


Substance Abuse and Mental Health Services Plan: 2007 – 2010

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Charlie Crist, Governor

Robert A. Butterworth, Secretary

NOTICE OF FILING

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Abstract:

Section 394.75, Florida Statutes, requires the Department of Children and Families 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 abuse and mental health services throughout the state.

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

The annual update provides a progress report on key strategic issues, program performance, budget and financial aid, and key trends and conditions. It also describes strategic activities for 2007.

Copies of this report will be available for viewing and downloading through the Department's website at:

http://www.dcf.state.fl.us/mentalhealth/publications/index.shtml

Copies of this report may be obtained by contacting:

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Substance Abuse and Mental Health Services Plan 2007-2010

Strategic Summary

Section 394.75, Florida Statutes (F.S.), establishes the planning process for the state's publicly-funded substance abuse and mental health service system. Every three years, beginning in 2000, the Department of Children and Families, in consultation with the Agency for Health Care Administration (AHCA), is required to submit a state master plan for the delivery and financing of a system of publicly-funded, community-based substance abuse and mental health services throughout Florida. This document represents the three-year plan covering 2007 -2010. The plan is consistent with all statutory requirements.

The mission of the Department of Children and Family Services is *"Protect the Vulnerable, Promote Strong and Economically Self-sufficient Families, and Advance Personal and Family Recovery."* The key strategic objectives and strategies that support the department's mission and direct the provision of services to Florida's citizens are detailed below. These represent the primary focus of the Substance Abuse and Mental Health programs.

Objective – Prevention and Early Intervention

This objective pertains to customers who are at-risk of or challenged by substance abuse problems or mental illness. Strategies and action steps correlating to this objective focus on decreasing the prevalence of substance use/abuse or mental illness and delaying the onset of substance involvement or emotional disturbances.

Strategies:

- ***Implement the strategic prevention framework for Substance Abuse.***
- ***Implement evidence-based programs (Substance Abuse and Mental Health).***
- ***Target early intervention strategies to at-risk youth (Substance Abuse and Mental Health).***
- ***Continue initiatives to address children with co-occurring disorders (Substance Abuse and Mental Health).***
- ***Develop and implement early childhood strategic plan with the Department of Health (Mental Health).***
- ***Ensure that families and youth are full partners in the development and implementation of individual recovery plans and have a prominent voice in designing supports and services (Substance Abuse and Mental Health).***

Objective – Recovery and Resiliency

This objective addresses the needs of customers with substance abuse and/or mental health concerns and focuses on empowering these individuals to achieve their greatest potential.

Strategies:

- ***Increase consumer access to recovery and evidence-based services and supports (Substance Abuse and Mental Health).***
- ***Secure adequate and equitable funding across all districts and region (Substance Abuse and Mental Health).***
- ***Collaborate with law enforcement agencies, the criminal justice system, stakeholders, and service providers to identify safe and therapeutic alternatives to jail thereby reducing public safety risks (Substance Abuse and Mental Health).***
- ***Improve linkages with other programs and agencies to ensure uninterrupted services when consumers move between provider agencies and different levels of care (Substance Abuse and Mental Health).***
- ***Sustain recovery support services that were developed under the Access To Recovery grant to improve client outcomes (Substance Abuse).***
- ***Transform the mental health system to a customer driven and integrated system of care, including:***
    - ***Increased access to stable housing, employment and transportation;***
    - ***Increased customer participation in all aspects of program planning and policy making;***
    - ***Expansion of trained, qualified Peer to Peer and Family to Family support;***
    - ***Timely access to a continuum of care ranging from routine outpatient to acute residential care; and***
    - ***Comprehensive workforce development to ensure availability of skilled, culturally competent service providers.***
- ***Utilize continuous quality improvement methods to increase client access to and retention in substance abuse services.***
- ***Establish uniform reporting and analysis of critical events, including suicide (Mental Health).***
- ***Continue collaborate with judicial and law enforcement partners to increase access to necessary mental health and competency restoration services for persons committed pursuant to Chapter 916, F.S. (Mental Health).***
- ***Collaborate with the Agency for Health Care Administration to ensure appropriate access to Medicaid funded substance abuse and mental health services.***

Objective – Resource Stewardship and Integrity

This objective addresses administrative and management functions that ensure that program funding is expended efficiently and in compliance with any specified requirements.

Strategies:

- ***Expend funds as appropriated (Substance Abuse and Mental Health).***
- ***Perform quarterly, monthly, or as appropriate, monitoring of expenditures through the Performance and Resource Team (PaRT) process (Substance Abuse and Mental Health) (Substance Abuse and Mental Health).***
- ***Ensure that federal and other grant funds are managed and expended in accordance with specified requirements (Substance Abuse and Mental Health).***
- ***Maximize Medicaid earnings in order to diversify provider funding sources (Substance Abuse and Mental Health).***
- ***Conduct cost analysis studies to determine most efficient methods for funding services (Substance Abuse and Mental Health).***
- ***Strengthen invoice verification procedures (Substance Abuse and Mental Health).***
- ***Expand use of managing entities to purchase flexible systems of care (Substance Abuse and Mental Health).***

Objective – Continuous Performance Improvement

This objective is achieved through a consistent review of program performance that includes outcome and process indicators. Actions are taken at state and district levels to impact program performance. The agency has adopted the Sterling criteria for performance management and improvement.

Strategies:

- ***Implement a comprehensive performance improvement program that integrates state and district/regional level activities (Substance Abuse and Mental Health).***
- ***Communicate and deploy the Department of Children and Families Strategic and Annual Business Plans (Substance Abuse and Mental Health).***
- ***Deliver training in problem solving, analysis, and related results-based content (Substance Abuse and Mental Health).***
- ***Implement the Strengthening Treatment Access and Retention-State Implementation (STAR-SI) grant (Substance Abuse).***
- ***Implement the Robert Wood Johnson, Advancing Recovery grant (Substance Abuse).***

- ***Develop and implement the Florida Learning System in order to identify statewide trends and initiate systemic actions across various organizations that promote effective substance abuse service delivery (Substance Abuse).***
- ***Implement the National Outcome Measures (NOMS) (Substance Abuse and Mental Health).***

Objective – Technology Support

This objective supports the performance measurement system and impacts how the program analyzes its performance data and information in order to make strategic management decisions.

Strategies:

- ***Identify resources and priorities for data system changes (Substance Abuse and Mental Health).***
- ***Integrate electronic record-keeping and data-sharing systems to facilitate continuity of care when customers move between providers and to accurately track provider performance and customer outcomes (Substance Abuse and Mental Health).***
- ***Develop a statewide licensure data-base (Substance Abuse).***
- ***Develop the capacity to generate reports than enable data-based decision-making (Substance Abuse and Mental Health).***
- ***Revise procedures to improve user friendliness of current data system (Substance Abuse and Mental Health).***
- ***Create data system capacity to generate invoices from service event data.***

Objective – Consumer Satisfaction

This objective relates to meeting consumer needs and expectations.

Strategies:

- ***Continue use of customer satisfaction survey (Substance Abuse and Mental Health).***
- ***Stratify survey results and provide reports to districts/region and provider agencies (Substance Abuse and Mental Health).***
- ***Increase consumer involvement on program workgroups, committees, and improvement initiatives (Substance Abuse and Mental Health).***

CHAPTER 1: ORGANIZATIONAL PROFILE

Substance Abuse and Mental Health Programs

1) PROGRAMS AND DELIVERY MECHANISMS

The Department of Children and Family Services provides a wide variety of programs and services in the areas of Child Welfare, Child Care, Economic Self-Sufficiency, Adult Protective Services, and Substance Abuse and Mental Health services. The mission of the Department of Children and Family Services is *"Protect the vulnerable, Promote Strong and Economically Self-sufficient families, and Advance Personal and Family Recovery."*

Florida's Substance Abuse and Mental Health Programs have statutory responsibility for the planning and administration of all publicly funded mental health and substance abuse services. The goal of both programs is *"Persons with or at risk of substance abuse and or mental illnesses live, work, learn and participate fully in their community."*

The Substance Abuse and Mental Health Programs serve as the primary contact for the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services on all issues pertaining to substance abuse and mental health. Both programs also work closely with the Florida Agency for Health Care Administration. In addition, both programs work cooperatively with the Department of Education, Department of Health, Department of Juvenile Justice, Department of Corrections, Department of Elder Affairs, as well as, other partners and stakeholders.

The headquarters for the Substance Abuse and Mental Health Program Offices are located in Tallahassee, Florida. The operational management of service delivery occurs at the local level, through 13 districts and 1 region.

There are currently 135,321 adolescents/children and 441,723 adults in Florida with family incomes below 250% of the federal poverty level that are in need of substance abuse services. In FY 2005-2006, the department served 43,870 adolescents/children and 98,735 adults meeting these income criteria. This represents 32 percent of the adolescents/children in need being met and 22 percent of the adults in need being met.

The Mental Health Program provided mental health services to approximately 155,334 adults and 86,979 children in a community setting. The State Mental Health Treatment Facilities provided services to 2,214 civil clients, 2,084 forensic clients, and 592 sexually violent predators. This represents 41.48 percent of need met for adults and 18.04 percent of need met for children.

While services are provided within two distinct program areas, most of the service delivery is accomplished through contracts implemented at the

district/regional level with community-based substance abuse and mental health provider organizations and professionals. However, the State Mental Health Treatment Facilities also provide mental health and some substance abuse services directly to clients.

The programs provide many types of clinical treatment and recovery support services including prevention, acute interventions (i.e., crisis stabilization or detoxification), residential, transitional housing, and outpatient treatment services. They are also responsible for substance abuse provider licensure, regulation, financing, and contracting which play a significant role in the provision of effective substance abuse and mental health services.

Substance Abuse Services

Chapters 394 and 397 of the Florida Statutes govern the provision of substance abuse services, which provide direction for a continuum of community-based prevention, intervention, and treatment services. The Substance Abuse Program Office is also responsible for oversight of the licensure and regulation process of the substance abuse provider system. Staff at the local level, within the 14 districts/region throughout the state is responsible for licensing providers.

Prevention services include activities and strategies designed to preclude the development of substance abuse problems by addressing the risk factors known to contribute to substance use. In the case of children, these services may be provided in school-based settings and include parental participation. Prevention services for adults include activities and strategies that target the workplace, parents, pregnant women, and other potentially high-risk groups.

Treatment services include various levels of residential, outpatient treatment, and recovery support services with levels varying based upon the severity of the addiction. The Substance Abuse Program places increasing emphasis on the use of evidence-based practices in order to improve client outcomes. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child protection system, employment-increased earnings, and better health.

Detoxification services focus on eliminating substance use. Specifically, detoxification services utilize medical and clinical procedures to assist children and adults to withdraw from the physiological and psychological effects of substance abuse. Detoxification may occur in either a residential or an outpatient setting, depending on the individual needs of the client.

PDSA is responsible for administering and maintaining a comprehensive regulatory process for **licensure of service providers** who provide substance abuse services to individuals and families who are at risk of or challenged by substance abuse. This licensure process is governed or regulated by Chapter 397, F.S, and Chapter 65D-30, Florida Administrative

Code (F.A.C.). Minimum standards for licensure are specified for the following components: addictions receiving facilities, detoxification, intensive inpatient treatment, residential treatment, day or night treatment with host homes, day or night treatment with community housing, day or night treatment, intensive outpatient treatment, outpatient treatment, aftercare, intervention, prevention, and medication and methadone maintenance treatment. Specific criteria must be met in order for an agency to receive a license for the above components.

Mental Health Services

Chapters 394 and 916, F. S. provide direction for the delivery of mental health services for adults and children that includes both acute and long-term mental health services as well as oversight of state mental health treatment facilities and the Sexually Violent Predator Program.

Children's Mental Health serves children and adolescents with mental health problems who are seriously emotionally disturbed, emotionally disturbed or at risk of becoming emotionally disturbed as defined in Section 394.492, Florida Statutes. Mental health services for children are all delivered through contracts with providers, and are designed to enable children to live with their families or in a least restrictive setting and to function in school and in the community at a level consistent with their abilities. A variety of traditional and non-traditional treatments and supports are available.

Adult Community Mental Health operates a community-based system of acute, residential, and outpatient care, through contracts with private providers, designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders.

State Mental Health Treatment Facilities (also known as mental health institutions/state hospitals) serve adults who have been committed for intensive inpatient treatment by a circuit court. Such commitments are for civil reasons (i.e., without associated criminal charges, pursuant to Chapter 394, F.S.) or forensic reasons (i.e., with associated criminal charges, pursuant to Chapter 916, F.S.). Civilly committed customers include persons who require service intensity beyond that available in community crisis stabilization units, and sexually violent predators, who require long-term care and treatment in a secure setting. Forensically committed customers include those determined to be incompetent to proceed with trial or not guilty by reasons of insanity. State mental health treatment facilities work in partnership with the community to facilitate successful return to the community, when appropriate. For individuals committed as incompetent to proceed with trial, this includes achieving trial competency and returning to court in a timely manner.

Sexually Violent Predator Program (SVPP) was established within DCF to enhance the safety of Florida's communities by identifying and providing secure long-term care and treatment for sexually violent predators. Protection of the public through involuntary confinement of dangerous individuals is also a traditional governmental function.

The Substance Abuse and Mental Health Programs **contract management** unit serves both program offices and performs two important roles:

- Support for the management of district contracted services; and
- Direct contract management for all substance abuse and mental health central office contracts.

This unit is responsible for the management of approximately 70 contracts within the two program offices. Contract managers collaborate with program personnel, the content experts, to ensure the program offices receive the desired outcomes for all contracted services. Section 287.057, F.S., specifies that the contract manager is responsible for enforcing contract performance and serving as a liaison with the contractor. The contract unit is also responsible for providing support to district/regional offices that collectively manage 646 contracts with a total budget of $610 million. The contract unit is responsible for establishing contract policies, procedures and rules specific to substance abuse and mental health service delivery.

2) STAFFING

The Substance Abuse and Mental Health Programs have a total of 4,098.5 FTE positions and 541.5 OPS employees for a total workforce of 4,640 employees. Two and one-half percent of the workforce is located in Tallahassee, at the central headquarters; three and one-half percent of the work force is located in the 14 districts/region, while the remaining 94 percent is located in one of the three mental health treatment facilities operated by the state (Florida State Hospital, Northeast Florida State Hospital, and North Florida Evaluation and Treatment Center).

SAMH Program
FTE and OPS Employees

	Status	Headquarters	Disticts/Region	Treatment Facilities	Total
SA	FTE	27	31		58
	OPS	17	54		71
MH	FTE	51.5	73.5	3,915.5	4,040.5
	OPS	22.5*	2**	446	470.5
Total		118	160.5	4,361.5	4640.0

* In addition to the 22.5 above, 8 additional Headquarters OPS positions are hurricane related and will be removed from People First on March 15, 2007.

** In addition to the 2.0 above, 124 more District OPS positions are hurricane related and should have been removed from People First as of December 15, 2006.

-3) INFORMATION TECHNOLOGY

The Substance Abuse and Mental Health Data System, also known as the One Family SAMH system, is a web-enabled application. The system integrates the following information: (a) socio-demographic and clinical characteristics of clients served in state mental health treatment facilities and state-contracted community substance abuse and mental health provider agencies; (b) the types and amounts of services received by these individuals; and (c) the profiles of the service provider agencies.

This data system is the repository for both client service and contract information. Information retrieved from this system is fed into the department's Dashboard and posted on the department's internet site where performance at the state, district, and provider level, as well as performance on key indicators can be viewed.

The department will initiate a Request for Information (RFI) in fiscal year 2006-2007, which will be followed by a Request for Proposal (RFP), to acquire and implement a comprehensive and person-centered behavioral health management information system (BHMIS) in fiscal year 2007-2008. This new system will significantly improve the current system by integrating clinical, social, financial, and administrative information to support transformation of the mental health system of care.

4) REGULATORY ENVIRONMENT

Section 394.655, F.S. established the Florida Substance Abuse and Mental Health Corporation, which is a non-profit corporation, to oversee the state's publicly funded substance abuse and mental health service delivery system. The Corporation's twelve-member board of directors is appointed by the Governor, the President of the Senate, and the Speaker of the House. The Corporation is charged with making recommendations annually to the Governor and the Legislature on policies designed to improve coordination and effectiveness of the state's publicly funded mental health and substance abuse systems. The Corporation coordinates and oversees the Transformation Working Group (TWG), which is a state-level steering committee whose members were invited by the Governor to provide critical interagency oversight of the transformation of the mental health system in Florida.

The State Mental Health Planning Council was established under the Code of Federal Regulations. A funding agreement for a grant under Section 1911 of Public Law 102-321 is that the state involved will establish and maintain a State Mental Health Planning Council in accordance with the conditions described in Section 1914. Under this section, the duties of the Council are:

- To review plans provided to the Council pursuant to Section 1915 (a) by the state involved and to submit to the state involved any recommendations of the Council for modifications to the plans
- To serve as an advocate for adults with serious mental illness, children with severe emotional disturbance or other individuals with mental illnesses or emotional problems
- To monitor, review, and evaluate, at least once annually, the allocation and adequacy of mental health services within the state
- The Substance Abuse and Mental Health Programs are subject to Federal, State and Agency regulations relative to employment, the environment, treatment, services and occupational health and safety.

5) ORGANIZATIONAL STRUCTURE

In 2003, the Florida Legislature enacted legislation that established separate Substance Abuse and Mental Health Program Offices pursuant to Section 20.19(4), F.S. The Assistant Secretary for Substance Abuse and Mental Health, appointed by the Secretary, provides leadership for the program offices. The Secretary is also responsible for appointing a Program Director for Substance Abuse and a Program Director for Mental Health. Each of these directors has direct authority over all substance abuse and mental health headquarters and district/regional staff, as well as direct control of the programs' budget and contracts for services. Memoranda of understanding have been developed with each District or Regional Administrator describing the working relationships within each geographic area.

Operational functions for the programs are the responsibility of the Chiefs of Operation, who answer directly to the respective Program Director, and are members of the leadership teams. The Chiefs of Operation also have direct line of authority over the Program Supervisor in each district/region program office. The Chief of Operations for the Substance Abuse Program also functions as the Performance and Resource Team (PaRT) Leader and provides a linkage to the department's Executive Performance and Resource Team. Collaboration and linkages with the department's Assistant Secretary for Operations is achieved via the Assistant Secretary for Substance Abuse and Mental Health.

The Central Office responsibilities include:

1. Developing statewide rules, policies and standards
2. Providing technical assistance to the service districts, providers, and families
3. Assisting in the development of statewide legislative budget requests
4. Assisting in setting priorities for the use of resources
5. Allocating funds to the service districts
6. Coordinating the collection and analysis of data, including performance measures
7. Coordinating the development of statewide plans and programs

8. Collaborating with other state-level agencies, advocacy groups, and provider organizations
9. Managing statewide contracts

The Substance Abuse Program Office uses a "Team Leader" approach that specifies a lead individual as Team Leader with other staff performing functions that support the "team." Specified task areas include Prevention, Treatment, Performance Management, Budget, Information Technology (which also provides support to the Mental Health Program Office) and Operations. Each Team Leader reports directly to the Program Director.

Within the Mental Health Program Office, operations are organized around five main areas. These areas include: 1) Community Operations (includes Adult Mental Health Services, Children's Mental Health Services, and District/region Operations); 2) Mental Health Treatment Facilities (including the Sexually Violent Predator Program); 3) Budget; 4) Contract Management (which also provides contracting support to the Substance Abuse Program Office); and 5) Consumer and Family Affairs. Each of the five areas has a Chief responsible for operations within their area, reporting to the Director of Mental Health. The Contracts and Information Technology sections are jointly responsible to both Mental Health and Substance Abuse offices. In addition to the five main areas above, the Mental Health Program Office also includes a Disaster Response Unit, established in response to state disasters associated with recent hurricanes.

A Program Supervisor manages each district or region. Program Supervisors have a direct reporting relationship to the Directors of both programs in central office and a collaborative relationship with the District/Regional Administrator in their district/region. The Program Supervisors have a broad range of responsibilities focused to ensure effective management of substance abuse and mental health services at the community level, including the oversight of contracting, budgeting, licensure, and quality assurance activities. They are the department's representatives at the local level for mental health and substance abuse issues, and are expected to collaborate with local partners to ensure that a comprehensive system of substance abuse and mental health services are provided to citizens of their respective district/region. Local partners include, but are not limited to Persons receiving Substance Abuse and/or Mental Health services, Community-Based Care agencies, Department of Juvenile Justice, Department of Corrections, Department of Health, local government, the judiciary, law enforcement, advocacy groups, and providers of Substance Abuse and/or Mental Health services.

6) STRATEGIC CHALLENGES

The Substance Abuse and Mental Health Programs face a number of strategic challenges. These include, but are not limited to, the following:

1. Access to services in an environment where a low percentage of the need is met.

2. Appropriate services and supports for adults and children with mental illnesses who are involved in the criminal justice system.
3. Changes to state contracting requirements have resulted in better systems accountability, but have also presented a number of challenges. Current financing and contracting methods do not support flexible, prospective, client-focused/client-directed treatment services. Further, the financing and contracting methods do not sufficiently promote the use of evidence-based practices.
4. The SAMH data management systems are frequently not user-friendly, are not sufficiently integrated to support continuity of care or to track customer outcome, and often do not produce needed information at the state or provider level.
5. Most substance abuse and mental health services are provided through local contracted providers. These providers have experienced increasing difficulty in hiring and retaining a competent, well-trained workforce. This trend negatively impacts the ability to offer high quality and effective treatment services.
6. The SAMH Programs currently exist in a rapidly changing environment, particularly in the areas of contract management, service delivery through a managing entity structure, and Medicaid reform. In order to be successful, the programs must be flexible regarding the management of resources.
7. Programs are required to serve certain statutorily defined “target populations” within the state. However, there are a number of “priority” populations that have been identified for services through federal grant requirements, legislative actions, court decisions, or policy decisions. The department is not providing services to Medicaid recipients for covered services. There is a need to strengthen the capability of determining clinical and financial eligibility for services in order to most effectively deliver services with available resources. Statutory changes may be required to perform both of these functions.
8. Medicaid reform within the state has significantly impacted the funding and delivery of mental health services.
9. Over-reliance on OPS staff to perform functions that were previously performed by FTE’s has been identified as a unique challenge. Budget reductions over the past several years have resulted in fewer FTEs in the substance abuse and mental health programs. Subsequently, critical functions such as data management, contracting and program oversight have been assumed by OPS staff.
10. Communication and coordination of initiatives across agencies serving the same target population is challenging, and may result in fragmented services and inefficient use of limited resources.
11. Limited pools of state and federal funds are frequently the only sources of funding for low-income recipients of mental health and substance abuse services who are uninsured, or underinsured.

7) SUCCESS FACTORS

The keys for the future success of the Substance Abuse and Mental Health programs' missions are as follows:

1. establishing a well-articulated, strategic plan of action through statewide and district/regional plans that include prominent participation by customers and other stakeholders
2. monitoring resources and proactively adjusting resources to meet emerging needs
3. collaborating with other state agencies to eliminate redundancies and close gaps in services
4. establishing a well-defined, empirically-validated performance outcome system that allows the programs to accurately gauge the impact of the service system, and the effectiveness of service delivery

Both Substance Abuse and Mental Health programs are engaged in the following ongoing efforts to accomplish all of these objectives:

1. purchase services that are effective
2. provide incentives for good performance
3. reduce funds when performance does not meet expected standards and outcomes

Both Substance Abuse and Mental Health programs have a process in place to evaluate all departmental strategic performance measures and intervene with districts/regions and with providers as indicated by these measures, implementing corrective actions, contract revisions, data collection techniques, or provider selection. A Performance Management Team is currently working to incorporate and align the department's business plan with its strategic plan and budget plan. While these plans will continue to be authored as separate documents, efforts are underway to link these plans in a meaningful, well-articulated manner. The Performance Management Team and executive staff are also partnering with other state agencies and program offices to provide support for customers in areas not directly funded in the DCF budget, such as housing, employment, and other areas vital to achieving our customers' personal recovery goals. Several workgroups are specifically tasked with developing an ongoing interagency network.

Finally, the Performance Management Team is examining all the performance measures currently used to gauge the effectiveness of state-funded treatment and prevention programs. The Team has developed action plans designed to improve the operation of the Substance Abuse and Mental Health information system, improve the quality of data received from service providers, change current measures to adhere to national outcome measures, and validate all measures using scientifically based principles of statistics and data collection. These changes will allow the Substance Abuse and Mental Health programs to remain competitive with alternative service delivery mechanisms in a changing funding environment.

8) PERFORMANCE IMPROVEMENT APPROACH

Performance improvement initiatives are organized through the Department's Performance and Resource Management Teams. These Teams were chartered by the Secretary in August 2005 to integrate performance and expenditure decision-making using Sterling quality management principles. The teams are responsible for identifying performance and resource gaps, providing corrective action strategies and monitoring implementation impact. Core team membership consists of representatives from all sectors of the department in the central office, zones, region and districts.

Service providers that contract with the Substance Abuse and Mental Health Program Offices are required to enter admission, service, and discharge data into a centralized relational database. Provider performance is then compared to the required outcomes within districts/region and district/region performance across the state. The program offices report the outcomes on the department's web-based performance management tool called the Performance Dashboard, http://dcfdashboard.dcf.state.fl.us/. The Dashboard provides a visual display of performance data, and includes statewide, district/region, and provider-level data and outcome information. The program offices use the Dashboard to compare the performance of providers and districts/region.

In addition, the Performance Management Team regularly compares Florida's performance with other states, using data reported on the Substance Abuse and Mental Health Services Administration's web tool known as the National Outcome Measures (NOMs) Dashboard. The department benchmarks against national data to provide interstate comparisons on similar services

Staff training on quality management principles is also an integral component of the Performance and Resource Management Team process. District staff uses the Sterling quality management principles to identify root causes of performance deficiencies, and to design and implement countermeasures.

9) COMPETITIVE POSITION

Despite Florida's status as the third-largest state in population, Florida's per-capita funding for mental health and substance abuse services is ranked 48th and 37th, respectively in the nation. Efficiency is imperative in order to achieve the department's objectives.

Community-based services have been outsourced since the program's inception. Annual budgets, managed by the local program offices, are primarily allocated using an equity formula based on treatment need and population. Providers compete among themselves to secure contracts, with the marketplace driving competition. The Florida Legislature, the department, and the Substance Abuse and Mental Health Programs establish performance outcome targets for service providers, districts/region, and the

agency as a whole. The relative effectiveness of providers and districts/region is gauged using these targets, and they compete to produce the best allocation of resources.

Substance Abuse and Mental Health services are funded primarily through Federal Block Grants, other Federal grants, General Revenue, and Medicaid resources. Medicaid currently funds approximately 80 percent of children's and 60 percent of adult mental health services. These funds are not directly controlled by the programs. However, they continue to work closely with the state Medicaid authority (Agency for Healthcare Administration) in policy and program development. The programs must anticipate and adjust for changes in funding, such as managed care and Medicaid reform, competing with other potential recipients for these funding resources.

CHAPTER 2: SUBSTANCE ABUSE PROGRAM

Substance abuse inflicts enormous damage upon our state, affecting the rich and poor, educated and uneducated, white-collar and blue-collar workers, as well as students, homemakers, and retirees. The devastation resulting from substance abuse is well known: physical, mental and emotional traumas for individuals, their families, neighbors and friends, and enormous preventable financial costs to society.

Current Conditions and Trends:

- There are an estimated 1,153,325 adults and 353,319 adolescents in Florida with substance abuse and dependence problems.
- There are currently 135,321 adolescents/children and 441,723 adults in Florida with family incomes below 250% of the federal poverty level that are in need of substance abuse services. In FY 2005-2006, the department served 43,870 adolescents/children and 98,735 adults meeting these income criteria. This represents 32 percent of the adolescents/children in need being met and 22 percent of the adults in need being met.
- Alcohol continues to account for the highest percent of treatment admissions for adults (34%) and is followed by cocaine/crack (27%) and marijuana (21%).
- Marijuana accounts for the highest percent of adolescent admissions (76%) followed by alcohol (16%). The rate of underage drinking is of significant concern in Florida.
- Research proves that treatment works and is cost effective.
- Treatment completion rates for children and adults continue to improve.
- However, in recent years, there has been an upsurge in:
    - Prescription drug misuse/abuse, particularly opiates and benzodiazepines which has created an added demand for medically assisted detoxification programs; and
    - The use of methamphetamines. The greatest increases have been noted along the corridors of I-4, I-75, and I-95, and in some rural areas.
- Since FY 1998-1999, the PDSA has received increased funding for both children's (67%) and adult's (65%) services. A significant portion of this funding has come from increases in the federal block grant.

Strategic initiatives:

- Refocus the system of care to better support client recovery and resiliency.
- Promote the adoption of evidence-based practices.
- Evaluate and improve the service financing system.
- Improve information technology systems.
- Expand and refine the implementation of Managing Entities.
- Create an environment to support performance improvement in the service delivery system including implementation of the Florida Learning System.
- Expand epidemiological efforts to include the adult population in Florida.
- Develop an outcome based-service system that is responsive to the changing needs of the state's population (i.e., increasing misuse of prescription drugs by an aging population and the associated increased medical needs).

The Substance Abuse Program plans to strategically position the service delivery system and to become a better purchaser of services. By organizing key strategies around core objectives, systemic changes can be accomplished that will result in re-tooling the current regulatory, financing, and data systems, resulting in a system that is customer-focused and managed based upon levels of performance and desired outcomes. The core programmatic objectives and strategies are indicated below.

Objective – Prevention and Early Intervention

This objective pertains to customers who are at-risk of or challenged by substance abuse problems. Strategies and action steps correlating to this objective are focused on decreasing the prevalence of substance use/abuse and delaying the onset of substance involvement.

Strategies:

- ***Implement the strategic prevention framework.***
- ***Implement evidence-based programs.***
- ***Target early intervention strategies to at-risk youth.***

Objective – Recovery and Resiliency

This objective addresses the needs of customers with substance abuse and/or mental health concerns and focuses on empowering these individuals to achieve their greatest potential.

Strategies:

- ***Increase consumer access to recovery and evidence-based services and supports.***
- ***Collaborate with law enforcement agencies, the criminal justice system, stakeholders, and service providers to identify safe and therapeutic alternatives to jail thereby reducing public safety risks.***
- ***Improve linkages with other programs and agencies to ensure uninterrupted services when consumers move between provider agencies and different levels of care.***
- ***Sustain recovery and support services that were developed under the Access To Recovery grant to improve client outcomes.***
- ***Utilize continuous quality improvement methods to increase client access to and retention in substance abuse services.***

Objective – Resource Stewardship and Integrity

This objective addresses administrative and management functions that ensure that program funding is expended efficiently and in compliance with any specified requirements.

Strategies:

- ***Expend funds as appropriated.***
- ***Perform quarterly, monthly, or as appropriate, monitoring of expenditures through the Performance and Resource Team (PaRT) process.***
- ***Ensure that federal and other grant funding is managed and expended in accordance with specified requirements.***
- ***Maximize Medicaid earnings in order to diversify provider funding sources.***
- ***Conduct cost analysis studies to determine most efficient methods for funding services.***

Objective – Continuous Performance Improvement

This objective is achieved through a consistent review of program performance that includes outcome and process indicators. Actions are taken at state and district levels to impact program performance. The agency has adopted the Sterling criteria for performance management and improvement.

Strategies:

- ***Implement a comprehensive performance improvement program that integrates state and district/regional level activities.***
- ***Communicate and deploy the Department of Children and Families Strategic and Annual Business Plans.***
- ***Deliver training in problem solving, analysis, and related results-based content.***
- ***Implement the Strengthening Treatment Access and Retention-State Implementation (STAR-SI) grant.***
- ***Implement the Robert Wood Johnson, Advancing Recovery grant.***
- ***Develop and implement the Florida Learning System in order to identify statewide trends and initiate systemic actions across various organizations that promote effective substance abuse service delivery.***
- ***Implement the National Outcome Measures (NOMS).***

Objective – Technology Support

This objective supports the performance measurement system and impacts how the program analyzes its performance data and information in order to make strategic management decisions.

Strategies:

- ***Develop a statewide licensure data-base.***
- ***Identify resources and priorities for data system changes.***
- ***Develop the capacity to generate reports than enable data-based decision-making.***
- ***Revise procedures to improve user friendliness of current data system.***

Objective – Consumer Satisfaction

This objective relates to meeting consumer needs and expectations. The PDSA has adopted a customer satisfaction survey that is provided to clients as they complete an episode of care. This survey is available in English and Spanish, it can be benchmarked against other states and nation-wide performance.

Strategies:

- ***Stratify survey results and provide reports to districts/region and provider agencies.***
- ***Increase consumer involvement on program workgroups, committees, and improvement initiatives.***

Current Conditions

Substance abuse significantly affects the health of Floridians. Birth defects, Fetal Alcohol Syndrome, learning disabilities and low birth weight are among the consequences related to the use of substances during pregnancy. Additionally, high number of HIV infections and pediatric AIDS cases are related to high-risk behaviors of persons abusing substances.

We know that treatment works. A 1998 national survey found that addicted persons who undergo treatment are much less likely to consume drugs or commit crimes to support their use, even five years after treatment. Not only does treatment work, but it is also cost effective. In a 2004 policy paper, the Office of National Drug Control indicates that the estimated cost of drug abuse to society was $180.0 billion, a substantial portion of which - $107.8 billion – is associated with drug related crime, including criminal justice system costs and costs borne by the victims of crime. Comparatively, the

cost of treating drug abuse (including research, training, and prevention efforts) was estimated to be $15.8 billion, a fraction of the overall societal costs.

Completion of treatment rates in Florida have increased from 49 percent for adults in FY 1995-1996 to 77 percent in FY 2005-2006, and from 50 percent to 80 percent for children. Additionally, survey results in 2003 indicated that 68 percent of adults and 56 percent of children discharged from treatment were abstinent from drug use 12 months following completion of treatment. The same survey, conducted again in 2005, revealed that 82 percent of adults and 62 percent of children discharged from treatment reported being abstinent after 12 months following their discharge.

In recent years, Florida has seen a marked upsurge in prescription drug misuse/abuse, particularly opiates and benzodiazepines. The increase in prescription opiate and benzodiazepine abuse has created an added demand for medically-assisted detoxification programs and treatment programs that specialize in the treatment of these addictions. In response to the increases in opiate use and the need for safe treatment for opioid dependence, the National Institute on Drug Abuse developed a synthetic medication called burenorphine, similar to methadone but with fewer side effects.

The Drug Addictions Treatment Act of 2000 permitted physicians to prescribe buprenorphine for the treatment of opioid addiction from their private office with certain restrictions. These physicians are required to be certified by The Substance Abuse and Mental Health Services Administration (the Administration) and receive a minimum of eight hours of training in addictions. Currently, in Florida, 351 physicians have been certified by the Administration to prescribe buprenorphine. Buprenorphine may also be dispensed by state-licensed and federally approved methadone clinics as an alternative to methadone. To date, ten licensed methadone clinic sites have been approved to dispense buprenorphine in Florida.

Methadone is also a widely accepted medication that is used to treat opioid addiction. Regulations *(42 Code of Federal Regulations, Part 8)* govern medication-assisted treatment for opioid addiction. The regulations require all methadone programs to be certified by the Administration as a condition of operation. One of the requirements of certification is that methadone programs must become accredited by a government-approved accrediting organization. All state licensed methadone treatment programs have been certified by the Administration. To date, there are 35 licensed methadone treatment sites and two satellite maintenance dosing sites in Florida.

Additionally, there has been a sharp increase in methamphetamine use, however, this substance only accounts for 3 percent of the admissions to the substance abuse treatment. Alcohol accounts for 35 percent of admissions and continues to be the most prevalent substance found in drug-related

deaths in Florida, followed by benzodiazepines, cocaine, and opioids. Most drug-related deaths in Florida involved more than the use of one substance.

Children and Adult Substance Abuse System of Care

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

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

Substance Abuse Service Array

Through the community-based provider system, the Substance Abuse Program provides a range of prevention, detoxification, treatment, and aftercare services to families, children and adults. Prevention services include activities and strategies that are designed to preclude, forestall, or impede the development of substance abuse problems by addressing risk factors known to correlate to substance use. In the case of children, these services may be provided in school-based settings and require parental participation *(For more detailed information on prevention services refer to the section on prevention services.)*.

Detoxification, treatment, and aftercare services focus on reducing and eliminating substance use among identified populations in order to promote positive outcomes such as contributing to family unity and stability for minor children, reducing involvement in the criminal justice system and maintaining a drug-free lifestyle. Specifically, detoxification services utilize medical and clinical procedures to assist children and adults to withdraw from the physiological and psychological effects of substance abuse. Treatment includes various levels of residential treatment and non-residential treatment, the type and duration of which varies according to the severity of the addiction. Aftercare consists of services designed to provide continued support to persons who have completed treatment and focuses on promoting recovery and the prevention of relapse.

The array of substance abuse services is designed to assist individuals and families to respond to addiction problems. Many specialized populations throughout Florida, including individuals involved in the criminal justice system, parents with dependent children, persons with co-occurring substance abuse and mental illness, families involved in the child protection system, and persons at-risk of or having HIV/AIDS are targeted for services *(See Figures 1 and 2)*.

Figure 1: Conceptual Flow of System of Care Model for Substance Abuse Services for Children

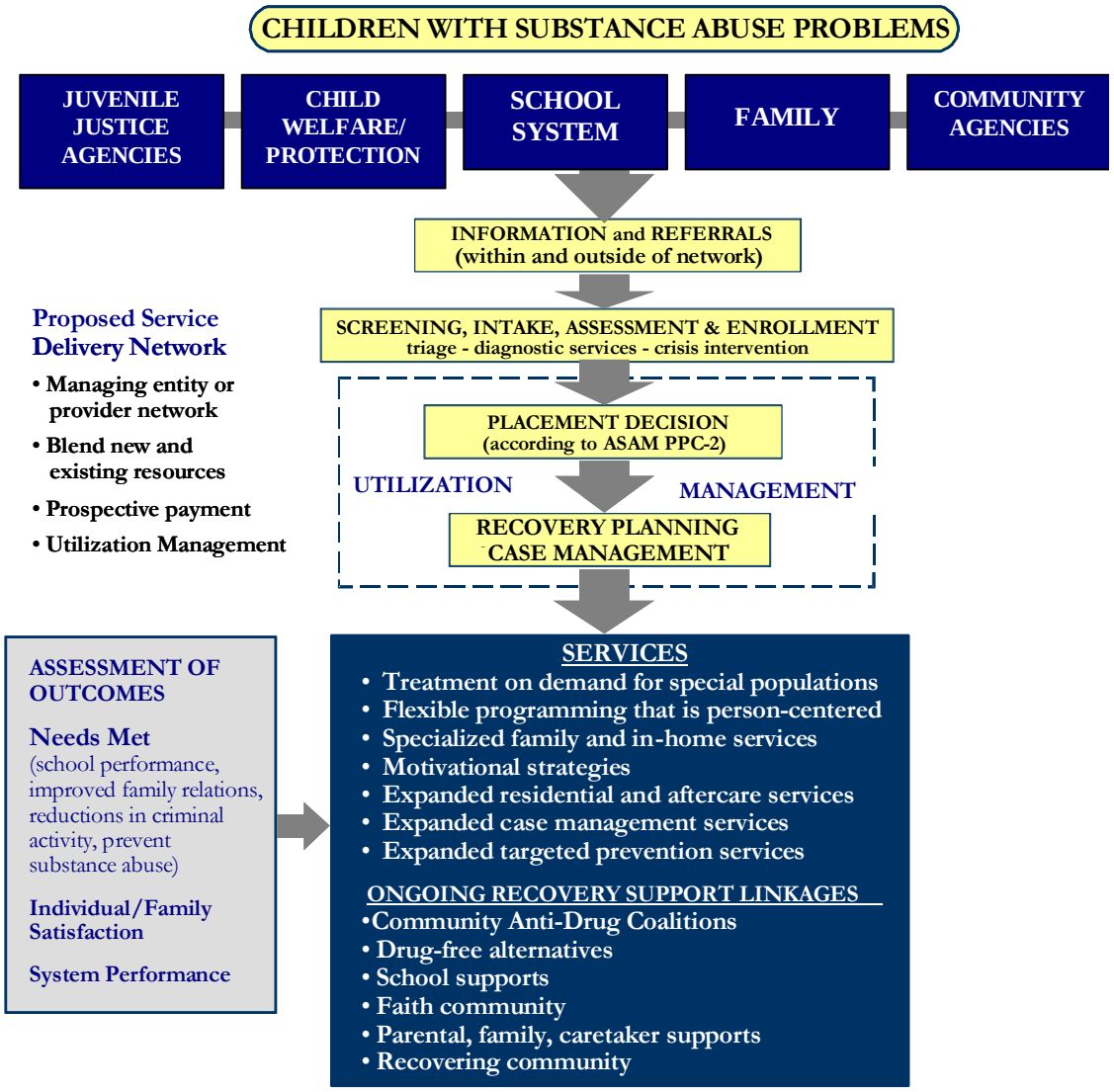
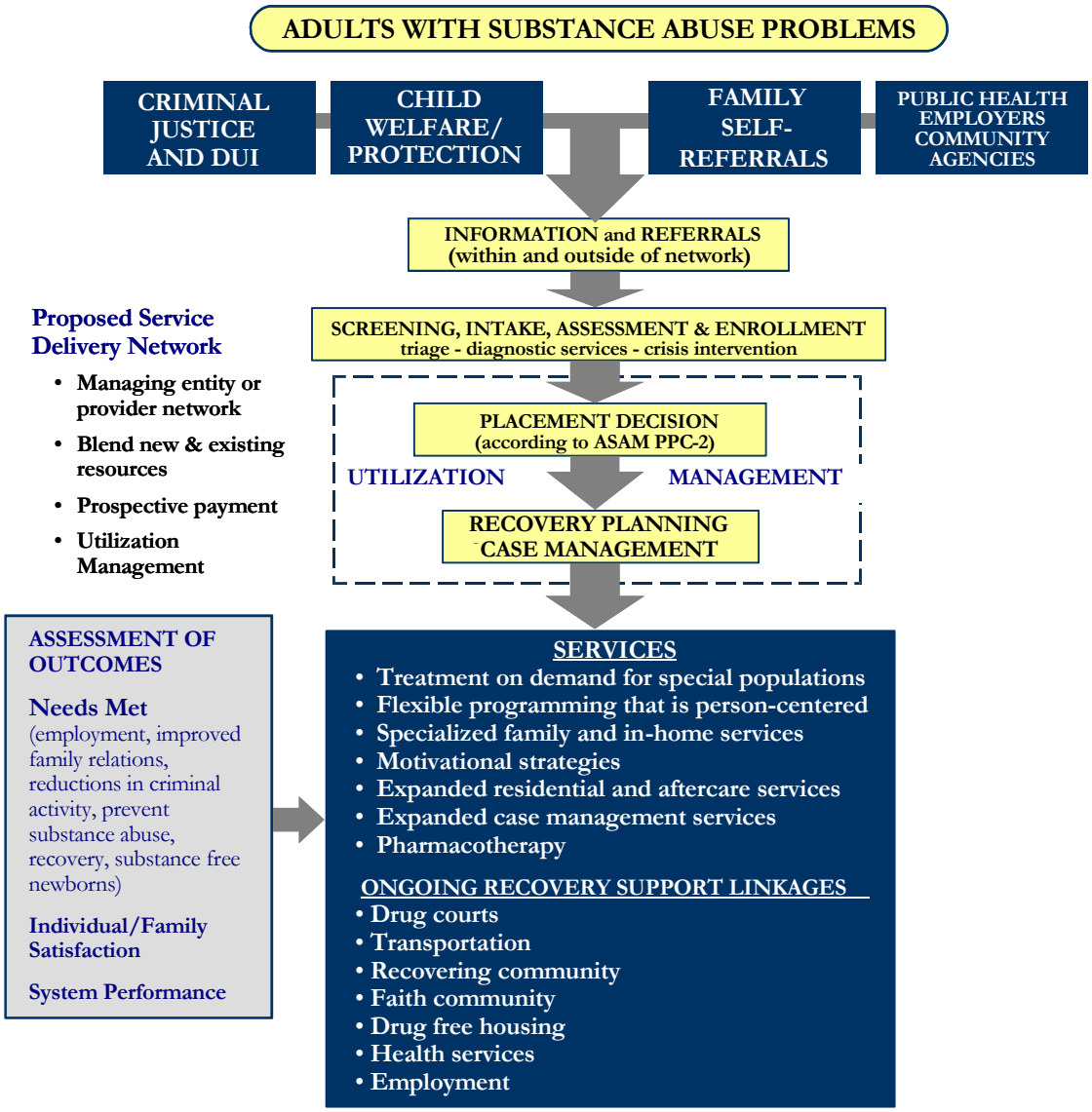


Figure 2: Conceptual Flow of System of Care Model for Substance Abuse Services for Adults



Uniform Placement Criteria

The Substance Abuse Program supports the use of the American Society of Addiction Medicine Patient Placement Criteria and requires its use by all contracted substance abuse providers, except for prevention and aftercare. Individuals who present for services are screened to determine appropriateness for substance abuse services. If an individual is determined appropriate for services, a psychosocial assessment and a medical assessment, if applicable, is completed. Information from the assessment is then used in conjunction with Patient Placement Criteria to place the individual in the most appropriate level of care. Using predetermined clinical criteria, client placement decisions are made regarding: (1) admission of a person to a specific level of care; (2) continued stay within a specific level of care; and (3) discharge or transfer of the individual from that level of care.

Since its implementation in 1998, the Patient Placement Criteria have been revised to include criteria for persons with co-occurring mental and substance use disorders. Persons who meet the specified criteria may be designated to receive services from programs that are identified as "dual diagnosis capable" or "dual diagnosis enhanced". Additional revisions were completed in 2005 to include the licensure designation "Intensive Inpatient Treatment."

The Substance Abuse Program's experience in implementing the Patient Placement Criteria will enhance the program's ability to implement evidence-based screening and assessment instruments within the next three years.

Housing

One of the primary goals of the Substance Abuse Program is to promote access to and successful discharge from appropriate services. It is believed that providing access to clean and safe housing will increase the likelihood that this goal will be met. Accordingly, the department promulgated administrative rule s. 65D-30.0081(1), Florida Administrative Code (F.A.C.), in December 2005 in an attempt to address this need. Specifically, a licensure designation called "Day or Night Treatment with Community Housing" was developed. Clients who meet the criteria for Day or Night Treatment with Community Housing as define in the aforementioned administrative code have the opportunity to reside in a setting that promotes sobriety. This level of care is only appropriate for individuals who are able to live in a supportive, community housing location and who are not in need of structured 24-hours-per-day, 7-day-per week residential treatment. According to the administrative code, the community housing is used to assist individuals in making a transition to independent living. In no case, are treatment services provided at the community housing site. However, individuals who receive day or night treatment services need a place to live; preferably one that is in proximity to the treatment site and one that is therapeutically appropriate. That is, in a setting where clients can hone life skills such as housekeeping, shopping and meal preparation; and, for many, it means living with other

individuals who also are in treatment so that they can provide support to one another in order to live a safe, drug-free lifestyle. Typically, clients receiving Day or Night Treatment with Community Housing do not require more than a few months of treatment. However, since most landlords will not lease for less than one year, the only way some clients can secure the housing accommodations they need is through housing leased by the treatment provider. The substance abuse treatment provider, by committing to rent one or more apartments for a minimum of one year, is able to reserve suitable housing accommodations for clients. This level of care serves to meet the needs of a specific segment of the population in need of housing while receiving substance abuse day treatment services in the community in which they reside.

Additionally, to assist the Substance Abuse Program in meeting this housing need, a component of the Access to Recovery grant enables the department to purchase short-term transitional housing for adult clients while they received outpatient treatment or recovery support services. This service is different from Day or Night Treatment with Community Housing. Specifically, this service is available to individuals who are homeless, in dependent living situations, or who have a history of instability in their living situation. Again, this practice is implemented in an effort to increase access to and successful discharge from appropriate services. Further, the availability of transitional housing reduces reliance on more costly residential services and thereby better serves the citizens of Florida.

Substance Abuse Licensure System

The Substance Abuse Program administers a comprehensive substance abuse licensure system. Chapter 397, Florida Statutes (F.S), and Chapter 65 D-30, F.A.C., govern the licensure system. In order to be licensed, private and publicly funded agencies providing substance abuse services must submit applications to DCF for licensure initially and annually thereafter. The state mandates minimum standards for licensure for the following components:[1] addictions receiving facilities, detoxification, intensive inpatient treatment, residential treatment, day or night treatment with host homes, day or night treatment with community housing, day or night treatment, intensive outpatient treatment, outpatient treatment, aftercare, intervention, prevention and medication and methadone maintenance treatment. Specific criteria must be met in order for an agency to receive a license for the above components.

The types of licenses which may be issued in Florida are: Probationary, Interim, and Regular Licenses.[2] A brief description of each is noted below:

- Probationary License: May be issued for a period of 90 days to new

[1] s. 65D-30.002(16), F.A.C.
[2] s. 65D-30.003(2), F.A.C.

applicants or licensed providers adding new components, upon completion of all application requirements.

- Interim License: May be issued for a period of 90 days if the department finds that a provider is in substantial noncompliance with licensing standards; or if the provider has failed to comply with fire, safety and health requirements; or if the provider is involved in license suspension or revocation proceedings.
- Regular License: May be issued at the end of a probationary period to a provider that has satisfied requirements for a regular license; or to a provider seeking renewal of a regular license that has satisfied the requirements for renewal; or to a provider operating under an interim license that has satisfied the requirements for a regular license.

Within each district/region employees have been identified who are considered Licensure Specialists or Authorized Agents of the department. These Licensure Specialists are responsible for monitoring substance abuse providers within each district/region to ensure compliance with applicable statutory and regulatory standards.

The department's licensure process facilitates the development of an improved service delivery system for Florida's citizens by providing consistent standards for licensure. The Substance Abuse Program has devised a performance rating system that is used to evaluate performance and compliance with licensure standards. Providers must obtain at least 80% compliance overall for each component reviewed using a state-sanctioned monitoring instrument. This process provides credibility and validity to the licensure process and helps to identify areas for improvement or areas of best practice.

In accordance with provisions in Chapter 397, F.S. and Chapter 65D-30, F.A.C., the department must accept, in lieu of its own inspections for licensure, the survey or inspection report of a department-approved accrediting organization. The department-recognized accrediting organizations are as follows: The Rehabilitation Accreditation Commission, also known as CARF, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation (COA) and National Committee on Quality Assurance (NCQA). However, the state does not require all licensed substance abuse providers to be accredited by a national organization.

Efforts to strengthen the substance abuse licensure system are on-going. District/regional licensure personnel coordinate licensure and administrative monitoring reviews with the department's Contract Oversight Unit whenever possible. The goal of this practice is to reduce duplication regarding administrative and programmatic monitoring of contracted providers. Additionally, the Substance Abuse Program schedules quarterly conference calls with district/regional licensure staff, for the purpose of information transmittal and technical assistance.

In an effort to further plans to strengthen the substance abuse licensure system, the program has developed a legislative budget request to be submitted for FY 2007-08 to request funding to develop an automated licensure database. If funding is made available, it is anticipated that the following goals will be met to further strengthen the licensure system:

- Increase substance abuse provider satisfaction by reducing variability in the licensure process;
- Increase efficiency in conducting and reporting results of licensure inspections; and
- Increase the department's ability to enter and retrieve information on licensing through a central database mechanism that can be used to evaluate the overall effectiveness of the licensure process.

Revision of Administrative Rule 65D-30, Florida Administrative Code

Administrative rules under Chapter 65D-30, F.A.C., entitled Substance Abuse Services, were amended and adopted as of December 12, 2005. The administrative rules were amended in an effort to ensure that the rules correlated with changes made in Chapter 397, F.S., by the Florida Legislature in 2005. The major revisions to the administrative rules included adding two new licensable components: Intensive Inpatient Treatment and Day or Night Treatment with Community Housing.

The Substance Abuse Program is currently in the process of revising the administrative rules in order to address or emphasize the following:

- Identify potential areas to be revised or deleted to streamline the monitoring process and to reduce redundant requirements;
- Insert language or requirements to promote recovery and resiliency, use of evidence-based practices and continuous quality improvement; and
- Ensure that the rule accommodates serving individuals with co-occurring diagnoses.

Participation in the administrative rule revision process is a collaborative effort undertaken by the Rule Revision Workgroup. The workgroup consists of members of the provider network, other state agency representatives, district/regional licensure staff, a consumer, and other stakeholders of the department. It is anticipated that the administrative rule revision process will be finalized in 2008.

Trends in Service Funding

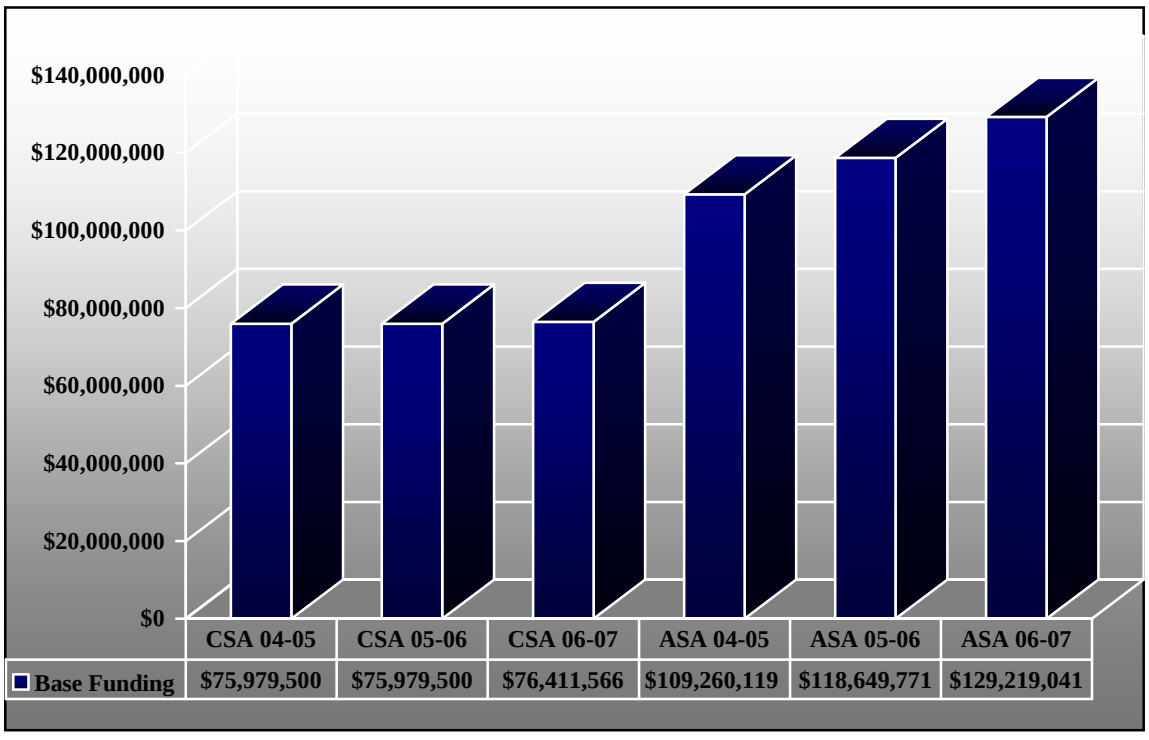
Since FY 1998-1999, the Substance Abuse Program has received a 67 percent increase in funding for children's substance abuse services. A significant portion of the increased funding has come through Substance

Abuse Prevention and Treatment Block Grant (SAPT) increases. When compared to federal funding, the state contributes funding at a rate slightly higher than 1.5:1 for children's substance abuse services. The program has used the funding increases to strengthen service infrastructure, including expanding and enhancing prevention, detoxification and treatment services. The result has been a significant increase in the number of children served in these programs.

For adults, FY 2006-2007 funding represents a 65 percent increase over FY 1998-1999 levels. A significant portion of the increased funding has also come through increases in Substance Abuse Prevention and Treatment Block Grant funds. When compared to federal funding, the state contributes funding at a rate of 1:2 for adult substance abuse services. The program used the funding increases to add detoxification, clinical treatment, and recovery support service capacity throughout the state and to strengthen service infrastructure.

Funding for Children's Substance Abuse services remained the same for FY 2004-2005 and 2005-2006 and increased by 1 percent in FY 2006-2007. In contrast, funding for Adult Substance Abuse services increased by 9 percent for FY 2005-2006 from FY 2004-2005 and increased by 9 percent for FY 2006-2007 from FY 2005-2006. *Figure 3* below depicts the funding for Children's and Adult Substance Abuse services for FYs 2004-2005, 2005-2006, and 2006-2007.

Figure 3: FY 04-05, FY 05-06, & FY 06-07 Funding for Children's Substance Abuse (CSA) and Adult Substance Abuse (ASA) Services



Substance Abuse Target Populations

For FY 2003-2004, the Substance Abuse Program established two primary target groups that correspond to individuals' presenting substance abuse service needs: (1) persons who are at-risk for developing substance abuse problems; and (2) persons with substance abuse problems. A description of each target group and persons admitted from FY 2002-2003 are described below:

Adults

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

Children

- Children At-Risk: Children who are at risk of initiating drug use or developing substance problems due to individual and environmental risk factors.
- Children Under State Supervision**:** Children with substance use disorders who are under supervision of the Department of Juvenile Justice or are recipients of services from Family Safety.
- Children Not Under State Supervision**:** Children with substance use disorders who are not under the supervision or custody of a state agency.

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

During FY 2005-2006, the department provided substance abuse service funding to 169 community-based agencies. These agencies served 162,485 individuals, of whom 52,863 were children and 109,622 were adults. An additional 119,938 children and 13,086 adults received Level 1 prevention services.

Persons At-Risk for Developing Substance Abuse

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

Persons with Substance Abuse Target Groups

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

Pursuant to s. 394.9081, F.S., the department established target groups for adults age 60 and older who are (1) at-risk of being placed in a more restrictive environment (residential treatment, assisted living, nursing homes, etc.) due to their substance abuse or mental illness; and (2) in need of substance abuse treatment. Data on these target groups is captured within the "Persons with Substance Abuse" target group. The department tracks and reports specifically on substance abuse services provided to older adults.

Prevalence and Estimated Need

Prevalence estimates for alcohol/drug use are developed using the *Florida Youth Substance Abuse Survey (FYSAS) 2004*, the *National Survey on Drug Use and Health (NSDUH)*, and the census population figures for 2005. Persons with substance abuse problems include those individuals that have progressed in their use to a point where they are abusing or becoming dependent on alcohol and/or other drugs. At-risk populations are targeted for more front-end services such as prevention, intervention and outreach because the services are brief in nature and intended to prevent or reduce substance use.

There are an estimated 1,153,325 adults and 353,319 children in need of substance abuse services statewide. Currently, the department is meeting 10 percent of the substance abuse services' need for adults and 15 percent of the substance abuse services' need for children.

Primary Substance Abuse Problem at Admission

In FY 2005-2006 there were 27,200 children admitted for substance abuse services. One-third of these individuals were female and two-thirds were male. Most youth received services on an outpatient basis such as assessment, counseling, case management, and intervention. The primary drugs of abuse in order of prevalence were marijuana, alcohol, and crack/cocaine. More than three of every four youth presented with a primary problem of marijuana.

During the same period, there were 62,516 adults admitted for substance abuse services of which one-third were female and two-thirds were male. The primary drugs of abuse in order of prevalence were alcohol, crack/cocaine, marijuana, and opioids. Slightly more than a third of the adult individuals presented with alcohol as the primary problem and one in every four individuals presenting with crack/cocaine as the primary problem. As indicated earlier in this chapter, there is a significant problem in Florida relative to opioid use, specifically the use of prescription painkillers such as oxycodone and hydrocodone. *Figure 4* below depicts the specific prevalence rates for primary substance use among children and *Figure 5* depicts the primary substance use for adults.

Figure 4: FY 05-06 Primary Substance Use Problem at Admission – Children

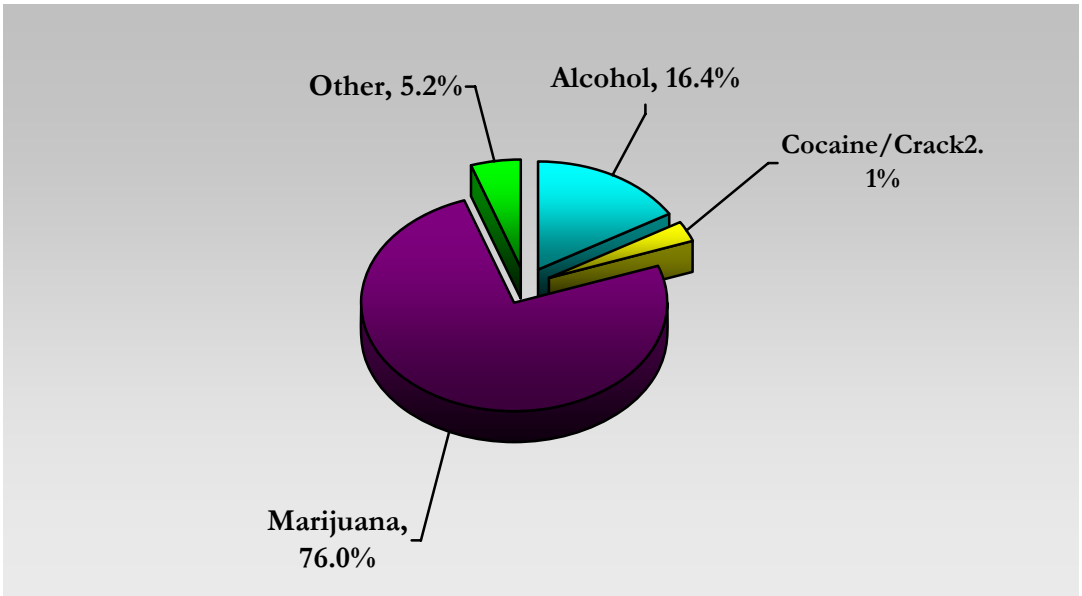
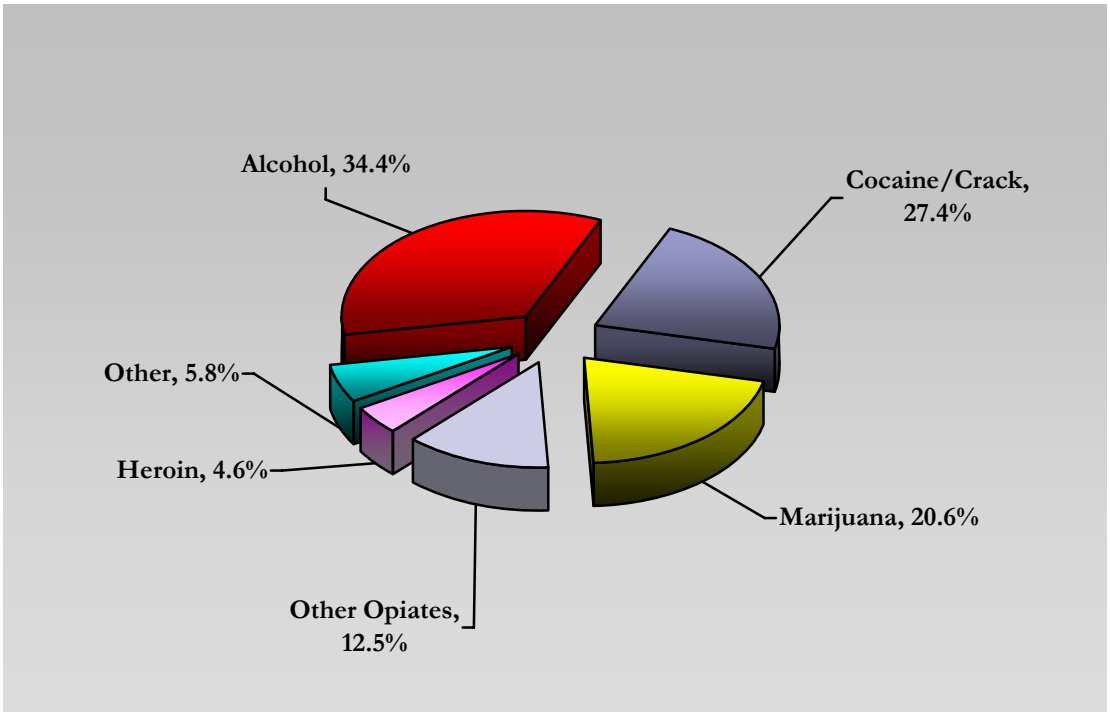


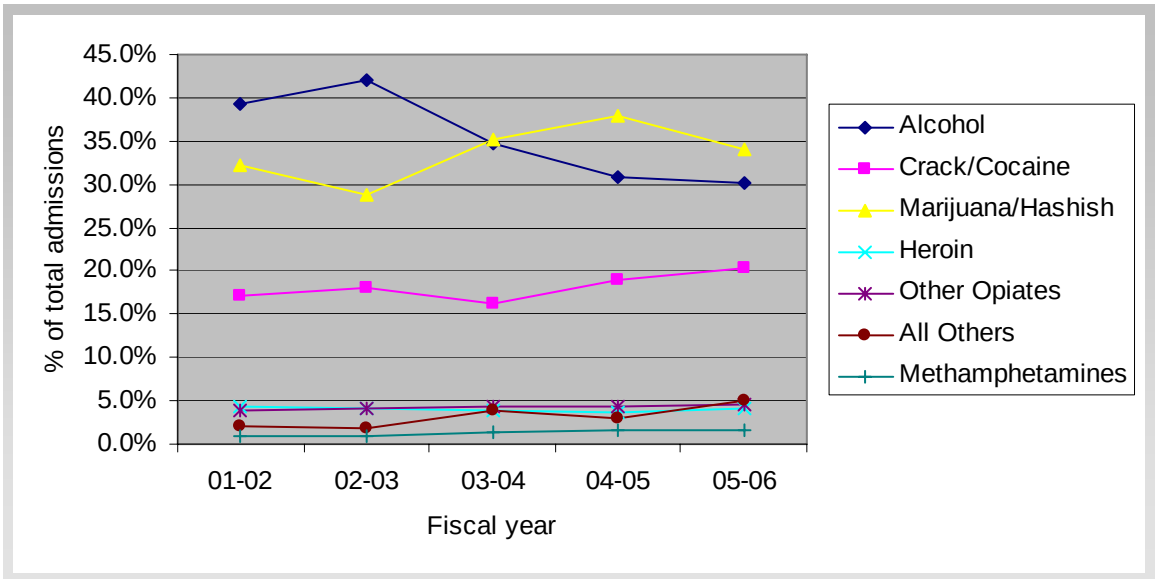
Figure 5: FY 05-06 Primary Substance Use Problem at Admission – Adults



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

The five-year trend in substance use problems at admission for children and adults showed a decline in alcohol as the primary drug of abuse in FY 2005-2006. Alcohol moved from the number one spot as the primary drug of abuse to number two, while marijuana/hashish moved to the number one spot. *Figure 6* depicts the comparison of the primary drugs of abuse in order of prevalence from FY 2001-2002 through FY 2005-2006. Crack/cocaine continues to rise and is the third drug of abuse in the order of prevalence at admission.

Figure 6: 5-Year Trend in Substance Use Problems at Admission – All Clients



Methamphetamines

Methamphetamines are posing a global threat. According to Karen Tandy, U.S. Drug Enforcement Administration (DEA), more people throughout the country are using methamphetamines than cocaine and heroin combined. This amounts to 26 million users worldwide. In some parts of the western United States, methamphetamine abuse has become an epidemic. Although methamphetamines as the primary drug of use presented at admissions by Floridians is less than 3 percent, Florida has begun to see a steady increase in methamphetamine use and abuse statewide (*see Figure 6*). The greatest increases in Florida have been seen along the interstate corridors including I-4, I-75, and I-95, as well as some rural areas.

The state has seen a sharp rise in the number of clandestine labs as producers of the drug move eastward from the west coast to avoid tougher laws and enforcement. In response to this trend, new legislation was enacted in Florida during the 2005 legislative session to increase criminal penalties for methamphetamine production and trafficking, and to make it more difficult for individuals to gain access to large quantities of pseudoephedrine and other chemicals used to produce methamphetamines. Several communities in central Florida (e.g., the city of Lakeland) have initiated several new strategies to combat methamphetamine production and use. The Office of Drug Control, Florida Department of Law Enforcement (FDLE), and the federal DEA have developed "The Florida Statewide Methamphetamine Guideline", which is designed to advise federal, state and local agencies and other organizations that respond to methamphetamine labs and the related criminal, environmental, sociological and economical issues such as:

- Clandestine Labs – law enforcement identifies clandestine laboratories through ongoing investigations or inadvertently through other criminal

or domestic investigations. Once discovered, law enforcement personnel work with specialty teams including DEA and the Florida Department of Environmental Protection to assess the environmental hazards and impacts, in addition to criminal evidence.

- Drug endangered children – the Department of Children and Families has the authority to remove children from homes where methamphetamines are being produced, used or distributed.
- Medical evaluation – individuals residing in homes where clandestine labs are located are evaluated by Emergency Medical Service (EMS) personnel, emergency room staff, or primary care physicians to determine the physiological impacts of exposure to chemicals.

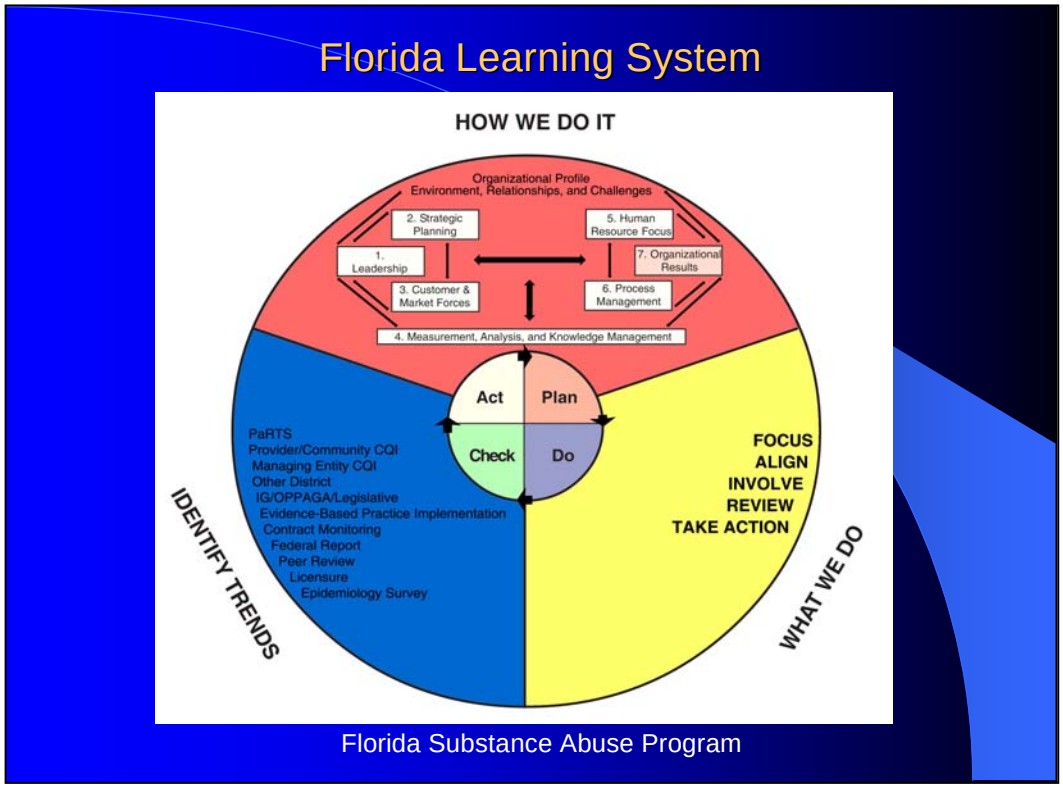
According to data collected by the department for FY 2005-2006, of the individuals presenting for treatment for methamphetamine abuse:

- 54 percent were women (compared to 35 percent in other treatment programs);
- 95 percent of clients were Caucasian (compared to 68 percent in other treatment programs);
- 61 percent had no history of arrest; and
- 68 percent had no prior admissions for treatment.

Quality Improvement and Evidence-Based Practice - The Florida Learning System

The Substance Abuse Program is shifting its service model to a recovery and resiliency paradigm. The Florida Learning System *(see Figure 7)* is a strategic management design that will allow the program to continuously review statewide service trends, needs profiles, service delivery, monitoring results/trends, performance outcomes, and resource utilization. The implementation of the Florida Learning System will help to ensure that the systems of care and administrative oversight process operate efficiently and effectively. Obtaining feedback and input from consumers, stakeholders, and partners is critical to designing services and systems that are both effective and responsive to the needs of clients and their families. The Florida Learning System also concentrates on improving efficiencies that includes an emphasis on early identification of substance abuse problems and the engagement of effective, less costly intervention and services. It is anticipated that this proactive approach will help to disrupt the cycle of substance abuse/dependence and reduce the need for expensive residential crisis and treatment services. These types of system changes will also promote recovery and resiliency initiatives.

Figure 7: Conceptual Flow of the Florida Learning System



The Florida Learning System will help the Substance Abuse Program to:Focus on the important/key characteristics of the statewide substance abuse services.

- Align substance abuse treatment and performance improvement initiatives across the state.
- Involve all partners and stakeholders.
- Review information in a systemic fashion.
- Take action based upon data and facts that have been collected.

At the center/core is the Plan, Do, Check, Act cycle, which helps the program to build a system that supports continuous quality improvement. Two recently acquired grants, Strengthening Treatment Access and Recovery - State Implementation, and Advancing Recovery, will assist in the implementation of the Florida Learning System.

Best Practice Awards Program

The Best Practice Awards Program was initiated in 2001, by the department and Florida Alcohol and Drug Abuse Association (FADAA). This program serves to recognize substance abuse programs that utilize evidence-based practices and that have measurably improved their service outcomes. The Best Practice Awards Program includes a competitive application process that is open to all

licensed substance abuse prevention and treatment providers in Florida. Applications are evaluated and scored by a panel of expert reviewers who have experience in the field of research as well as in the development and management of substance abuse programs.

Awards for the 2006 Best Practice Awards Program were presented to recipients at Florida Alcohol and Drug Abuse Association's 30th Anniversary Conference in August, during the General Session. The applicants represented substance abuse prevention, intervention and treatment services, as well as small and innovative programs. A synopsis of each of The Best Practices Awards Program recipient's program was published in the *2006 Best Practices Recognition Program Manual*. The manual is available to the public on Florida Alcohol and Drug Abuse Association's website, www.fadaa.org/services/publications/index.htm, and on the statewide prevention website, www.preventioninflorida.

Florida Clinical Consultation Treatment Improvement Project (FCCTIP) and Clinical Trials

The Federal Substance Abuse Prevention Treatment (SAPT) Block Grant regulations [45 CFR part 96, §96.136] requires that states receiving SAPT block grants funding conduct a "Peer Review" of 5 percent of Block Grant supported treatment programs. These reviews must be conducted separately from activities that drive funding decisions and are not part of any licensing/certification process. As part of the Independent Peer Review process, the reviewers are to examine: admission criteria/intake process; assessments; treatment planning, including appropriate referrals; documentation of treatment services provided; discharge and continuing care planning; and indications of outcome-oriented treatment processes.

In order to meet federal requirements, The Florida Clinical Consultation for Treatment Improvement Project (FCCTIP) was conceptualized. This project is an exciting new initiative occurring within the state of Florida. The primary purpose of the project is to improve the effectiveness of substance abuse services and provides an opportunity for service providers to voluntarily explore issues and barriers associated with the provision of services, to identify innovations and best clinical practices that are supported by published studies in archival peer reviewed scientific journals, and to gather and share information with each other that helps to improve services.

The project is administered by an independent entity under contract with the department. An advisory board provides direction and oversight. This board's membership consists of substance abuse treatment providers and research professionals. The Florida Clinical Consultation for Treatment Improvement Project targets the completion of eight clinical consultation reviews annually. The goal of the project is to help substance abuse treatment providers improve their services through a peer-to-peer consultation. The peer consultations focus on

the service delivery process and emphasize improvement in quality as guided by empirically supported evidence.

In FY 2005-2006, a total of eight peer consultations were completed. Peer consultations were conducted on three residential programs (including two adolescent programs) and five outpatient programs (including one women's program). The findings from these reviews indicated that clinical documentation was an area needing improvement. As a result of these findings, a series of training pertaining to clinical documentation has been developed and will be provided during the next year.

Additionally, the Substance Abuse Program supports the National Drug Abuse Treatment Clinical Trials Network and maintains relationships with the Florida Clinical Trials Network Node at the University of Miami.

The Florida Research to Practice Consortium

Recognizing that evidence-based treatment practices must be the predominant model for improving substance abuse treatment services, the Substance Abuse Program established the Florida Research to Practice Consortium in 2000. The Consortium consists of policymakers, practitioners, researchers, and consumers who are interested in improving substance abuse treatment services in Florida through better linkages across disciplines. The Consortium is sponsored by the department, Florida Alcohol and Drug Abuse Association, and the Suncoast Practice and Research Collaborative (SPARC)/Tampa Practice Collaborative (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 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 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 serves in a planning and advisory capacity to the Substance Abuse Program. The program will continue to support the Consortium through the Florida Learning System.

The Florida School of Addiction Studies (FSAS)

The Florida School of Addiction Studies (FSAS) on the University of North Florida campus, is financially supported by the department. The School 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. Scholarships and merit awards sponsored by the department provide access and recognition to front line workers in the field of addiction studies.

The Southern Coast Addiction Technology Transfer Center (SCATTC)

The department collaborates with the Southern Coast Addiction Technology Transfer Center (SCATTC) on many training and coordination initiatives related to substance abuse treatment and prevention. One of the primary initiatives of the Center is to enhance workforce development and leadership within the field of substance abuse treatment. Additionally, the Center is a co-sponsor, along with the department and Florida Alcohol and Drug Abuse Association, of the Florida Research to Practice Consortium. The Consortium's goal is to enhance statewide coordination in the areas of substance abuse treatment and prevention research. The Southern Coast Addiction Technology Transfer Center participates in the peer review process.

In FY 2006-2007, the department contracted with Southern Coast Addiction Technology Transfer Center to provide training on clinical documentation and treatment planning for all substance abuse providers doing business with the state. The Center plays a vital role in Florida's substance abuse training and coordination initiatives.

Prevention Evidence-Based Programs, Practices, and Policies

In 2000, the Substance Abuse Program made a commitment to funding prevention programs that had been rigorously tested and found to be effective in reducing the risk of substance abuse. Since that time, all district/regional program offices prioritize model prevention programs in their contracts. The program contracts with the University of Miami to provide prevention evaluation field support services so that all programs under contract with the district/regional offices have a foundation of evidence of effectiveness. Additionally, the program, through the Strategic Prevention Framework (SPF) Grant, is working with community anti-drug coalitions to support the implementation of evidence-based strategies to address environmental issues and to develop effective prevention policies.

Services for Substance Use

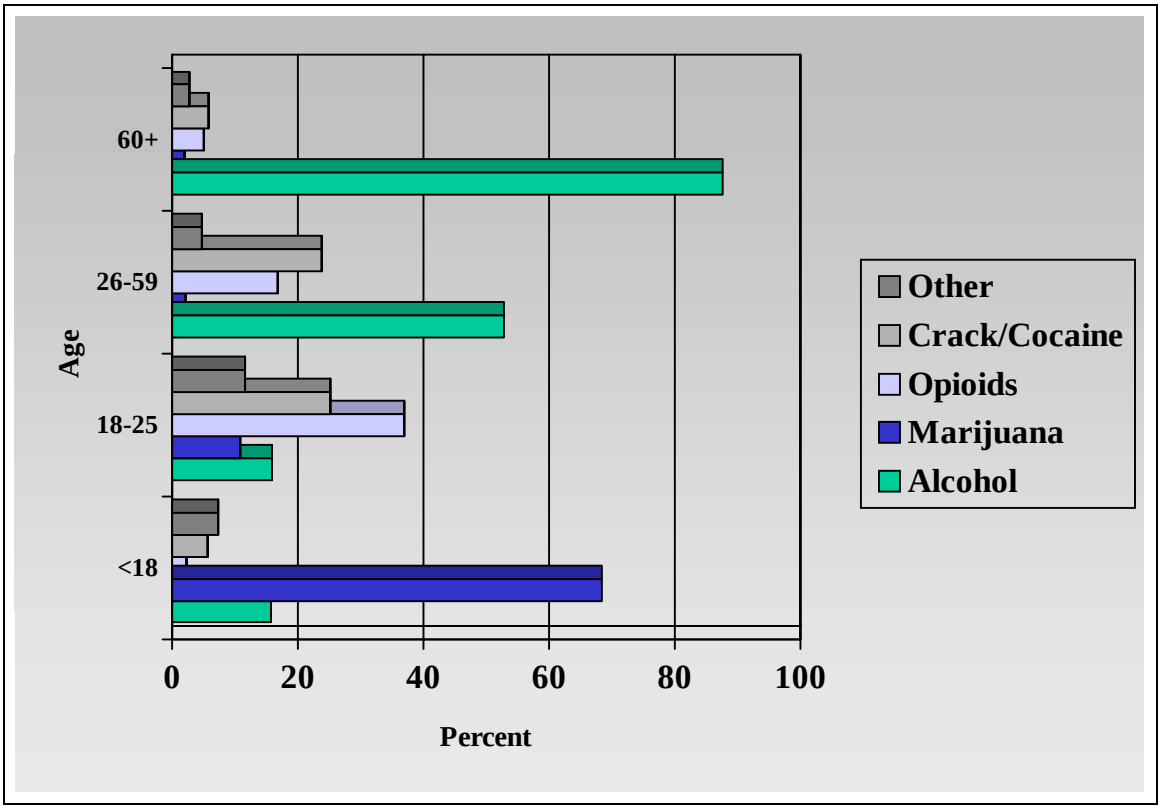
Detoxification

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

Detoxification services are a critical part of the substance abuse services continuum. Individuals who are physically dependent on alcohol or other drugs need medical and counseling assistance while the physiology of the body adjusts to the absence of alcohol/drugs. Once a person has physically readjusted, the

individual is ready to address the psychological aspects of recovery and fully engage themselves in treatment. Detoxification is appropriate for individuals that need medical assistance and oversight while withdrawing from substance use. It is not a necessary precursor to participation in treatment for most individuals.

Figure 8: Individuals Presenting Substance Abuse Problems in Detoxification, FY 2005-2006



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

Approximately 6 percent of children and adults in Florida are in need of treatment services; 3-5 percent of this group will also need detoxification services. In FY 2005-2006, contract agencies provided detoxification services to 23,376 adults and 2,501 children. In recent years there has been a significant increase in detoxification admissions due to opioid use. As *Figure 8* demonstrates, the presenting substance abuse problems vary considerably across age groups.

Treatment

The array of substance abuse treatment services is designed to assist individuals and families to respond to addiction problems. Many special populations throughout Florida, including individuals involved in the criminal justice system, parents with dependent children, persons with co-occurring substance abuse and mental illness, families involved in the child protection system and persons at-risk of or having HIV/AIDS are targeted for services. The Substance Abuse

Prevention and Treatment Block Grant mandates specific services to include primary care, prenatal care, gender-specific services, transportation, child care, outreach, screening/testing/counseling for HIV/TB and referral services to target pregnant women, women with dependent children, individuals awaiting admission to treatment, intravenous drug users and HIV at-risk populations.

Since 2004, the Substance Abuse Program and the Office of Drug Control have received more than 37 million dollars in grant funding to improve treatment access and capacity for special populations. These grants have enabled the state to implement best practice models, improve service efficiencies, and enhance client outcomes. Combined, the grants will serve an additional 28,000 adults, adolescents, and their families.

Adolescents

On August 1, 2005, the department received a three-year, 1.2 million dollar grant award to improve service infrastructure for adolescent substance abuse treatment in Florida from the Center for Substance Abuse Treatment (CSAT). The grant provides oversight and coordination for adolescent treatment in all state agencies. The Florida Office of Drug Control has assumed the lead for coordinating and enhancing adolescent treatment services throughout Florida via this grant. The Southern Coast Addiction Technology Transfer Center provides training and coordination for the grant. The project focuses on the development of best practices and special training/certification for clinical professionals, and increased efficiency for treatment providers to allow for more adolescents to be served and served more effectively

Drug Courts

Drug courts are another cost-effective alternative to incarceration, providing mandated substance abuse treatment in lieu of jail/prison time for non-violent offenders, conditionally based on their successful participation and completion of treatment programs. Although Florida has the second largest drug court system in the United States, it is only able to reach a small portion of persons who offend. This situation is being further complicated by the loss of federal funding for this purpose. With the program's proven success in reducing criminal recidivism and costs, the Substance Abuse Program, in conjunction with Florida Alcohol and Drug Abuse Association, the Florida Supreme Court’s Task Force on Treatment Drug Courts, district/regional offices and providers is exploring ways to continue these valuable programs.

In May 1999, only 34 operational drug courts existed in Florida. By 2006, the courts have expanded to 102 operational drug courts, an increase of 200 percent, with an additional nine programs in the planning stages of development. The breakdown of courts includes:

- 46 Adult Drug Courts
- 31 Juvenile Drug Courts
- 21 Dependency Courts
- 2 Misdemeanor Drug Courts
- 1 DUI/Drug Court
- 1 Juvenile Re-entry Court

Special Populations and Initiatives

The Access to Recovery (ATR) Program, a Presidential initiative, began implementation in 2005. The program is funded through a three-year, 20.4 million dollar grant from the federal Substance Abuse and Mental Health Services Administration. This client choice program uses vouchers for the purchase of clinical treatment and/or recovery support services through traditional, licensed treatment programs and non-traditional, faith-based entities in Districts 7, 8, 9, 13, 15 and the Suncoast Region. Through the end of October 2006, the program had committed 14.1 million dollars to vouchers and expended a total of 9.4 million dollars, serving 8,173 clients. The grant ends in August 2007.

As part of the sustainability effort, the department has begun purchasing recovery support services through its traditional system of care. Recovery and Support services allow for a combinations of services related to substance abuse education, life skills, medical or health education, employment and educational skills, support counseling and anger/stress management copin skills, and family/marital/parenting relationship skills to be obtained by the client. Additionally, these services allow for “client choice” in the development natural supports from of non-traditional treatment service providers.

The Florida Brief Intervention and Treatment for Elders (BRITE) Program was expanded to include the Center for Drug-Free Living in District 7 (Orlando) for FY 2005-2006. Through the program’s four pilot sites, the department was able to serve an additional 1,428 adults age 60 and older for substance abuse, depression, and suicide issues in FY 2005-2006, compared to 892 older adults served through the traditional substance abuse system of care. For FY 2006-2007, the Suncoast Region added a Brief Intervention and Treatment for Elders program in Hillsborough County, bringing the statewide total to five. In September 2006, the department received a five-year, 14 million dollar grant from the Substance Abuse and Mental Health Services Administration to provide Screening, Brief Intervention, Referral and Treatment services to older adults, bringing the total number of programs to 12 statewide. The federal grant will serve 17,440 older adults over the five-year period and will have a primary emphasis on engaging elders with substance abuse problems through primary

health care settings such as emergency rooms, family/gerontology physicians, and public health clinics. The primary goals for the grant include:

- Enhance outreach services and improve access to care;
- Identify and alleviate systemic barriers to intervention and treatment;
- Improve linkages with primary care system;
- Increase the level of cultural competence among professionals and providers; and
- Enhance overall treatment capacity for older adults.

In October 2006, the department received a three-year Strengthening Treatment Access and Retention grant from the Substance Abuse and Mental Health Services Administration to improve client access to and retention in outpatient treatment in Florida. This is a significant challenge as there are a number of barriers to treatment such as long waiting times to begin service and inability to access needed programs. This project will use a utilize learning community approach to implement the Network for the Improvement of Addiction Treatment (NIATx) rapid cycle process improvement model to assist the state and outpatient treatment providers to continuously identify and reduce barriers that impede timely entry into treatment, and increase the number of individuals who complete detoxification services that transition to outpatient services. Additionally, this project is designed to build the state's infrastructure to monitor and report on performance outcomes statewide as well as to build state level and provider capacity to implement ongoing process improvements. The key goals include:

- Reduce average time between an individual's first contact for outpatient treatment and an initial screening/assessment;
- Reduce average time between initial screening/assessment and delivery of first outpatient treatment service; and
- Increase the number of persons who complete detoxification and then enter outpatient treatment.

In October 2006, the department received an Advancing Recovery grant from the Robert Wood Johnson Foundation to identify and address clinical and administrative practices that impede the use of evidence-based practices within the alcohol and other drug treatment system. The department will serve as the lead statewide agency for the Foundation's, Advancing Recovery Project. The project represents a partnership between the department, the Substance Abuse Program and the Florida Alcohol and Drug Abuse Association to collaborate in the development and implementation of a state initiative that identifies provider and state strategies to implement evidence-based practices in Florida's substance abuse treatment system. Both the Robert Wood Johnson and the Strengthening Treatment Access and Retention projects will additionally support and promote the development of the Florida Learning System.

Criminal Justice Populations

Criminal activity and substance abuse are irrevocably related, resulting in enormous social and economic costs to society. Approximately half of the adults and three-quarters of the children receiving publicly supported substance abuse services in Florida have some level of involvement with the criminal or juvenile justice system. Department-funded providers throughout the state provide an array of clinical treatment and/or support services for these individuals. The Substance Abuse Program works closely with the Department of Corrections, Department of Juvenile Justice and local criminal justice entities (courts, jails) to ensure offenders receive needed services.

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

Faith-Based Substance Abuse Services

The Access to Recovery grant enabled the department to increase the involvement of faith-based organizations in the provision of recovery support services for adults affected by substance abuse. There are currently 165 faith-based organizations participating in this grant program. The Substance Abuse Program has provided a series of training events to promote professional development and service collaboration in the faith community. The key services being provided by faith-based organizations include transitional housing, recovery support counseling, employment coaching, child care, and transportation.

Women's Services

A network of 49 programs served pregnant women and women with dependent children throughout the state in FY 2005-2006, with a funding contribution of over 13 million dollars in Substance Abuse Prevention and Treatment Block Grant funds. Pregnant women, women who inject drugs and persons referred from the child welfare and Community-Based Care program received priority for services. Thirty-nine of these programs have services specifically designed for pregnant women and 13 allow women to bring their children into treatment. Quality women's treatment programs are one of the most critical strategies for responding to the prevention, intervention and treatment needs of substance-involved families in the child welfare system.

Additionally, the Substance Abuse and Mental Health Programs are assisting with the department's development and implementation of the federal Strengthening Families initiative through its Temporary Assistance to Needy Families (TANF) program. The initiative provides training for professionals and families, promoting strong marital relationships, improved family functioning, and reduced out-of-wedlock births.

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

The Florida Department of Health reports that Florida ranks third in the nation for AIDS cases and second for pediatric AIDS cases. The Substance Abuse Prevention and Treatment Block Grant requires the state to provide HIV and early intervention services to individuals who receive substance abuse services. These services are provided in each of the districts/region.

In FY 2005-2006, there were 32 service providers under contract with the department to provide HIV Services. These projects are located at substance abuse treatment sites and are designed to provide the following services:

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

During FY 2005-2006, there were 16,831 individuals discharged from care who also received HIV Early Intervention services or were referred to other agencies to receive these services.

Additionally, HIV early intervention programs provide educational workshops for churches, schools, community groups, social services organization and businesses. Education topics include issues concerning addiction, the relationship between intravenous drug use and HIV, and the types of services available for persons in need. Staff from the HIV programs also participate in local health fairs and other community activities to bring local, state and national attention to the issues surrounding HIV/AIDS.

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The Substance Abuse Program remains actively involved with the Department of Health's Bureau of Infectious Diseases, HIV/AIDS Office to address issues associated with HIV. The program is active in the statewide planning process for community-based HIV services, provides representation to the Annual HIV Conference, which provides educational information, training and state-of-the-art models regarding prevention, transmission and care. In addition, the Substance Abuse Program works collaboratively with the Department of Health to sponsor a workshop to produce policy for the integration of substance abuse, HIV and Hepatitis C services.

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

- Intravenous drug use accounts for 11 percent of adult exposure to AIDS for men and 16 percent for women. The goal of the Substance Abuse Program is to provide more outreach services to intravenous drug users. This can be achieved with the HIV dollars, providing a substance abuse counselor is either present during or providing the outreach services.

- Seventy percent of the cumulative number of HIV cases in Florida and 65 percent of the AIDS cases are among minorities. The goal of the Substance Abuse Program over the next three-years will be to extend HIV services to areas where the greatest identified needs exist. The statewide allocation for HIV funds is based on the number of persons with AIDS per district, this ensures that dollars are going to communities with the greatest need.

The department is working with the Department of Health to implement Substance Abuse and Mental Health Services Administration's Rapid HIV Testing Initiative (RHTI)**.** This initiative is designed to increase the abilities of the Department of Health and substance abuse providers to reach out to more at-risk individuals. For FY 2005-2006, the department selected 13 providers to participate in the project who are equipped to meet the federal readiness requirements. Participating providers will be required to collect and report on several key measures during the 3-year initiative.

Homelessness

According to reports by Florida's network of 29 local homeless coalitions, based on data released in December 2005, on any given day in Florida there are 83,391 homeless persons. Florida's homeless population has increased in recent years, due in large part to the 2004 hurricanes. More than one-third of Florida's homeless population is identified as having a substance abuse disorder and another three percent are dually diagnosed with mental health and substance abuse problems. During FY 2005-2006, the department served 5,936 clients who were homeless at the time of admission to services, representing 6.7 percent of all admissions.

The Access to Recovery grant enabled the department to purchasing short-term transitional housing for adult clients while they received outpatient treatment or recovery support services. This service was made available to those individuals that were homeless, in dependent living situations, or had a history of instability in their living situation. The Substance Abuse Program is examining potential funding sources for continuation of transitional housing as a service option following expiration of the grant in August 2007.

Prevention

- The department provides a wide array of substance abuse prevention services to the citizens of Florida. Prevention services are divided into two categories: Level 1 and Level 2. Level 1 prevention services consists of prevention services aimed at changing the community or environment, while Level 2 prevention services focus on specific needs of individual youth. In Fiscal Year 2005-2006 a total of 115,681 children and 12,253 adults were provided Level 1 prevention services, and 4,257 children and 833 adults received Level 2 prevention services. These services are congruent with the federal Center for Substance Abuse Prevention's six prevention strategies and include:
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  - Information Dissemination: The intent of this strategy is to increase awareness and knowledge of the risks of substance abuse and available prevention services.
  - Education: The intent of this strategy is to improve skills and to reduce negative behavior and improve responsible behavior.
  - Alternatives: The intent of this strategy is to provide constructive activities that exclude substance abuse and reduce anti-social behavior.
  - Problem Identification and Referral Services: The intent of this strategy is to identify children and youth who have indulged in the use of tobacco or alcohol and those who have indulged in the first use of illicit drugs, in order to assess whether prevention services are indicated or referral to treatment is necessary.
  - Community-Based Process: The intent of this strategy is to enhance the ability of the community to more effectively provide prevention and treatment services.
  - Environmental: The intent of this strategy is to establish or change local laws, regulations, or rules to strengthen the general community regarding the initiation and support of prevention

Some strategies are applied via direct service programs or prevention practices that are aimed at individuals or groups of individuals (Level 2). Other strategies deal with effecting changes through engaging communities (Level 1). For

example, environmental and community-based process prevention strategies attempt to change community or environmental norms or conditions that are favorable to alcohol, tobacco and other drug use.

Prevention services target children, youth, and adults that are “at risk” of substance abuse, and include caregivers, and other community stakeholders. Prevention strategies reach out to: (1) general population, both youth and adult; (2) high-risk communities; and (3) high-risk individuals. The Substance Abuse Program Office promotes the use of prevention programs and practices that are highly rated by the *National Registry for Effective Programs and Practices* of the Federal Substance Abuse and Mental Health Services Administration.

The risk factors used for determining the “at-risk” adult population for prevention services differ considerably from those used for youth. Adults who are targeted must have experienced some physiological or social problems due to use of substances within the past year to receive prevention services. While some adults in general may match the “at-risk” profile, the elderly are increasingly becoming "at-risk”. As Floridians age, their use of over-the-counter and prescription medications tend to increase. When drug use is combined with alcohol, tobacco and other drug use, and poor nutritional habits, many adults begin to experience problems. Without early intervention to assist them in effectively addressing these problems, these individuals are "at-risk" of developing substance abuse or dependence problems and may eventually need more intense services such as detoxification and treatment. The Brief Intervention and Treatment for Elders program will enable the Substance Abuse Program to better meet the service needs of aging Floridians.

Level 1 Prevention (General)

All youth and adults can benefit from receiving Level 1 prevention strategies. These strategies assist individuals by providing reliable information, education and training, and alternative activities. Research shows, that in addition to addressing individual factors, it is just as important, and more important in some instances, to engage community institutions and address environmental factors.

Direct Prevention Services

While children and youth are certainly the most critical prevention target, the need for prevention services continues throughout adult life. Everyone needs information and training on how to avoid problems associated with alcohol, tobacco and other drug use. There is an ongoing need for information and education on the following:

- the dangers of alcohol, tobacco and other drug use;
- the drug problem in the local community, state and nation;
- prevention strategies to use in schools, families, communities, and personal lives;

- prevention and treatment services available; and
- the positive and beneficial effects of a drug-free lifestyle.

Community Process and Environmental Strategies

Some environments present multiple risk factors, e.g., high drug-traffic and/or crime neighborhoods, poverty, high unemployment, domestic violence, and family history of drug use/crime. People who live in these environments are impacted by these risk factors; therefore, sub-populations are targeted with particular information and educational strategies, alternative activities, and problem identification and referral services. The Substance Abuse Program supports the development of local capacity, through the development of anti-drug coalitions which help to assess local needs and plan accordingly, select best-practice strategies, and monitor progress toward community-level improvements.

Level 2 Prevention (Individual-Specific)

Level 2 prevention services are tailored to meet the specific needs of individual youth who have been identified as exhibiting multiple risk factors such as low academic performance, favorable attitudes toward drug use/use of violence, anti-social behavior, low self confidence, poor community bonding, and early signs of experimentation. This target population requires the most direct and intense forms of prevention strategies.

Children

The emphasis of prevention activities continues to be targeted toward 12 to 17 year old youth and their families. Since the year 2000, the Substance Abuse Program has initiated several strategies to improve program operations and outcomes for children. These included an increase in the utilization of rigorously evaluated program models, support for community anti-drug coalitions, coordination with other state agencies, and establishing reliable data sources for assessing needs and performance. Simultaneously, there has been a significant reduction in youth drug use as measured by the Florida Youth Substance Abuse Survey (FYSAS). As the science of prevention grows so will the scope of the department's prevention services.

According to the Florida Youth Substance Abuse Survey, the alcohol, tobacco and other drug use among youth has generally declined since 2000, although the trend has leveled off since 2004 (see Table 2). The Survey is a statewide survey conducted annually at the state level and on even years at the county level. The 2006 survey results show a steady decline in youth related alcohol, tobacco and other drug use for the state and most counties since its inception in 2000. However, results indicate that girls are being impacted by the prevention messages the same way that boys are.

Although Florida has led the nation in leading children away from substance abuse, the area of underage drinking continues to be a problem and poses a serious threat to the state's youth. For almost a decade, alcohol has been the most widespread substance of abuse by youth. In order to better target and address the issue of underage drinking, the Office of Drug Control has established a workgroup, *Changing Alcohol Norms (CAN): Florida's Initiative to Lower Youth Drinking.*

Among youth entering young adulthood, binge drinking and illicit and prescription drug abuse show marked increases. Binge drinking among 18 year olds increased from 29.8% in 2000 to 33.3% in 2006. Table 1 below depicts the reduced substance use among middle and high school students in Florida from 2000-2006, and reflects a slight increase from 2005-2006.

Table 1: Reduced Substance Use Among Middle and High School Students from FY 2000 - FY 2006 and FY 2005 – FY 2006

30-Day Use:					
Current Use and Overall Decrease for Fiscal Years 2000-2006 & 2005-2006					
		% Change			
	% Current Use	2000-2006		2005-2006	
LSD or PCP	0.8%	73	⇓	33	⇑
Ecstasy	1.2%	57	⇓	20	⇑
Methamphetamine	0.7%	56	⇓	0	⇔
Heroin	0.4%	50	⇓	33	⇑
Steroids	0.5%	50	⇓	25	⇑
Cigarettes	10.6%	42	⇓	4	⇑
Rx. Amphetamines	1.4%	26	⇓	27	⇑
Crack Cocaine	0.6%	25	⇓	50	⇑
Marijuana	11.4%	21	⇓	10	⇑
Cocaine	1.6%	20	⇓	45	⇑
Rx. Pain Relievers	3.2%	9	⇓	14	⇑
Alcohol	32.0%	7	⇓	4	⇑
Mushrooms	1.2%	0	⇔	8	⇓
Depressants	2.5%	47	⇑	14	⇑
Binge Drinking	16.8%	11	⇓	11	⇑

Note: Binge drinking is defined as having five or more alcoholic drinks in a row in the past two weeks.

Comparison of 2004, 2005, and 2006 data show a leveling off of alcohol, tobacco and other drug use among middle and high school students in Florida. Table 2 below depicts this leveling off effect.

Table 2: Comparison of ATOD Use Among Middle and High School Students for FYs 2004, 2005, and 2006

30-Day Use: Comparison of Fiscal Years 2004, 2005, & 2006			
	2004	2005	2006
	% Use	% Use	% Use
LSD or PCP	0.7%	0.7%	0.8%
Ecstasy	1.1%	1.0%	1.2%
Methamphetamine	0.9%	0.7%	0.7%
Heroin	0.3%	0.3%	0.4%
Steroids	0.5%	0.4%	0.5%
Cigarettes	11.4%	10.2%	10.6%
Rx. Amphetamines	1.3%	1.1%	1.4%
Crack Cocaine	0.6%	0.4%	0.6%
Marijuana	11.5%	10.4%	11.4%
Cocaine	1.5%	1.1%	1.6%
Rx. Pain Relievers	3.3%	2.8%	3.2%
Alcohol	32.3%	30.8%	32.0%
Mushrooms	1.1%	1.3%	1.2%
Depressants	2.8%	2.2%	2.5%
Binge Drinking	16.0%	15.2%	16.8%

Note: Binge drinking is defined as having five or more alcoholic drinks in a row in the past two weeks.

The Substance Abuse Program is working with the Governor's Office of Drug Control on a program called "Changing Alcohol Norms" to combat underage alcohol use, with emphasis on working with colleges and universities throughout the state.

Adults

While the most critical ages for prevention services appear to be pre-adolescence and adolescence, adults have their own substance abuse challenges. The Substance Abuse Program is working to improve prevention

services to adults. The primary foci during the next three years will be on 18 to 24 year olds and the elderly. Older adults have been a target group for substance abuse prevention services over the last four years. Services primarily focus on the prevention of medication misuse and/or acceleration of substance abuse/dependence by adults age 60 and older due to life changes/stressors.

Communities

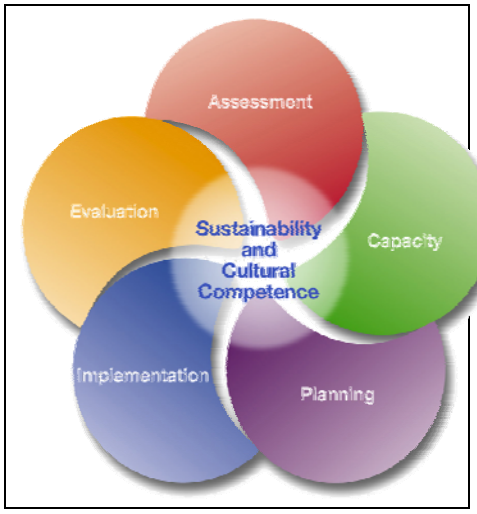
Studies indicate that a community's prevention environment and its coordination around substance abuse issues provide the foundation for effective direct prevention services. The Substance Abuse Program will continue to support the establishment and strengthening of Florida's community anti-drug coalitions through the "Coalition Mini-Grant Program". The "Coalition Mini-Grant Program" awards grants to prevention coalitions to strengthen the organizational structure of local anti-drug coalitions and provides for training on environmental strategies. These environmental strategies give Florida's local community anti-drug coalitions new skills for recognizing and addressing environmental issues that slow progress toward the prevention goals of the Drug Control Strategy. Currently, all 67 counties have a community anti-drug coalition. Coalitions consist of representatives of key local institutions and organizations who can effectively address policies, practices, policy enforcement and other social norming issues, as well as coordinated resource distribution. Representatives from these community anti-drug coalitions participate on the Florida Substance Abuse Prevention Advisory Council (FSAPAC). The scope of the Advisory Council encompasses strengthening substance abuse prevention services for children, youth and adults. The Substance Abuse Program uses coalition plans to improve resource allocation and service quality.

In addition to the "Coalition Mini-Grant Program", the department competitively bids approximately $4.5 million per year in substance abuse prevention programs that require collaboration between schools or school districts and community-based organizations. These funds are disbursed through competitively-bid two-year contracts and are held to a high standard of evaluation which is provided by the University of Miami.

Infrastructure

The Substance Abuse Program continues to strengthen the prevention infrastructure to enhance efficiency and achievement of community-level outcomes. The foundation for this infrastructure is Florida's Strategic Prevention Framework (SPF). Florida's Strategic Prevention Framework project, a five year federal grant, is increasing state and community capacity. The Framework project implements a five step process in response to alcohol, tobacco and other

drug consumption and consequences data to effectively plan, implement, and evaluate prevention activities at state and local levels. The grant, now in its third year, supports a State Epidemiology Workgroup[3], capacity-building activities for up to 55 community coalitions and implementation of evidenced-based programs, practices, and policies. The State Epidemiology Workgroup's *Initial Report of Florida's State Epidemiology Workgroup (SEW), June 7, 2006* can be viewed on the internet at: http://cdrc.med.miami.edu/x58.xml. The Epidemiology Workgroup collects and analyzes data for all age groups. The Substance Abuse Program is particularly interested in the Workgroup's findings with regard to youth, young adults (18 to 24 years old) and the elderly. The program hopes to conduct an adult epidemiological survey during the next three years.



The Performance-Based Prevention System (PBPS), initiated in 2004, is a web-based data system to track the performance of the department and its contracted service providers. The system is designed specifically for the field of substance abuse prevention. Data coming in or going out of the system are electronically encrypted to prevent outside sources viewing the information. This is the same type of coding that is used by banking systems to transmit large amounts of money. All contracted prevention service providers use this web-based, secure, real time reporting system. The system tracks information needed to determine achievement of contract performance measures, preliminary invoice verification, and information required for reports to federal and state fund sources. Contract performance measures include: (1) the number of children and adults served; (2) the number of participants who complete a program; and (3) the timeliness of entering data into the system. The system links the various components of substance abuse prevention into a coherent system. The system allows a substance abuse prevention provider to track staff hours, participant profiles, contract requirements and service events as well as, measures of performance, either separately or in terms of their relationship to each other.

Strategic Planning

Since 1999, the Substance Abuse Program has provided staff support to the Florida Substance Abuse Prevention Advisory Council. The Council has produced two editions of the *Florida Prevention System: The Prevention Component of the Florida Drug Control Strategy*, most recently published in 2004. As part of the Strategic Prevention Framework Grant, the Council will work with the State Epidemiology Workgroup to develop a state strategic prevention

[3] Florida's State Epidemiology Workgroup (SEW) is composed of members with expertise in epidemiologic data and/or drug policy drawn from a wide variety of state agencies, universities, and community-based organizations. The SEW is coordinated by the Comprehensive Drug Research Center at the University of Miami – Miller School of Medicine.

plan that addresses the prevention needs of all age groups. The Strategic Prevention Framework Grant will also provide resources to local anti-drug coalitions to develop epidemiology-based plans for addressing the prevention needs of their communities. Currently, all 67 counties have a community anti-drug coalition. District/Regional Substance Abuse and Mental Health Program Offices will use coalition plans to improve resource allocation and service quality.

Evidence-Based Programs, Practices, and Policies

In 2000, the Substance Abuse Program made a commitment to fund prevention programs that had been rigorously tested and found to be effective in reducing the risk of substance abuse. Since that time, all district/regional offices prioritize model prevention programs in their contracts. The Substance Abuse Program Office contracts with the University of Miami to provide prevention evaluation and field support services so that all programs under contract with the district/regional offices have a foundation for evidence of effectiveness. Additionally, through the SPF Grant, the program office is working with community anti-drug coalitions to support the implementation of evidence-based strategies to address environmental issues and to develop effective prevention policies.

Substance Abuse Partnership Initiatives

The Department of Children and Families, Substance Abuse Program is designated by the Federal Substance Abuse and Mental Health Services Administration as the "Single State Agency" for substance abuse services within the state of Florida. This program and the Governor's Office of Drug Control are viewed across the executive branches of government as the focal points of strategic planning, public policy, and funding of substance abuse prevention and treatment services. With this designation and its inherent responsibilities, the department is the leader in the field of public substance abuse treatment, prevention, as well as public policy and inter-agency collaboration.

Outlined below is a listing of agencies that the department and the Substance Abuse Program Office have formal written agreements, as well as those agencies where there is a substantive collaborative relationship.

<u>Executive Office of the Governor, Office of Drug Control</u>

The department works closely with the Office of Drug Control in several areas. The State Drug Control Plan is the framework for collaboration with executive agencies to interdict drugs and to enforce Florida's laws against drug possession, sales, and use. It further identifies areas of attention in the areas of substance abuse treatment. Initiatives in the areas of substance abuse treatment for adolescents, the elderly as well as initiatives designed to prevent and reduce the incidence of suicide within the state are areas of close collaboration between the Office of Drug Control and the department.

The department is also a principal in the development and implementation of the goals and strategies contained in the Florida Drug Control Strategy, the Governor and the Office of Drug Control's Strategic Plan. The goals of the Drug Control Strategy are:

Goal 1: Protect Florida's youth from substance abuse
Goal 2: Reduce the demand for drugs in Florida
Goal 3: Reduce the supply of drugs in Florida
Goal 4: Reduce the human suffering, moral degradation, and social, health, and economic cost of illegal drug use in Florida.

The department is engaged with the Office of Drug Control in the development of an updated Drug Control Strategy that reflects the progress made since 1999 and establishes the new goals for 2006 and beyond.

Department of Health

The department's relationship with the Department of Health has been one of long-term effective collaboration in the areas of prevention and intervention. The two departments share an initiative aimed at the prevention and reduction in the use of tobacco and drugs. In addition, the department partners with the Department of Health in the annual administration of the *Florida Youth Substance Abuse Survey*, *National Survey on Drug Use and Health*, and surveys conducted in conjunction with the Center for Disease Control (CDC).

The collaboration between the two departments is especially evident in the prevention and intervention activities promoting a reduction in the incidence of HIV/AIDS. There is a Memorandum of Agreement between the two departments that implement the Substance Abuse and Mental Health Services Administration's Rapid HIV Testing Initiative (RHTI). This initiative is designed to increase the abilities of the Department of Health and the state's substance abuse providers to reach more at-risk individuals with testing and HIV services.

Agency for Health Care Administration

The department and the Agency for Health Care Administration have a broad array of material interest in several arenas including the ACCESS (Food Stamp) program, TANF, child welfare, mental health, and substance abuse.

The collaboration between the Agency and the Substance Abuse Program Office is evident in several areas. For example, substantial modifications in the Agency's Medicaid Handbook have resulted in an expansion in the types of substance abuse treatment services that are Medicaid-compensable. The two agencies have collaborated in a Robert Wood Johnson-funded initiative that resulted in improved access to treatment services by Medicaid-eligible clients. The initiative led to an increase in the number of Medicaid-enrolled substance abuse agencies.

Further, in conjunction with the Florida Association of Counties and the Agency, a substance abuse-certified match program was established that promotes the use of local government funds to match Medicaid services.

Child Welfare and Community-Based Care

The Substance Abuse Program is engaged in a number of initiatives in the area of child welfare in order to better meet the substance abuse treatment needs for persons who are involved in that system. Effective collaboration has proven to be essential in providing services that are critical to the accomplishment of permanency-planning as well as prevent the re-occurrence of child maltreatment.

- The Substance Abuse, Mental Health, Child Welfare, and Community-Based Care Program Offices are parties to an agreement entitled the "Policy Working Agreement". The purpose of the agreement is to develop and maintain a well-integrated and coordinated response to the problems of parental substance abuse and/or mental illness and its effects on child maltreatment and neglect.

The agreement establishes several goals and the framework for meeting those goals. The goals are as follows:

1. Protect and ensure the safety of children;
2. Prevent and remediate the consequences of substance abuse and mental health issues for families involved in or at-risk for involvement in the child welfare system;
3. Plan for family preservation and/or permanency through strengthened engagement of families and involved professionals; and
4. Support families in recovery with substance abuse and mental health issues.

- The Substance Abuse Program is currently funded for 70 Family Intervention Specialist (FIS) positions. These positions provide substance abuse screening and service linkages for adults with substance abuse problems who are involved in the child protection system. These positions perform a critical role by linking parents who need substance abuse services to those services. This activity helps to reduce the likelihood of further child maltreatment as well as improve the chances for family reunification.

- The substance abuse program has initiated a contract with the Northeast Florida Addictions Network (NEFAN) to specifically manage the functions of the Family Intervention Specialists in districts 4 and 12. The purpose of this contract is to improve coordination between the Intervention specialists and community-based care entities, which manage the state's child protective services programs, in order to better meet the needs of adults who are involved in the child welfare system who also need substance abuse services.

Collaborative Activities with the Department of Juvenile Justice, Criminal Justice Systems, and the State Courts Administration

Fully two-thirds of the persons in substance abuse treatment are, to some extent, involved with the courts and/or the juvenile/criminal justice system. A premium is placed on opportunities for collaboration with these systems to ensure that those persons in the greatest need for treatment receive treatment and to ensure that alternatives to incarceration are available to persons who are viewed as appropriate for and benefiting from treatment. As examples:

- The department and the Department of Juvenile Justice are principals in an interagency agreement aimed at improving service integration and coordination. The agreement promotes improved performance on the part of the two agencies and their contracted providers, as well as joint planning and submission of complementary Legislative Budget Requests.
- The department and the Department of Corrections jointly fund community-based treatment programs aimed at diverting persons from the criminal justice system or ensuring that treatment is available for persons seeking treatment at the end of their respective sentence and upon their return to the community.
- The department's collaboration with the State Court Administrator's Office is based on mutual support of drug court programs, both for persons involved in the criminal justice system and for persons receiving treatment under the auspices of the Dependency Drug Courts. Florida has been a leader in establishing, maintaining, and expanding drug courts throughout the state which are designed to provide treatment services to persons who would otherwise be incarcerated or to families at-risk of losing their children due to child maltreatment or neglect.

CHAPTER 3: MENTAL HEALTH PROGRAM

A. Introduction

This chapter contains the Mental Health program plan for the next three years, projecting those activities and initiatives that will, in part, address the needs of the persons we serve. The plan reflects the department's commitment and ongoing efforts to fundamentally change (transform) the current provider-driven, fragmented, and symptom-focused system of care, to a customer-driven and integrated system of care that promotes recovery (restoration of function) and resiliency (ability to cope with life stressors). The transformed, customer-driven system of care goes well-beyond the current focus on managing symptoms of mental illnesses (e.g. depressed mood and hallucinations) to enabling persons with severe and persistent mental illnesses and emotional disturbances to live, learn, work, and otherwise participate fully in their communities.

This fundamental shift to a customer-driven system of care, with the goal of enabling customers to function adequately in their communities is otherwise known as **Mental Health Transformation**, and, among other things, requires renewed focus on the following strategic initiatives:

1. Adequate and equitable funding across the 14 service districts/region
2. Timely access to a continuum of care ranging from routine outpatient to acute residential care
3. Integrated record-keeping and data-sharing systems to facilitate continuity of care when customers move between care levels or providers, and to accurately track provider performance and customer outcomes
4. Increased use of technology to enhance customer access to information and services, to enhance cost-efficiencies, and to expand service delivery in remote and rural areas
5. Reduced customer involvement in the juvenile and criminal justice systems
6. Increased use of evidence-based and promising treatments
7. Increased customer access to stable housing, employment, and transportation
8. Comprehensive workforce development to ensure availability of sufficient numbers of skilled, culturally competent service providers
9. Promote the use of recovery services and supports through Medicaid Purchased Services and amendment to the Medicaid State Plan to include Recovery Services.
10. Ensure that families and youth are full partners in the development and implementation of individual recovery plans and have a prominent voice in designing supports and services.

B. The Mental Health Program Statutory Framework

Statutorily, the department is charged with the following responsibilities:

- Administering and managing the state public mental health program, providing a range of mental health services for children and adults statewide (section 394.453, F.S.)
- Providing quality treatment in the least restrictive clinically appropriate setting, and in a manner consistent with the right to individual dignity, the right to treatment, and the right to express and informed consent (section 394.459, F.S.)
- Administering and managing secure facilities and programs for the treatment or training of defendants charged with a felony and who have been found to be Incompetent to Proceed or have been acquitted of felonies by reason of insanity (section 916.105, F.S.)
- Administering and managing the screening and evaluation of individuals previously convicted of a sexually violent offense, and managing the provision of treatment to individuals determined to be sexually violent predators as defined by section 394, Part V, F.S.
- Administering and managing secure facilities and programs for the treatment or training of juvenile defendants charged with a felony and found to be Incompetent to Proceed or have been acquitted of felonies by reason of insanity (section 985, Part IV, F.S.)

Regarding the administration and management of the public mental health program, Section 394.453, F.S., states: “It is the intent of the Legislature to authorize and direct the Department of Children and Family Services to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders.” Section 20.19(4), F.S., creates a Mental Health Program Office within the Department of Children and Family Services.

The Mental Health Program Office is comprised of a central office with responsibility for overall management of the statewide system of care, 14 Substance Abuse and Mental Health local offices in 13 districts and one region around the state, and seven state mental health treatment facilities. All community-based mental health services are provided through contracts initiated and managed by the 14 local offices. In contrast, three of the seven state mental health treatment facilities are operated by the state, and the other three are outsourced using contracts managed from the central office.

Florida’s System of Care - Florida’s system of care serves individuals and families at-risk of or challenged by mental illnesses or co-occurring substance use disorders and mental illnesses, and is organized in three broad areas:

- Adult Community Mental Health – which includes regular outpatient care (typically at community mental health centers) and residential care (e.g., crisis stabilization units, limited license alternative living facilities, and short-term residential treatment units)

- Children's Community Mental Health – which includes regular outpatient (wraparound) care, and residential care (e.g., State Inpatient Psychiatric Program and Therapeutic Group Home) provided through joint Medicaid and Mental Health Program contracts with local vendors and coordination and management of the Juvenile Incompetent to Proceed (JITP) program

- Civil and Forensic State Mental Health Treatment Facilities – which comprise the most intensive and costly level of care available to adults. Two of the facilities serve persons civilly committed to the department as needing inpatient care beyond that available in the community (e.g, care in a crisis stabilization unit), one serves persons committed the department as sexually violent predators, two serve persons forensically committed (as not guilty by reason of insanity or incompetent to proceed), and one serves both civil and forensic customers.

C. The Department's Strategic Plan

The department's 2005–2008 Strategic Plan reflects its mission of protecting the vulnerable, promoting strong and economically self-sufficient families, and advancing personal and family recovery. The strategic plan (Plan) also reflects our core values of choice, opportunity, empowerment and personal responsibility. The Mental Health Program Office is authorized by Chapter 394, F.S. to serve both adults and children who reside in the community and who are in need of mental health services. The adult target populations are:

Adults with severe and persistent mental illnesses (SPMI)
Adults in mental health crisis
Adults with forensic involvement

The children target population includes:

Children with serious emotional disturbance
Children with emotional disturbance
Children at risk of emotional disturbance

In addition to the above target populations, the PDMH also serves three target populations in state mental health treatment facilities:

Adults committed for civil reasons, that is, they lack criminal charges and are in need of service intensity beyond that available in the community
Adults committed for civil reasons, that is, they lack criminal charges but are determined to be sexually violent predators who require long-term treatment in a secure setting
Adults committed for forensic reasons, that is with criminal charges, and determined to be incompetent to proceed with trial or not guilty by reason of insanity

The Plan includes the following objectives and associated performance measures/strategies for the Mental Health Program:

- Reduced incidence of suicide in Substance Abuse, Mental Health, and Department of Juvenile Justice facilities

  The performance measure is the suicide rate per 1000 customers served. The strategy to achieve this objective is to establish a uniform, system-wide procedure for reporting, analyzing, and following-up significant events, including suicides.

- Increased days functioning in the home and community

  The performance measures include:

  - annual days seriously emotionally disturbed children (excluding those in juvenile justice facilities) spend in the community
  - projected annual days emotionally disturbed children (excluding those in juvenile justice facilities) spend in the community
  - average annual days spent in the community for adults with severe and persistent mental illnesses
  - average annual days spent in the community (not in institutions or other facilities) for adults with forensic involvement
  - average number of days to restore competency for adults in forensic commitment
  - percent of adult civil commitment patients, per Chapter 394, F.S., who show improvement in functioning level
  - percent of adults in forensic commitment, per Chapter 916, F.S., Part II, who are Not Guilty by Reason of Insanity, who show an improvement in functional level
  - annual number of harmful events per 100 residents of a facility

  The strategies to achieve this objective include improving access to appropriate support services, including child care, therapeutic and coaching services, wrap-around services, supportive housing, respite care, accessible

crisis services, and crisis counseling; and collaborating with law enforcement agencies, criminal justice system stakeholders, and service providers to identify safe, therapeutic alternatives to jail and thereby reduce public safety risks.

- Increased percent of individuals receiving services that are employed or are serving as volunteers

  The performance measures include average annual earnings and average annual days worked for pay for adults with severe and persistent mental illnesses. The strategy to achieve this objective is to increase supports for employment and volunteer activities.

- Increased days in school or training for children and adolescents with or at risk of emotional disturbance/serious emotional disturbance or at risk for substance abuse

  The performance measure is the percent of school days children with serious emotional disturbance attended school. The strategies to achieve this objective include partnering with the Agency for Health Care Administration, including pre-paid Medicaid plans, and schools to ensure continued access to substance abuse and mental health services; and implement substance abuse and mental health prevention partnerships.

The Mental Health Program Office also participates in the Substance Abuse and Mental Health Services Administration's ***National Outcome Measures*** initiative. The goal of this initiative is to ensure uniform reporting of specific measures on a nation-wide basis in order to gather critical information on services that are evidence-based best practices or emerging practices. The National Outcome Measures include ten domains. These domains and related outcomes for persons with mental illnesses are:

- *Reduced Morbidity:* the measure is still under development. The outcome will be decreased symptoms of mental illness.
- *Employment/Education:* the measure is a profile of adults by employment status and of children by increased school attendance. The outcome is increased/retained employment or returns to/stays in school.
- *Crime and Criminal Justice:* the measure is a profile of individual involvement in criminal and juvenile justice systems. The outcome is decreased criminal justice involvement.
- *Stability in Housing*: the measure is a profile of a person's change in living situation (includes homeless status). The outcome is increased stability in housing.
- *Social Connectedness:* the measure is under development. The outcome is increased supports/social connectedness.
- *Access/Capacity:* the measure is the number of persons served by age, gender, race, and ethnicity. The outcome is increased access to services (service capacity).

- *Retention*: the measure is a decreased rate of readmission to state psychiatric hospitals within 30 days and 180 days. The measure is reduced utilization of psychiatric inpatient beds.
- *Perception of Care*: the measure is individuals reporting positively about outcomes. The outcome is individual perception of care.
- *Cost Effectiveness:* the measure is the number of persons receiving evidence-based services/number of evidence-based practices provided by the state. The outcome is cost effectiveness (average cost).
- *Use of Evidence-Based Practices*: the measure is the same as for cost effectiveness. The outcome is the use of evidence-based practices.

D. Local Participation in Planning, Organizing, and Financing

Legislative intent with respect to local participation is cited in Section 394.66(3), F.S., which states, "Involve local citizens in the planning of substance abuse and mental health services in their communities." Section 394.75(1) (e) also cites that state and district substance abuse and mental health plans "…must include input from persons who represent local communities; local government entities that contribute funds to the local substance abuse and mental health treatment systems; consumers of publicly funded substance abuse and mental health services, and their families; and stakeholders interested in mental health and substance abuse services."

The department has initiated a proactive strategy to ensure local participation in the development of district plans. This strategy is addressed at greater depth in later sections of this plan.

Stakeholder Input

Specific to this plan, the department facilitated face-to-face meetings to solicit stakeholder input, and engaged in the development, distribution, and analysis of an online survey. On December 19, 2006, the Substance Abuse and Mental Health Program Offices held a stakeholder forum specifically to obtain input on the development of this Master Plan. The stakeholder meeting was the last phase in a series of discussions held across the state, throughout the year, to solicit input on the needs of our constituents and the quality and availability of current services & supports. SAMH staff also conducted an online survey, addressing issues affecting both substance abuse and mental health.

At the stakeholder meeting, break-out sessions were held for mental health and substance abuse. Stakeholders had the opportunity to identify priorities the department must address. For mental health, the identified priorities were:

- An adequately funded continuum of care - which among other things, ranges from acute crisis to respite care, includes the prevention of mental illnesses and emotional disturbances, utilizes evidenced-based and

promising practices, addresses co-occurring substance use and mental disorders, and promotes employment and education of customers

- Housing - Access to safe, affordable, community-integrated housing, including accommodations for individual household needs, and subsidies and bridge-funding when necessary
- An articulated Transformation vision - detailed plan of where we are going in terms of transforming the public mental health system
- No loss of services via Medicaid Managed Care implementation - this includes maintaining the 80 percent medical loss ratio, ensuring access to necessary care, and preventing erosion of existing services

Through the online survey**,** an overwhelming number of respondents cited co-occurring disorders as an important emerging issue. They identified the lack of adequate funding and resources as the predominant barrier to establishing an adequate system of care. Funding problems affect the ability to implement evidence-based and promising practices, reduce waiting lists, add infrastructure, continually train staff, and provide salaries that retain a competent workforce.

The following issues were among the major concerns of stakeholders responding to the survey:

- the movement towards delivering Medicaid-funded services through a capitated managed care system
- an ever increasing need for services in the face of decreasing budgets and beds
- the overall impact of Medicaid reform on the public mental health system

Regarding our effectiveness as a partner, twenty-nine percent (29%) of respondents replied in the negative. This relatively high level of dissatisfaction with our performance as a partner is of concern, and will be addressed through further identification and exploration of specific areas of dissatisfaction with customers and stakeholders at the district level.

Customer Involvement

During fiscal year 2006, the Mental Health Program Office actively sought direct input from individuals receiving services and supports through the public mental health system. In conjunction with the Transformation activities, central office and regional staff spoke with over 500 consumers during visits to seven districts and the SunCoast Region. Rather than convening a public forum, we met with these individuals where they live, work, and receive services. Public forums are less effective in reaching the widest variety of mental health service consumers, due to transportation limitations experienced by many of these consumers. Our primary purpose in establishing this dialogue was to gain a more complete understanding of what people believe they need in order to attain and maintain optimal functioning in their communities.

A transformed system responds to the needs of persons with mental illnesses as identified and conceptualized by those individuals. Current research clearly indicates that recovery is a real expectation and that positive outcomes are achieved when we listen, learn, and respond to persons experiencing the effects of mental illnesses. The top needs/issues presented by the individuals who provided input during these meetings were:

- housing
- transportation
- productive use of their time (job/volunteering, etc.)

These dialogues were extremely valuable and the Mental Health Program Office will continue to receive input on the needs of consumers. Each district/region will similarly continue an ongoing dialogue with people receiving publicly funded mental health services and that our system will continue to change in response to these identified needs. We have adopted the theme of the national consumer movement, "nothing about us, without us." In addition to these visits with adult consumers, Children's Mental Health staff conducted several family forums throughout the state to solicit input about the struggles that children and their families endure as they seek mental health services. The results of these forums are detailed in the Children's Mental Health section of this chapter.

E. Adult Community Mental Health Services

Adult Community Mental Health serves Floridians 18 years of age and older who meet one of the legislatively mandated priority service populations. These populations are groupings of individuals who share similar characteristics and/or manifestations of symptoms.

Priority Service Populations

Adults with severe and persistent mental illnesses (SPMI):
This group includes persons 18 years of age and older who have a diagnosis of schizophrenia, affective disorders, paranoid states, other non-organic psychoses, or psychoses with origin specific to childhood, or a diagnosis other than these, who also meet one of the following conditions:

- The individual is unable to perform independent activities of daily living (e.g., personal hygiene, dressing, nutrition, housekeeping, etc.);
- The individual receives disability income for a psychiatric condition (e.g., Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), veteran's benefits); or
- The individual is at risk of institutionalization or incarceration for mental health reasons.

Adults with serious & acute episodes of mental illnesses:
This group includes persons 18 years and older who have a presenting mental health problem and meet criteria for admission to an acute care mental health facility.

Adults with mental health problems:
This group includes persons 18 years and older who have a presenting mental health problem and meet any of the following criteria:

- The person shows evidence of a recent, severe stressful event and problems with coping; or
- The person displays mental health symptoms that if untreated could lead to the need for more intensive/restrictive intervention

Due to resource limitations, provision of state funded mental health services is generally limited to individuals in the first two priority groups above; that is, adults with severe and persistent mental illnesses and adults with serious and acute episodes of mental illnesses.

In FY 2005-2006, a total of 155,344 adults were served in community mental health programs around the state: 127,077 persons with severe and persistent mental illnesses (82 percent), 25,438 (16 percent) with serious and acute episodes of mental illnesses or mental health problems; and 2,919 (2 percent) with forensic involvement.

Program Priorities

Mental Health Transformation – changing the current system of care to promote recovery and resiliency – is the main focus of the Adult Community Mental Health Office. To facilitate the desired change to a recovery and resiliency-based system of care, the department will address the following priority issues during the next three years:

➢ Adequate and equitable funding - During fiscal year 2005-2006, the number of adults with serious mental health needs who would need to access Florida's public mental health system was about 326,000. In contrast, 155,344 adults (48 percent) were served in the public mental health system during that year, indicating significant unmet need. Moreover, current funding for adult community mental health services remains inequitable across districts, as six of 14 districts receive less than the statewide average per capita funding for persons with severe and persistent mental illnesses. The department will address both issues – inadequate and inequitable funding – in its legislative budget requests over the next three years.

➢ Use of evidence-based practices - Evidence-based practices have consistent scientific evidence of working well to improve outcomes in the lives of individuals with serious mental illnesses. National studies have shown that a majority of individuals with serious mental illnesses do not have reliable access to these evidence-based practices. In Florida, as part of its *mental health transformation* agenda, increased use of evidence-based practices will continue to be a priority of this three-year plan.

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration recognizes the following as evidence-based practices, most of which are being used on a limited scale within the state, and one more extensively (Assertive Community Treatment):

1. Standardized pharmacological treatment
2. Illness management and recovery skills
3. Supported Employment
4. Family Psychoeducation
5. Assertive Community Treatment
6. Integrated co-occurring treatment (substance abuse & mental illness)

The use of evidence-based practices will be increased during the next three years.

➢ Involvement in the juvenile and adult criminal justice systems - The GAINS Center receives federal funding to provide technical assistance to states on criminal justice issues relating to persons with mental illnesses. The Center reports that approximately 11.4 million Americans are booked into jails each year and as many as 700,000 of these individuals have active symptoms of a serious mental illness. Currently, five percent of the adult persons served by the mental health system are in the county jail system.

In Florida, up to 23 percent of county jail inmates and 16 percent of state prison inmates have serious mental illnesses. These individuals frequently come to the attention of the criminal justice system as a result of circumstances related to their mental illness. Because of untreated or under-treated mental illnesses, many commit minor or non-violent criminal offenses, for which they are arrested and taken to jail, rather than to a more appropriate community mental health facility. As a result, they may be committed to a state mental health treatment facility for competency restoration.

Indeed, forensic customers (persons committed to the department as incompetent to proceed or not guilty by reason of insanity) are by far the fastest growing mental health customer group in the state. Forensic commitments have increased by 72 percent since 1999, including an unprecedented 16 percent increase between fiscal years 2004-2005 and 2005-2006, far exceeding existing forensic treatment bed capacity (currently 1339 beds). At the same time, prison sentences of a year and a day have increased by 25 percent. As the criminal justice population increases, so may the number of individuals being committed to the department. This in turn has led to an increasingly large number of persons waiting in county jails for long periods of time for the next available bed at a state forensic mental health treatment facility. Approximately 60 percent of these forensic commitments are new to the mental health treatment system, and many require ongoing treatment after release. A similar, albeit less significant trend exists for children under supervision with the Department of Juvenile Justice: More than 60 children now comprise a juvenile forensic waiting list, as

they wait for the next available treatment bed in the juvenile forensic treatment system.

The above data suggests that a significant amount of needed care and treatment of persons with mental illnesses and emotional disturbances is being shifted, albeit inadvertently, to county jails, state prisons, and state forensic treatment facilities. During the next three years, the department will work collaboratively with interested parties and stakeholders to reduce customer involvement in the criminal and juvenile justice systems.

Solutions to the current mental health forensic crisis require aggressive action on several fronts. First, there must be a significant increase in secure forensic treatment beds at state mental health treatment facilities to eliminate individuals waiting over 15 days.

Second, communities must join together to develop local community intervention strategies that target persons committed to, or who are at risk of being committed to the department, and address the over-representation of persons with mental illness in the criminal justice system. Excellent examples of this approach are Broward, Dade, Orange, Escambia, Pinellas and Duval counties. Stakeholders must include at a minimum mental health consumers and families, county government and municipalities, law enforcement, the courts, the Department of Children and Families, and mental health service providers. Communities need specific strategies to address individuals in the criminal justice system, as well as broader approaches to divert individuals from entering the criminal justice system.

Finally, courts, in partnership with local communities, should convene community leaders and stakeholders to focus strategies to divert individuals from the criminal justice system, and assure appropriate treatment of individuals in the criminal justice system. Specific actions should include the court's willingness to use conditional release when appropriate community placements are available, promptly return individuals to jail when notified that their mental health treatment is completed, and immediately hold hearings to determine whether an individual is competent to proceed to trial or disposition. The expansion of mental health courts and mental health coordinators to every judicial circuit will help divert non-violent offenders from deep-end forensic mental health and criminal justice placements, and coordinate strategies and services for persons with mental illness in the criminal justice system.

The department has developed the following **"Comprehensive Six Point Plan"** to address the needs of persons with mental illness who are involved in the criminal justice system.

1. Prevent persons with mental illness from coming in contact with law enforcement by expanding community mental health services.

- Expand clubhouses and drop-in centers
- Expand peer supports and use of peers in recovery
- Increase access to appropriate, safe and affordable housing for persons with mental illness and provide wrap-around services to support independent living
- Increase access to effective medications
- Expand availability of low-cost or free transportation
- Provide life and employment skill training
- Assure recovery services and supports are provided through the Medicaid program
- Expand crisis services and alternatives to hospitalization and crisis stabilization unit admissions
- Expand residential treatment options
- Expand use of Assertive Community Treatment Teams

2. Increase the diversion of persons with mental illness from the criminal justice system.

- Implement community coalitions or planning initiatives to develop strategies to divert persons with mental illness from the criminal justice system
- Develop comprehensive community services teams that will target services and supports to persons in/or at risk of entering the criminal justice system
- Expand Crisis Intervention Teams to divert the mentally ill to appropriate community mental health treatment upon contact with police in lieu of arrest
- Deploy a coordinated crisis response system across urban and rural communities that includes law enforcement, public and private receiving facilities, emergency departments, community mental health providers, and the Department of Children and Families
- Increase availability of long-term supervised housing, residential facilities, assisted living facilities, and adult family-care homes with adequate mental health support services
- Expand use of involuntary outpatient commitment by expanding access to needed community services

3. Expand basic mental health services to individuals in jail.

- Assure that individuals have adequate access to appropriate medications
- Improve the provision of screening, assessment, and mental health services
- Assure continuity of services, including medications, for persons receiving community services upon admission to and discharge from jails
- Expand access to co-occurring drug abuse programs

- Expand community and in-jail competency restoration and maintenance services
- Expand community residential treatment and housing options for forensic clients
- Create mechanism for suspending, not terminating Medicaid enrollment, for persons who are jailed
- Provide statutory authority for involuntary treatment similar to provisions used in state mental health treatment facilities

4. Manage the use of state treatment facility beds

- Expand secure bed capacity at state mental health treatment facilities and community agencies to assure compliance with Florida Statutes
- Reduce the waiting time for individuals being returned to jail for adjudication
- Strengthen safety and security measures for forensic staff
- Monitor residents' length of stay and rates of discharge to assure appropriate utilization of state treatment beds
- Provide urgent notification to courts of an individual's readiness to return to court
- Work with district/regional forensic coordinators to develop approved discharge plans for persons who can be safely treated and supported in community placements
- Assure effective and timely competency restoration services

5. Enhance Court Services for Adjudicating Individuals in the Criminal Justice System

- Increase the use of conditional release to appropriate community placements
- Schedule hearings within seven days of a defendant's return to jail from a state mental health treatment facility
- Use administrative orders to assure timely return of individuals to jail from a state mental health treatment facility
- Expand Mental Health Courts for non-violent misdemeanor violators to reduce jail time and obtain treatment for the mentally ill
- Create mental health coordinators in each judicial circuit to coordinate mental health and criminal justice system services to persons in the criminal justice system
- Assure that evaluations to determine and individuals' mental health competency meet all statutory requirements
- Convene community leaders and stakeholders to develop strategies to divert individuals with mental illness from the criminal justice system

6. Improve coordination of aftercare services for persons with mental illness upon their release from jail or state prison system

- Implement contracted aftercare coordinators to coordinate services for persons released from the state prison system
- Improve processes for restoring social security and Medicaid benefits to eligible persons upon discharge from prison
- Increase availability of long-term supervised housing, residential facilities, assisted living facilities, and adult family-care homes
- Provide access to employment services

Legislative Recommendations

- Provide incentives for community planning or community coalitions to address the issues of persons with mental illness and the criminal justice system.
- Promote the establishment of mental health coordinators and mental health courts in each judicial circuit.
- Add forensic commitments and secure beds to the Criminal Justice Estimating Conference
- Provide in statute the circumstances under which an inmate in a county jail may be provided involuntary medication treatment for mental illness.

➢ Adequate continuum of care - Crisis stabilization units (CSU) around the state are typically full, while large numbers of customers wait in general hospitals for the next available bed. Some 8,000 persons with severe and persistent mental illnesses reside in limited license mental health alternative living facilities, with access to few outpatient mental health services (typically case management and psychotropic medications). Significant numbers of mental health treatment facility residents remain hospitalized long after they are discharge-ready because of the lack of suitable community placements, especially placements with on-site mental health outpatient services. Significant numbers of persons who do not require hospitalization are nevertheless committed to state mental health treatment facilities due to lack of suitable community alternatives. A growing number of persons with mental illnesses are becoming involved in the criminal and juvenile justice systems. The Mental Health Program Office regularly receives calls and complaints about customers who cycle in and out of Crisis Stabilization Units and jails due to lack of suitable treatment alternatives. Only 48 percent of persons with serious mental health needs, and who would likely access public (versus private) mental health services due to income level, were served by the public mental health system in fiscal year 2005-2006.

Collectively, the above information suggests that the available continuum of care is inadequate to consistently meet the needs of priority customers of the public mental health system. In a meeting with stakeholders from around the state held on December 19, 2006, the need for a full continuum of mental health services and care was one of the priority issues identified. During the next three years, the

department will work collaboratively with stakeholders to expand the continuum of care, consistent with customer need.

Any analysis and expansion of the current continuum of care must include review of the acute care component of the public mental health system, namely the distribution and operation of crisis stabilization units under the Florida Mental Health Act, also known as the Baker Act. Enacted in 1971, the Baker Act brought about a dramatic and comprehensive revision of Florida's mental health evaluation and treatment statutes. It substantially strengthened the due process and civil rights of persons in mental health facilities.

A number of amendments have been enacted since 1971 to strengthen these rights, in accordance with evolving national mental health case law. Most recently, in January 2005, the Baker Act was revised to include Involuntary Outpatient Placement.

Without question, the Baker Act has stood the test of time. However, in recent years Florida's mental health budget has not kept pace with its increasing population. There has been erosion in the availability of front-end community-based mental health services, resulting in a substantial increase in the demand for acute care interventions. One result is that hospitals are witnessing increasing numbers of people in their emergency rooms experiencing mental health crises, awaiting transfer to a publicly-funded acute care facility (i.e., Crisis Stabilization Units). Law enforcement also relies heavily on the acute care system, and we anticipate that an unintended effect of Medicaid Reform will be even greater demands for acute care interventions.

In the fall of 2006, the department convened a work group to address the issues facing Florida's acute care system. The work group made the following preliminary recommendations, which will be addressed and acted upon during the period covered by this Plan:

- ✓ Examine existing language in Chapter 394, F.S., and recommend changes as needed
- ✓ Examine the existing capacity of the acute care system and the need for crisis services
- ✓ Consider alternatives to acute care by establishing best practices as they relate to a recovery-oriented system of care

Additional recommendations from the workgroup are anticipated within six months, and they too will be addressed and acted upon.

Medicaid Reform and Medicaid Managed Care Initiatives in Florida -The continuum of care accessible to priority customers of the public mental health system will be impacted by Medicaid Reform and Managed Care initiatives in Florida.

Since 2004, the Agency for Healthcare Administration, Florida's state Medicaid authority, has increasingly moved from a fee-for-service healthcare environment to a capitated healthcare system. However, mental health care for children with emotional disturbances and adults with serious and persistent mental illnesses has – for the most part – continued to be provided on a fee-for-service basis.

During 2006, increasing numbers of public mental health customers have been enrolled in either a Health Maintenance Organization (HMO) providing comprehensive healthcare benefit (i.e., a Medicaid 'carve-in' service model), or in a Pre-paid Mental Health Plan (i.e., a 'carve-out' service model). Continuing this trend, there are two significant Medicaid initiatives that will affect the operation of public mental health during the period covered by this plan. One is the implementation of a Medicaid Child-Welfare Pre-paid Plan, and the other is "Medicaid Reform", which will capitate comprehensive healthcare benefits to the majority of Medicaid eligible customers – including mental health – under a 'carve-in' model.

Broward and Duval counties have been designated as 'pilots' for Florida's Medicaid Reform initiative and it is currently anticipated that the rest of the state will move to a Medicaid 'carve-in' model within three (3) years.

This fundamental operational shift in the Medicaid program has altered both the accessibility and availability of mental health treatment services and supports. It has also changed the locus for decision-making with regard to individual service planning. In a fee-for-service environment, service planning is a process occurring between case managers and the individuals they serve. It is based upon clinical recommendations; an individuals self-determined recovery goals, and the availability of local resources. Prior authorization procedures and limitations on service utilization place new constraints on service planning, and may not reflect a thorough understanding of the specialized needs of persons with serious mental illnesses.

Managed care companies are expected to provide a complete health benefit package. The Mental Health Program will therefore focus scarce resources in two ways: 1) the provision to 'priority clients' of services and supports not incorporated into the Medicaid Behavioral Health Handbook; and 2) the provision of services and supports to the large number of Floridians with serious mental illnesses who are not Medicaid eligible, and have very low incomes. It is estimated that approximately 3.3 million non-elderly persons are uninsured. Of these, 2.4 million have incomes below 250 percent of poverty, and persons with serious mental illnesses are over-represented in this group.

Changes in the way Florida provides healthcare to low income residents will be the subject of ongoing review and policy discussion. It is particularly important that the department continue to monitor the effects of managed care on persons served in the public mental health arena, and take a proactive approach to delivering coordinated, comprehensive mental health treatment and supports.

Though healthcare rendered in a managed care environment presents new opportunities for Floridians, the advent of restricted formularies, service pre-authorizations, and limits on service units provided to persons with serious and persistent mental illnesses also creates new challenges. Radical change has occurred in a relatively short period of time, and stakeholders in the public mental health service system are actively working to adjust to these changes. During the December 19, 2006 meeting with stakeholders from around the state, one of the highest priority issues was to prevent erosion of services and to ensure access to necessary care during the implementation of Medicaid managed care.

Customer access to stable housing **-** Although not yet an evidence-based practice, supportive housing/living has been embraced by many states in their efforts to address the growing crisis in obtaining safe, decent, affordable housing for persons with mental illnesses. This was one of the major issues voiced by consumers and other stakeholders during statewide meetings seeking input on the mental health system in Florida.

Housing is a broad societal issue that directly impacts mental health. Without housing, people with mental illnesses are at greater risk of both inpatient hospitalization and interfacing with the criminal justice system. They may also remain in restrictive settings longer than necessary, because the lack of housing alternatives precludes a timely return to their home communities.

With housing costs well above the national average in Florida, construction costs increasing and land availability decreasing, people with disabilities are continuously “priced out” of the housing market because of limited or no income. About 2,072 individuals discharged from Florida’s state civil facilities every year have no source of income and are reliant upon state resources for housing and services. A housing supplement program would provide a means for clinically appropriate individuals to return to their communities on a timely basis, rather than occupy a bed needed by individuals who are waiting for hospital placement (e.g., in crisis stabilization units).

Florida’s Fair Market Rent as established by the United States Department of Housing and Urban Development (HUD) is $703 per month. The lowest Fair Market Rent is in Baker County at $409 per month, and the highest in Broward County, at $998 per month. For housing to be ‘affordable’ in accordance with standards set by HUD, the cost should not exceed 30 percent of income. Many persons with psychiatric disabilities have incomes far below the poverty level, and therefore cannot access most community housing options. In addition, individuals spending most or all of their income on housing are unable to afford other basic needs. Florida’s William E. Sadowski Affordable Housing Trust Fund generates over $200 million each year in documentary stamp revenues. A portion of these funds could be designated to promote community living for individuals with mental illnesses and/or co-occurring substance abuse needs.

Customer access to transportation - Inadequate transportation is a significant barrier to recovery from mental illnesses and full participation in one’s

community. Transportation problems make it difficult for customers to shop for food and other essential goods, keep mental health appointments, commute to work/volunteer settings, or travel to social functions. Improved access to transportation was second only to housing assistance in terms of critical needs identified by adult customers during statewide forums conducted in the spring and summer of 2006. This was especially salient for customers residing in remote or rural areas. During the next three years, the department will work collaboratively with customers, providers, and other community stakeholders to increase customer access to reliable transportation. If necessary, funding support with be requested through the legislative budgeting process.

Customer employment and other meaningful community involvement - Unemployment among people with serious mental illnesses is estimated to be as high as 85 percent, making this population the single largest unemployed disability group in the country. Despite this estimate, approximately 75 percent of these individuals express a desire for paid employment.

Many states began to address this issue through incorporating the principles of supported employment. Supported employment services for persons with severe and persistent mental illnesses are community-based employment services in an integrated work setting, which provide regular contact with non-disabled co-workers or the public. Beyond securing such employment, a job coach provides long-term, ongoing support as long as it is needed to assist the individual to maintain employment.

This evidence-based practice began as part of the service continuum for people with developmental disabilities, but expanded to the mental health community in the 1990s. Historically, a major barrier to full and successful implementation of this evidence-based practice was the difficulty in obtaining funding to pay for the second phase of the supported employment model - i.e., ongoing job coaches. This remains a barrier, but we have experienced some measure of success through collaboration with the Division of Vocational Rehabilitation and the Medicaid program.

In state fiscal year 2005-2006, 3,478 adults with severe and persistent mental illnesses received supported employment services. Supported employment is now available in each of the department's service districts, and is helping the department to meet its employment performance measure: 40 average annual days worked for pay. In fiscal year 2005-2006, the statewide target was exceeded, averaging 42.32 days of paid employment.

The Mental Health Program Office will promote increased utilization of supported employment during the course of this three-year plan.

Mental health clubhouse - is also an evidence-based service that effectively promotes employment of persons with mental illnesses. Mental health clubhouses are structured, community-based services designed to:

- strengthen and/or regain members' interpersonal skills

- provide a psychosocial approach to rehabilitation
- develop environmental supports necessary to successful community living
- meet employment and other life goals in the process of achieving recovery from the negative effects of psychiatric disabilities

Services are provided in a community-based program, where trained staff and members of the clubhouse work as a team to address life goals, and to perform the tasks necessary for the operation of the program. Clubhouses emphasize a holistic approach to recovery, focusing on strengths and abilities while challenging the person to pursue his or her life goals.

This is the first reference of mental health clubhouses in the three-year Master Plan. The first mental health clubhouse was started in 1974, in New York City (Fountain House). The United States has 196 clubhouses in 32 states serving approximately 37,500 people. Of all clubhouses, approximately 150 are certified by the International Center for Clubhouse Development (ICCD). The Center was established to create and maintain a standard of program performance to promote fidelity to a proven model, thus assuring that positive outcomes generally achieved in a clubhouse setting could be replicated. At least one national study compared employment outcomes in both clubhouses and the original Assertive Community Treatment model. Results indicated that Clubhouse members obtained jobs of higher quality than those obtained by Assertive Community Treatment participants, and that the cost of obtaining employment through the clubhouse model was lower.

Vincent House, Florida's first and only certified clubhouse. Mental health clubhouse development is still in its infancy in Florida. In fiscal year 2004-2005, only two districts reported the purchase of clubhouse services (SunCoast Region and District 15). Since then, the number of districts purchasing or planning to purchase this service has expanded to include Districts 2, 3, 4, 7, and 13. Experience so far indicates that model clubhouses provide a vital element of hope for people working toward recovery from the effects of mental illnesses.

In addition to increased use of supported employment and mental health clubhouses, the Mental Health Program Office will also facilitate employment of customers through continued development of the certified peer specialist and family specialist disciplines, and statewide deployment of such disciplines through paid employment to provide customer services, and to perform ongoing evaluation of program process and effectiveness.

Workforce development - The department will collaborate with mental health customers, mental health providers, and other community stakeholders to establish a *Best Practice Institute* to provide a program of regionalized training to district and provider staff on issues related to recovery and resiliency, including but not limited to the following:

- ✓ transitional youth services
- ✓ co-occurring substance abuse and mental health treatment

- ✓ clubhouse development
- ✓ suicide prevention models
- ✓ supported employment
- ✓ supported housing/living
- ✓ infant mental health
- ✓ family-to-family training
- ✓ trauma-informed care
- ✓ individualized recovery planning and implementation
- ✓ HIPAA and other privacy/confidentiality requirements
- ✓ culturally competent mental health care

Preadmission Screening and Resident Review (PASRR) - The Federal Omnibus Budget Reconciliation Act of 1987 and 1989 contained requirements for pre-admission screening and annual resident reviews for persons suspected of having mental illness or mental retardation who are seeking admission to a nursing home. This requirement is to ensure that persons with disabilities are receiving appropriate therapeutic services relevant to their disability. Funding for Florida to be able to conduct these reviews would address this requirement. The mental health program does not have the capacity to conduct these evaluations and needs additional funding to purchase these. Florida has been out of compliance with the past review and the Center for Medicaid Services has threatened financial sanctions due to Florida's lack of compliance. Funding has been requested to bring the Department into compliance.

F. Children's Mental Health

Children's Mental Health continues to prioritize services and supports for children who are involved with the child welfare and juvenile justice systems. Within these priority groups, children birth to five years of age, youth transitioning to adulthood and children at risk of residential treatment are the focus of specific activities and initiatives. System transformation is the driving force for current and future activities, with an emphasis on evidence based practices that are culturally competent, focused on prevention, early identification and intervention, and family-centered.

Priority Service Populations

Florida's publicly-funded children's mental health system annually serves over 80,000 eligible children with serious emotional disturbance, children with emotional disturbance, and children at risk of emotional disturbance, within the amount of funds appropriated for these services. Children found incompetent to proceed due to mental illness, which prevents them from participating in their defense are also served.

Children with serious emotional disturbance:
A child under the age of 18 must meet one of the following criteria:

- Diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder or personality disorder, or

- Currently classified as a student with serious emotional disturbance by a local school district, or
- Currently receiving Supplemental Security Income benefits for a psychiatric disability, or a combination of the following two criteria
- Has allowable diagnosis other than those listed in the Diagnostic and Statistical Manual *(i.e.: 293; 294; 297; 299; 300; 302; 306-314, & 316)*, and
- Has Children's Global Assessment Scale (C-GAS) score of 50 or below.

Children with emotional disturbance:
A child under the age of 18 who meet one of the following criteria:

- Currently classified as a student with an emotional handicap by a local school district; or
- Has allowable diagnosis other than those listed in the Diagnostic and Statistical Manual *(i.e.: 293; 294; 297; 299; 300; 302; 306-314, & 316).*

Children at risk of emotional disturbance:
A child under the age of 18 who has a mental health presenting problem, and meets one of the following criteria:

- Does not have a mental health diagnosis but has factors associated with an increased likelihood of developing an emotional disturbance (such as homelessness, family history of mental illness, abuse or neglect, domestic violence exposure, substance abuse, chronic physical illness, or multiple out-of-home placements); or
- Has a current referral for placement in Emotionally Handicapped (EH) program in accordance with Individuals with Disabilities Education Act (IDEA).

Overarching & Future Goals

To ensure Florida's children with emotional disturbances have good outcomes, the department must take steps to ensure that its providers are knowledgeable and have trained staff who can identify and deliver services that have the highest likelihood of success. Over the next three years Florida must do the following:

- Increase provider and family knowledge regarding what therapy and medication practices work for what diagnosis. One size does not fit all.
- Ensure that families are full partners in the design of individual recovery plans and have a prominent voice in designing services and supports
- Ensure that culturally competent care is a reality for the children and families we serve
- Continue collaboration between the departments of Health, Mental Health and Substance Abuse, Juvenile Justice, Education, and the Agency for Health Care Administration, in order to maximize the effectiveness of scarce resources by coordinating programs to ensure seamless transitions, early intervention and prevention programs, and to avoid duplication of effort

- Increase the number of children and youth at risk for mental health and substance abuse disorders who are, with the consent of parents or guardians, screened in primary care and educational settings
- Ensure that services and supports for children, youth, and families are sensitive to the impact of trauma, and are designed to address treatment issues and minimize system elements that might produce further trauma
- Reduce the time to access treatment and training services for juveniles found incompetent to proceed by the courts

Recovery and Resiliency-Based System of Care

Florida's Mental Health Program envisions the development of coordinated systems of care for children that provide services and supports that promote recovery and resiliency by being:

- community-based
- culturally competent
- strength-based
- evidenced-based
- individualized, child focused, and family directed
- inclusive of early intervention with the child and family
- coordinated across agencies and time lines

To achieve this vision, we must develop services and supports that will allow children to remain in the community. Services and supports must be delivered in a manner that promotes the natural resilience of children and recognizes each child's needs, based on his or her culture and background. Additionally, children with emotional disturbances must have access to school and leisure activities. Services/recovery plans will be inclusive of the child's and family's needs through the development of comprehensive wraparound plans that include transition services, family therapy, and respite. Providers will be knowledgeable about evidence-based practices and will ensure that children are receiving appropriate services and supports, based on a comprehensive assessment.

Evidence-Based Practices

As a field, Children's Mental Health is young. Only in the last twenty years have professionals begun to move away from a treatment model made up of residential programs that placed children in large state institutions, far from home, to one that is focused on creating community-based "systems of care." Following the President's New Freedom Commission Report, mental health professionals, funders, and researchers from across the country began taking a closer look at the treatment services for children that had demonstrated evidence of improved outcomes when compared to other treatments in clinical trials. Currently, there are few practices meeting all levels of criteria established by the Society of Clinical Psychology in the previous decade. These include Multisystemic Therapy for children and youth with or at risk of juvenile justice

involvement, Therapeutic Foster Care, Family Support and Education, Cognitive Behavioral Therapy for traumatic stress, Dyadic Therapy for infants and toddlers, and the Wraparound Approach.

Florida is fortunate to have two active and two recently completed Substance Abuse and Mental Health Services Administration grants that target two of the evidence-based practices discussed above - wraparound and Dyadic Therapy for infants and toddlers. All four grant structures also emphasize the importance of family support and have created family run organizations as a basis for providing family support partners. Additionally, the department funded four Infant Mental Health pilots in 1999, using the Dyadic Therapy model. Because of that work, Florida is viewed as a national leader in the area of early intervention for children birth to age five. Dyadic Therapy for infants and toddlers is currently available in all of Florida's 14 districts/regions.

Children's Mental Health is working with other states at the national level to create a web-based directory of evidence-based practices that is available to funding sources and practitioners. Based on the Hawaii Evidence-Based Practice Guidelines, the web-based format will provide information that matches diagnoses to components in each evidence-base practice. In the meantime, Children's Mental Health is working with Hawaii to adopt a static form of the information, and to make that available to all providers through our website.

Florida will continue to support Dyadic Therapy for infants and toddlers through support of training through the State Infant Mental Health Association and the local Coalitions for Infant Mental Health. Our goal over the next three years is to expand services to child care centers. The early intervention will be aimed at targeting the reduction of expulsions from child caring facilities for children birth to age 5.

For children with Serious Emotional Disturbance, the Wraparound Approach shows strong evidence of success. While the term "wraparound" is used frequently, there is still a lack of understanding of the methodology, and there is poor fidelity to the model. The availability of training to improve use and fidelity will be critical to our success for this population. To address this need, Children's Mental Health will work with Florida Mental Health Institute (FMHI) to research and identify training options for this and other emerging evidence-based practices.

Florida's Family to Family Peer Specialists Certification will lead our efforts to provide Family Support and Education. This certification program for families of children with emotional disturbance is based on Florida's Peer-to-Peer Specialist Program. The department is working with the Florida Certification Board to develop standards. It is anticipated that the certification process will be ready for implementation in the spring of 2007. The Family-to-Family Peer Specialists Certification will provide a basis for funders and providers to expand the utilization of this evidence-based practice.

Children's Mental Health staff will continue to be involved in initiatives designed to identify best practices in the use of psychotherapeutic medication, reduce the need for seclusion and restraint in all settings serving children and youth, increase family and youth involvement in all levels of planning and evaluation of service delivery, and decrease the need for residential placement.

Cultural Competency

The population of Florida is changing rapidly to one that consists of people from all countries and cultures. The Children's Mental Health Program is charged with developing a culturally competent system of care to guarantee that children and their families are adequately and appropriately served. Children's Mental Health endorses the Georgetown University's definition of cultural competence. Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors that are unique to each child and their family's culture.

Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations, and communities served. Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions. Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

To improve culturally competence practices throughout Florida, Children Mental Health will work with the State Mental Health Planning Council to survey contracted providers to identify areas of excellence and areas that may need technical assistance.

Family Directed Care

In our efforts to transform the children's mental health system to a more child focused and family-directed system, we understand that children must be seen in the context of their social environments - family, peers, and physical and cultural surroundings. Children's Mental Health recognizes that family involvement is critical to achieving positive outcomes for the children we serve, and to that end, during 2006 we have conducted Family Forums across the state. These Forums provided us an opportunity to hear about the struggles that children and their families endure as they seek mental health treatment in our state. Concerns expressed by involved youth and families are as follows:

1. Many parents are unable to maintain employment due to their children's behavioral health needs and frequent calls from the child's school. They expressed a desire for more support from teachers and the school system. Parents need child care, after school care, summer camps, and recreational activities facilitated by personnel trained to work with children who have emotional disturbances.
2. Parents do not feel respected by "professionals." Families are often excluded from their child's care. They have little opportunity to provide input and communication is poor. They feel no one is listening.

3. There is a lack of knowledge about how to access mental health services and navigate the system for children. When a provider is located, the parents experience long waiting lists for appointments. Parents expressed a desire for more family advocates and mentors to provide a guiding hand.
4. The high turnover in mental health providers affects continuity of care.
5. Parents want mental health issues treated with the same intensity as physical health issues. New Medicaid limits on the number of therapy sessions, limitations on choice of providers, and medication restrictions are not well understood by families.
6. There is a critical need for better information, planning, and assistance for eligible children transitioning into the adult mental health system.

Steps to address these concerns include the following activities:

- Florida is creating a curriculum for certified Peer-to-Peer Specialists with significant input from family members. The Family-to-Family Peer curriculum will be developed in early 2007. It is anticipated that certification of Family-to-Family Peer Specialists throughout the state will facilitate their eligibility for Medicaid, private insurance, and publicly funded reimbursement.
- The department is continuing to support family voice through meetings with families in each district/region across the state. To date, visits have been held in 12 of 14 district/regions. Families' concerns and recommendations from those meetings are being shared statewide.
- Children's Mental Health supported families to come together in December 2006. The purpose of this meeting was to develop local strategic plans to promote transformation of the role of families to one that recognizes that families should provide guidance in the development of services, budgets, policies and procedures, quality assurance, and training for mental health treatment services and supports.
- A statewide family contact list, along with a listing of all of Florida's family organizations targeting families of children with emotional disturbance, has been created. Beginning January 2007, the Substance Abuse and Mental Health Corporation will sponsor monthly calls to support continued development of family organizations and support networks for families of children with emotional disturbance.
- Children's Mental Health is working with the Department of Education/SEDNET (Severely Emotionally Disturbed Network) program to develop materials designed to improve professionals' understanding of the need to work more closely with families. Once completed, these materials will be distributed through schools and mental health provider organizations.

Collaborative Efforts

Collaborative partnerships have been crucial in meeting the challenges faced by Florida's mental health system. Our partners around the state are committed to the vision of a seamless system of care. The Children's Mental Health Program has a long established working relationship with Child Welfare, the Departments of Education, Juvenile Justice, Health, and the Agency for Health Care Administration.

- Department of Juvenile Justice

Children's Mental Health is involved in the juvenile justice system on several fronts. Past and current collaborative efforts include:

- *Establishment of Interagency Agreements:* An Interagency Agreement was signed between the Department of Juvenile Justice and the Department of Children and Families on May 11, 2005. The agreement reestablished guidelines for the roles and responsibilities of each department relative to children jointly served by both departments. This agreement includes guidelines concerning access to Mental Health treatment and "Juvenile Incompetent to Proceed" services for children in the Juvenile Justice system.

- *Cross Training and Continuity of Care:* In December of 2005, cross training was provided by the National Association of State Mental Health Program Directors for State Inpatient Psychiatric Programs and residential facilities contracted by the Department of Juvenile Justice. This training focused on:
  - the effects of trauma in the lives of children served by both systems
  - the possible impact on behavior of this trauma
  - the additional effects introduced by the use of seclusion and restraint

Children's Mental Health staff serve on the Department of Juvenile Justice's Trauma Informed Care Leadership Committee and the Leadership Council for Florida's Comprehensive Approach to Managing Juveniles who Sexually Offend.

The Mental Health Program is working in collaboration with Juvenile Justice to address the needs of individuals with mental health needs being discharged from juvenile justice facilities. The intent is to promote continuity of care in community settings for the individuals we serve, and to reduce recidivism/return to criminal justice systems.

- Behavioral Health Overlay Services (BHOS)

Services are currently provided to children with mental health and substance abuse needs who reside in residential programs under contract with the Office of Child Welfare/Community-Based Care or the Department of Juvenile Justice.

These medically necessary Medicaid funded services are child specific, and are directed toward improving a child's mental status, and emotional and social adjustment. These services support a child in the current setting in order to avoid a more intensive, restrictive level of care. Services are monitored jointly by Juvenile Justice, Medicaid, and Children's Mental Health staff to ensure fidelity.

- Juvenile Incompetent to Proceed Program (JITP)

The Mental Health program is responsible for the coordination and management of the Juvenile Incompetent to Proceed Program for the Department of Children and Families, Agency for Person's with Disabilities, and indirectly, the Department of Juvenile Justice. The Juvenile Incompetent to Proceed Program was instituted in 1997, with the transfer of $2.8 million from the Department of Juvenile Justice to the Department of Children and Families.

Past and continuing collaborative efforts with regard to the Juvenile Incompetent to Proceed Program include the following:

- The department's districts and Central Office staff continue to work with the courts to ensure that juveniles who become competent to proceed are returned to court in a timely manner, allowing the provider to discharge the juvenile and then admit other juveniles on the waiting list. Training was conducted September 25 and October 24, 2006, for staff from the Department of Juvenile Justice, Department of Children and Families and the Agency for Persons with Disabilities, representatives of the State Attorney and Public Defenders offices, district legal staff, judges, and their staff.

- Educational material about the program is provided to each Chief Circuit Judge, Public Defender and State Attorney, as well as to evaluators who have completed the Florida Institute of Mental Health "Juvenile Competencies in the Justice System" training.

- **Weekly communication at the state and district levels has increased cooperation between the Department of Juvenile Justice and the Juvenile Incompetent to Proceed Program.**

During fiscal year 2005-2006, the number of juveniles ordered by the courts into competency restoration services increased by 57 percent for community-based competency restoration services by 53 percent for secure residential competency restoration services. Courts across the state are increasingly filing Motions to Show Cause against the department, due to a lack of resources for competency restoration services. The department has requested an additional $4,265,360.00 to expand competency restoration services for an additional 56 juveniles in the community, and up to 48 additional juveniles in the secure residential program. This funding would increase capacity for competency restoration services to 202 children in the community program, and up to 80 juveniles in the secure residential program, effectively eliminating the waitlist for both.

- Department of Education

Children's Mental Health district staff are members of the district multi-agency Service Network for Students with Emotional Disturbance (SEDNET) boards and have good working relationships with the regional Project Managers. The Service Network is a unique partnership of mental health, education, social services, and families. It promotes a coordinated system of care through multi-agency partnerships and positive provider-family relationships for students with emotional disturbances and their families. Individualized plans developed by individualized multidisciplinary teams include educational services, even though mental health services are the foundation for the plans.

Children's Mental Health staff were appointed to the Department of Education's State Advisory Board for exceptional education in 2006. These relationships facilitate open communication between programs, and provide opportunities to improve outcomes for children.

- Department of Health

Through continued collaborative efforts with the Department of Health, Agency for Health Care Administration, Children's Medical Services (Department of Health), and the Legislature, Florida has worked to expand services for children with serious emotional disturbances, and improve in-home services, family supports and wrap-around supports. Florida Statutes require the Department of Health to contract with the Department of Children and Families to provide Behavioral Health Services to Title XXI Florida Kid Care eligible children with special healthcare needs. The Mental Health Program seeks to ensure a high level of integration of physical and behavioral healthcare, and meet the more intensive treatment needs of enrollees with the most serious emotional disturbance or substance abuse problems.

The Children's Mental Health Office administers the Behavioral Health Services/Behavioral Health Network (BNET). The Behavioral Health Network provides a comprehensive behavioral and physical health benefits package for eligible children. Children's Medical Services (Department of Health) and their network of providers provide the physical health needs. Behavioral health benefits are delivered through a consortium of providers contracted with Substance Abuse and Mental Health district offices. A liaison is located in each district office to ensure coordination of all health and behavioral health needs. Services include treatment planning and review, evaluation, case management, rehabilitative and therapy services, family support, and other services. The Children's Mental Health Office is also active on the Florida Kid Care Council.

- Agency for Health Care Administration (AHCA)

The department collaborated with the Departments of Juvenile Justice and Education and the Agency for Health Care Administration on an application for a Medicaid 1915 C Waiver Demonstration Grant in October 2006. The Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF) was enacted by the

Deficit Reduction Act (DRA) of 2005. Florida is one of 10 States awarded the five-year grant to provide community alternatives to psychiatric residential treatment facilities for children. The five-year grant is designed to promote the adoption of strategic approaches for improving the quality of community-based services and supports, and to thereby maintain and improve each child's functional level in the community, avoiding residential care. The demonstration will also test the cost-effectiveness of providing home and community-based care, as compared to the cost of residential care. The grant provides Florida the opportunity to earn federal funds from match otherwise targeting Statewide Inpatient Psychiatric Programs residential treatment programs for children. This grant provides a waiver that would permit the provision of community-based care for children meeting criteria for residential placement, as an alternative to inpatient treatment.

Transition to Adulthood

Youth approaching adulthood need improved access to appropriate and effective services. There are many state-level collaborative efforts underway to integrate transition efforts across public and private agencies and providers. Partners in Transition is a statewide group consisting of customers, parents of customers, and public and private agency and provider representatives. This group has developed a state level strategic plan, based on focus groups in communities across the state. Goals include educating lawmakers and the public, as well as collaboration across all service systems. There are also several local transition pilot sites throughout the state. Future focus will be placed on deterring youth with serious emotional disturbances from dropping out of school, when their prospects for meaningful employment to support their independent living, are small.

For children involved in the child welfare system, transition to adulthood without family support and encouragement can be difficult. Youth with serious emotional disturbance or emotional disturbance in out of home placement face learning to navigate an additional system, the Adult Mental Health system. Mental health and substance abuse providers, while not primarily responsible for providing transition services, need to ensure that youth served by their facilities have access to services and supports necessary to build the skills they will need. Chapter 394.491(13), F.S. states, “An adolescent should be assured a smooth transition to the adult mental health system for continuing age-appropriate treatment services.” Additional examples of state-level collaborative efforts are:

- An “Interagency Articulation Agreement to Support the Transition Process of Students with Disabilities,” was signed May 2006. This agreement is a state-level agreement between the departments of Education, Health, Children & Families, and Agency for Persons with Disabilities. It will encourage and facilitate cooperation and collaboration among local leadership, and staff of education agencies, the Division of Vocational Rehabilitation, Division of Blind Services, Agency for Persons with Disabilities, Children’s Medical Services, and the Mental Health Program. The goal is to provide a smooth and successful transition of students with disabilities to meaningful, gainful, and sustained employment and/or post-secondary education, with access to adult healthcare and mental health services needed to maintain a healthy life.

- Children's Mental Health staff collaborate with youth and families, community providers, and other stakeholders to prepare and disseminate a Transition Handbook in 2007. The handbook is designed for youth with serious emotional or emotional disturbance, as well as their caregivers, to aid their ability to assume desired adult roles in their community of choice.

Prevention, Early Identification and Intervention

Children's Mental Health has been a leader in recognizing the needs of infants and young children and the need to intervene early to prevent or reduce the development of serious emotional disturbance. Special project funding has been provided to each district for the past three years to enhance community capacity to serve young children at risk due to family involvement in the child welfare system. A partnership with the Florida State University, Harris Institute of Infant Mental Health, has increased the number of providers trained in this specialty area of community service capacity.

The desired outcome of this partnership is to provide early childhood mental health consultation for children in child care centers that receive funding through the Office of Early Learning, and fall under the auspices of the local Early Learning Coalitions. Consultation is designed to build the capacity of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six and their families.

A recent study conducted on the rate of expulsion in pre-kindergarteners released in May 2005, indicated that pre-kindergarten students are expelled three times more often than their older peers in grades K through 12. When compared to other states, Florida falls in the median, with 4 to 7 expulsions per 1,000 Pre-Kindergarten students. Consultation programs can help preschools assist children in achieving healthy emotional development and prevent expulsions. As a leader in the establishment of infant mental health services, Florida actively promotes the development of early childhood consultation to child care and education programs. At least two community pilot projects in Florida are envisioned that will develop a partnership between children's mental health, local Early Learning Coalitions, and community-based providers serving children.

Children's Mental Health is also working with the Department of Health to develop an early childhood strategic plan through their Early Childhood Care System Grant. The five critical components of the grant are:

1) access to "medical homes" that coordinate comprehensive healthcare services
2) services and supports to promote the positive social and emotional development and mental health of young children
3) early care and education services
4) parenting education services
5) family support services

The coming year will provide opportunities to move forward in developing a common vision for young children and their families.

Medications

Over the past three years the use of psychotherapeutic medications for children has been highly scrutinized. In June 2006, departmental staff from both Children & Families and the Agency for Health Care Administration participated in an "Expert Panel, Medications Best Practices in Children and Adolescents", convened by the Center for Mental Healthcare Improvement, and made up of physicians from Florida and national experts in pediatric psychiatry. The guidelines are located at http://flmedicaidbh.com/recommended_guidelines.htm.

The department continues to partner with the Agency to monitor the use of psychotherapeutic medication for the children served. A joint workgroup continues an initiative launched in 2005 to monitor the use of emergency intramuscular injections in emergency situations, with a goal of reduced use of these interventions.

The department continues to contract with the University of Florida's Department of Psychiatry to provide information and recommendations regarding best practices in psychotherapeutic medication use for children and youth, as follows:

- The MedConsult line is a toll free consultation line available for physicians, parents, department personnel, guardians, court personnel, and others to call with questions and concerns regarding mental health and medication issues.

- A PreConsent line service was added in 2005 for the review of plans for psychotherapeutic medication provision for children in out of home care aged 0 to 5. The department's policy regarding preconsent may be found at this link: http://www.dcf.state.fl.us/publications/policies/175-98.pdf

- The main findings of the Mental Health office's report to the Senate Committee on Children and Families on ensuring appropriate and informed use of psychotherapeutic medications for Florida's children in the department's care and custody were that between September-November 2004 and the same period in 2005, the use of psychotherapeutic medications declined from 13.4 percent to 11.8 percent.

Children's Mental Health will monitor psychotherapeutic prescribing practices and support best practices by monitoring HomeSafeNet Data, looking for unusual practices affecting children in departmental custody. We will also participate in workgroups designed to identify best practices, and in the provision of technical assistance to providers serving children and youth.

Services for Children with Co-Occurring Disorders

Historically, children with co-occurring disorders were treated in parallel systems. Mental health issues were addressed through the mental health service system, and substance abuse issues were addressed separately through the substance abuse system. This has led to many children receiving duplicative services, while others receive inadequate services. The department recognizes the need for comprehensive, integrated services for persons with co-occurring disorders. The Mental Health and Substance Abuse Programs have worked jointly on a number of initiatives to serve children with co-occurring disorders. Initiatives include the following:

- Joint Children's Crisis Stabilization Unit / Juvenile Addictions Receiving Facilities (JARFs) were piloted in District 8 and the SunCoast Region. The service model blends the programmatic and funding elements of each of these programs, improving service to youth with co-occurring disorders. Based on their success, the legislature authorized expansion of this model to additional sites during fiscal year 2005-2006.
- The Program Offices continue to collaborate closely with the Department of Health and Florida Healthy Kids, Inc., in implementing the behavioral health provisions of the Title XXI Florida KidCare Program. The Behavioral Health Network is located in Children's Mental Health Program but also coordinates substance abuse services for children insured under this part of the State Children's Health Insurance Program (SCHIP).
- Behavioral Health Network liaisons were trained on the integration of mental health and substance abuse services at their annual statewide meeting. Providers were encouraged to develop Memorandums of Agreement to promote integration of services where dual providers were routinely utilized. Liaisons also received Substance Abuse screening tool options, and were encouraged to disseminate these tools to children's medical services, thereby increasing awareness and referrals for services.
- Behavioral Health Overlay Services (BHOS) are provided to children with co-occurring disorders who are placed in Medicaid eligible residential programs under contract with the Family Safety /Community-Based Care or Department of Juvenile Justice. These medically necessary services are child-specific, and are directed toward improving a child's mental status and emotional and social adjustment. These services provide a therapeutic overlay to support children with mental health or substance abuse needs in their current setting to avoid a more intensive, restrictive level of care.
- Mental health and substance abuse cost centers are merged, allowing providers to meet the needs of youth with co-occurring disorders. The "Outpatient – Group/Individual" cost center allows the creation of a therapeutic environment to improve the functioning, or prevent further deterioration, of persons with mental health and/or substance abuse problems.
- Children's Mental Health staff are members of both the Needs Assessment and Outcome Workgroups for the Florida Adolescent Treatment Coordination Grant awarded to the Florida Office of Drug Control. We are involved in developing strategies to better identify and provide appropriate

services for children and youth entering either the mental health or substance abuse system who have co-occurring mental health and substance abuse treatment needs.

To continue these efforts, Children's Mental Health will continue to partner with substance abuse to develop services that recognize and treat youth with co-occurring disorders.

Assessing clinical guidelines and standards

- Reducing the Need for Seclusion and Restraint

Since 2003 the department has partnered with the children's Statewide Inpatient Psychiatric Program to develop training and strategies focused on eliminating the use of seclusion and restraint procedures.

District children's mental health staff participate in monitoring seclusion and restraint use, policies, and procedures in contracted facilities. Technical assistance is provided by both the department and Agency for Health Care Administration.

In December 2005, cross training was provided to providers of the Statewide Inpatient Psychiatric Program and residential facilities contracted by the Department of Juvenile Justice. The focus was broadened to explore the effects of trauma in the lives of children served by both systems, the possible impact on behavior of this trauma, and the additional effects introduced by the use of seclusion and restraint.

A third training was held in December of 2006. Efforts to date to reduce the need for seclusion and restraints were reviewed, and strategies were developed to address barriers and sustain gains.

With the support of a technical assistance grant from the National Technical Assistance Center, developers of the "Roadmap to Seclusion- and Restraint-Free Mental Health Services" will present a two day train-the-trainer program to a three-person training group from each of the Statewide Inpatient Psychiatric Programs in January of 2007. A training director, direct care staff, and a parent/former customer will train staff in their respective providers. Program developers will conduct monthly technical assistance calls for training teams to ensure learning transfer and support the trainers. Our goal is that these in-state trainers will be able to provide training to staff in other settings. The curriculum is specifically designed for direct care staff, and may be reviewed at http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/

- Legislation Related to Seclusion and Restraint

Chapter 2006-227, Laws of Florida amended sections of chapters 393, 394, 400, and 916, F.S., to add legislative intent, definitions, and regulatory authority relating to the use of restraint and seclusion with persons with mental illnesses or developmental disabilities. Rules subsequently adopted by the Department of Children and Family Services assure that the use of restraint and seclusion is consistent with recognized best practices and professional judgment, and provide for reporting, data-collection, and information dissemination to include children services.

Section 394.875(10), F.S. mandated the department, in consultation with the Agency for Health Care Administration to adopt rules governing residential treatment centers. The rule was to specify licensure standards for admission, length of stay, program and staffing, discharge and discharge planning, seclusion, restraints and timeouts, rights of residents under Section 394.459, use of psychotropic medications, and standards for the operations of such centers. The promulgation of Chapter 65E-9, F.A.C. in July of 2006 fulfilled this requirement. The Agency assumed responsibility for licensure of residential treatment centers and therapeutic group homes currently licensed by the department as child caring agencies. Residential treatment centers licensed as specialty hospitals under Chapter 395, F.S. are not included. Affected facilities will be phased in as their licenses come due. The rule prohibits the use of seclusion or mechanical restraints in group homes, and updates language, definitions and requirements regarding the use of seclusion and restraints in residential treatment facilities. An existing rule, Chapter 65E-10, F.A.C. will be amended in 2007 to ensure consistency.

G. STATE MENTAL HEALTH TREATMENT FACILITIES

The Department of Children and Families directly operates or contracts for the operation of seven state mental health treatment facilities in Florida (also known as mental health institutions/state hospitals). These facilities provide mental health treatment and services for individuals with severe and persistent mental illnesses who can no longer live in the community, and need the structured and intensive therapeutic environment of the state treatment facility.

The state mental health treatment facilities serve three distinct target populations:

- Individuals admitted to a civil facility
- Individuals admitted to a forensic facility
- Individuals civilly committed under the Jimmy Ryce Act as Sexually Violent Predators

Three of the seven state facilities are managed by the state, two are currently operated under contract with GEO Care, Inc., and one is operated under contract with the GEO Group, Inc., a commercial vendor. A seventh facility, West Florida Community Care in Milton, Florida, has 80 beds designated as state civil treatment beds. The state contracts with Lakeview Center, a community mental health center, to manage this facility.

The civil and forensic facilities have a combined capacity of 2,440 beds statewide. Four hundred ninety-seven of the civil beds are currently designated as "step-down" capacity, to house individuals committed under the forensic statute who no longer require the security of a forensic facility.

The following table shows the state mental health treatment facilities and bed capacities as of June 30, 2006:

Facility/Location	Type	Bed Capacity	Operated by	Number Served FY 2005-06
Florida State Hospital - Chattahoochee	Civil and Forensic	180 civil 310 forensic step-down 528 forensic 1018 total beds	DCF	750 civil 1,159 forensic
Northeast Florida State Hospital – Macclenny	Civil	461 civil 132 forensic step-down 593 total beds	DCF	750
North Florida Evaluation and Treatment Center - Gainesville	Forensic	216	DCF	505
South Florida Evaluation and Treatment Center - Miami	Forensic	208	GEO Care, Inc.	522
South Florida State Hospital - Pembroke Pines	Civil	280 civil 55 forensic step-down 335 total	GEO Care, Inc.	540
West Florida Community Care Center - Milton	Civil	80	Lakeview Center	224
Florida Civil Commitment Center (FCCC) - Arcadia	Sexually Violent Predators (SVP)	580	GEO Group	592

While civil facilities admit individuals based on geographic catchment areas, persons committed to secure forensic facilities are assigned by the central office to one of the three forensic facilities based on bed availability. On a daily basis, the Forensic Admission Office of the department's Mental Health Program Office monitors the bed availability at each forensic treatment facility, and schedules admissions with county sheriffs as treatment facility vacancies occur.

The department has completed contracts with GEO Care, Inc., to design, build, and operate a new forensic mental health treatment facility in Florida City (South Florida Evaluation and Treatment Center), that will be operational in 2008 and will replace the current facility in Miami. The department has also completed contracts with the GEO Group to design, build, and operate a new secure facility for sexually violent predators in Arcadia (Florida Civil Commitment Center) that will be operational in 2009 and will replace the current facility in Arcadia.

Target Populations - Criteria for Admission

Adults meeting **civil** commitment criteria for placement in a state mental health treatment facility: This group includes persons 18 years and older who meet the following criteria:

- Committed in accordance with the provision of services provided in Chapter 394, Florida Statutes
- Person has a major mental illness
- Due to mental illness, person is either a danger to themselves or others, or is likely to suffer from neglect or refuse to care for themselves
- A less restrictive placement in the community is not available
- Admitted on either a voluntary or involuntary basis

Adults meeting **forensic** commitment criteria for placement in a state mental health treatment facility: This group includes persons 18 years and older or a juvenile adjudicated as an adult who meet the following criteria:

- Committed in accordance with the provision of services provided in Chapter 916, Florida Statutes
- Person has a felony charge
- Adjudicated either Incompetent to Proceed through the Judicial System or Not Guilty By Reason of Insanity
- Person has a mental illness and due to the illness is: unable to survive alone or with the willing help of others, likely to suffer from neglect or refuse to care of him/herself, and is likely to inflict serious bodily harm to self/others, and all less restrictive alternatives have been judged inappropriate

Individuals civilly committed under the Jimmy Ryce Act pursuant to Chapter 394, Part V, Florida Statutes. Individuals served in this Sexually Violent Predator Program include those who:

- have been convicted or found not guilty by reason of insanity for sexual offenses and have completed their imposed prison, juvenile justice, or forensic state treatment facility commitment; and,
- for whom it has been determined that their release would pose a significant risk to the community.

Service Provision:

The mission of Florida's Civil and Forensic State Mental Health Treatment Facilities is to provide the highest quality mental health treatment, services, and

supports to empower individuals to be actively involved in their recovery, and to ensure their timely and successful return to the community or court.

The state civil and forensic treatment facilities provide the following services:

1. Basic support services - include provision of the basic requirements for survival such as shelter, food, clothing, and a sense of personal safety.
2. Healthcare Services - are intended to identify and treat physical and mental illness and promote good health. The priorities of health services are: 1) routine physical and mental health assessment, evidence-based treatment, and health education; 2) rapid response to acute illness or injury; 3) on-going management of chronic health conditions; and 4) provision of pharmacotherapy with clinical pharmacology oversight.
3. Recovery Services - consists of psychiatric evaluation, diagnosis, holistic recovery planning with the individual and interdisciplinary team, stabilization of the symptoms of mental illness through psychotherapeutic medication and recovery therapies, restoration of optimum level of functioning, and transition to community placement with the appropriate support services in place.
4. Continuity of Care Services - include internal case management services and community linkages designed to ensure that essential services are being provided consistent with the individual's recovery plan. The state mental health treatment facilities work in partnership with the community providers and districts to facilitate continuous services and supports for people transitioning from the facility back into the community.
5. Competency Restoration Training and Evaluation Services - involve group and/or individual processes. The focus of training is on helping individuals to understand the judicial process, the role of the court, the nature of their charges, the possible penalties, and their personal legal rights. Competency evaluations are completed, as needed, and competency evaluation reports are prepared for the courts indicating the individual's progress, as required.

The Florida Civil Commitment Center (FCCC) provides security, treatment, and services for persons detained or committed under the Jimmy Ryce Act as Sexually Violent Predators. The GEO Group, in concert with the department, is in the process of enhancing medical and mental health treatment at the facility to address issues of concern in a class action lawsuit that alleges inadequate mental health care and sex offender specific treatment at the facility.

Pursuant to Florida Statutes, the Sexually Violent Predator Program (SVPP) serves two main functions:

- screening and evaluation of persons in state custody (state prisons, state juvenile facilities, and state forensic mental health treatment facilities) to identify suspected sexually violent predators (this function is organized and coordinated at department headquarters)

- long-term confinement and treatment of persons committed to the department as sexually violent predators (at the Florida Civil Commitment Center).

The sex offender treatment program managed by the GEO Group at the Florida Civil Commitment Center complies with the Association for the Treatment of Sexual Abusers (ATSA) treatment guidelines. As the guidelines point out, it is not the expectation in the sexual offender treatment field that these behavior patterns are "cured," rather that the individual is provided with both accountability and tools that allow him/her to make different choices.

All of the state mental health treatment facilities, including civil, forensic, and Florida Civil Commitment Center, offer vocational opportunities for their residents. Individuals have the opportunity to work in various positions while learning valuable employment skills, such as responsibility, communicating effectively with supervisors, completing applications, managing anger/feelings, staying on task, etc. Residents receive compensation for their work in addition to the therapeutic value of maintaining a job and being productive, which can increase self-confidence, hope, and motivation to recover.

Each of the facilities offers at least some degree of services for residents with co-occurring substance abuse and mental illness however, this varies by facility.

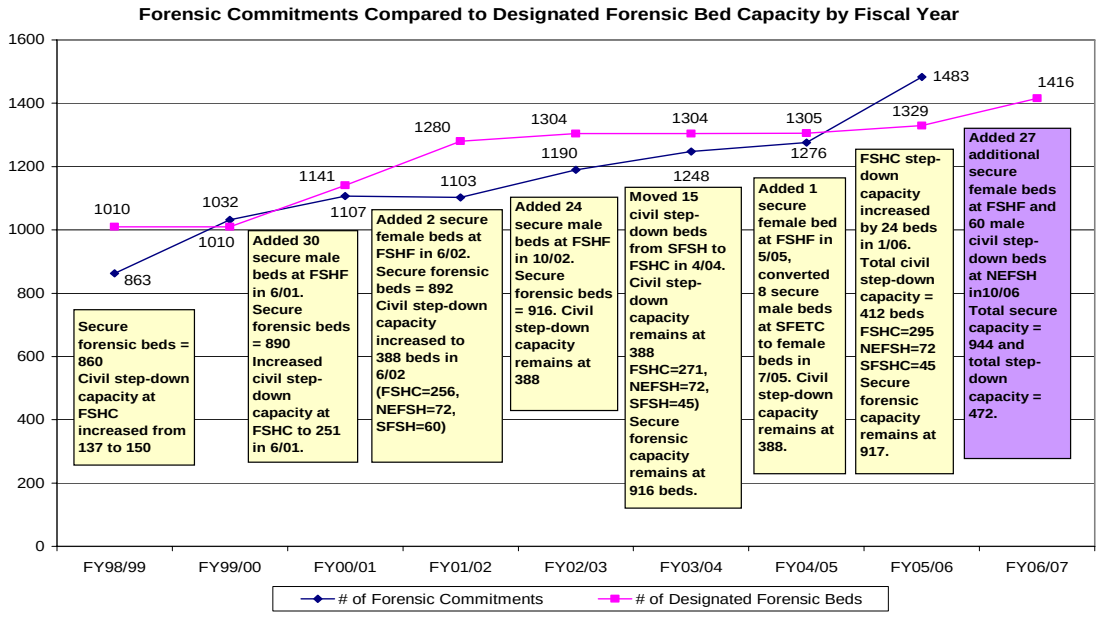
Priorities and Future Directions

The following issues are considered priorities for the state mental health treatment facilities, and will establish direction for future improvements:

1. Forensic Crisis

As of February 1, 2007, there were 289 (233 males and 56 females) on the forensic waiting list with 218 or 75 percent waiting in excess of the statutory 15 days to admit. The average waiting time was 71 days. As a result, individuals in need of intensive mental health treatment are forced to spend an excess number of days in jail awaiting admission to a state forensic facility, and the department has been the subject of numerous show-cause and contempt orders around the state.

Contributing to this issue is that forensic commitments to the department have increased by 72 percent since 1998 - 1999 with an unprecedented increase of 16 percent between fiscal year 2004 - 2005 and fiscal year 2005 - 2006. In order to address this issue, the department has repeatedly added beds in the forensic treatment facilities, and has converted civil beds to forensic step-down capacity for persons committed under Chapter 916, F.S., who no longer require the security of a forensic setting. However, commitments have far exceeded designated forensic bed capacity. The graph below depicts increases in forensic capacity relative to the increased number of commitments.



In a meeting held December 19, 2006, with mental health stakeholders from around the state, participants pointed out that many of the individuals committed to forensic facilities could be more appropriately served in the community if alternative treatment services and resources were available. Often, adults with mental illnesses come to the attention of law enforcement as a result of circumstances related to their mental illnesses. Many commit minor criminal offenses and are arrested and taken to jail, rather than to a more appropriate community mental health facility. The stakeholders supported focusing on a full array of adequately funded community mental health services to prevent forensic admissions as an alternative to continuing to increase the forensic bed capacity.

Actions Taken:

- Implemented 87 additional beds with additional funds provided in the 2006 – 2007 General Appropriations Act.
- Implemented 23 additional beds through internal budget actions.
- Initiated internal budget actions to create 47 additional beds this year.
- Provided 30 days of medications for individuals returned to jail to maintain competency while awaiting court action.
- Completed a forensic review of 198 people from 18 counties, on the waiting list. With court approval, 38 individuals can be treated safely in community placements.
- Sought and received approval from the Legislative Budget Commission on January 10, 2007 to transfer funding to provide an additional 220 secure forensic treatment beds and 140 community residential treatment beds. These are in addition to 13 secure forensic treatment beds provided in a previous amendment for a total of 373 beds during the remainder of FY 2006-2007, at a cost of $16.6 million.

Of these funds, $3,152,073 is immediately available to communities through DCF district/regional offices. These funds will be used to expand community and in jail competency restoration and treatment services; assist with the diversion of individuals from the waiting list to other community living situations; and help facilitate the discharge of individuals from state treatment facilities by paying for housing and continued treatment in the community.

- The department is working with the offices of the Public Defender, Sheriff, State Attorney and Judicial System in Pinellas, Orange, Broward and other counties to treat individuals on the waiting list to identify strategies to divert individuals from forensic mental health commitment.
- Admission procedures include screening for severity so that emergency situations are given priority, based on assessment of clinical professionals.
- Action is being initiated to speed the return to of individuals whose competency has been restored, thus freeing treatment resources for others waiting in jail. In December 2006, there were 82 individuals waiting to return to jail who were occupying a state hospital bed. On February 1, there were 47 individuals.
- Implementation of 373 beds funded by the Legislative Budget Commission.
- Initiate competency restoration in counties allowed by the jail for every individual awaiting placement in a state mental health treatment facility.

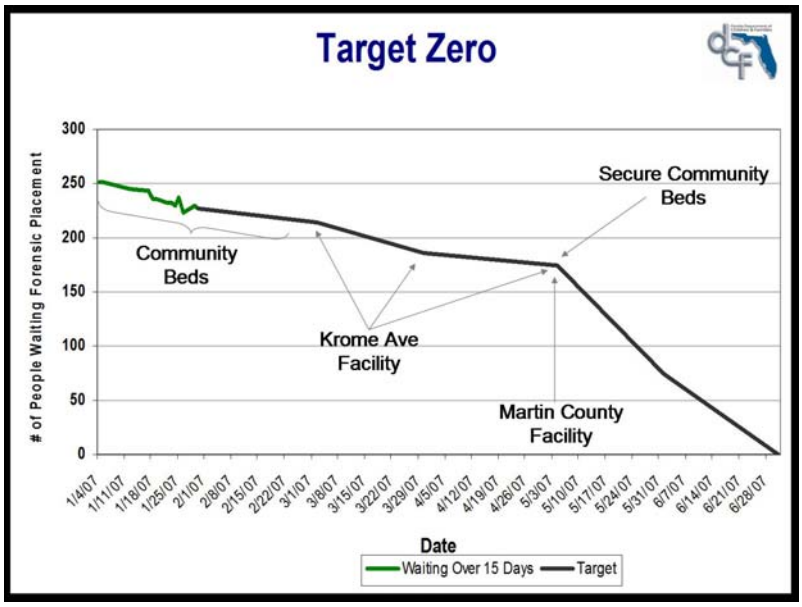
Additional Actions Planned for Next Fiscal Year:

The department will request funding for fiscal year 2007 – 2008 to:

- Provide full, annualized continuation of all actions initiated this year to alleviate the crisis.
- Create 120 additional secure forensic treatment beds.
- Create Comprehensive Community Support Teams to provide competency restoration and maintenance for individuals in jail and provide community treatment services to divert individuals from the criminal justice system.

Impact of Current and Planned Actions:

The following chart shows the impact of actions this year to reduce the forensic waiting list. Implementation of actions described above is designed to eliminate the waiting list by June 30, 2007. Full funding of the fiscal year 2007-2008 budget request should allow the department to meet its statutory obligation to place individuals within fifteen days of commitment.



2. Sexually Violent Predator Program - Workload and Bed Capacity –

Pursuant to Chapter 394, Part V, Florida Statutes, the Sexually Violent Predator Program (SVPP) serves two main functions:

- screening and evaluation of persons in state custody (state prisons, state juvenile facilities, and state treatment facilities) to identify suspected sexually violent predators
- long-term confinement and treatment of persons committed to the department as sexually violent predators (at the Florida Civil Commitment Center).

The screening and evaluation function for referrals to the Sexually Violent Predator Program is organized and coordinated in the Mental Health Program Office. The program receives referrals from the Department of Corrections, Department of Juvenile Justice, and the state mental health treatment facilities of persons committed as Not Guilty by Reason of Insanity.

There has been a drastic increase in workload demand related to screening and evaluation services in the Sexually Violent Predator Program. During FY 2005 – 2006, the program received 4,015 referrals, the largest number received since the program began in 1998. This number reflects 1,549 more referrals than were received during fiscal year 2004 – 2005, a 63 percent increase in one year. The higher workload is expected to continue, particularly because future referrals will likely include higher numbers of individuals with convictions for non-sex crimes (e.g. burglary, murder, false imprisonment, kidnapping) that were nevertheless "sexually motivated."

Another major issue is the projected shortage of bed capacity at the Florida Civil Commitment Center (FCCC). Based on the 9 percent increase in census over the past three years, program capacity (580 beds) for confinement and treatment

at the Center will likely be exceeded around July 2007. Since fiscal year 2000 - 2001, the facility population has increased by 67 percent, from 341 residents (June 30, 2001) to 571 residents (December 19, 2006) while the Sexually Violent Predator Program budget entity's appropriation has increased 30 percent.

Recent legislative action limits the number of continuances that detainees may be granted. This legislation should have no effect on the number of referrals received by the Sexually Violent Predator Program. However, the law may have an effect on the length of time a person is in detainee status, which could affect the census (e.g., fewer residents in detainee status for long periods of time). Notably, the actual effect of the new law is unknown, as a court still has authority to order continuances if it finds a manifest injustice would otherwise occur.

In order to meet the statutory requirements of the Sexually Violent Predator Program, the Mental Health Program Office plans to work with the legislature to:

- seek general revenue funding for additional staff to complete the increased screening responsibilities, to manage the large volumes of records, and to provide Quality Improvement activities
- seek contract services funding to increase the bed capacity of the Center to 660 beds, since the current capacity will likely be exceeded around July 2007.

3. Safety and Security in Forensic Mental Health Treatment Facilities -
The state forensic facilities serve many individuals who have histories of criminal violence and pose continuing risk for violence after commitment. This creates the unique challenge for secure forensic facilities to provide a safe, orderly, and secure environment in which potentially violent customers can readily access and actively participate in restorative treatment services. The challenge requires ongoing balancing of safety and security concerns with treatment needs because meaningful and effective mental health treatment of these customers cannot occur in a disorderly, unsafe and/or non-secure environment, and an overly secure and controlled environment reduces access to necessary treatment services.

The forensic facilities have experienced a rising trend in assaults, workers compensation injuries, use of one-on-one staff supervision of high-risk residents, use of overtime, and use of staff performing double shifts. Data also shows a decline in the percentage of staff who feel that their work area is safe. Collectively, these data paint a picture of high stress and threatening environments that probably attenuate program capacity to deliver effective services and supports. Significant direct care staff resources perform security functions, such as escorting and transporting residents into the community for medical appointments, de-escalating violent and potentially violent situations, continuous supervision of residents in acute care areas. This occurs because of an inadequate number of certified security officers. The provision of security services by direct care staff significantly reduces the availability of those staff to perform essential care and support services.

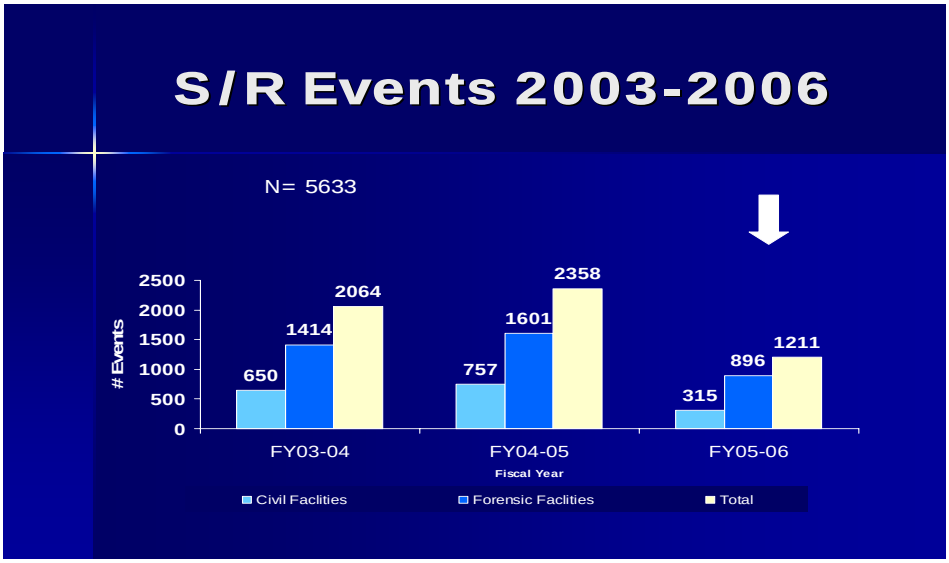
The department will be requesting sufficient resources to enhance safety and security within our forensic facilities.

4. Other Priorities:

➢ Seclusion and Restraint Reduction/Elimination-

The National Association of State Mental Health Program Directors (NASMHPD) issued a position statement on seclusion and restraint which states, "….The use of seclusion and restraint creates significant risks for people with psychiatric disabilities. These risks include serious injury or death, retraumatization of people who have a history of trauma, and loss of dignity and other psychological harm. In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others, and no other safe and effective intervention is possible. It is NASMHPD's goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint, and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel…."

The state mental health treatment facilities in Florida have decreased the use of seclusion and restraint events by 41 percent between fiscal year 2004-2005 and fiscal year 2005-2006 (see chart below) and have taken measures to further reduce/eliminate the use of these restrictive procedures.



Each of the facilities has:

- Received training from the National Association of State Mental Health Program Directors on Creating Violence Free and Coercion Free Environments
- Provided internal training with an emphasis on personal safety and individual preferences and a focus on verbal de-escalation and behavioral triggers so seclusion and restraint can be avoided

- Developed comprehensive action plans to achieve reductions of seclusion and restraints and create an environment consistent with trauma informed care
- Collected and monitored data relative to Seclusion and Restraint on an ongoing basis

Chapters 2006-227 and 2006-195, Laws of Florida, passed during the 2006 Legislative session, require the department to develop rules regarding seclusion and restraint use and data collection.

- The department has initiated the rule promulgation process as directed by these newly created statutory requirements.
- The central mental health program office leads annual Quality Reviews of each state facility, using staff from the central office and peer reviewers from other facilities. This review includes monitoring the use of seclusion and restraints.

➢ Recovery Services

Consistent with transformation of the community mental health system, the state civil facilities currently incorporate the recovery model in their service delivery approach, and the forensic facilities have also begun to implement a recovery-based treatment model. This approach is person centered and revolves around empowering the individual to learn skills, make choices, and be actively involved in their treatment and recovery.

- Florida State Hospital is recognized nationally for their role recovery program, which was implemented in 1998.
- Florida State Hospital and GEO Care, Inc./South Florida State Hospital utilize recovery models from the Boston Center for Psychiatric Rehabilitation.
- Northeast Florida State Hospital's recovery approach is modeled after Robert Lieberman's work.
- The facilities continue to assess and revise their services and approaches in order to provide treatment in an environment that supports each individual's recovery, and to support the cultural changes associated with this transformation.

➢ Utilization of Civil Beds

In order to ensure access to care for people who need the most structured and intensive environments, the department ensures maximum and appropriate utilization of civil facilities.

1. The Mental Health Program Office will continue to monitor the admission and discharge data of individuals served in civil mental health treatment facilities to ensure maximum utilization of facility resources and appropriate use of facility beds, and to ensure individuals are returned to the community as quickly as possible.

2. Trend analysis will be conducted to ensure people are admitted to and discharged from the state mental health treatment facilities in a timely manner. The length of stay **and discharge barriers of individuals in the facilities will continue to be monitored to ensure the most appropriate and least restrictive placement possible.**

➢ Significant Incident Tracking and Reporting

The Mental Health Program Office is working collaboratively with the department on the development of a comprehensive significant incident reporting and tracking data system and operating procedure. As part of this initiative, a computer program is being developed that will collect data from mental health providers and facilities regarding significant incidents, restraint and seclusion use, and any deaths of people receiving substance abuse or mental health services. This will substantially improve the Program Offices' ability to assess service provision and identify areas of fragility that need improvement.

➢ Risk Management

The mental health program office will be instituting another quality of service improvement and risk management initiative through the formation of a Risk Management Review Committee for the purpose of:

- providing pattern and trend analysis of significant incidents for the Program Office Director
- standardizing the mortality review process across community and state programs
- accessing the incidence and prevalence of suicide within the state so that appropriate education can be targeted to needed areas
- supporting the ongoing plan to further integrate mental health and substance abuse treatment and recovery
- investigating significant incidents involving clients of the department that are referred by the Program Office Director to ensure mental health providers are using evidence-based best practices to facilitate individual recovery.

➢ Additional Initiatives

Statewide Electronic Recovery Planning - We have invited many of our partners to join us in developing a standardized, flexible, and portable recovery plan that can follow a person from one agency/service to another as an individual accesses mental health services in various settings. Pilot testing of this standardized recovery plan is anticipated to begin by February 2008.

Assessing Clinical Guidelines and Standards - The department will implement a series of programs to ensure the evidence-based use of psychotherapeutic medications to maximize therapeutic benefit and promote individual recovery. These will include formulating specific best-practice guidelines for use of antipsychotics, antidepressants, mood stabilizers, and other classes of psychotherapeutic medications along with specific educational and quality assurance strategies to continually promote their consistent application.

Functional Assessment Rating Scale (FARS) - In an effort to provide treatment based on the individual functional skills of each person, the state treatment facilities utilize the Functional Assessment Rating Scale (FARS). The FARS is a meaningful, reliable, and valid multi-dimensional instrument that aids in service planning, drives the development and assessment of evidence based practices, and has a recovery focus. It rates impressions of cognitive, social, and role functioning, and is being utilized in both the community and state treatment facilities. This allows for meaningful comparison of outcomes for individuals across treatment settings, encourages a view of persons served as multifaceted individuals rather than a collection of symptoms, and promotes recovery.

Community Needs Assessment - The central program office, districts, and facility staff successfully developed and are implementing a community needs assessment (CNA) tool and operating procedure, which will allow for ongoing, electronic communication between treatment facilities and the community. This tool, when fully implemented, will provide constant communication between facilities, districts, and providers, so that communities are informed of the services, supports, and treatment individuals will need in order to live successfully in the community upon discharge.

Living Environment Alternative Preferences - L. E. A. P. (Living Environment Alternative Preferences) is a website of potential living environments in the community that can be surfed by individuals in state facilities, facility staff, family members, district/regional staff, and providers. The website provides admission criteria, community resources, and programmatic information on living environments in all districts and regions so that individuals will be able to make an informed choice regarding preferred community placements and services.

Emerging Issues -

SVPP Lawsuit - *Canupp v. Hadi, et al*., is a federal class action lawsuit filed by Florida Institutional Legal Services, Inc. and Southern Legal Counsel, Inc. on behalf of certain residents at FCCC. The lawsuit alleges that the sex offender treatment program is inadequate in terms of its design and the intensity of services, and that the facility does not provide adequate services to residents with special needs - those with mental illness or developmental disabilities. The primary remedy plaintiffs seek is injunctive relief – i.e. a court order directing that the defendants provide services at a level to be determined by the court. The lawsuit is currently in the discovery phase, and trial is tentatively scheduled for the summer of 2007.

Alternatives to Secure Facility / Conditional Release of Sexually Violent Predators - There are proponents who suggest that it is important to establish provisions in the Jimmy Ryce Act for less restrictive alternatives to the secure facility and/or a conditional release program for those individuals who are determined ready for community reintegration. For example, a less restrictive alternative component, similar to alternatives used in other states (e.g., Arizona) with Sexually Violent Predator Programs, would allow for a structured, monitored

transition into the community while still assuring community safety. Research suggests the importance of using a containment model to provide sexually violent predators with structured, viable, post-commitment options. This would include provisions for community monitoring including utilizing Global Positioning Satellite (GPS), community-based sex offender treatment, and regular polygraph testing. All conditional release provisions would need to be under the jurisdiction of the court. In addition, there would need to be a mechanism to revoke the conditional release if the individual were to violate any of the conditional release stipulations.

Proposed Sale of SFETC Property - If approved by the Board of Trustees of the Internal Improvement Trust Fund, the Department of Environmental Protection could sell the existing South Florida Evaluation and Treatment Center (SFETC) complex in Miami-Dade County, currently under lease to the Department of Children and Family Services, for the appraised value of $19.1 million. The Division of State Lands may sell the existing South Florida Evaluation and Treatment Center to Miami-Dade County. The sale of the property may take place in fiscal year 2007-2008, and the buyer shall lease the facility to GEO Care, Inc. for $1.00 per year until the new South Florida Evaluation and Treatment Center is completed on or about February 2008.

The proceeds from the sale ($16 million) could be deposited into the accounts of the Department of Children and Family Services' Administrative Trust Fund and Miami-Dade County ($3.1 million). Subject to legislative appropriation, the proceeds to the Department of Children and Family Services' may be used to expand other approved capacity beds and fixed capital outlay projects for mental health treatment facilities. The proceeds to be returned to Miami-Dade County may be used to renovate the existing SFETC which will be used for the County's expanded jail diversion program.

Possible Statutory Changes –

Screening Cases Referred for Sexually Motivated Crimes - Section 394.912(9), F.S., defines "sexually violent offense" for purposes of determining what crimes may subject an offender to civil commitment as a sexually violent predator. Section 394.912(9)(h) includes "any criminal act" that may be determined "beyond a reasonable doubt" to have been sexually motivated. According to the statute, determination that a crime was sexually motivated must be done at the time of sentencing for the crime in question, or subsequently during the trial. In eight years of program operation and over 24,000 referrals, staff has never seen a "sexually motivated" determination on sentencing or other court dispositional documents. Therefore, while the statute requires that "sexually motivated" offenses be considered during the screening process, no current mechanism exists to systematically label or flag such offenses for later consideration during the screening process. Without such a mechanism, some sexually violent predators will go undetected.

As such, the Sexually Violent Predator Program is requesting assistance in identifying criminal acts that had a sexual component by seeking a statutory change which would require state attorneys to indicate at the time of sentencing whether the apparently "non-sexual offense" appeared to be sexually motivated. This would allow for sexually motivated offenses to be accurately identified and therefore appropriately considered in the review, screening, and evaluation process.

Use of force at the Florida Civil Commitment Center (FCCC) - There is lack of clarity surrounding the parameters of use of force against persons who have been civilly detained or committed to the Florida Civil Commitment Center. As such, the department proposes adding language to Chapter 394, part V, F.S., to authorize the use of non-lethal force at the facility, the state's only secure sexually violent predator treatment facility. Section 944.35, F.S., provides express statutory authority for use of force within a correctional facility. Section 916.1091, F.S., provides similar authority for forensic facilities. There is no constitutional impediment to providing a similar statutory authorization for the facility. This authorization would establish the parameters of use of force at facility and in turn would contribute to a safer and more secure facility for residents, staff, and the community at large.

Quality Improvement in State Facilities - The mental health program office will be instituting another quality of service improvement and risk management initiative through standardizing the mortality review process across community and state programs. A strong emphasis will be placed on assessing the incidence of suicide among individuals receiving mental health services to identify areas of potential need relative to staff and client education, adequate assessment of risk, and rapid deployment of services to reduce the risk of morbidity and mortality for the people served in this program.

The department has proposed an addition to Chapter 766, F.S. that will allow for a new quality assurance, peer review process to be conducted by a Medical Review Committee of the State Mental Health and Substance Abuse Program Offices. This proposal supports the intent of the Legislature for the department to evaluate mental health and substance abuse treatment programs as outlined in Chapters 394, 397, and 916 of the Florida Statutes. The proposed addition to the statute would allow for a risk management, quality assurance committee to assess service provision by mental health and substance abuse treatment facilities and programs to ensure clients of the department have access to comprehensive assessment and interdisciplinary treatment planning that are recognized best practices and current standards of personal recovery. The newly formed committees will issue factual finding as outlined in the Chapter 766 in advisory reports to the program office directors and the service providers.

Criminal Justice Estimating Conference - The Criminal Justice Estimating Conference (CJEC) is directed to project the number of "commitments" under Chapter 394, part V, Florida Statutes, and not the number of confined persons. However, the estimates for the sexually violent predator population have not

been factored into the legislative appropriations process, as are the prison population forecasts for the Department of Corrections. This results in inaccurate forecasting, since the population of Florida Civil Commitment Center includes both "commitments" and "detainees," detainees comprising the majority of FCCC residents. Since fiscal year 2000-2001, the facility population has increased by 115 percent, from an average of 265 residents per year to a fiscal year 2005-2006 average of 515 residents per year, while the Violent Sexual Predator Program budget entity's appropriation has increased 30 percent from $20,018,010 to $26,098,541. The huge disparity between the 115 percent population growth and the 30 percent funding growth amounts to a real world reduction in program funding over the past five years. For that reason, the department is requesting that the legislature include the Sexually Violent Predator Program in the Criminal Justice Estimating Conference. Additionally, the increase in the need for forensic beds should be addressed by the estimating conference.

H. Mental Health Disaster Response Team

The Mental Health Program Office sponsored Project H.O.P.E., a federally funded crisis counseling project, to assist in the emotional recovery from Hurricanes Charley, Frances, Jeanne, Ivan, Dennis, Katrina, and Wilma. Funding was provided by the Federal Emergency Management Agency and the U.S. Department of Health and Human Services. The project provides outreach activities, information and referral services to facilitate disaster survivors resume their normal patterns of living. Over 1.5 million individuals were served in 2005-2006 in response to Hurricanes Katrina and Wilma.

Additionally, more intense recovery services were provided by Project Recovery, a supplementary grant from the Department of Health and Human Services. Through Project Recovery, interdisciplinary teams were placed in the counties that were most impacted by the storms of 2004. The services were for survivors experiencing long term emotional recovery issue. The techniques employed were service models developed by the National Center for Post-Traumatic Stress and the National Center for Child Trauma.

Teams of mental health employees from state mental treatment facilities and community centers were dispatched to Mississippi to assist in Katrina recovery efforts. The Florida teams supported the recovery activities in Mississippi for four weeks.

The two years of extensive response has resulted in the Florida Disaster Behavioral Health Plan, a joint venture of the departments of Health and Children and Families. The Plan, has been adopted by the Florida Domestic Security Taskforce and will be an appendix to the Comprehensive Emergency Management Plan.

CHAPTER 4: FINANCIAL MANAGEMENT

Substance Abuse and Mental Health Contracting System

A. Methods of contracting

The department contracts with service providers who operate programs as an integral part of performance-based program service provision. All contracts entered into by the department contain a set of performance measures, standards, terms and methodologies by which the performance of the provider may be evaluated. This system accomplishes the following: verifies that the funds expended by the department for contractual services benefit the citizens of Florida and promotes the achievement of the department's Long Range Program Plan outcomes. Additionally, it promotes efficient use of funds through identification and reduction of ineffective services, provides quantitative information regarding the effectiveness of service delivery and assists the department in determining the modifications needed in future contracts.

Performance contracting is an integral part of the department's planning, budgeting, and evaluation system. Performance contracts specify that a quantifiable level of performance be achieved by the provider for a particular performance measure. Measures of performance include outputs (direct counts of program activities and clients served) and outcomes (results of program activities in the lives of those served).

(1) Assessing the efficiency of the methods

While performance based contracting has increased accountability in many areas, it has also presented challenges. Currently, contracting and financing methods do not support flexible, client-focused and directed treatment services, prospective payment mechanisms, or promote Evidence-Based Practices (EBP) or other "best" practices. Performance contracting has proven not to be compatible with Medicaid Reform initiatives and consequently can be inefficient and administratively costly for the department and its contracted service providers. The current method of payment also presents challenges in verification of services billed to the department, as the volume of documentation required far exceeds the department's resources to verify billings. Additionally, there is no data system that captures billings made to the department. The type of information collected by the department in its data systems does not translate to services billed to the department as the units of measure are not the same. This presents additional challenges in verifying that the services paid for are actually received.

(2) Recommendations for improvement

Work is underway to address these issues. A recent workgroup made a number of recommendations for improvements to the performance contracting system. The recommendations that were implemented on July 1, 2006 included contracting for a broader range of activities allowing providers to deliver the

needed service without a prior contract amendment. This will result in a reduction in the administrative burden for providers and the department and will allow providers to focus on delivering the services needed by the client, as opposed to the necessary contract service unit.

New cost centers were developed to provide a flexible service delivery model, allowing for greater client and family choice, including traditional and non-traditional service options. These cost centers are Comprehensive Community Service Teams (mental health) and Substance Abuse Recovery Support Services.

Other areas of focus to improve financing mechanisms include case rate development, furthering the administrative infrastructure for consumer-directed programs, and managing entities.

B. Processes and challenges

The 2006 legislative session brought additional process-oriented requirements for contract managers. Shrinking administrative resources coupled with additional legislative requirements has proven challenging. As a result of these challenges, the department is constantly seeking new ways to streamline administrative activities. Along with improved financing mechanism, a data system that can be used for billing purposes is necessary to enable the department to tie funding directly to clients and their clinical outcomes.

Currently, s. 409.906(8)(a), F.S. states in part, "The agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the agency or the Department of Children and Family Services to provide such services." The operational affect of this mandate is the requirement that any provider wishing to enroll as a Medicaid provider of community mental health services must first have a contract with the Department. As this only applies to providers who operate under the fee for service system, providers under the prepaid plans or contracting through health maintenance organizations are not required to contract with the Department. Substance Abuse and Mental Health programs currently have over 100 contracts with these providers. There are no funds encumbered under the contracts and the providers do not render a service to the Department. This has become an intense workload issue for contract managers, who are required by Statute to provide oversight and management of agreements where no benefit to the Department is realized. The department is currently seeking the removal of this statutory provision.

C. Contract Oversight Units (COUs)

Contract Oversight Units, as defined in s. 402.7305(4), F.S. are responsible for the monitoring of both administrative and programmatic contract terms and conditions. These units are independent of the substance abuse and mental health organizational structure.

D. Need for more integrated feedback

Section 394.741, F. S. requires the department not to duplicate any service standard reviewed by accrediting bodies or through audits conducted by independent certified public accountants. Limitations are also placed on the frequency of on-site visits conducted by department monitors to accredited facilities. This limits in many cases the scope and frequency by which providers are reviewed. It will be essential that systems be developed to integrate these reviews with information available from other sources such as accrediting bodies, licensing bodies, independent audits, other fund sources and internal quality assurance and improvement activities.

E. Future directions

In an effort to promote a more flexible client centered and directed system of care, the programs will review alternative financing strategies, including prospective case rates. Work is currently underway in developing a case rate for methadone treatment services. This new payment model will be implemented during the third quarter of the 2006-2007 state fiscal year. As this system is developed, other services or population groups will be reviewed for possibility of inclusion.

The department will engage the services of a fiscal agent for consumer directed purchasing programs. This will allow for greater expansion of these programs, as well as streamline and economize administrative efforts.

F. Better alignment with funding/budget, performance measures

In addition to supporting system transformation efforts, the goal of the above initiatives is to better align funding with performance outcomes and the implementation of national outcome measures.

Substance Abuse Funding for FY 2006-2007

In FY 2006-2007, the Substance Abuse Program Office (PDSA) was appropriated $214 million for children and adult substance abuse services and program management. The table below depicts state and federal funding for children's substance abuse services, adult substance abuse services and administration.

	PROGRAM MANAGEMENT COMPLIANCE *	CHILD SUBSTANCE ABUSE	ADULT SUBSTANCE ABUSE	TOTAL
General Revenue	$2,647,794	$32,137,190	$37,687,508	$72,472,492
Other State Funds	$137,952	$14,463,552	$6,682,199	$21,283,703
Total State Funds	$2,785,746	$46,600,742	$44,369,707	$93,756,195
Federal Trust Funds				
ADAMH TF (SAPT BG)	$1,721,790	$28,959,758	$64,209,958	$94,891,506
Welfare Transitions Trust Fund (TANF)		$640,000	$14,097,500	$14,737,500
Federal Grants Trust Fund	$4,084,355	$211,066	$5,841,876	$10,137,297
Social Services Block Grant Trust Fund			$700,000	$700,000
Total Federal Funds	$5,806,145	$29,810,824	$84,849,334	$120,466,303
Total	$8,591,891	$76,411,566	$129,219,041	$214,222,498

* Includes $3,435,288 in grant funded contracted services.

Determination of Service and Funding Needs

The PDSA uses the Florida Youth Substance Abuse Survey (FYSAS) to calculate the number of children and adolescents in need of substance abuse services in each district/region. The survey is administered on an annual basis to middle school and high school students throughout Florida to determine the prevalence of alcohol, illicit drug, tobacco, and prescription drug use. The alcohol and drug use rates are then applied against population figures by county to derive local service need figures. All service needs figures are used in the formula for determining funding allocations. For FY 2006-2007, there are 353,319 children and adolescents in Florida that are in need of substance abuse services.

The National Survey on Drug Use and Health (NSDUH) is conducted annually by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to identify alcohol and drug use among adults in the United States. The PDSA uses the state-specific prevalence estimates from the survey and calculates them against the adult population estimates for each county to derive local prevalence numbers. As with the children's prevalence figures, the adult prevalence figures are used in the determination of budget allocations to each district/region. For FY 2006-2007, there are 1,153,325 adults in Florida that are in need of substance abuse services.

Funding Allocations

Substance abuse funding for FY 2006-07 has been appropriated and allocated with the special funding provisions contained in Section 394.908, F.S., stipulating how substance abuse and mental health funds are to be allocated to the department's districts.

The Legislature recognized that over the years the allocation of funds to districts/region became inequitable. To rectify this inequity and provide for more equitable funding in the future, thresholds for substance abuse and mental health services were established. These thresholds were based on the current number of persons in each district receiving substance abuse and mental health services. Any additional funding beyond the 2005-2006 fiscal year base appropriation for alcohol, drug abuse, and mental health services is allocated to districts based on target populations and required mental health or substance abuse services. A pro rata share distribution is utilized to ensure that districts below the statewide average funding level per person in each target population of "persons in need" receive funding necessary to achieve equity. Target populations for persons in need are displayed for each district and distributed concurrently with the approved operating budget. The display by target population shall show:

- The annual number of persons served based on prior year actual numbers, the annual rate per person served, and the estimated number of the total target population for persons in need.

- The annual rate per person served shall be defined as the total actual funding for each target population divided by the number of persons served in the target population for that year.

Children's Substance Abuse Prevention, Evaluation and Treatment

The Children's Substance Abuse Prevention, Evaluation and Treatment Services budget was allocated based on FY 2005-2006 Approved Operating Budget using the base funding for each district/region. Reductions in funding ($700,000) were taken from those districts/region funded at levels higher than the per capita statewide rate, as a proportion of total budget. The FY 2006-2007 *Closing the Treatment Gap* (new funding) amount of $1,096,000 was then allocated to the districts/region. The new funding was targeted to those districts/region that had a per capita funding rate less than the statewide per capita rate, with highest priority given to the areas of the state that were furthest under the statewide average. The total amount needed to bring the districts/region up to the statewide average was used to derive a proportionate weighting of need. This weighted need/percentage was then multiplied against the available funding to determine each district/region need amount. The resulting amounts were then added into the FY 2005-2006 base funding amount for each district/region. New special projects were then added into specific districts/region to arrive at a total allocation for FY 2006-2007 with a statewide per capita rate of $203.58. All of the Special Projects are non-recurring for FY 2006-2007.

Child Substance Abuse

District	District Budget	Target Population	Allocation Per Target Population
1	$3,301,321	15,610	$211.49
2	$3,051,501	13,645	$223.64
3	$2,226,386	11,152	$199.64
4	$5,641,650	29,243	$192.92
7	$8,348,066	40,508	$206.08
8	$3,678,045	18,902	$194.58
9	$4,629,959	24,208	$191.26
10	$6,131,221	30,717	$199.60
11	$11,071,528	57,324	$193.14
12	$2,567,277	10,968	$234.07
13	$3,389,703	17,400	$194.81
14	$2,701,067	12,360	$218.53
15	$2,300,639	10,820	$212.63
SC	$12,890,401	60,462	$213.20
Total	**$71,928,764**	**353,319**	**$203.58**

Note: Totals include special projects.

As the table above shows, seven districts have per capita funding rates that are lower than the statewide average of $203.58. The amount of funding needed to bring these districts up to the current statewide average is outlined below:

Districts	Average Amount Per Child/Adolescent in Need	Additional Resources Needed
3	$199.64	$66,019.44
4	$192.92	$369,540.59
8	$194.58	$207,449.65
9	$191.26	$346,237.39
10	$199.60	$182,965.44
11	$193.14	$561,993.20
13	$194.81	$187,041.06
Total resources needed to bring the seven under-funded districts to the state average of $203.58.		**$ 1,921,246.76**

Adult Substance Abuse Prevention, Evaluation and Treatment

The Adult Substance Abuse Prevention, Evaluation and Treatment Services budget was allocated based on Fiscal Year 2005-2006 Approved Operating Budget using the base funding for each district/region. Reductions in funding ($910,407) were taken in from those districts/region funded at levels higher than the per capita statewide rate, as a proportion of total budget. The new funding for FY 2006-2007 *Closing the Treatment Gap* of $10,672,529 was then allocated to the districts in a three-step process. The first step allocated $5.8 million to those districts below the state per capita rate of $94.08 to bring them in line with the statewide rate. The second step allocated $4.1 million to bring districts/region below the revised state per capita rate of $99.12 up to the state rate. The final step allocated $767,841 to bring the districts/region below the revised per capita rate of $102.67 up to the state rate. The resulting amounts were then added into the FY 2005-2006 base funding amount of each district/region. New special projects were then added into specific districts/region to arrive at a total allocation for FY 2006-2007. All of the Special Projects were non-recurring for FY 2006-2007.

Adult Substance Abuse

District	District Budget	Target Population	Allocation Per Target Population
1	$4,696,783	45,999	$102.11
2	$5,170,151	51,042	$101.29
3	$4,172,712	41,117	$101.48
4	$8,631,675	80,775	$106.86
7	$14,428,551	142,315	$101.38
8	$6,405,543	67,302	$95.18
9	$7,772,424	79,961	$97.20
10	$11,032,889	109,539	$100.72
11	$18,372,956	160,134	$114.73
12	$5,990,695	37,353	$160.38
13	$5,547,962	57,520	$96.45
14	$4,266,753	41,992	$101.61
15	$3,373,805	34,290	$98.39
SC	$20,563,340	203,896	$100.85
Total	**$120,426,239**	**1,153,235**	**$104.42**

Note: Totals include special projects.

As the table above shows, nine districts have per capita funding rates that are lower than the statewide average of $104.42. The amount of funding needed to bring these districts up to the current statewide average is outlined below:

Districts	Average Amount Per Adult in Need	Additional Resources Needed
1	$98.09	$291,321.32
2	$94.60	$500,984.64
3	$95.43	$369,845.67
4	$102.19	$179,796.28
7	$95.00	$1,340,532.33
10	$95.68	$957,478.14
14	$95.96	$355,293.61
15	$104.00	$14,333.74
SC	$98.73	$1,160,407.77
Total resources needed to bring the nine under-funded districts to the state average of $104.42.		**$5,169,993.51**

Mental Health Program Funding for FY 2006-2007

FY 2006-07 mental health funding appears in Table 3 below. A total of $751.9 million was appropriated: $291.4 million in Adult Community Mental Health; $99 million in Adult Community Mental Health, $310.1 million in Mental Health Treatment Facilities; $26.1 million in the Violent Sexual Predator Program; and $25.3 million in Program Management and Compliance.

Table 3: FISCAL YEAR 2006-2007 Mental Health Funding

FUNDING SOURCE	PROGRAM MANAGEMENT & COMPLIANCE	ADULT MENTAL HEALTH	CHILDREN'S MENTAL HEALTH	MENTAL HEALTH TREATMENT FACILITIES	SEXUALLY VIOLENT PREDATOR PROGRAM	% TOTAL FUNDING	TOTAL
General Revenue	$8,374,877	$231,326,094	$79,450,610	$202,139,655	$26,098,541	72.80%	$547,389,777
Alcohol, Drug Abuse & Mental Health Trust Fund	$4,845,228	$16,759,477	$8,464,303	$0	$0	4.01%	$ 30,069,008
Tobacco Settlement Trust Fund	$0	$18,129,419	$712,772	$2,000,000	$0	2.77%	$ 20,842,191
Federal Grants Trust Fund	$11,878,194	$13,305,612	$8,079,412	$67,970,295	$0	13.46%	$101,233,513
Operations & Maintenance Trust Fund	$0	$450,002	$0	$20,939,958	$0	2.84%	$21,389,960
Grants & Donations Trust Fund	$0	$1,099,807	$725,193	$0	$0	0.24%	$1,825,000
Administrative Trust Fund	$182,447	$0	$0	$17,066,799	$0	2.29%	$17,249,246
Welfare Transitions Trust Fund	$0	$7,693,789	$0	$0	$0	1.02%	$7,693,789
Social Services Block Grant Trust Fund	$0	$2,650,000	$1,600,000	$0	$0	0.57%	$4,250,000
TOTAL	$ 25,280,746	$ 291,414,200	$99,032,290	$310,116,707	$26,098,541	100.0%	$751,942,484

Notes:

- *Program Management and Compliance appropriation includes $14.3 million in federal funds for Project Recovery and Project H.O.P.E programs to provide crisis counseling for victims of 2004 and 2005 hurricanes.*

- *Mental Health Treatment Facilities appropriation includes $20.3 in Operations and Maintenance Trust Fund budget authority only. Spending authority was appropriated by the Legislature several years ago to Florida State Hospital for the implementation of the Sheriff's Drug Purchasing Program.*

Determination of Mental Health Service Needs

Need estimates for community-based mental health services, excluding acute care services, are based on the number of adults with severe and persistent mental illnesses and the number of children with emotional disturbances who live in Florida, and who would likely utilize public (versus private) mental health services, due to relatively low income levels.

Acute care bed needs are based on a formula of 10 Crisis Stabilization Unit beds per 100,000 population. This formula which was established many years ago does not take into account factors that likely drive the need for acute care services, such as the availability of and access to regular and effective outpatient services. Consequently, the formula may not yield reliable estimates of the need for acute care services. A work group will review and make recommendations concerning this and other issues associated with the acute mental health care delivery system in the state.

Need estimates for service delivery in mental health treatment facilities are based on service demand (annual rate of referrals/commitments), bed capacity, and the average length of stay.

Adult Mental Health Allocation Methodology

Adult Mental Health Services budget is allocated based on the Fiscal Year 2005-2006 Approved Operating Budget. The distribution of new dollars was made to districts below the statewide average based on percentage of gap from equity. Statewide average was calculated by taking the base FY 06-07 appropriation, and subtracting the $20.9 million of FY 01-02 appropriation of non-FACT resources for the GPW Catchment area (Districts 8, 14, 15 & Suncoast Region). In FY 2001-2002, the Legislature appropriated $39 million to the community due to the closure of G. Pierce Wood Memorial Hospital. $20.9 million of these dollars were appropriated to the GPW Catchment Area (Districts, 8, 14, 15 & Suncoast Region) for Indigent Drug Program, Baker Act Services (including Mobile Crisis Units), short-Term Residential Treatment Beds, Supervised Apartments, Group Homes and Case Management.

Total resources were divided by the April 2006 Severe & Persistently Mentally Ill (SPMI) population to compute statewide average spent per consumer. Districts 1, 3, 4, 7, 9, 10, 11, 12 & 13 fell below the statewide average of $711.17, and received a portion of the Mental Health Equity new appropriation. The new SPMI amount for Districts 8, 14, 15, and Suncoast Region reflects the base amount, less GPW Non-FACT FY 01-02 funding. This is not a reduction in appropriation.

This allocation methodology does not apply to Special Member Projects. Special member projects are allocated in accordance with proviso in the General Appropriations Act. Please note that all Special member projects were non-recurring for Fiscal Year 2006-2007.

Children's Mental Health
Children's Mental Health Services budget is allocated based on Fiscal Year 2005-2006 Approved Operating Budget. No new dollars were appropriated for Fiscal 2006-2007 for this budget entity with the exception of non-recurring Special Member Projects.

Mental Health Treatment Facilities
Mental Health Treatment Facilities budget is allocated based on Fiscal Year 2005-2006 Approved Operating Budget. The Legislature appropriated $6.8 million for increases in forensic beds. Allocation was based on cost per bed with additional start-up costs for equipment, renovations, etc. for Florida State Hospital and Northeast Florida State Hospital. The Legislature also appropriated $5.4 million increase for medications and allocation was based on each facilities percentage of beds.

Violent Sexual Predator Program
Violent Sexual Predator Program budget is allocated based on Fiscal Year 2005-2006 Approved Operating Budget. No new dollars were appropriated for Fiscal 2006-2007 for this budget entity.

Funding Discrepancies Between Districts:

Adult Mental Health:
After the allocation of the $10 million equity budget appropriated by the Legislature in FY 2006-2007, the Severe & Persistently Mentally Ill statewide average funding spent per consumer was $802.80. The chart below displays each district, amount per SPMI and percentage over/under statewide average.

District	FY 2006-2007 Appropriation	SPMI Population	Amount Per SPMI	% Over/Under Statewide SPMI
1	$ 9,630,541	13,467	$715.12	(12.26%)
2	$10,558,863	14,284	$739.21	(8.60%)
3	$ 8,351,361	11,226	$743.93	(7.91%)
4	$16,860,114	24,888	$677.44	(18.50%)
7	$27,275,469	44,214	$616.90	(30.13%)
8	$20,422,758	18,521	$1,102.68	27.20%
9	$15,789,638	22,917	$688.99	(16.52%)
10	$23,273,289	33,982	$684.87	(17.22%)
11	$32,974,479	48,046	$686.31	(16.97%)
12	$ 7,621,639	10,313	$739.03	(8.63%)
13	$10,966,534	15,475	$708.66	(13.28%)
14	$ 12,831,890	11,731	$1,093.84	26.61%
15	$11,915,672	9,415	$1,265.61	36.57%
Suncoast	$62,059,475	58,505	$1,060.76	24.32%
Statewide Total	$270,531,722	336,984	$802.80	

Please note that the statewide average differs from the amount above in the allocation methodology explanation of how the $10 million was distributed. The $802.80 is consistent with the appropriation in the General Appropriations Act and does not include deducting the $20.9 for the GPW Area Districts.

As the table above shows, ten districts have per capita funding rates that are lower than the statewide average of $802.80. The amount of funding needed to bring these districts up to the current statewide average is outlined below:

Districts	Average Amount Per Adult in Need	Additional Resources Needed
1	$715.12	$1,180,767
2	$739.21	$908,332
3	$743.93	$660,872
4	$677.44	$3,119,973
7	$616.90	$8,219,530
9	$688.99	$2,608,130
10	$684.87	$4,007,460
11	$686.31	$5,596,850
12	$739.03	$657,637
13	$708.66	$1,456,796
Total resources needed to bring the ten under-funded districts to the state average of $802.80		**$28,416,347**

Children's Mental Health:

The Severely Emotionally Disturbed (SED) statewide average funds spent per SED customer is $182.27. The chart below displays each district, amount per SED and percentage over/under statewide average.

District	FY 2006-2007 Appropriation	SED Population	Amount Per SED	% Over/Under Statewide SED
1	$2,419,774	12,730	$190.08	4.11%
2	$2,208,741	11,819	$186.88	2.47%
3	$2,239,628	9,165	$244.37	25.41%
4	$4,577,863	25,309	$180.88	(0.77%)
7	$7,638,538	43,322	$176.32	(3.37%)
8	$3,023,079	16,960	$178.25	(2.26%)
9	$3,611,205	21,914	$164.79	(10.61%)
10	$5,933,827	33,038	$179.61	(1.48%)
11	$8,829,618	48,311	$182.77	0.27%
12	$1,525,729	8,768	$174.01	(4.75%)
13	$3,222,260	14,049	$229.36	20.53%
14	$2,096,852	12,206	$171.79	(6.10%)
15	$2,090,807	8,779	$238.16	23.47%
Suncoast	$9,013,133	54,203	$166.28	(9.62%)
Statewide Total	$58,431,054	320,573	$182.27	

As the table above shows, eight districts have per capita funding rates that are lower than the statewide average of $182.27. The amount of funding needed to bring these districts up to the current statewide average is outlined below:

Districts	Average Amount Per Children in Need	Additional Resources Needed
4	$180.88	$35,208
7	$176.32	$257,763
8	$178.25	$68,220
9	$164.79	$383,060
10	$179.61	$88,009
12	$174.01	$72,414
14	$171.79	$127,936
SC	$166.28	$866.448
Total resources needed to bring the eight under-funded districts to the state average of $182.27		**$1,899,058**

Budget Policies:
Chapter 216, Florida Statutes mandates budget procedures for transferring budget and establishing positions for all state agencies. Pursuant to a bill passed in 2003, the Substance Abuse & Mental Health (SAMH) Program Offices have direct line authority over the districts/region and mental health treatment facilities. A PaRTS team convenes through a conference call scheduled bi-weekly. The purpose of the PaRTS review is to approve budget amendments transferring between districts/region or budget categories, spending plans, and legislative updates. The agenda also includes a standing item reminding districts/region to closely monitor spending patterns to ensure no over or under spending of appropriation.

Legislative Budget Requests
The Legislative Budget Request for Fiscal Year 2007-2008 includes funding to reduce the forensic waiting list and enhanced community funding for persons leaving jails or state prisons, or in need of competency restoration.

Managing Entities
The SAMH Programs have over 600 contracts for a broad range of prevention, intervention, treatment, and support services with over 350 agencies across 13 districts and one region throughout the state. Although this system of contracting for services has served the state well for a number of years, it is no longer adequate to meet the needs of a growing state or the needs of persons residing in our communities who are attempting to navigate complex systems in order to access treatment. In addition, the needs of persons seeking treatment are generally more complex, involving services for co-occurring needs, criminal justice, and child welfare. Further complicating access to care are the changing

approaches by Agency for Health Care Administration (AHCA) in methods of providing behavioral health services to Medicaid-covered service recipients.

Clearly a new business model that addresses the issues outlined above, as well as those issues that we work with daily around contracting, methods of payment, and information technology needs to be developed. One business model that is under consideration is the adoption of a managing entity model at the sub-state district or regional level. The adoption of this model is a recommendation of the *"Managing Entity Substance Abuse and Mental Health Services Workgroup Report:"* submitted to the Assistant Secretary for Substance Abuse and Mental Health in October 2006.

The workgroup made several recommendations that, if adopted and implemented by the department, should make the systemic reforms necessary to meet the needs of persons seeking mental health and substance abuse services. There were five major recommendations made by this workgroup as noted below:

I. Define DCF's SAMH-covered populations for substance abuse and mental health by establishing eligibility criteria.

   a. Reserve DCF funding for the medically indigent with medical indigence defined as lack of insurance coverage for needed services and the lack of income to pay for needed services. The workgroup recommends establishing financial eligibility at 250 percent of the poverty guideline.

   b. Direct DCF funds to priority populations, most of which are predetermined through federal grant requirements, legislative actions, court decisions, and policy decisions.

   c. Review eligibility criteria on a periodic basis and revise as needed.

   d. Monitor individual exceptions to eligibility guidelines and use the data gathered in this process to inform policy decisions about eligibility.

II. Support an effective and orderly transition to Medicaid reform.

   a. Convene stakeholders to help them understand the payment changes and the responsibilities of DCF and Heath Maintenance Organizations (HMOs).

   b. Work with HMOs to help them identify potential problems and to encourage and support their use of evidence-based practices.

   c. Assure that stakeholders, service recipients, and providers are aware that DCF is not the funding body for Medicaid recipients.

d. To ease the transition to Medicaid reform, DCF would continue to fund Medicaid recipients for certain mental health services not in the Medicaid Handbook. This practice would be reconsidered within two years. Likewise, DCF would continue to cover Medicaid recipients for certain substance abuse services while Medicaid-covered substance abuse services remain reimbursed on a fee-for-services basis.

III. Identify uniform managing entity functions as baseline. Support several approaches to service management and managing entities depending on the characteristics of the districts. Phase implementation of functions, with long-term goal of the functions performed by the managing entity.

a. Service management functions for managing entities were identified. The workgroup categorized three broad methods of service management, including managing entities responsible for both contract and service management, managing entities responsible for certain service management functions but not contract management, and district staff members providing service management functions directly with the possibility of relying on lead agencies. Managing entities could also be responsible for all ten functions.

b. The workgroup discussed several sources of funding for managing entities: reserving a percentage of revenues for managing entities that manage contracts, directing funds directly to service management functions, and funding managing entities from efficiencies achieved with case rates and capitation funding.

IV. Align statutes and state policy in the areas of eligibility, enrollment, case rates, and authorizations of the managing entities.

V. Improve the data management and payment systems so they can support flexible, prospective-payment systems such as case rates and provide the more refined utilization data needed by districts and managed entities.

These recommendations constitute a very ambitious agenda that should drive many of the strategic objectives of the SAMH Programs over the next three years.

CHAPTER 5: INFORMATION TECHNOLOGY

Description of the Current System

The goal of the SAMH Program Offices is to transform the current data system into an effective decision-making model to provide timely and accurate information needed by various stakeholders, and to meet the following state and federal data reporting requirements:

- Chapter 2003-279, LOF, requires the department and AHCA to establish or develop data management and reporting systems that:
    a. promote efficient use of data by the service delivery system
    b. address the management and clinical care needs of the service providers and managing entities
    c. provide information needed for various state and federal data reporting requirements

- Section 394.745, F.S., requires the department to submit a report by November 1, which describes the status of provider compliance with the annual performance outcome standards established by the Legislature

- Section 394.77, F.S., requires the department to establish a uniform management information system and fiscal accounting system for use by providers of community substance abuse and mental health services

- Section 394.9082, F.S., requires the department and AHCA to:
    a. improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes
    b. improve accountability for local system of behavioral health care services to meet performances outcomes and standards

- At the federal level, SAMHSA requires each state to be fully compliant with various federal data reporting requirements including, but not limited to, the following:
    a. HIPAA standards for security and privacy
    b. Block Grant data
    c. National Outcome Measures data
    d. Data Infrastructure Grant tables for Uniform reporting system
    e. Decision Support 2000 uniform data reporting standards
    f. Treatment Episode Data System requirements

The Substance Abuse and Mental Health (SAMH) Program Offices uses the OneFamily SAMH system to collect, analyze and report data on persons served in state mental health treatment facilities and state-contracted community provider agencies. This system is designed to support not only the above statutory data requirements, but also the department's goals of strengthening

fiscal accountability and increasing quality of service interventions by providing information on system performance, service utilization, and quality and quantity of interventions. This information includes, but is not limited to, the profiles of service providers, the characteristics of persons served, the types and amounts of services provided, as well as the outcomes of these services.

The OneFamily SAMH system is managed by the SAMH Program Offices' Data Section staff who, in collaboration with district and provider staff, are responsible for the following activities:

a. developing business data requirements based on user needs assessment
b. testing, accepting, and implementing computer programs based on approved business requirements
c. maintaining and updating system documentation, including data policies and procedures
d. training system users and providing on-going technical support
e. data processing and validation of data quality
f. analyzing data and producing ad hoc and standard reports
g. using data to conduct special studies.

The staff in the DCF Office of Information Systems provides ongoing technical assistance and support, including the development of computer programs to reflect the business requirement specifications, as well as the installation, configuration, and maintenance of the hardware and software that are used for hosting the OneFamily SAMH system.

Need for a Comprehensive Behavioral Health Management System

In their final report, the DCF Information Technology Self-Directed Team recommended that the RFI and RFP processes be used to implement a comprehensive behavioral health management information system (BHMIS). LBR funding was requested to effect these improvements but was not approved. In the absence of these LBR funds, the SAMH Program Office is taking the following steps to improve the capability of the current data system:

a. The DCF Office of Information Systems has partitioned the current computer server into two separate instances to facilitate data submission and processing through direct data entries via input screens and batch processing via the File Transfer Protocol (FTP). This partition is designed to improve the system performance and response time.
b. The FMHI contract for data analysis and reporting is being outsourced using the RFI and RFP processes to find a vendor who will perform these functions more effectively and efficiently, using fixed cost contracts for professional services.
c. The State Outcomes Measurement and Management System (SOMMS) grant will be used for acquiring some hardware and software needed for data analysis and reporting. The Data Infrastructure Grant (DIG) will

continue to be used for programming activities related to development of stored procedures and queries, which produce and update user views of the data warehouse tables that are used as sources for data analysis and reporting.

d. Fiscal year 2007-2008 operating budget will be analyzed to examine the extent to which contracted funds for administrative oversight activities can be used to enhance the current data system, by implementing the BHMIS system and developing the data warehouse system.

2. System Refinements and Enhancements

The migration of the OneFamily SAMH system from CACHE platform to JAVA/Oracle database environment started in fiscal year 2005-2006. The statewide deployment of the OneFamily SAMH system in this new environment became effective September 15, 2006. The following major refinements and enhancements were implemented as a result of this deployment:

a. Improved the data validation process to minimize or eliminate existing system defects
b. Redesigned the input screens to improve online data entries
c. Improved the ad hoc reporting capability to query data and display the results on screens or to download the raw data on user's medium of choice
d. Increased the data security by implementing a dual sign-on process
e. Improved the data analysis and reporting capabilities by revising the user views of the Query Facility data tables
f. Automated data queries that are used to retrieve and submit data in the Uniform Reporting System (URS) tables required by the SAMHSA Center for Mental Health Services (CMHS) as part of the Data Infrastructure Grant (DIG)
g. Created online prompted Crystal reports for tracking data submission status
h. Created online exception reports that are used by staff at the state, district and local levels for various quality assurance and improvement activities

To further enhance functionality of the data system, the department will initiate a Request for Information (RFI) in fiscal year 2006-2007, which will be followed by a Request for Proposal (RFP), to acquire and implement a comprehensive and person-centered behavioral health management information system (BHMIS) in fiscal year 2007-2008. This new system will significantly improve the current system by integrating clinical, social, financial, and administrative information to support transformation of the mental health system of care in the following areas:

1. Electronic medical records, including but not limited to, information related to clinical evaluation, diagnosis, recovery goals/plans, customer outcomes, medication management, and emergency information

2. Managed care coordination, including but not limited to, information related to utilization management, clinical appeals, and resolution of grievances, evidence-based and promising practices, case management and quality assurance, eligibility information management

3. Service scheduling and claims payment, including information needed for tracking appointments for staff and customers, maintaining fee schedules, processing service claims, and tracking invoice payments

Data Used for Program Performance Evaluation

At the minimum, the OneFamily SAMH system is designed to provide ad hoc data needed to answer the following management questions at the state, district and local provider levels: who receive what services from whom to achieve what outcomes at what costs?

- The "**who receive"** question is answered using data elements reported in the system as part of the socio-demographic and clinical characteristics of the persons served.

- The "**what services**" question is answered using data elements pertaining to programs areas, cost centers, procedures and interventions.

- The "**from whom"** question is answered using data elements pertaining to districts, counties, provider sites, contracts, and staff responsible for service provisions.

- The "**what outcomes"** question is answered using data elements reported in the system as part of the substance abuse and mental health outcomes data modules.

- The "**at what costs"** question is answered using a combination of data elements reported in the system as part of data modules.

In addition to ad hoc data needed to answer the above management questions, the OneFamily SAMH system also provides data needed by the DCF Performance and Resource Teams (PaRTs) for various activities, including strategic and business planning, program budgeting, contract monitoring, and program performance evaluation and improvement.

At the national level, SAMHSA has created ten National Outcome Measures (NOMS) domains in collaboration with States to set performance targets for substance abuse and mental health initiatives and programs, including

prevention, early intervention, and treatment services. These domains are designed to reflect real life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live and participate fully in their communities.

Data Used for Customer Outcome Evaluations

Data currently used to evaluate customer outcomes includes FARS and CFARS functional assessments of persons served in mental health programs, customer satisfaction surveys, mental health and substance abuse admission and discharge records, and other data to evaluate customer outcomes related to days spent in community, days worked and income earned, and school days attended.

In addition to these individual-based outcome data, the SAMH Program Offices' plan is to use the Recovery Oriented System Indicators (ROSI) measures to advance the transformation of the mental health system of care. Data on ROSI measures will be collected by teams of peer support specialists using stratified samples of customers per district.

Current Performance and Future Plans

The SAMH Program Office has used available information sources to identify the strengths and weaknesses of the current system and to propose strategies needed to resolve pending problems. Concern has been noted in the following areas:

<u>Compliance with Auditing and Monitoring Report Findings</u> -
In the past few years, the report findings from the State monitoring and auditing offices, including Florida's Auditor General and DCF's Inspector General, have criticized the SAMH Program Offices for the following data issues:

a. insufficient data to correlate provider invoice payments with services provided
b. inability to provide reasonable assurance that overpayments and erroneous billings do not occur
c. inability to use data to perform quality assurance and quality improvement activities
d. lack of timely resolution of system defects and implementation of new system enhancements.

To address these concerns, recommendations have been made to:

a. Improve the current data system infrastructure by increasing the capacity of the hardware and software needed for online data submission and validation, and data analysis and reporting
b. Improve technical skills of individuals responsible for system development activities to reduce system defects and time needed to implement new system enhancements

c. Modify existing data system to collect and report data needed to produce standard online reports, which are readily accessible and available statewide to all authorized users to support quality assurance and quality improvement activities
d. Modify existing data system to implement a billing data module for tracking and approving invoice payments based on actual services provided and documented in OneFamily SAMH system

Compliance with Emerging National Outcome Measures (NOMS) Requirements:
All the SAMHSA agencies, including the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS), are encouraging States to move federally-funded programs and initiatives toward outcome-based financing through the use of the ten NOMS domains. The SAMH Program Office has received Federal data infrastructure grants (e.g., Access to Recovery Grant, State Outcomes Measurement and Management System Grant, and Data Infrastructure Grant) and have used these grants to capture data on the majority of the NOMS domains. More financial resources may be needed to complete this transformation.

CHAPTER 6: QUALITY IMPROVEMENT/ PERFORMANCE MANAGEMENT

Overview

In August 2005, Secretary Hadi chartered the Performance and Resource Management Teams (PaRTs) to integrate performance and expenditure decision-making utilizing the following steps:

a. review and assess performance on Strategic Plan measures and Business Plan action steps that affect delivery of services to customers
b. review expenditure projections to ensure that resources are planned wisely to support those services.
c. monitor, analyze, and report on program performances
d. ensure that program resources are managed effectively and efficiently
e. identify need and strategies for corrective action and monitor implementation impact
f. conduct continuous SWOT environmental analysis
g. report monthly status, progress and issues to executive performance and resource management team
h. Identify needed policy and resource changes

These Performance and Resource Management Teams (PaRTs Teams) are responsible for identifying performance and resource gaps, providing corrective action strategies and monitoring implementation impact. Core team membership consists of representatives from all sectors of the department in the central office, zones, region and districts. The teams publish periodic reports that include:

a. status report, including implemented improvement measures as necessary
b. expenditure projection analysis with proposed budget amendments
c. quarterly spending plans
d. team actions
e. major issues for Executive Performance and Resource Management Team decision or direction.

Performance measures and resource use are linked to strategic and business plans and support service delivery in the community. Current PaRTs Team meetings addressing Substance Abuse and Mental Health (SAMH) issues are scheduled approximately every six weeks.

Data Collection and Monitoring Procedures

Ongoing updates on performance measures are available to SAMH staff, legislative and other governmental entities, providers, and the public through the Department of Children and Families (DCF) Dashboard, an internet site. Providers and state-managed facilities are required through contracts or departmental regulations to provide monthly updates of services delivered and outcome measures. These measures are uploaded to the DCF Dashboard on a monthly basis.

Ongoing PaRTs Team Activities
Within the SAMH Offices, PaRTs team members meet on an ongoing basis throughout the review cycle to assess performance and formulate countermeasures. As new data are posted, it is reviewed and assessed against prior performance and departmental targets. District/regional staff and providers are contacted, and analysis necessary to design and implement countermeasures is implemented. These PaRTs reports are the periodic assessment of the design and implementation of these countermeasures.

Critical Few Measures
Certain performance measures are identified as of primary importance due to the criticality of the services they measure. Currently, the following measures are identified as belonging to the critical few for the Substance Abuse and Mental Health Program Offices:

a. Average annual days spent in the community for adults with severe and persistent mental illnesses
b. Average annual days seriously emotionally disturbed (SED) children (excluding those in juvenile justice facilities) spend in the community
c. Percent of adults employed upon discharge from substance abuse treatment services
d. Average days to admit adults committed pursuant to Chapter 916, F.S.

Other Measures
Other measures not included in the critical few, but still included in the strategic plan or business plan, are:

a. Substance usage rate per 1,000 in grades 6-12
b. Percent of prevention program groups showing pre-post improvements in at least 3 of 4 National Outcome Measures (Abstinence)
c. Average age of first substance abuse
d. Percent of children at risk of substance abuse who receive targeted prevention services who are not admitted to substance-abuse services during the 12 months after completion of prevention services
e. Rates of serious injuries and death per 1,000 Substance Abuse & Mental Health (SAMH) customers served
f. Average annual days spent in the community for adults with forensic involvement
g. Average annual days emotionally disturbed (ED) children (excluding those in juvenile justice facilities) spend in the community
h. Annual number of harmful events per 100 residents in civil commitment in each mental health institution
i. Annual number of harmful events per 100 residents in forensic commitment in each mental health institution
j. Percent of adults in civil commitment, per Ch. 394, F.S., who show an improvement in functional level

k. Percent of adults in forensic commitment, per Chapter 916, Part II, who are Not Guilty by Reason of Insanity, who show an improvement in functional level
l. Average number of days to restore competency for adults in forensic commitment
m. Percent of children with substance abuse who are drug free during the 12 months following completion of treatment

Recent Initiatives/Plans for Further Improvements in the PaRTs Process

During fiscal year 2005-2006, a dedicated position was created and filled to coordinate PaRTs presentations within the Mental Health Office, resulting in improvements in the coordination of analysis, design of PaRTs presentation materials, and in applying Sterling principles to the PaRTs process. In addition, increased involvement with district/regional staff and providers on an ongoing basis in data monitoring and countermeasure development has been initiated and will be completely implemented by the end of FY 06-07. Future enhancements in access to data and data analysis through the Crystal reports system now coming online will allow further expansion of the participatory roles of Central Office, district/regional, and provider staff to rapidly identify performance deficiencies and design countermeasures. Spending plan reviews are regularly scheduled on a quarterly or more frequent basis to identify unspent funds in a timely manner in order to reallocate them and avoid funding lapses.

CHAPTER 7: MENTAL HEALTH TRANSFORMATION

Mental Health Transformation: Moving Towards a Recovery and Resiliency-Based System of Care

In April 2002, President Bush established the *New Freedom Commission on Mental Health*. He charged it to study the country's mental health system, with the goal of making recommendations for improvement. In July 2003, the Commission published its final report, *Achieving the Promise: Transforming Mental Health Care in America*. Among other findings, the report noted that our country's mental health services and supports remain fragmented, disconnected, and inadequate. Additionally, the current national mental health system of care provides limited choice for service participants, employs few services that have demonstrated effectiveness, and focuses on controlling individuals' symptoms of mental illnesses (e.g., hallucinations and delusions) versus facilitating their recovery from mental illnesses. To address such fundamental problems, the Commission recommended profound, fundamental changes (transformation) such as:

- Addressing mental health needs with the same urgency as physical health needs; and
- Making mental health care consumer and family-driven by granting individuals and families a larger role in managing the funding for services they choose.

While there are isolated exceptions in various areas of the state, the systemic, nationwide problems delineated in the Commission's report certainly apply to mental health care in Florida. Consequently, far too many of our citizens have little hope of recovering from mental illnesses and participating as accepted, contributing members of their communities. Facing barriers to recovery such as limited access to effective services and supports, social stigma and discrimination, limited purchasing power, and limited choice, it is no surprise that many Floridians with persistent mental illnesses and emotional disturbances live as second class citizens, frequently in local and state mental facilities, jails or prisons. They are often forgotten, feared, and blamed for their relative disadvantaged status.

Nothing less than profound, fundamental change – *transformation* - is required to replace our long-standing preferred provider-driven system of care with one that is driven by the needs, preferences, and choices of individuals and families.

What changes are required to approach a "transformed" mental health system?

The Commission provides guidance on the scope of our endeavor by suggesting that transformation focus on six goals:

1. Enhancing people's understanding that mental health is essential to overall health;.
2. Ensuring that mental health care is consumer and family- driven;
3. Eliminating disparities in mental health services;
4. Ensuring that early mental health screening, assessment, and referral services are common practice;
5. Ensuring delivery of adequate mental health care and acceleration of pertinent research; and
6. Using technology to access mental health care and information.

The above goals mainly target system changes in service delivery mechanisms and associated infrastructure. Such system changes include, for example, aligning existing programs to deliver services to individuals more effectively, changing laws and funding mechanisms to support recovery, and using technology to enhance access to mental health care and information.

While such changes to systems and infrastructure are necessary, they will not be sufficient. They do not address, at least not directly, the fundamental barrier to restoration of function and full participation in one's community (recovery): the individual's social status relative to other members of his community (e.g., teachers, service providers, employers, family members, neighbors, and law enforcement officials). This is of critical importance because one's relative social status in a community largely determines how he/she is perceived and treated by others. The importance of this issue for individual recovery and mental health transformation cannot and must not be underestimated.

Accordingly, in addition to the Commission's six recommended goals, Florida's general roadmap for transformation also include the additional goal of *reducing stigma surrounding mental illnesses and otherwise increasing opportunities for individuals to participate fully in their communities*.

How did *mental health transformation* begin in Florida?

Community advocates, customers of public mental health services, and their families have been calling for "mental heath transformation" in Florida for many years, long before the issue received national attention through the Commission's work. In June 2005, Governor Bush joined the call for transformation by establishing a statewide *Transformation Working Group*, comprised of stakeholders such as local and state agency representatives, customers of public mental health services, and providers of those services.

In November 2005, the Transformation Working Group (TWG) had its inaugural meeting to fulfill its charge of developing and implementing a statewide plan to transform mental health care in Florida. Shortly thereafter, the TWG established its operational arm, the Recovery and Resiliency Taskforce (R & R Taskforce), which has established a statewide plan for transformation and begun ongoing dialogue and consultation with *community action teams* and other local stakeholder groups to facilitate plan implementation.

The statewide transformation plan is by necessity broad and general, incorporating principles and goals that are consistent with person-centered, person and family-directed, and recovery-oriented mental health care. In turn, local communities throughout the state, in partnership with Department of Children and Families district/region staff and other community stakeholders, have developed and begun implementation of more specific transformation plans consistent with the statewide plan and local needs.

The department and its many partners, including but not limited to, customers of mental health services and family members, the Substance Abuse and Mental Health Corporation, other state agencies, and providers of mental health services, have enthusiastically begun the process of transforming mental health care in Florida because of our common commitment to improving the lives of persons with mental illnesses and emotional disturbances, and because it is the right and fiscally responsible thing to do.

What significant changes have occurred to date?

Substantive accomplishments through December, 2006, include but are not limited to the following:

- Established the *Office of Consumer and Family Affairs* within the Central Mental Health Program Office. The primary goal of the office is to ensure that customers of mental health services, their families, and other community stakeholders participate in decision-making that impacts mental health services, including but not limited to, resource allocation and evaluation of quality and effectiveness of service delivery.

- Established the *Comprehensive Community Support Teams Cost Center.* This is a more comprehensive and flexible service purchasing option created by bundling services under one cost center that would otherwise have to be purchased or billed through multiple cost centers. The new bundled service is referred to as *Comprehensive Community Support Teams* (CCST), and it reduces fragmentation by increasing a customer's ability to receive an array of services that meets his or her individual needs.

- Established *Crisis Respite* service in Nassau County. Crisis Respite is a homelike environment that serves as an alternative to a crisis stabilization unit by providing a safe refuge for individuals who do not require the intensity and structure of a crisis stabilization unit.

- Established a *Certified Peer Recovery Specialist* discipline, which will lead to training and employment of adult consumers to provide peer support and recovery coaching services for other adult customers. Similarly, development of a *Certified Family Recovery Specialist* discipline is in process to serve children and family customers.

- Expanded *Crisis Intervention Teams* (CIT) in several districts. CIT is an innovative first responder model that provides law enforcement with training required to effectively intervene with persons with mental illnesses during a crisis. Through such intervention, arrest is often minimized and individuals' access to care and treatment is enhanced.

The success of Florida's transformed system will be measured by the following outcomes:

Fewer individuals with mental illnesses will be homeless or in county jails;
More people with mental illnesses will have jobs and live independently in the community;
Fewer children will be removed from their homes and the number of children entering the juvenile justice system will decrease;
Individuals with mental illnesses have a choice of services and supports that meet their needs;
More children with serious emotional disturbances will graduate from high school; and
Florida's consumers and family members will be the ones to advise if the state's transformation activities helping them advance their recovery.

Additional and updated information about mental health transformation is available on the department's Mental Health Transformation website at http://www.dcf.state.fl.us/mentalhealth/mhtransform/ .

APPENDIX 1: DISTRICT PLANS

Development of District Plans

As a key component of the state's planning process, each district/region is required to develop its own comprehensive plan with local participation. The planning process enables each district/region to better address its unique needs and serves to establish departmental planning initiatives. The alignment of these plans is critical in order to strengthen the substance abuse and mental health community service delivery system.

While the SAMH Programs have responsibility for establishing guidelines for the development of district plans, specific content requirements are provided by ss. 394.75, 394.4574, and 397.321, F.S. Accordingly, the SAMH Program Offices provided a structure for district/regional planning to meet these requirements. The planning process will be completed in phases and will complement the development of the state planning process.

During the first phase of the planning process, the districts/region were asked to: 1) complete an organizational profile, describing the unique characteristics of the district; 2) conduct planning activities with local Assisted-Living Facilities holding a Limited Mental Health License (ALF-LMHL); 3) develop a business plan for each district/region reflecting local priorities that are inclusive of critical elements identified by the department; and, 4) to develop a short narrative describing the district/region. The second phase of district planning process focuses on budget and funding allocations, performance improvement initiatives, special projects, further prioritization of program initiatives, and continuing efforts to include stakeholders in community-based meetings.

DISTRICT 1
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 1 is a four-county district located in the northwest panhandle of Florida. The district is composed of the following counties: Escambia, Santa Rosa, Okaloosa, and Walton. The district is bordered by Alabama to the north and west, and the Gulf of Mexico to the South. District 1 is primarily rural in the northern and central areas with population density closer to the coast. Escambia County is one of the poorest counties in Florida with most of the jobs being in the service and construction industries. A high number of working people without health insurance coverage reside within the district.

The District 1 Substance Abuse and Mental Health (SAMH) Program Office continues to improve the system of care for clients in need of substance abuse and mental health services. New and ongoing issues and initiatives include the following:

A) The district is currently in the fifth year of the Medicaid/SAMH Prepaid Mental Health Plan (PMHP) as authorized by s. 394.9082, F.S. The legislation authorizes the district to contract with the same Managing Entity (Managed Care Organization) that is the Medicaid PMHP to better integrate services and funding. The Medicaid PMHP must go through a new procurement cycle during the fall of 2007. The outcome of that process could potentially have a dramatic impact on the district's current system of care. The district has begun a contingency planning process to explore possible alternate contractual, financing, and service delivery strategies.

B) West Florida Community Care Center (WFCCC) implemented several measures to eliminate a large accruing financial deficit that was jeopardizing the viability of the entire WFCCC program. In addition to aggressive expense reductions, a Service Reduction Plan was developed to align expenses and projected revenues. The service delivery structure was reorganized to reduce nursing-related expenses and improve service delivery. The Service Reduction Plan also included the closure of the Baker Act Unit. The closure of the Baker Act Unit was well-planned and implemented with very little disruption to the system and its stakeholders. The implementation of the above actions has been effective in restoring the financial viability of WFCCC.

C) Hurricane Ivan created, and continues to create, numerous challenges for the district. The physical, emotional, and economic toll of this disaster will affect our services in many ways, including increased demand for services coupled with decreased local financial support from county and local government. The lack of affordable housing has become a major barrier for many people in Escambia and Santa Rosa counties including individuals needing SAMH services. The district has experienced a

significant reduction in housing options for clients in the SAMH system. The increased demand for social services has far outpaced the capacity of current systems, and a dramatic increase in criminal cases has severely strained an already overburdened criminal justice system. To partially address these issues the district has implemented several new initiatives which are discussed in more detail later in this document.

D) The District 1 SAMH Program Office has undertaken a number of initiatives related to the department's goal of a Recovery and Resiliency-based system of care. These include the following:
   1) Continuation of the Certified Peer Specialist program first initiated in District 1.
   2) The establishment of Certified Peer Specialist positions at both Mental Health Associations and all the District 1 Community Mental Health Centers to work with the SAMH-funded Client Assistance Program and other programs.
   3) The implementation of ongoing Crisis Intervention Training (CIT) for area law enforcement agencies and corrections staff. Clients and family members were involved in the CIT planning teams, design of the curriculum, and the training of law enforcement officers.
   4) The implementation of mobile Project Recovery teams has allowed the district to provide much needed therapeutic services to persons emotionally devastated by Hurricanes Ivan, Dennis, and Katrina. The district received additional funding to continue the program until October 1, 2007.

E) The District 1 SAMH Program Office has implemented several collaborative initiatives with the criminal justice system designed to positively impact rising forensic admission rates and jail over-crowding. These include:
   1) The ongoing expansion of the CIT program cited in D (4) above.
   2) The establishment of specialized Mental Health Pretrial Release Officers in Okaloosa and Escambia counties.
   3) The expansion of the Mental Health Court in Okaloosa County, and the planned implementation of a Mental Health Court in Escambia County.

F) Several organizational issues have impacted the functioning of the SAMH Program Office:
   1) After many years of staff stability, the office has experienced turnover in key positions. That turnover depleted the "senior" leadership in the District 1 SAMH Program Office.
   2) The long-tenured Adult SAMH Services Director passed away after a courageous battle with cancer. The position is anticipated to be filled in January 2007.

3) The long-tenured Children's SAMH Services Director resigned in the spring of 2006. A very competent individual was hired to fill the vacant position, but she is still relatively new to the job.
4) The District 1 SAMH Budget Director has been on extended medical leave since July 2005 and is expected to return full-time in December 2006.
5) The long-tenured Substance Abuse Director was promoted to the Central Office. The resulting vacancy was used to establish a "shared" contract manager/data reporting function that is intended to serve both Districts 1 and 2 SAMH Program Offices.
6) The District 1 SAMH Office has also experienced turnover in the Contract Manager position.

The district continues to refine the implementation of s. 394.9082 F.S. (SB 1258). Continuing initiatives include: Florida Algorithm (FALGO); implementation of the "Minkoff Model" for co-occurring disorders; Client Assistance Program; family education and support; and Network Quality Improvement Plan.

A) FALGO- Even though the "official" FALGO program was discontinued by Medicaid, network providers are utilizing the FALGO system and new diagnosis-specific algorithms have been added. FALGO implementation is a contract requirement for the Managing Entity.
B) Minkoff Model- The implementation of the Minkoff Model is also a requirement of the district's contract with the Managing Entity. Although progress was slowed by the effects of Hurricane Ivan, all network providers are in varying stages of becoming "co-competent".
C) The Client Assistance Program and family education and support initiatives have been expanded in Escambia and Santa Rosa counties. In addition to the expansion of the original programs, education and support services have been developed for families with younger children, utilizing the "Visions For Tomorrow" Program. Additionally, the implementation of Advance Directives continues to be a district priority. As stated in an earlier section, Certified Peer Specialist positions have been added to the Client Assistance Programs operated by the two Mental Health Associations in District 1.
D) Network Quality Improvement Plan- The district and Managing Entity are currently operating under the framework provided by the Network Quality Improvement Plan (Network Performance Plan) which specifies how performance is tracked and measured. Specific performance measures were developed collaboratively by the district and Managing Entity, and include a large number and variety of contractual, financial, operational, and service-related performance measures. Performance is reviewed quarterly at a scheduled performance review meeting with a formal presentation by the Managing Entity. Measures related to the implementation of Recovery/Resiliency initiatives have been added to the Network Performance Plan.

The availability of accurate data continues to remain problematic and is receiving the attention of Headquarters leadership. The district is continuing to develop reporting mechanisms and reports that are necessary for the full implementation of the Network Performance Plan. This initiative is ongoing.

DISTRICT 2
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 2, located in north central Florida, is a 14 county sparsely populated rural area. District 2 has 21% of the counties in Florida and 4% of Florida's population. The two largest cities in the 14 counties are Tallahassee (population-156,512) and Panama City (population-37,079). The 14 county district is divided into two subdistricts. Subdistrict 2A is comprised of Bay, Gulf, Washington, Holmes, Jackson, and Calhoun counties. Subdistrict 2B is comprised of Leon, Wakulla, Gadsden, Liberty, Franklin, Madison, Jefferson, and Taylor counties. Our District 2 Substance Abuse and Mental Health (SAMH) program has two office locations. The location in Bay County has two full-time professional staff and one part-time administrative assistant. The location in Leon County has four full-time and five part-time professional positions and one part-time administrative assistant.

While our District 2 SAMH Program office has 32 contracts for substance abuse and mental health services, the majority of the mental health funds are contracted with Apalachee Center in Subdistrict 2B and Life Management Center in Subdistrict 2A. These agencies both deliver comprehensive mental health services (including Crisis Stabilization Units, 24 hour emergency assistance, and residential services) to both adults and children across multiple counties. The majority of the substance abuse funds are contracted with Chemical Addictions Recovery Effort (CARE) in Subdistrict 2A and DISC Village, Inc. in Subdistrict 2B. These agencies deliver comprehensive substance abuse services to both adults and children across multiple counties. The CARE manages the substance abuse detoxification program in Subdistrict 2A and Apalachee Center manages the substance abuse detoxification program in Subdistrict 2B.

The most significant challenge to effective delivery of mental health and substance abuse services in our large sparsely populated area is accessibility. Our largest counties (Bay and Leon) provide a full range of specialized services and multiple service providers. In the outlying counties, basic services are available but consumer choice is limited regarding providers, and consumers typically must travel to Leon or Bay counties to receive specialized care. Serving persons who are involved with the forensic system is also a challenge because we are partnering with 14 different sheriffs, jails, county courts, three different State Attorney and Public Defender offices, and three different Circuit Courts. While we have been quite successful at reducing the number of persons from counties in District 2 who reside and receive services at Florida State Hospital, we struggle due to a dearth of specialized residential facilities. Our primary residential resources are Assisted Living Facilities or persons' own homes or homes of relatives.

With new funding received in the last three years, we have effectively met our top need and have increased the number of beds in Crisis Stabilization Units (CSUs) in both subdistricts. We have also funded a drug court that serves Jackson,

Calhoun, Washington, and Holmes counties. Through a special appropriation received by Apalachee Center, we are opening a sixteen-bed Short Term Residential facility for adults with a serious and persistent mental illness. This facility will help us divert persons from both civil and forensic involuntary hospital placements.

Our vision is to instill hope for recovery for our consumers and their families. Our initiatives promote that vision as we continue to explore consumer-driven supports and services and to encourage evidence-based practices.

DISTRICT 3
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 3 covers a geographic area that is largely rural and sparsely populated. The area encompasses 7,433 square miles. As of 2004, the district had a population of 534,101. District 3 providers maintain clinics in the ten largest counties, with residential programs managed centrally in the two most populous counties, Alachua and Columbia. District 3 comprises about 11.5 percent of the land area of Florida. One of the most obvious characteristics of the district is poverty. About a quarter of the children of District 3 live in poverty. In none of the counties does the per capita income approach Florida's average. Seven counties are among the 15 with the lowest per capita income in the state.

In FY 2005-2006, District 3 providers served approximately 13,500 clients. Eighty percent of persons served are at or below poverty. Much of the economy of the area is based on agriculture and service industries that keeps unemployment low, but also keeps wages low. The single biggest barrier to access to services is transportation. Gainesville is the only community with a mass transit system. Some district residents must drive 50 miles or more for medical care or other basic services. Families who don't have a reliable vehicle may be especially vulnerable.

District Strategies and Initiatives

A. Adult Mental Health/Forensic
    1. Assure Recovery Models are in place with our mental health providers
        - Pursue development of a Clubhouse program
        - Expect consumer representation on boards and committees
    2. Particularly concerned with the performance measure - "Improving Days in the Community"
    3. Continue work with the judicial system
    4. Providers and other stakeholders address priority populations without increased funding: Department of Corrections End of Sentence consumers, Assisted Living Facilities (ALF) residents, State Hospital Discharges, Forensic Clients, Homeless
    5. Continue to participate on Homeless Implementation Committee 10-Year Plan to end Homelessness
    6. Continue Anti-Stigma Committee to achieve the goal of quarterly presentations in the community
    7. Continue to address Baker Act issues with the community including Department of Juvenile Justice (DJJ), the courts and local police department, and County Sheriff's offices
    8. Expand Mental Health Court to include non-violent felons

B. Children's Mental Health
    1. Assure smooth transition of Specialized Therapeutic Foster Care (STFC) Services to Community-based Care (CBC) Oversight
    2. Continue to work closely with "Partnership for Strong Families" to assure system of care processes are working
    3. Continue relationship developed with DJJ during the Memorandum of Understanding (MOU) process
    4. Expand collaboration with SEDNET, a Multi-agency Service Network for Students with Severe Emotional Disturbance, by developing Family Resource Team Meetings at all Child Welfare Service Centers
C. Adult Substance Abuse
    1. Support Dependency Drug Court Programs and continue to expand into other counties
    2. Continue involvement with coalitions
    3. Continue bi-monthly substance abuse provider meetings to assure that best practices are achieved and also district collaboration of substance abuse providers
    4. Expand dually-diagnosed program as possible
    5. Continue to work with providers to assure the elderly are targeted to receive services
D. Children's Substance Abuse
    1. Continue to expand outpatient and intervention programs
    2. Expand Prevention Programs as possible
    3. Assure best practices are in place
    4. Work closely with DJJ in program coordination
    5. Expand work with the schools

Meeting the needs of "Families at risk of or challenged by substance abuse and/or mental illness."

Mission, Vision, and Values	**How District 3 supports and serves its target populations**
Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency	The District 3 SAMH Program Office is dedicated to contracting for services that address target populations who are the most vulnerable with special attention to child welfare families. The district's top priority for FY 2006-2007 is to initiate programs that address recovery and resiliency.
Vision: DCF will be recognized as a world class social services system, delivering valued services to our customers. We are committed to providing a	All consumers' complaints are dealt with immediately relative to our contract providers. Providers are aware of our high standards and respond immediately to us when we ask for modification in services in order to provide the highest level of care. We communicate

level and quality of service we would want for our own families.	constantly with our providers and are aware of issues. All issues are handled quickly and corrections are made in a timely manner.
Integrity… To conduct business in a manner that earns the trust and respect of our partners, customers, and the public.	The District 3 SAMH Program Office partners with providers and with community stakeholders. The partnerships are based on integrity. We share information and we follow through with our commitments.
Accountability… We will be accountable for the effectiveness of the department's programs and continuously improve the efficiency and quality of the services provided.	District 3 SAMH personnel participate in regular stakeholder meetings, meetings with consumers, and meetings with providers to consistently address needed improvements to the system of care.
Quality… The level of quality we are committed to providing is the quality of service we would want for our own families.	The District 3 SAMH Program Office employees meet regularly with providers to address low performance issues. All consumer complaints are addressed and contract changes are made when necessary to assure quality service.
Urgency… We value urgency, but not at the expense of what is right.	Consumer concerns are addressed immediately. Incident reports are addressed for necessary follow-up. Whatever can be done quickly to attend to consumers' needs occurs immediately. Execution of contracts moves quickly to assure services are put in place as soon as possible.
Responsiveness… Every action will be driven by the needs and choices of our customers.	All calls are returned promptly with consumer needs always given priority.
Choice… We will promote family and personal self-determination and choice.	The implementation of recovery initiatives ensures that consumers have a choice and can participate fully in their own treatment.
Empowerment… Empowerment is a consequence of a style of management, and not an action. You cannot get empowerment by forcing it, but by creating the conditions for empowerment to flourish. It is the process of sharing	Recovery and resiliency initiatives have created a climate for consumers to have more control over their own lives. District 3 SAMH staff are given autonomy to manage their own jobs and actualize their own talents to obtain optimum results.

information, training, and allowing employees to manage their jobs in order to obtain optimum results.	
Personal Responsibility… Every employee of the department will act in an ethically, socially, and culturally responsible manner.	District 3 SAMH staff pride themselves on being personally responsible to consumers, stakeholders, and providers. Each employee is fully responsible in their daily interactions.
Collaboration… Create workable forms of collaboration with partners in regulation, service delivery, and management.	District 3 SAMH Program Office employees are strong in community collaboration at all levels. Each specialist meets regularly with providers and takes initiative in linking community partners to ensure a proactive service delivery environment.
Innovation… Foster flexibility and encourage innovation in the effective delivery of direct and contracted services.	The District 3 SAMH Program Office works closely with providers to support flexibility and the latitude needed to provide the best possible services to consumers.

DISTRICT 4
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 4 encompasses five counties in northeast Florida. One large urban county has a growing economic base, but contains pockets of poverty and low income housing. Three counties are rural, but are rapidly growing into suburban areas. These counties are dealing with the impact of growth and the increased demands on social services. The fifth county is predominantly rural with a low tax base. Service access due to both transportation and service adequacies are issues of concern. The impact of Medicaid reform will negatively impact most service providers in the district, and will cause significant changes in service levels to persons served by the mental health providers.

County	Population	White %	Black %	Below pov. %
Baker	24,569	85	15	14
Clay	171,095	87	13	7.4
Duval	826,436	65	35	13
St. Johns	161,525	92	8	8
Nassau	64,746	91	9	9

In FY 2005-2006, District 4 providers served over 31,000 clients, including adults and children with mental health and substance abuse issues.

District Strategies and Initiatives

E. Adult Mental Health/Forensic
   9. Implement peer specialist services
   10. Create a ten-bed transitional housing service for persons released from jail who have mental health issues
   11. Create a district Peer Advisory Council
   12. Create a coordinated care system for frail elderly with mental health issues using the United Agencies of Coordinated Treatment (U-ACT) model
   13. Support and maintain respite services as alternatives to Baker Act admissions
   14. Support the mission of the Duval Mental Health Coalition
   15. Support the development of a Mental Health Court
   16. Continue the expansion of the Self-Directed Care project
   17. Closely coordinate with Medicaid Managed Care organizations to assure smooth transitional services

F. Children's Mental Health
   1. Assure smooth transition of Child Welfare/Medicaid administrative functions to the Child Welfare/Magellan system
   2. Expand mobile crisis teams for children and develop a safe haven alternative to Baker Act admission

3. Expand collaboration with SEDNET, a Multi-agency Service Network for Students with Severe Emotional Disturbances, expanding planned respite for non-foster care youth

G. Adult Substance Abuse
   1. Develop a Duval County anti-drug coalition
   2. Support the development of dual disorder services
   3. Continue to expand and support core treatment services
   4. Continue to support Drug Court efforts
   5. Support, expand and refine the work of Northeast Florida Addictions Network (NEFAN), as it serves the families in the child welfare system

H. Children's Substance Abuse
   1. Assure service movement towards evidence-based practices
   2. Develop a Duval County anti-drug coalition

Meeting the needs of "Families at risk of or challenged by substance abuse and/or mental illness."

Mission, Vision, and Values	**How District 4 supports and serves its target populations**
Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency.	District 4 SAMH supports and expands both core services and transformational programming.
Vision: DCF will be recognized as a world class social services system, delivering valued services to our customers. We are committed to providing a level and quality of service we would want for our own families.	The district values and respects our co-workers, providers, and people served. We listen to their concerns and do the right thing.
Integrity… To conduct business in a manner that earns the trust and respect of our partners, customers, and the public.	District 4 SAMH Program Office communicates regularly and shares information with our partners, customers, and the public.
Accountability… We will be accountable for the effectiveness of the department's programs and continuously improve the efficiency and quality of the	The district presents information to stakeholders regularly and informs them of the district's programs and plans.

services provided.	
Quality… The level of quality we are committed to providing is the quality of service we would want for our own families.	The District 4 SAMH Program Office utilizes an internal PaRTs process to assure appropriate service levels and contractor performance.
Urgency… We value urgency, but not at the expense of what is right.	The district sets realistic time standards and expects adherence.
Responsiveness… Every action will be driven by the needs and choices of our customers.	All inquiries and requests are responded to in a timely manner by District 4 SAMH staff.
Choice… We will promote family and personal self-determination and choice.	The district implements recovery initiatives to ensure that consumers have a choice and can participate fully in their treatment.
Empowerment… Empowerment is a consequence of a style of management, and not an action. You cannot get empowerment by forcing it, but by creating the conditions for empowerment to flourish. It is the process of sharing information, training, and allowing employees to manage their jobs in order to obtain optimum results.	District 4 SAMH employees are skilled, self-directed, and share the goals of the organization.
Personal Responsibility… Every employee of the department will act in an ethically, socially, and culturally responsible manner.	Staff in the District 4 SAMH Program Office responds professionally.
Collaboration… Create workable forms of collaboration with partners in regulation, service delivery, and management.	District 4 SAMH employees meet with a variety of groups and stakeholders on a regular basis.
Innovation… Foster flexibility and encourage innovation in the effective delivery of direct and contracted services.	The District 4 SAMH Program Office converts innovation to reality.

SUNCOAST REGION
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

The SunCoast Region is located in the western-central portion of the state of Florida. The region is comprised of six counties: Hillsborough, Pinellas, Pasco, Sarasota, Manatee and DeSoto counties. The region contains both urban and rural communities. The region's population is 3,197,690 as of 2005 according to the U.S. Census Bureau.

During FY 2005-2006, the SunCoast Region served approximately 71,273 people. The region funds substance abuse and mental health services through 70 contracts. Contracted services range from a Managing Entity contract for most regional substance abuse services to a contract for a mental health clubhouse. The region has adopted "Recovery" as its operating paradigm for both substance abuse and mental health services. Access to Recovery in substance abuse, and Comprehensive Community Services Teams in mental health, are prime examples of this.

Regional Strategies and Initiatives

A. Substance Abuse and Mental Health

1. Continue working with contracted providers and Central Florida Behavioral Health Network to promote and implement an integrated approach to providing services to persons with co-occurring disorders.

2. Continue to work with community stakeholders via the four local recovery and resiliency meetings and the Regional Recovery and Resiliency Work Group to address the needs of both children and adult mental health consumers.

B. Adult Mental Health/Forensic

1. Expand and improve upon the region's system for expediting discharges from and diversions from state forensic facilities. This includes a focused team approach going into a county jail as well as expanding available forensic residential capacity in the community.

2. Fully implement and refine the Comprehensive Community Service Team approach in the region. The region currently has nine contracted agencies providing this service.

3. Fully develop a second International Center for Clubhouse Development-certified clubhouse in the region in Hillsborough County.

4. Promote and assist the region's self-directed recovery and resiliency groups in actualizing the recovery principle of community integration.

C. Children's Mental Health

1. Innovative implementation of the principles of recovery and resiliency into the system of care for children's mental health throughout the SunCoast Region. Collaboration with families, community partners and providers will occur in order to meet this goal.

2. Ongoing partnership with both community-based care organizations with the six counties of the SunCoast Region (Hillsborough Kids, Inc. and Safe Children's Coalition).

3. Continuous collaboration with community providers, SEDNET, a Multi-agency Service Network for Students with Severe Emotional Disturbance, Department of Juvenile Justice (DJJ), and the three Medicaid offices in working toward the smooth transition and implementation of the Child Welfare Prepaid Plan.

4. Ongoing service to community families with a focus on assistance in navigating the children's mental health system of care.

D. Adult Substance Abuse

1. Completed an evaluation and currently implementing changes to the acute care system in Pinellas and Hillsborough counties to include the implementation of outpatient detoxification services.

2. The region is involved in three new state grants this year: Methadone Case Rate, Strengthening Treatment Access and Retention (STAR) and Naltrexone Treatment.

3. Added an additional Brief Intervention and Treatment for Elders (BRITE) program in Hillsborough County with the new state dollars.

4. Evaluated the adult prevention system and made the changes necessary to comply with evidence-based practices or approved innovation program based on a logic model.

E. Children's Substance Abuse

1. Added three and a half Family Intervention Specialists this year to strengthen our ties to the Child Welfare system.

2. The region is currently evaluating the children's substance abuse treatment system and will implement recommendations within boundaries of current resources by 7/1/07.

3. Evaluated the children's prevention system and made the changes necessary to comply with evidence-based practices or approved innovation program based on a logic model.

DISTRICT 7
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 7 is Florida's second largest region for the delivery of social services to eligible individuals living in the four counties that comprise the heart of Central Florida -- Orange, Seminole, Osceola and Brevard. With the presence of world-famous entertainment sites such as Walt Disney World and Epcot Center, Universal Studios, and Sea World, the Orlando area plays host to more than 3 million visitors each year.

According to the 2000 Census, the current population of this area is more than 1.9 million. The district's size and rapid growth has been logistically challenging. It is second highest in the number of child abuse/neglect reports received -- 24,201 in fiscal 2002-2003.

DESCRIPTION OF GEOGRAPHICAL AREA

Brevard County: Seventy-five miles long, it forms the district's east coast and has a current population of 485,178-- the district's second largest population. At 95,759, it has the second highest number of residents over age 65.
Orange County: The sixth largest county in Florida has a population of more than 930,034. There is a large transient population attracted by employment in the hotel and theme park sectors. It also, at 92,753, has the second largest number of residents over age 65.
Osceola County: Borders Disney World and has 179,534 residents. Most of its employment is concentrated in the service and tourism industries. There is a large and increasing Hispanic population in this county that was once primarily known for its cattle ranches. The county's over-65 population is 20,640, which is the lowest of the four counties in the district.
Seminole County: Since 1980 this northernmost county has seen its population more than double from 180,000 to more than 377,960 currently. Of the latter number, about 39,985 are people age 65 and older. It has a higher per capita income than both the state and national averages and Orlando's urban sprawl has primarily encroached into this county.

DISTRICT 7 UNIQUE FACTS

- Large district with multiple counties, mixture of urban, rural and suburban.
- Continued high growth.
- Extremely low unemployment but it is largely a service economy. This affects recruitment and retention of staff.
- In-migration and transient population weakens family and community support systems and compounds problems relating to substance abuse, domestic violence and adult and child abuse and neglect.

District 7 continues to experience substantial population and economic growth due to its climate and tourist attractions such as Disney World, Universal Studios, Sea World, the Kennedy Space Center and associated contractors. Immigration into the district is significant, as the weather and associated lifestyle attracts many visitors and transients, particularly during the winter. The actual population, at any given moment, is much higher than the official census and thus increases the demand for services.

The District 7 Substance Abuse and Mental Health (SAMH) Program Office in Orlando provides policy direction, technical assistance, resource development, oversight and administrative support to a four-county service area. The district has eight career service employees and another 11 non-career service employees. It has a total budget of over 60 million dollars; 42 providers and 49 provider contracts. The district also licenses 212 substance abuse providers and has enrolled 93 providers for the Access to Recovery (ATR) substance abuse program.

The SAMH Program Office in District 7 secures services for children and adults with alcohol and drug-related disorders, emotional problems, and mental illnesses. Services are totally privatized and delivered through a network of provider agencies within each county. Florida is transforming its publicly-funded mental health system to an individual and family-driven system that embraces prevention, resiliency, and recovery as guiding principles. In a transformed mental health system, the individual's self-direction should impact nearly every aspect of the mental health service delivery system, including planning, financing, workforce training, provider networks, and oversight and quality improvement.

With the transformation of mental health services, **recovery** has become a realistic goal for individuals with mental illnesses, and a guiding principle for service delivery. Recovery is seen as a process in a continuous system of building and developing personal strengths, and it means that despite the symptoms of the mental illness, life can go on. In the recovery process, relapses are not failures, but rather an opportunity to learn, and perhaps revisit issues and situations simply for personal strength-building.

Components of Recovery

- Individualized and Person-Centered
- Self-Direction
- Hope
- Responsibility
- Empowerment
- Respect
- Peer Support

- Strengths-Based
- Non-Linear
- Holistic

Transforming the mental health system, and implementing a recovery-based model requires shedding old stereotypes regarding individuals with mental illnesses and replacing them with new attitudes that support people with mental illnesses to achieve their greatest potential. Recovery should provide the **hope** that individuals with a mental illness **can live, work, learn and participate fully in their community.**

Our Mission: To provide a system of care, in partnership with families and the community, that enables children and adults with mental health and/or substance abuse problems to live successfully in the community, to be self sufficient or to attain self-sufficiency at adulthood, and to realize their full potential.

Our Vision: Persons needing publicly-funded substance abuse and mental health services will have a responsive system of care spanning all the needed services and related agencies. Services and supports will be planned and provided in the most efficient and effective manner possible. The system of care is based on these values:

* Individualized pathways of care, enhanced by the recipient's natural supports and strengths;
* Services based in the community, in the least restrictive environment consistent with safety and treatment needs; and
* Quality care that leads to improved outcomes for recipients.

The District 7 SAMH Program Office is responsible for planning, coordination, evaluation and contract management in order to implement a comprehensive system of care, which includes community services, as well as receiving and treatment facilities. We contract with 42 agencies to provide the following services: mental health services include emergency stabilization, residential care, case management, outpatient services and community support, while substance abuse services include detoxification, prevention, treatment, and aftercare.

DISTRICT 8

SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

The District 8 Substance Abuse and Mental Health (SAMH) Program Office is located in southwest Florida, which is comprised of Charlotte, Hendry, Glades, Lee, and Collier counties. District 8 is a combination of urban and rural areas, with the majority of the population closer to the coast. The inland areas accommodate the agricultural and cattle industry.

The geographic area of District 8 encompasses 5,440 square miles. To give perspective, distances from Englewood in Charlotte County, the northern most city in District 8, to the southern most town, Everglades City located in Collier County is 109 driving miles. There is a distance of 61 miles from downtown Fort Myers near the western coast of the district to Clewiston, the town furthest to the east. The north to south routes, I-75 and U.S. 41 are heavily congested with major accidents, delays, and often times bumper-to-bumper traffic. The highway and secondary road infrastructure cannot keep pace with our growing permanent population and tourist industry. This makes maneuverability throughout the district frustrating and time consuming.

The headquarters for the District 8 SAMH Program Office is centrally located within the district in downtown Fort Myers. Supervision and oversight is provided directly by the state Substance Abuse and Mental Health Program Offices based in Tallahassee.

The number of customers served during the 05/06 fiscal year were as follows:

Children's Mental Health Services	8,864
Adult Mental Health Services	7,610
Children's Substance Abuse Services	1,961
Adult Substance Abuse Services	4,708

The demand for services in District 8 will only continue to increase. The district's population growth since April 1, 2004 according to the U.S. Census Bureau, is 20.40%. Individual county growth is as follows:

Charlotte County	11.20%	+ 15,858	people
Collier County	22.20%	+ 54,809	people
Glades County	6.40%	+ 157	people
Hendry County	9.80%	+ 1,184	people
Lee County	28.60%	+ 80,865	people

District Strategies and Initiatives

The District 8 SAMH Program Office is continuing to support specialty courts and Crisis Intervention Training (CIT) for law enforcement.

As a diversion from both civil and forensic state hospitals, the Alternative Family Care Program was recently created through a contract with Gulf Coast Jewish Families Services, Inc. This will serve ten adults with severe and persistent mental illnesses in the homes of licensed caregivers.

The district is now attempting to create a 10-bed forensic residential facility utilizing the former children's Crisis Stabilization Unit at the Lee Mental Health Center. This program will serve as a resource for diversions from state forensic facilities.

District 8 is attempting to increase community-based housing options by negotiating with Renaissance Manor to build a large Assisted Living Facility in Lee County that will have a Limited Mental Health License and focus on serving persons with severe and persistent mental illnesses.

The District 8 SAMH Office is partnering with other agencies in attempting to create an adult detoxification facility in Charlotte County.

The Self-Directed Care program in District 8 has been implemented and has proven to be very effective at maintaining persons in the community who have mental health disabilities, while increasing their choices of services. This program encompasses the most basic of self-determination concepts; the persons being served choose what services they want and need, how much they are willing to pay for them and where and when they wish to receive them. The program is a conduit for providing individuals with the funds allocated for their mental health care by the state, in as simple a process as possible. Participants are provided with the degree of assistance they desire to develop their Life Analysis and Life Action Plans and to navigate the mental health care system.

The district is attempting to improve access to care to historically under-served rural populations, such as on Pine Island, and in other rural areas of southwest Florida. One means of improving this access to care will be the use of telemedicine/telepsychiatry. It is cost-prohibitive to send psychiatrists to these rural areas, and it is often not feasible for persons with disabilities to travel long distances to community mental health centers. Telemedicine can be an effective and efficient way of providing psychiatric services and encouragement to take medications as prescribed. There is a precedent for Medicaid/Medicare reimbursement for telepsychiatry in other states. Discussions have been initiated with Lee Mental Health Center and United Way, and these organizations have agreed to purchase the necessary hardware to begin piloting this project in Lee County.

This office, in partnership with National Alliance for the Mentally Ill, Inc. of Lee County will be hosting a series of roundtable discussions with consumers, family members, provider agencies and advocacy groups. The purpose of these meetings will be to conduct in-depth discussions about a variety of topics, including managed care and system transformation. This format allows all

parties the opportunity to share their concerns, questions and positions in a calm and conducive environment. Roundtable dialogues follow the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines outlined in *Participatory Dialogues, A Guide to Organizing Interactive Discussions on Mental Health Issues among Consumers, Providers and Family Members, 2000.* NAMI offers educational programs, such as Peer to Peer, Family to Family, and In Our Own Voice.

Lee Mental Health Center (LMHC), Southwest Florida Addiction Services (SWFAS), the Salvation Army, and Lee County Government are jointly seeking legislative funding to develop the Lee County Triage Center. This center will be a one-stop facility for Lee County law enforcement agencies to bring adults and children for mental health and addictions evaluations and referral. In conjunction with the Crisis Intervention Training (CIT) program this will greatly aid in reducing the number of people entering services through our jail system, and will strengthen the system of care in Lee County. The LMHC is taking the lead on administering the state funds for the Triage Center.

The District 8 SAMH Program Office has been one of the partners with Lee County in implementing CIT. This program provides about 40 hours of education to police officers who volunteer to be part of a special squad that deals with persons suffering from mental illness. This squad is designed to:

- Employ de-escalation techniques with persons brought to the attention of law enforcement who appear to be in mental health crises
- Network with other agencies serving persons with mental health disabilities

The purpose of this program is to reduce arrests and recidivism of persons with mental health disabilities by diverting them from jails and arranging for the mental health treatment they need.

Meeting the needs of "Families at risk of or challenged by substance abuse and/or mental illness."

Mission, Vision, and Values	**How District 8 supports and serves its target populations**
Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency	The District 8 SAMH Program Office is dedicated to contracting for services that address target populations who are the most vulnerable with special attention to child welfare families. The district's top priority for FY 2006-2007 is to initiate programs that address recovery and resiliency.

Vision: DCF will be recognized as a world class social services system, delivering valued services to our customers. We are committed to providing a level and quality of service we would want for our own families.	All consumers' complaints are dealt with immediately relative to our contract providers. Providers are aware of our high standards and respond immediately to us when we ask for modification in services in order to provide the highest level of care. We communicate constantly with our providers and are aware of issues. All issues are handled quickly and corrections are made in a timely manner.
Integrity… To conduct business in a manner that earns the trust and respect of our partners, customers, and the public.	The District 8 SAMH Program Office partners with providers and with community stakeholders. The partnerships are based on integrity. We share information and we follow through with our commitments.
Accountability… We will be accountable for the effectiveness of the department's programs and continuously improve the efficiency and quality of the services provided.	District 8 SAMH personnel participates in regular stakeholder meetings, meetings with consumers and meetings with providers to consistently address needed improvements to the system of care.
Quality… The level of quality we are committed to providing is the quality of service we would want for our own families.	District 8 SAMH employees meet regularly with providers to address low performance issues. All consumer complaints are addressed and contract changes are made when necessary to assure quality service.
Urgency… We value urgency, but not at the expense of what is right.	Consumer concerns are addressed immediately. Incident reports are addressed for necessary follow-up. Whatever can be done quickly to attend to consumers' needs occurs immediately. Execution of contracts moves quickly to ensure that services are put in place as soon as possible.
Responsiveness… Every action will be driven by the needs and choices of our customers.	Calls are returned promptly with consumer needs always given priority.
Choice… We will promote family and personal self-determination and choice.	The implementation of recovery initiatives ensures that consumers have a choice and can participate fully in their treatment.
Empowerment… Empowerment is a consequence of a style of management, and not an	Recovery and resiliency initiatives have created a climate for consumers to have more control over their own lives. District 8 SAMH employees are given autonomy to manage their

action. You cannot get empowerment by forcing it, but by creating the conditions for empowerment to flourish. It is the process of sharing information, training and allowing employees to manage their jobs in order to obtain optimum results.	own jobs and actualize their own talents to obtain optimum results.
Personal Responsibility… Every employee of the department will act in an ethically, socially, and culturally responsible manner.	District 8 SAMH staff pride themselves on being personally responsible to consumers, stakeholders, and providers. Each employee is fully responsible in their daily interactions.
Collaboration… Create workable forms of collaboration with partners in regulation, service delivery, and management.	The district's SAMH employees are strong in community collaboration at all levels. Each specialist meets regularly with providers and takes initiative in linking community partners to assure a proactive service delivery environment.
Innovation… Foster flexibility and encourage innovation in the effective delivery of direct and contracted services.	The District 8 SAMH Program Office works closely with providers to support flexibility and the latitude needed to provide the best possible services to consumers.

DISTRICT 9
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 9 is following the State's lead in transforming the substance abuse and mental health service system. One of our biggest initiatives for this fiscal year is the development of a Consumer Advisory Board. Members of the Consumer Advisory Board will assist the District 9 Substance Abuse and Mental Health (SAMH) Program Office in the monitoring of contracted providers, attendance at contract negotiation meetings and will provide overall input into our service delivery system.

District 9 contracts with a variety of mental health and substance abuse provider agencies in order to offer our consumers a choice in participation of services. Geographic locations are taken into account as Palm Beach County is quite large and is "unofficially" sectioned into 3 areas – north, south and west. Consequently, the District 9 SAMH Program Office developed a mobile crisis team for the western part of the county in response to the unique needs of this community. In the substance abuse array of services, District 9 will continue work with its Access to Recovery (ATR) voucher program, which will enhance the ability of our consumers to choose their services/providers. Providing culturally competent/sensitive services are paramount to our values. Currently, District 9 contracts with an agency called Multilingual Psychotherapy Centers, which provides services in over 13 languages, including sign language. Not only do their employees speak the various languages, but most of them are from culturally diverse backgrounds themselves.

To ensure our services are accessible and transparent, program directors are continually providing education to the community at large regarding the resources available. Charts of contracted services for each program area have been developed and are distributed to community partners, such as schools, Department of Juvenile Justice (DJJ), child welfare, criminal justice and receiving facilities. These charts are updated on a regular basis and details regarding waiting lists, funding considerations and how to make a referral to contracted providers are made available. Children's Mental Health providers have now partnered with Children's Substance Abuse providers in the Treatment Alternatives for Safer Communities (TASC) initiative. This action was taken in response to feedback from DJJ regarding lack of linkages to mental health services.

District 9 conducts monthly operations meetings with program and contract managers in order to review trends of expenditures by program area/provider. This allows the district to be pro-active in directing our financial resources where they are needed most. District data/outcome measures are reviewed at this time as well. Plans are then developed to ensure our providers meet the state targets outlined in their contracts. Bi-monthly provider meetings are convened by the District 9 SAMH Program Supervisor to ensure contracted providers receive data, and are kept up-to-date regarding district initiatives, trends, etc.

In response to the needs of our community, District 9 has developed several new initiatives for FY 06/07 as follows:

- In order to decrease the number of Baker Acts and possible suicide attempts, a utilization case manager position has been funded to ensure linkage to community services upon discharge from receiving facilities.
- Co-location of substance abuse staff with Child Welfare.
- Development of a two-part residential transition program for severely emotionally disturbed children aging out of foster care.
- Development of a Co-occurring Children's Crisis Stabilization Unit.
- Development of a Co-occurring housing and treatment program using the innovative approach of client-directed outcome informed therapy.

As the district listens and responds to consumers, stakeholders, community partners, etc., we will continue to revise and update our plan as necessary.

DISTRICT 10
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

Broward County, on the southeast coast of Florida, is the home to District 10 and its Substance Abuse and Mental Health (SAMH) Program Office. Broward County is a diverse community. We have a population of almost 1.8 million people. Our county line goes east to west from the Atlantic Ocean to the Florida Everglades and from north to south from Palm Beach County line to the Miami-Dade County line.

Broward has a rich history dating back to when our area was inhabited by American Indian tribes, later as a trading post, and then onward to a settlement that began as mostly a farming community and now serves as a hub for both national and international travel and trade. Our community encompasses over 160 ethnic groups and embraces its reputation as the "Venice of Florida". The degree of diversity in the district challenges our ability to ensure the provision of affordable housing, quality education, meaningful employment and business opportunities, and accessible health and social services for its citizens. To a certain extent, we have managed to address these needs.

Additionally, we continue to confront many of the challenges seen across the state. A rather large homeless population, a rise in HIV cases, a high suicide rate, a rising underage drinking problem and prescribed drug misuse, a growing population within our jails of individuals suffering from mental illness, a continuing child abuse problem, and a rise in Department of Juvenile Justice (DJJ) admission rates are just some of the social and behavioral health problems communities like ours face.

Notwithstanding these challenges, our community continues to move forward in its commitment to its citizens. Further, the District 10 SAMH Program Office is committed to the almost 20,000 individuals it serves each year. Our vision is simple – to instill the hope for and possibility of recovery in the consumers and families we serve and the professionals and other key stakeholders involved in that service delivery system. Our initiatives promote that vision and our vow to our customers is to make that vision a reality. Increasing numbers of consumer-driven initiatives are being explored and developed. Evidence-based practices are being encouraged and more effective and consumer-oriented service delivery systems are being researched. It is our intention to not just reform our services but to transform them to be more reflective of the current knowledge and direction in the field of mental health and substance abuse services.

With recovery as the expectation and not the exception, District 10 intends to bring light and hope to a population of individuals who for so long have only experienced the disabilities and disadvantages of an illness for which many believed there was no recovery. We will continue to take the lead in mental health and substance abuse services, work collaboratively with our many partners, and hold high our vision of "Recovery".

DISTRICT 11
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

The Substance Abuse and Mental Health (SAMH) Program Office in Subdistrict 11A (Miami-Dade County) and Subdistrict 11B (Monroe County) strongly believes in implementing the state's mission to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. Our vision is to be recognized as a world class social services system, delivering valued services to our customers. District 11 is committed to providing the level and quality of service we would want for our own families. The district's plan to accomplish this vision is the creation of a System of Care Transformation Recovery and Co-Occurring initiative, which involves all consumers, stakeholders, and providers under the auspices of the Miami-Dade and Monroe SAMH District Planning Councils.

Monroe County is 115 miles long and rural, in contrast with Miami-Dade County, which is an urban area that services the highest volume of consumers of any county in the state of Florida. In order to achieve the goals of the district, we operate a skeleton crew consisting of only 19 FTEs and 18 OPS staff to effectively manage the approximately $65 million district budget. The District 11 SAMH staff work collaboratively with the not-for-profit providers in the community to secure the needed services for our consumers. Over the years, Subdistricts 11A and 11B have worked closely with numerous providers and stakeholders and managed our budget well to reduce lapses and maximize services. District 11 has been challenged with budget reductions, transformation of mental health services, transition to pre-paid mental health plans, and hurricane disasters; nonetheless, we have continued to serve over 70,000 consumers annually.

The District 11 SAMH Program Office has been recognized for its performance. District 11 received an award for the "Most Improved Performance in Substance Abuse" for FY 2004/05. Further, District 11 was awarded the Davis Productivity Award in 2005 for recognition of their Community Forensic Services and in 2006 for the Jail Diversion Expansion Program for Misdemeanants. In addition, one of the District 11 SAMH staff received the SAMH 2006 Outstanding Performance Award and an award from the Eleventh Judicial Criminal Mental Health Project. In summary, the SAMH Program Office in Subdistricts 11A and 11B strive to transform the lives of our many clients so that they can become productive citizens and contributing members within our service delivery system of care.

DISTRICT 12
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

The District 12 Substance Abuse and Mental Health (SAMH) Program Office is located in Daytona Beach, Florida. The district is comprised of two counties: Volusia and Flagler, both located on the east coast of central Florida. The population of Volusia County is 490,055. The population of Flagler County is 76,410 and has been called the fastest growing county in the state. The area has an over representation of retirees, many of which relocated to this area after visiting as tourists in previous years.

Daytona, New Smyrna, and Ormond Beaches are known as the most pristine 47 miles of Atlantic Ocean Beaches. The beaches attract visitors year round, and the racing tradition has found its roots in Daytona. The Daytona 500 brings more crowds to Daytona than the super bowl and is located on International Speedway Boulevard.

Some major companies have found their home in Daytona, e.g., Hawaiian Tropic and the Boston Whaler Boat company. The area is also known for higher education institutions - Bethune-Cookman College, Embry-Riddle Aeronautical University, Stetson University, Daytona Beach Community College, and the University of Central Florida have found their home here. Each of the educational facilities has national reputations for excellence.

Over the years the community of District 12 has collaborated with the SAMH Program Office to improve the overall delivery of substance abuse and mental health services. In this tight-knit area, the community has seen an influx of homeless individuals, families with members with severe mental illnesses, a rise in substance abuse problems, and an increase in the suicide rate.

The current environment in District 12 welcomes the concept of recovery and resiliency. As a community, the stakeholders feel engaged in the process of developing/improving the system of care and they take their participation very seriously.

The challenges in this area are many. With increased populations in Flagler County, more run away substance abusers find their way to the beaches, and homeless families arrive daily. The SAMH Program Office is committed to meeting their needs. We will empower family members to assist in the recovery of their loved ones, and collaborate with the community, provider agencies, local government, and area coalitions, while keeping focused on the department's vision.

DISTRICT 13
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 13 is a five-county district with a population of almost one million people. The counties that constitute the district include Marion, Lake, Hernando, Citrus and Sumter counties. Three major providers and other niche providers have served this district for many years. The three major providers serve three geographically different areas including the following: The Centers serves Marion and Citrus counties; The Harbor Behavioral Health serves Hernando County; The Life Stream serves Lake and Sumter counties. Each of these mental health and substance abuse agencies provide a wide range of residential and outpatient services.

The District 13 Substance Abuse and Mental Health (SAMH) Program Office has identified several strategies/initiatives and key priorities. These initiatives link to the Department of Children and Families' mission and vision in strategic ways in order to meet the key customer group, "Families at risk of or challenged by substance abuse and/or mental health." Key services are determined based upon direct involvement of consumers in the decision-making process. Consumers are involved with each of the contracted providers, in a continuous process of surveying as well as through consumer advocacy groups and direct face-to-face interaction between consumers and District 13 SAMH Program Office staff.

Improvements that have been driven by these various interactions include the addition of a contracted Recovery and Resiliency Coordinator who, as a consumer, works as a liaison with consumers throughout the district. This individual initiates peer supports and provides vital feedback to the contracted providers and the program office. A Clubhouse has been established that is operational with active participation of consumers. The Community Access to Recovery Empowerment (CARE) Network provides a CARE Consultant, CARE Coordinator, Consumer Coach and other stakeholders who provide information, referral and linkages for adults and children who may need mental health or substance abuse services. There is a team in each county which may come together to provide assistance regarding the SAMH service system and other individual needs for the consumer.

Services that are currently funded through the District 13 SAMH Program Office include crisis stabilization/support/emergency, residential services, and a broad range of recovery and resiliency services including Comprehensive Community Service Teams.

DISTRICT 14
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

Hardee, Highlands, and Polk counties are located in central Florida, and are home to District 14 and its Substance Abuse and Mental Health (SAMH) Program Office. Our three counties are fundamentally rural with a population that fluctuates with the growing season. We have an average annual population of almost 718,000 people. Our three counties comprise nearly 3,705 square miles and has a large agricultural industry. Unfortunately, District 14 has two unwelcome distinctions as we have become known as: 1) Hurricane Alley, with three major hurricanes hitting our district in 2004, and 2) Methamphetamine corridor, because of our proximity to Interstate 4 and location between Tampa and Orlando.

We continue to confront many of the challenges and struggles that face the rest of the state. There is a rather large homeless population, a rise in HIV cases, a high suicide rate, and a significant underage pregnancy problem. There are also problems with prescription drug misuse, a growing population within our jails of individuals suffering from mental illnesses, a continuing child abuse problem, and a rise in Department of Corrections' admission rates. These are just some of the social and behavioral health problems communities like ours face.

Notwithstanding these challenges, our community continues to move forward in its commitment to its citizens. Further, the District 14 SAMH Program Office is committed to the almost 70,000 individuals it serves each year. Our vision is deeply rooted in the fundamentals of recovery. That is, we seek to ensure that our system of care: 1) is self-directed and individualized: 2) empowers our consumers and their families: 3) provides hope and respect; and 4) addresses all facets of the consumer's life. The district's initiatives promote that vision and our commitment to our customers is to make that vision a reality. The district is exploring and developing a greater number of consumer-focused practices. Evidence-based practices are being encouraged and more effective and consumer-oriented service delivery systems are being researched. It is our intention to not just reform, but to transform our services to be more reflective of the latest knowledge and direction in the field of mental health and substance abuse services.

The district has embraced the principles of recovery and will strive to incorporate these fundamental practices in every area of our system development. We will continue to be open-minded to new and proven service deliveries that bring hope and empowerment to our consumers, stakeholders, and community. The district pledges that our staff will strive to increase our knowledge of best practices and implement those practices that are consistent with recovery and resiliency.

DISTRICT 15
SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OVERVIEW

District 15 is uniquely located on the east coast of Florida. It is comprised of four counties to include: Indian River, Martin, Okeechobee, and St. Lucie. Three of the counties are metropolitan and one county is rural. It has one of the fastest growing counties in the United States, but it does not have any major four-year universities or colleges. The Substance Abuse and Mental Health (SAMH) Program Office has promoted the nexus of mental health services with families and providers which has become a part of the integrated system of care for adults and children. The district is served by one major mental health center, New Horizons of the Treasure Coast. This agency has branches in all four counties; however, its Detoxification Center, Crisis Stabilization Unit (CSU) and Short-Term Residential Treatment (SRT) Unit are located on the same campus in Ft. Pierce. Okeechobee County is a rural county, and for many years because of its location, has not enjoyed the same type of attention the other three counties have enjoyed. The SAMH Program Office has had some success in focusing attention to this county. One of the significant accomplishments of the SAMH Program Office is its ability to get all four counties working together. Attaining this level of cooperation has greatly benefited the district.

The SAMH Program Office is located in Ft. Pierce within St. Lucie County but this is not the most affluent county. It is strategically placed, however, since Ft. Pierce is the hub of all federal and local governmental headquarters. The program office enjoys a positive working relationship with the judicial system including the Chief Judge, the Public Defender, and the State Attorney. Representatives of each of these offices participate on the District 15 Mental Health Planning Council. Additionally, two State Representatives, as well as local legislators, are members of this Council. The Mental Health Planning Council meets bi-monthly for three hours. During these meetings providers, consumers and other stakeholders plan and discuss the path the District 15 SAMH Program Office will pursue based on the needs and gaps in services identified in the district. This group was responsible for instituting the Mental Health Court. It was also responsible for developing the Crisis Intervention Training (CIT) which has graduated its first class. The SAMH Program Administrator is frequently invited to serve on local taskforces which directly relates to the program office's consumers and their related concerns. The plight of our forensic consumers has been a constant topic for the past three years and there is a subcommittee chaired by Representative Gayle Harrell which is pursuing legislative solutions and assistance for this problem.

Concomitantly, the district convenes a Substance Abuse Collaborative which meets every other month. This group is comprised of service providers, consumers and stakeholders. This group was responsible for creating the environment which was conducive to the development of Drug Courts in three of our counties and substance abuse coalitions in all four counties. The Collaborative is very interactive and encourages its members to achieve their

goals. There is a constant effort on behalf of the Collaborative to encourage the coalitions to address significant areas such as the results of the Florida Youth Substance Abuse Survey, which shows one of the counties in the district always near the top in many areas regarding substance use. A gradual breakthrough has been noted and concentrated efforts will continue to reduce youth substance abuse in this county.

There is a paucity of professionals such as doctors, nurses, therapists and other related persons working in our area. There are no schools from which to draw potential candidates. Further, the salaries are not sufficiently attractive to entice families to the area because the housing costs, though less expensive than the surrounding areas, are still too steep for young professionals. There is also a high attrition rate among staff. The District 15 SAMH Program Office is one of those entities which has suffered from this dilemma. We are encouraging new providers to bring their own staff with them before considering working in this district. There is much "cannibalizing" of staff among service providers. The program office has scheduled workshops to assist our providers to explore avenues to encourage and attract staff from outside our service area.

The District 15 SAMH Program Office will continue to strive to be a leader in offering new and innovative ideas for our service delivery system. We remain committed to our vision, goals and objectives.