of persons with disabilities into the mainstream of community life.

Within Florida, the implementation of a recovery-based and evidence-based approach to service delivery is a major part of redesigning Florida's system of care. A major goal of this redesign is to assist individuals achieving a successful community tenure of which affordable housing is a key element. This redesign is the result of recent legislative enactments as evidenced by Chapter 2000-349, Laws of Florida, Chapter 2001-191, Laws of Florida, and through legislative proviso language.

IV. Defining Key Elements of Supportive Housing

The first task of the workgroup was to define supportive housing. The workgroup arrived at the following definition:

> "Supportive housing" is an array of individualized services and supports to assist each person with a serious mental illness to choose, get and keep regular, integrated, safe and affordable housing. In order for supportive housing to work successfully, the program must have three elements: housing production; services and supports; and rent subsidies."

Federally sponsored affordable housing demonstrations incorporate the following characteristics:

- Individual either owns or has a lease;
- Housing is permanent, rather than part of a transitional continuum of care;
- Housing is not conditional upon the acceptance of any service;
- Housing is integrated into the community;
- Housing is affordable;
- Individual has choice in the selection and location of housing and services;
- Promotes independence and retention of housing with advocacy.
- Is for all individuals with serious mental illness; there are no readiness criteria and services are flexible to meet the person's changing needs;
- Services are community-based;
- Crisis services are accessible 24 hours a day, 7 days a week; and
- Requires compliance with all other federal, state, and local laws.

Additionally, the workgroup recommends that standards/rules be written to address the following supportive housing dimensions:

- **Eligibility:** means defining who is eligible for supportive services, and who is eligible for a housing subsidy; defines the process of resource allocation to rank among applicants.
- **Housing Choice:** means the process and extent of offering different housing choices.
- **Housing Affordability:** means determining each applicant's monthly income and establishing a personal budget to determine what amount of subsidy is needed.
- **Integration**: means promoting scattered-site housing and identifying provisions that may offset the impact of more segregated housing.
- **Service Choice**: means absence of any requirements to participate in activities or treatment as a condition of residence.
- **Service Individualization:** means informing the individual of choices; determining the extent that the individual is receiving the services of his/her preference.
- **Community-Based Service Availability**: means providing access to community mental health and other services and supports.
- **Structure**: means allowing individuals to plan their own daily schedule of activities.
- **Proximity to Transportation**: means housing located within a reasonable distance of public transportation routes.
- **Amenities**: means stores are nearby.

V. Supportive Housing Recipients' Health, Safety, Rights and Protections

Workgroup members were provided a copy of the United States Department of Housing and Urban Development (HUD) housing structural standards for the HUD Section Eight rental assistance program. These are minimum occupancy standards for defining decent and safe

publicly supported housing units. The workgroup recommends that service standards/rules be written to address individuals' rights, health, safety and welfare that include the following dimensions:

- **Informed Consent and Choice:** means explaining service options and ensuring the rights and dignity of service recipients.
- **Quality of Life, Personal Goals, Readiness for Change or Risk:** means ensuring these concepts and goals are defined by each individual.
- **Conditions of Residency:** means conditions/rules that do not exceed those applicable to non-disabled persons.
- **Quality of Housing:** means standards for subsidized housing units that incorporate HUD's Section Eight Rental Assistance Housing Criteria.
- **Access to 24-hour Crisis Services:** means ensuring on-site crisis services are accessible 24-hours a day, seven days a week.
- **Provider Accountability:** means licensure or certification standards for service appropriateness and responsiveness, and outcomes for individuals served.
- **State Provided Training**: means supportive housing fidelity training for all parties to promote continuous, quality improvement in the delivery of affordable housing and supportive housing services.
- **Equal Availability**: means standards that require equal access to services or housing subsidies for Medicaid eligible and non-Medicaid eligible individuals.
- **Reasonable Accommodation**: means standards for making physical modifications to individuals' living environments or homes.

VI. Housing Subsidy Funds

When using HUD's fair market rental calculations and HUD's definition of affordable housing, which is spending up to 30 percent of a person's monthly income, individuals on Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) cannot afford to pay the rent of a one-bedroom apartment. According to "Priced-Out 2000", a national index of housing affordability published by The National Low Income Housing Coalition, a person living on SSI in Florida would expect to pay more than their entire SSI for a one bedroom apartment. It is because of this disparity in rental costs and monthly income that the workgroup recommends the inclusion of a housing subsidy.

The workgroup recognizes the need for a housing subsidy and recommends a publicly funded subsidy for Supportive Housing. It also recommends that service standards/rules be written to include the following dimensions:

- **Purpose of Subsidy**: restricting subsidy to deposits and monthly costs for rent, utilities, and basic local telephone.
- **Affordability**: ensuring no more than 30% of an individual's income is used for housing and utilities.
- **Calculation of Affordability**: developing procedures for calculation of rent subsidy.
- **Subsidy Targets and Outcomes**: developing performance goals and measures.
- **Coordination of Benefits**: ensuring maximum benefits are applied for as a means of reducing subsidy needs.
- **Recruitment of New Service Providers**: providing incentives for new supportive housing service providers.

- **Leveraging Subsidies**: allowing districts' use of housing subsidies in cooperation with other fund sources to achieve lower rental rates or more integrated, scattered-site housing units than would otherwise be affordable.

VII. Workgroup Recommendations In Priority Order

- The Legislature is requested to consider:
  - Delegating the Department the necessary authority to write administrative rules consistent with this report. The rulemaking authority should include the definition of supportive housing and its dimensions specified in this report. The authority should also address how the Department will provide oversight for its supportive housing providers including training and a provider certification process.
  - Adopting the goal of developing permanent, affordable, integrated housing for persons with serious mental illness with an emphasis on persons with extremely low income.
  - Encouraging the coordination and expansion of funding opportunities for housing production by leveraging subsidies with other federal, state and local affordable housing resources.
  - Directing the Department of Children and Families and the Agency for Health Care Administration to plan, implement and administer a supportive housing program for adults with a serious mental illness, including persons with a co-occurring substance abuse problem.
  - Making a specific appropriation for Florida's publicly funded supportive housing program for adults with a serious mental illness. The appropriation should include funding for services and supports as well as rental subsidies.
  - Encouraging all entities of state government to implement publicly funded supportive housing in Florida.
- The Department should consider:
  - Submitting a legislative budget request for an appropriation to fund supportive housing;
  - Coordinating with Medicaid to ensure supportive housing services can be billed to Medicaid;
  - Continuing and expanding its activities to promote the development of affordable housing coalitions that include members of this workgroup with an emphasis on targeting rural and low-income counties.
  - Analyzing each district/region's current general revenue funds to identify opportunities to redirect funds to rental subsidies and services for non-Medicaid eligible individuals,
  - Designating new Federal mental health block grant funds for supportive housing.

ATTACHMENT I
SUPPORTIVE HOUSING WORKGROUP PARTICIPANTS

Agencies Named in SB 2254

Agency for Health Care Administration
Florida Health Care Association
Florida Assisted Living Affiliation
Florida Association of Homes for the Aging
Florida Council for Behavioral Healthcare, Inc.
National Alliance for the Mentally Ill
Florida Advocacy Center for Persons with Disabilities
Florida Coalitions for the Homeless
Florida Housing Coalition
Florida AIDS Action
Florida Hospital Association
Florida Long-Term Care Ombudsman
Florida Statewide Advocacy Council
Florida Sheriffs Association
Florida Psychiatric Society
Department of Elder Affairs
Florida Mental Health Counselors Association
Florida Association of Counties

Invited Members:
Florida Mental Health Institute
Office of Homelessness- DCF
Florida Housing Finance Corporation
District Program Office Supervisors (2)
Individuals with a Mental Illness (4)