Substance Abuse and Mental Health Annual Plan Update

January 2008

Charlie Crist, Governor

Bob 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 2008.

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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TABLE OF CONTENTS

Substance Abuse and Mental Health Plan Introduction 3

Chapter 1: Organizational Overview 9

- Programs and Delivery Mechanisms 9
- Staffing 10
- Information Technology 11
- Regulatory Environment 11
- Organizational Structure 12
- Strategic Challenges 14
- Success Factors 15
- Performance Improvement Approach 16
- Competitive Position 16

Chapter 2: Substance Abuse Program 19

- Introduction 19
- Substance Abuse Program Statutory Framework 19
- Current Trends 19
- Strategic Initiatives 20
- Substance Abuse System of Care 20
- Substance Abuse Licensure System 21
- Revision of Rule 65-D 30 22
- Trends in Service Funding 22
- Substance Abuse Target Populations 24
- Methamphetamines 27
- Best Practices Awards Program 27
- Substance Abuse Detoxification and Treatment Services 29
- Prevention 35
- Substance Abuse Partnerships Initiatives 42

Chapter 3: Mental Health Program 45

- Introduction 45
- Mental Health Program Statutory Framework 46
- Florida's System of Care 46
- The Department's Strategic Plan 47
- Local Participation in Planning, Organizing, and Financing 49
- Individual Involvement 49
- Adult Community Mental Health Services 50
- Children's Mental Health 62
- State Mental Health Treatment Facilities 75
- Mental Health Disaster Response Team 89

Chapter 4: Financial Management 91

- Substance Abuse and Mental Health Contracting System. 91
- Substance Abuse Funding for FY 2007-2008 93
- Mental Health Program Funding for FY 2007-2008 97
- Managing Entities 102

Chapter 5: Information Technology 103

Chapter 6: Quality Improvement / Performance Management 109

Introduction
Substance Abuse and Mental Health Plan

Purpose of Plan

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, the Department of Children and Families (DCF or the Department), 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. In the intervening years, the Department is required to submit a plan update that specifies which of the goals have been achieved and what steps are being taken to achieve remaining goal outlined in the triennial master plan. This 2008 annual plan update provides a status report on progress towards meeting these goals and reflects substantive legislative changes that occurred during the 2007 legislative session.

Organization

The DCF is the state agency that administers Florida's publicly-funded substance abuse and mental health treatment programs. The Department operates under the direction of Secretary Bob Butterworth, who reports directly to the Governor. The Assistant Secretary for Substance Abuse and Mental Health, Bill Janes, provides leadership and direction for the Substance Abuse and Mental Health Program Offices, and reports directly to the Secretary of the Department.

The mission of the Department is *"Protect the Vulnerable, Promote Strong and Economically Self-sufficient Families, and Advance Personal and Family Recovery."* The Substance Abuse and Mental Health Program (SAMH) has established key strategic objectives and strategies that support the Department's mission and direct the provision of services to Florida's citizens.

The objectives identified in the following section represent the primary areas of focus for the SAMH programs and the key strategies that were identified in the triennial plan. Many of these strategies were implemented during FY 2006-2007.

Substance Abuse and Mental Health (SAMH) Strategies

Objective – Prevention and Early Intervention

This objective pertains to individuals 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.***
- ***Target early intervention strategies for at-risk youth.***
- ***Develop and implement early childhood strategic plan with the Department of Health (Mental Health Program).***
- ***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.***

Objective – Recovery and Resiliency

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

Strategies:

- ***Increase individual access to recovery and evidence-based services and supports.***
- ***Increase access to SAMH services for individuals served in the Department's circuits and regions.***
- ***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 individuals move between provider agencies and different levels of care.***
- ***Sustain recovery support services developed under the Access to Recovery grant to improve individuals' outcomes.***
- ***Transform the mental health system to an individual-driven and integrated system of care, including:***
    - ***Increased access to stable housing, employment and transportation;***
    - ***Increased individual 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.***
- ***Use continuous quality improvement methods to increase individuals' access to and retention in substance abuse services.***
- ***Establish uniform reporting and analysis of critical events, including suicide (Mental Health).***
- ***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 specified requirements.

Strategies:

- ***Expend funds as appropriated.***
- ***Perform quarterly, monthly, or as appropriate, monitoring of expenditures.***
- ***Ensure that federal and other grant funds are 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.***
- ***Strengthen invoice verification procedures.***
- ***Continue to study and make determination about use of managing entities to purchase flexible systems of care.***

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 circuit levels to impact program performance.

Strategies:

- ***Implement a comprehensive performance improvement program that integrates state and circuit/region 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 (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).***

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

Objective – Individual Satisfaction

This objective relates to meeting individual needs and expectations.

Strategies:

- ***Continue use of satisfaction survey.***
- ***Stratify survey results and provide reports to circuits/regions and provider agencies.***
- ***Increase individual involvement on program workgroups, committees, and improvement initiatives.***

2007 Legislative Session

During the 2007 session of the Florida Legislature, legislation was enacted which relates to the substance abuse and mental health treatment systems:

Chapter 2007-174: authorized the Department to begin the process of Departmental reorganization, subject to further legislative review. The Department was also directed to integrate substance abuse and mental health programs into the overall structure and priorities of the Department and provided authority to the Department to plan for the realignment of circuits/regions with judicial circuits and to phase in organizational changes as necessary to ensure that children in the system are not adversely affected.

Chapter 2007-200: created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program within the Department. This program provides funding to counties which allow them to plan, implement, or expand initiatives to address the issues of adults and juveniles who have mental illnesses and/or substance abuse disorders. The chapter further directs the Florida Substance Abuse and Mental Health Corporation, Inc., to create a statewide grant review committee and specifies the membership and functions of that committee.

Chapter 2007-430: required that all facilities designated as public Baker Act receiving or treatment facilities report certain data to DCF. This requirement applies to both facilities under contract with the Department, as well as private facilities that do not contract with DCF. The data that must be reported includes the number of licensed beds, the number of contract days, the number of admissions by payer class, the average length of stay by payer class, and the total number of revenues by payer class.

Chapter 2007-241: authorized employees of the Florida Civil Commitment Center to use non-lethal force on persons committed to the program under certain circumstances. This chapter specifies the procedures for documenting use of force and incident reporting. Additionally, the agency having jurisdiction over an individual who is convicted of a sexually violent offense and who is being evaluated for civil commitment must provide any available documentation indicating whether the offender's criminal history includes incidents involving sexual acts or sexual motivation.

General Appropriations Act:

- Provided $329,616 for the Substance Abuse Program Licensing Information and Training Curriculum to support a statewide substance abuse automated licensure information system.
- Provided $495,933 to fund eight full-time equivalent (FTEs) positions, including rate, salaries and expenses to convert contracted services positions to FTEs for three Substance Abuse contracts with universities.

CHAPTER 1:
Substance Abuse and Mental Health Programs Overview

Substance Abuse and Mental Health Programs

PROGRAMS AND DELIVERY MECHANISMS

The Department 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 DCF is to *"Protect the Vulnerable, Promote Strong and Economically Self-sufficient Families, and Advance Personal and Family Recovery."*

Florida's SAMH 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 to assist *"Persons with or at risk of substance abuse and or mental illnesses live, work, learn and participate fully in their community."*

The SAMH 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 and 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.

During 2006-2007 FY, the Substance Abuse Program provided individualized prevention, intervention, treatment and detoxification services to approximately 115,729 adults and 53,024 children. The substance abuse prevention program served an additional 141,731 children and 14,265 adults through non-individualized prevention services. The Mental Health Program provided mental health services to approximately 168,683 adults and 92,905 children in community settings. The state mental health treatment facilities provided services to 1,592 civil individuals', 2,623 forensic individuals', and 703 sexually violent predators.

While services are provided within two distinct program areas, most of the service delivery is accomplished through contracts implemented at the circuit/region level with community-based substance abuse and mental health provider organizations and professionals. However, the state mental health treatment facilities directly provide mental health and limited substance abuse services to individuals.

The SAMH Program Offices administer the provision of 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. These program offices are 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, F.S., govern the provision of substance abuse services, and provide direction for a continuum of community-based prevention, intervention, treatment services, and detoxification. 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 is responsible for licensing public and private substance abuse providers.

Mental Health Services

Chapters 394 and 916, F.S., provide direction for the delivery of mental health services for adults and children. These services include both acute and long-term mental health services, as well as oversight of state mental health treatment facilities and the Sexually Violent Predator Program. Components of the mental health program include: Children's Mental Health, Adult Community Mental Health, State Mental Health Treatment Facilities, and the Sexually Violent Predator Program (SVPP).

Contract Management

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

- Support for the management of circuit 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, who are 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 also provides support to circuit/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.

STAFFING

The Substance Abuse and Mental Health Programs have a total of 4,191.5 FTE positions and 494.5 Other Personal Services (OPS) employees for a total workforce of 4,686 employees. Three percent of the workforce is located in Tallahassee, at the central headquarters; 4.6 percent of the work force is located in the 20 circuits/ 5 regions, while the remaining 92.3 percent is located in one of the three mental health treatment facilities operated by the state.

SAMH Program FTE and OPS Employees					
	Status	Headquarters	Circuits/Regions	Treatment Facilities	Total
SA	FTE	32	33	N/A	65
	OPS	25	38	N/A	63
MH	FTE	62.5*	75.5	3,988.5	4,126.5
	OPS	26*	69.5	336	431.5
Total		145.5	216	4,324.5	4,686

INFORMATION TECHNOLOGY

The Substance Abuse and Mental Health Information System (SAMHIS) is a web-enabled application. The system integrates the following information: (a) socio-demographic and clinical characteristics of individuals 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; and (d) the outcomes of services provided.

This data system is the repository for both individual service and contract information. Information is retrieved from this system and entered into the DCF Dashboard and posted on the Department's internet site. Performance at the state, circuit, and provider level, as well as performance on key indicators can be viewed at this site.

The Department initiated a Request for Information (RFI) in FY 2006-2007, followed by a Request for Proposal (RFP), to acquire and implement a comprehensive and person-centered behavioral health management information system (BHMIS) in FY 2007-2008. The acquisition of this new system will significantly improve the state's capacity to integrate clinical, social, financial, and administrative information.

REGULATORY ENVIRONMENT

In 2003, s. 394.655, F.S., the Legislature established the Florida Substance Abuse and Mental Health Corporation, Inc., 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 directed to annually submit recommendations to the Governor and the Legislature regarding policies designed to improve coordination and effectiveness of the state's publicly-funded mental health and substance abuse systems. The Corporation is responsible for the Transformation Working Group (TWG), a state-level steering committee that provides critical interagency oversight of the transformation of the

mental health system in Florida and more recently, during the 2007 legislative session, the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program.

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 include:

- Reviewing 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;
- Serving as an advocate for adults with serious mental illness, children with severe emotional disturbance or other individuals with mental illnesses or emotional problems; and
- Monitoring, reviewing, and evaluating, at least once annually, the allocation and adequacy of mental health services within the state.

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., and required the appointment of an Assistant Secretary for Substance Abuse and Mental Health by the Secretary of the Department. This legislation additionally provided the SAMH Programs with direct authority for the implementation of programs, supervision of circuit/region level staff, contract management, licensure, management of the budget, and quality assurance. Linkages with other departmental programs at the circuit/regional level were achieved through interagency agreements, which addressed specific responsibilities and priorities at that level.

However, in 2007, as a result of the provisions of Chapter 2007-174, the Department began reorganizing the circuit structure to align with the State's judicial circuits. This reorganization included the integration of the circuit/regional SAMH programs within the newly established circuit structure and assigned direct authority for the local SAMH Program Office to the Circuit Administrator. Additionally, budget management and contract responsibilities are now assigned to the circuits. At the central office level, the SAMH Program Directors continue to report directly to the Assistant Secretary for Substance Abuse and Mental Health Programs.

The Central Office responsibilities include:

1. Developing statewide rules, policies and standards;
2. Providing technical assistance to the service circuits/regions, 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 regions;

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; and
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 Substance Abuse 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 Circuit/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 Contract Management and Information Technology sections are jointly responsible to both Mental Health and Substance Abuse Program 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.

At the local or circuit level, a SAMH Program Supervisor manages both the mental health and substance abuse programs and reports directly to the Circuit Administrator. 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 areas. Local partners include, but are not limited to persons receiving substance abuse and/or mental health services, community-based care agencies, Agency for Health Care Administration, 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.

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. Improving client access to services in an environment where a low percentage of the need is being met.
2. Provision of services and supports for adults and children with mental illnesses who have unique needs such as those involved in the criminal justice system or who suffer from co-occurring disorders.
3. Changes to state contracting requirements have resulted in better system accountability. However, current financing and contracting methods do not support flexible, prospective, individual-focused/individual-directed treatment services or sufficiently promote the use of evidence-based practices.
4. Although progress has been made in the re-design of the SAMHIS, the system is still not sufficiently integrated to track clients as they move from one level of care to another or to track individual outcomes.
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 which negatively impacts the ability to offer effective treatment services.
6. The management of state resources in a rapidly changing environment, particularly in the areas of organizational structure, contract management, and service delivery through a managing entity structure is a challenge. The programs must become more flexible regarding the management of resources.
7. Programs are required to serve certain statutorily defined “target populations” within the state. Additionally, there are a number of “priority” populations that are specified to receive services through federal grant requirements, legislative actions, court decisions, or policy decisions. There is a need to strengthen the capability of determining clinical and financial eligibility for services in order to most effectively deliver services within available resources. Statutory changes are required to perform both of these functions.
8. Adapting to Medicaid reform initiatives has significantly impacted the funding and delivery of mental health services.
9. While funding was provided by the 2007 Legislature to the Substance Abuse Program for FTEs, there continues to be an over-reliance on OPS staff to perform critical functions such as data management, and contracting. The loss of staff during previous budget cuts continues to negatively impact the SAMH programs.
10. Communication and coordination of initiatives across multiple agencies serving the same target population is challenging, and often results 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. There have been reductions to this funding over the previous two years and additional reductions are likely next year.

12. Revising billing practices to seek Medicaid funding for eligible substance abuse services.
13. Realignment of the Departmental organizational structure presents challenges in coordination of tasks requiring input from all levels of the organization.
14. Performing the role of substance abuse and mental health state authority.
15. Identifying areas where the two program offices can more closely work together at the headquarters level.

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 circuit/regional plans that include prominent participation by individuals 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;
5. Continuing collaboration and planning with community-based programs in order to perform the role of substance abuse and mental health state authority; and
6. Aligning program offices to continuously monitor system performance and improve the quality of care.

Both Substance Abuse and Mental Health Programs are engaged in ongoing efforts to purchase services that are effective, provide incentives for good performance and reduce funds when performance does not meet expected standards and outcomes.

Both Substance Abuse and Mental Health Programs use a process to evaluate programmatic strategic performance measures. Based on levels of performance, interventions are initiated at the local level and with providers as indicated by these measures, to implement corrective actions, contract revisions, data collection techniques, or provider selection. A Performance Management Team (PMT) works to incorporate and align the SAMH initiatives (including planning) with the Department's business, strategic, and budget plans. 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 PMT and executive staff are also partnering with other state agencies and program offices to provide support for individual services in areas not directly funded in the DCF budget, such as housing, employment, and other areas vital to achieving our individuals' personal recovery goals.

Finally, the PMT examines all the performance measures currently used to gauge the effectiveness of state-funded treatment and prevention programs. The team has been engaged in developing algorithms for the National Outcome Measures (NOMs), identifying current measures which may be replaced by similar NOMs, and developing a timeline for implementation of the NOMs within the Federal requirements. The PMT is also developing and implementing action plans designed to improve the operation of the Substance Abuse and Mental Health Information System. Improving the quality of data received from service providers, changing current measures to adhere to National Outcome Measures, and validating all measures has been the primary focus during 2007.

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 quality management principles. The teams are responsible for identifying performance and resource gaps, providing corrective action strategies and monitoring the implementation of and impact of corrective action plans. Core team membership consists of representatives from all levels of the Department.

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 data-base. Provider performance is then compared to the required outcomes within circuits/regions and circuit/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, circuit/region, and provider-level data and outcome information. The program offices use the Dashboard to compare the performance of providers and circuits/regions.

In addition, the Substance Abuse PMT 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

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 49th 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, DCF, and the SAMH Programs establish

performance outcome targets for providers, local management areas, and the agency as a whole.

Substance abuse and mental health services are funded primarily through Federal Block Grants, other Federal grants, General Revenue, and Medicaid. Medicaid funds approximately 80 percent of children's and 60 percent of adult mental health services. The Mental Health Program works closely with the state Medicaid authority (Agency for Health Care Administration) in policy and program development. The programs must 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

Introduction

This chapter contains updates to the Substance Abuse program plan, projecting those activities and initiatives that will, in part, address the needs of the persons we serve. The plan reflects the Department's continued commitment and ongoing efforts to develop an integrated system of care.

Statutory Framework

Chapters 394 and 397 of the Florida Statutes, govern the provision of substance abuse services, and 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 are responsible for licensing providers.

Current Trends

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 1,297,336 adults and 332,355 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.
- Alcohol continues to account for the highest percent of treatment admissions for adults (32%) and is followed by cocaine/crack and marijuana (26%) each.
- 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.
- Historically, since 1999, the Substance Abuse Program Office has received increased funding for children (67%) and adult (65%) services, primarily through increases in the federal block grant.
- Some budget reductions were experienced during FY 2006-07 and additional reductions are expected during FY 2007-08.

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 individual-focused and managed based upon levels of performance and desired outcomes. The Substance Abuse Program Office has achieved some of these programmatic objectives through specific strategic initiatives throughout FY 2006–2007.

Strategic Initiatives:

- Refocus the system of care to better support individual 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., increased misuse of prescription drugs by an aging population and the associated increased medical needs).

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 circuit/regional staff that are responsible for administrative, fiscal, and regulatory oversight of substance abuse services.

Substance Abuse Service Array

Through the community-based provider system, the Substance Abuse Program provides a range of prevention, detoxification, treatment, and aftercare services for 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.

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.

- Detoxification services use 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.

Housing

One of the primary goals of the Substance Abuse Program is to promote individualized access to and successful discharge from appropriate services and providing access to clean and safe housing will increase the likelihood that this goal will be met. Accordingly, administrative rule s.65D-30.0081(1), Florida Administrative Code (F.A.C.), was revised in 2005 to address this need. In order to support this need, a licensure designation called “Day or Night Treatment with Community Housing” was developed. Individuals who meet the criteria for this level of care have the opportunity to reside in a setting that promotes sobriety. The community housing is used to assist individuals in making a transition to independent living.

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 individuals while they receive outpatient treatment or recovery support services. 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 to increase individualized access to and successful discharge from services. Transitional housing reduces reliance on more costly residential services and better serves the citizens of Florida.

Substance Abuse Licensure System

The Substance Abuse Program administers a comprehensive substance abuse licensure system pursuant to Chapter 397, F.S., and Chapter 65D-30, F.A.C. Private and publicly-funded agencies providing substance abuse services must be licensed in the state of Florida. The Substance Abuse and Mental Health Program Office in each circuit/region is responsible for licensure of substance abuse agencies. Specifically, Licensure Specialists or Authorized Agents of the Department based in each circuit/region monitor substance abuse providers to ensure compliance with applicable statutory and regulatory standards

The Department’s substance abuse licensure system facilitates the development of an improved service delivery system for Florida’s citizens by providing consistent standards for licensure. 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.

During 2007, continued efforts were made to strengthen the substance abuse licensure system. For example, DCF submitted a legislative budget request for funding to develop an automated substance abuse licensure information system. The Legislature approved funding for this system, which is scheduled to be operational by June 30, 2008.

Additionally, the 2007 Legislature approved funding for the development of a web-based training system for Licensure Specialists. This system will provide foundational knowledge for individuals who conduct licensure visits, which will result in increased effectiveness, competency, and ultimately, improved provider satisfaction. The Department's Training and Education Unit plans to develop the web-based training system by June 30, 2008**.**

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

Administrative rules under Chapter 65D-30, F.A.C., entitled "Substance Abuse Services", were improved and amended by the Department's substance abuse program staff and adopted as of December 12, 2005. Currently, the Substance Abuse Program is making additional revisions to the administrative rules in order to address the following:

- Identifying potential areas to be revised or deleted to streamline the monitoring process and to reduce redundant requirements;
- Inserting language or requirements to promote recovery and resiliency, use of evidence-based practices and continuous quality improvement; and
- Ensuring that the rule accommodates individuals with co-occurring substance abuse and mental health diagnoses.

The administrative rule revision process is a collaborative effort undertaken by the Rule Revision Workgroup which consists of members of the provider network, other state agency representatives, circuit/regional licensure staff, a representative from the community receiving substance abuse and/or mental health services, and other stakeholders of the Department. It is anticipated that the administrative rule revision process will be finalized in 2008.

It is noteworthy to mention that the workgroup has recommended changes to Chapter 397, Florida Statutes. The recommended changes have been routed within the Department and will be presented to the Florida Legislature for their consideration. Should the recommended statutory changes be approved, the administrative rule will be revised accordingly.

Trends in Service Funding

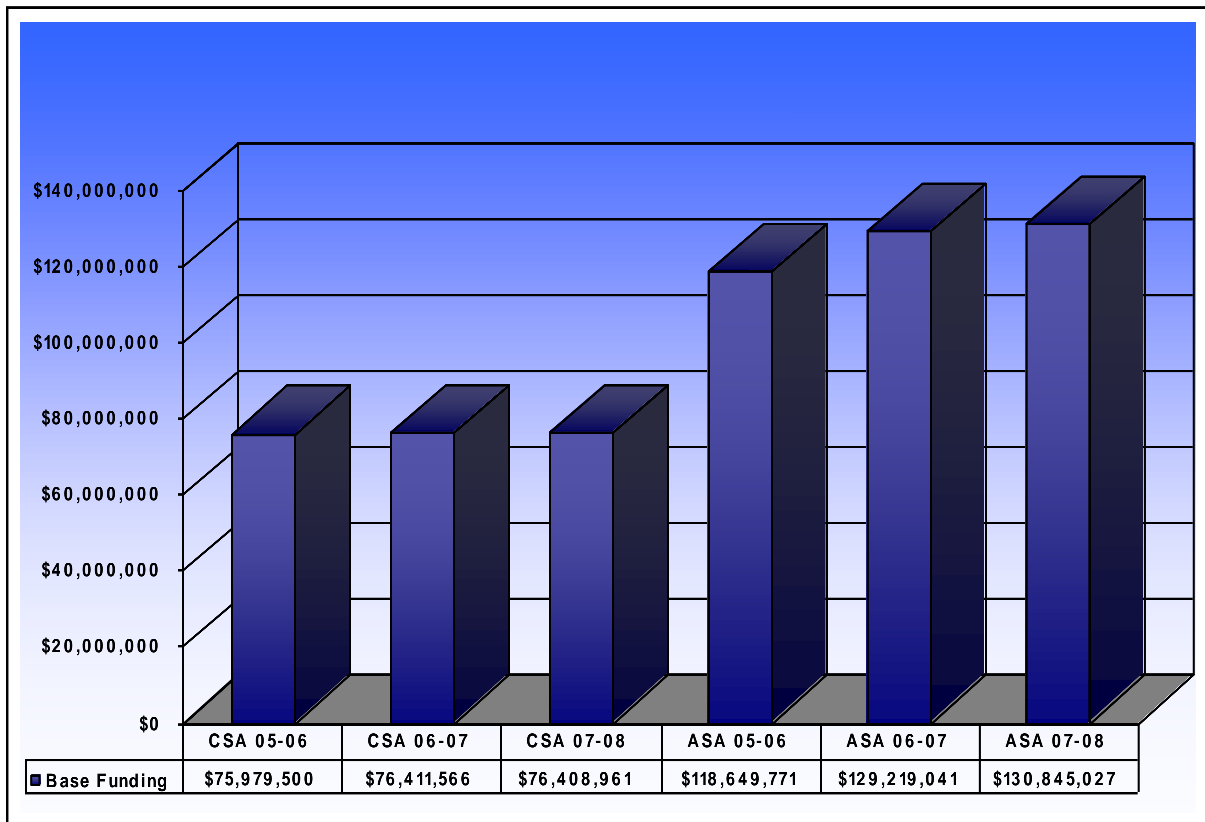
Since FY 1998-1999, the Substance Abuse Program has received a 67 percent increase in funding for children's and a 65 percent increase in funding for adult

services. A significant portion of the increased funding has come through Substance Abuse Prevention and Treatment Block Grant (SAPT).

The primary funding issue that has arisen since the publishing of the Substance Abuse and Mental Health Services Plan: 2007-2010 has been the notification by the Legislature that the state is experiencing projected reductions in state revenues. The Department will make every effort to make any required reductions in non-individual service categories. As an example, reductions to date have been taken primarily in Program Management and Compliance and other administrative categories. The Department is anticipating additional reductions as a result of legislative action during this coming legislative session.

Although funding for Children's Substance Abuse services was decreased for FY 2007-2008, overall funding has increased by half a percent since FY 2005-2006. In contrast, funding for Adult Substance Abuse services increased by 8.9 percent for FY 2006-2007 from FY 2005-2006 and increased by 1.25 percent for FY 2007-2008 from FY 2006-2007. *Figure 3* below depicts the funding for Children's and Adult Substance Abuse services for FYs 2005-2006, 2006-2007 and 2007-2008.

Figure 3: FY 05-06, FY 06-07, FY 07-08 Funding for Children's Substance Abuse (CSA) and Adult Substance Abuse (ASA) Services



	CSA 05-06	CSA 06-07	CSA 07-08	ASA 05-06	ASA 06-07	ASA 07-08
Base Funding	$75,979,500	$76,411,566	$76,408,961	$118,649,771	$129,219,041	$130,845,027

SUBSTANCE ABUSE TARGET POPULATIONS

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.

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.

Adults At-Risk

- At-Risk: Individuals who are at-risk of developing problems with substance misuse or abuse due to personal, social, economic, or environmental risk factors.

Adults With Substance Abuse

- 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 At-Risk

- Children At-Risk: Children who are at risk of initiating drug use or developing substance problems due to individual and environmental risk factors.

Children With Substance Abuse

- 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 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 2006-2007, the Department provided substance abuse service funding to 169 community-based agencies. These agencies served 168,753 individuals, of whom 53,024 were children and 115,729 were adults. Of those served 4,509 children and 1,139 adults participated in Level 2 Prevention Programs. An additional 141,731 children and 14,265 adults received Level 1 prevention services – these services are not structured on an individualized basis.

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 are 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) 2006*, the *2006 National Survey on Drug Use and Health (NSDUH)*, and the census population figures for 2006. 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.

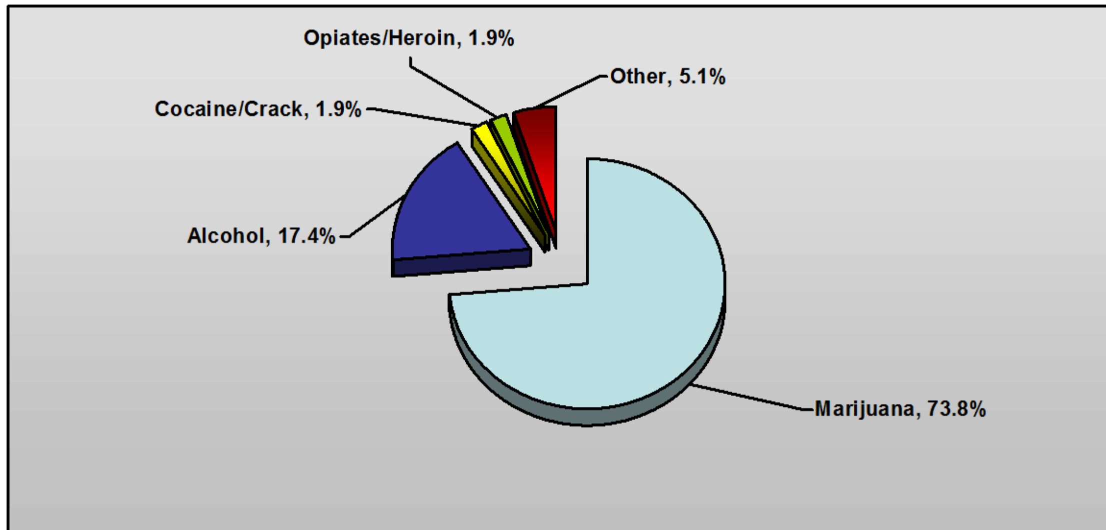
There are an estimated 1,153,224 adults and 332,355 children in need of substance abuse services statewide. Currently, the Department is meeting 10 percent of the substance abuse services' need for adults and 16 percent of the substance abuse services' need for children.

Primary Substance Abuse Problem at Admission

In FY 2006-2007, there were 18,841 children/adolescent admissions for substance abuse services with an identified primary substance use problem. One-third of these individuals were female and two-thirds were male. Most youth

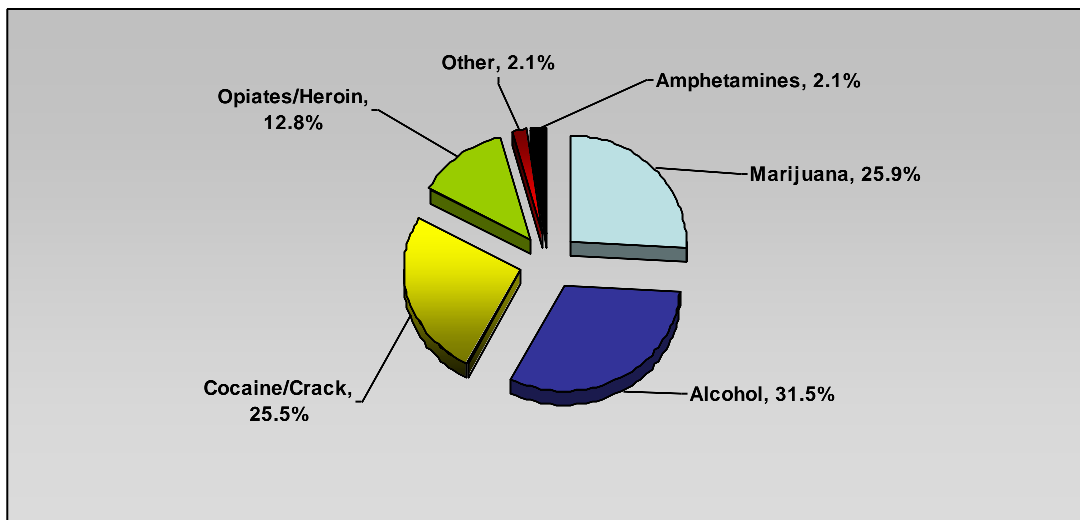
received services on an outpatient basis such as assessment, counseling, case management, and intervention. The primary drugs of abuse in order of prevalence were marijuana, alcohol, and cocaine/crack. More than three of every four youth presented with a primary problem of marijuana use.

Figure 4: FY 06-07 Primary Substance Use Problem at Admission- Children



During the same period, there were 79,387 adult admissions for substance abuse services with an identified primary substance use problem. 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.

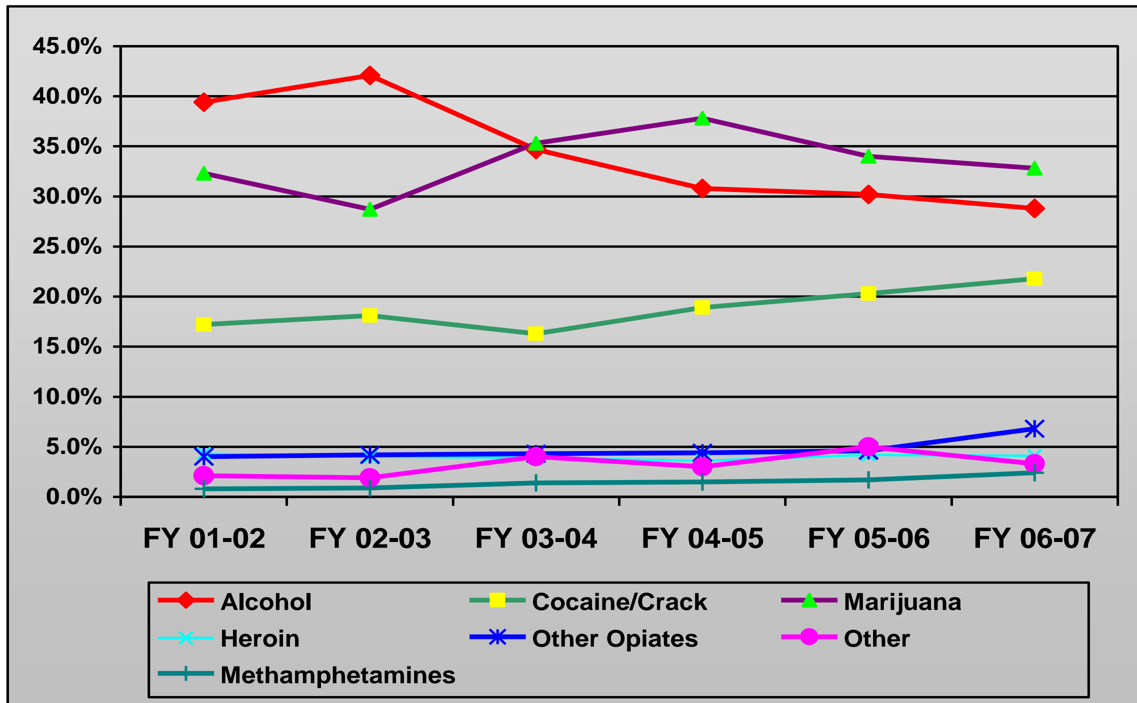
Figure 5: FY 06-07 Primary Substance Use Problem at Admission – Adults



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

The six-year trend in substance use problems at admission for children and adults, portrayed in the figure below, show a decline in alcohol as the primary drug of abuse in FY 2006-2007. Alcohol moved from number one as the primary drug of abuse to number two, while marijuana/hashish moved to number one. Crack/cocaine continues to rise and is the third drug of abuse in the order of prevalence at admission.

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



Methamphetamines

Methamphetamines are posing a global threat. 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-10, I-75, and I-95, as well as some rural areas. In response to this increasing trend, 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.

BEST PRACTICE AWARDS PROGRAM

The Best Practice Awards Program recognizes substance abuse programs using evidence-based practices that measurably improve their service outcomes. Recipients of the 2007 Best Practice Awards Program were recognized at Florida Alcohol and Drug Abuse Association Annual Conference in August, during the General Session. Award recipients include:

- Best Exemplary Program – Family Achievement in Recovery, Operation PAR, Inc.

- Best Treatment Program – Family Ties Program, Gateway Community Services
- Best Prevention Program – Prevention Services, Tri-County Human Services, Inc.
- Best Intervention Program – New D.A.Y., Memorial Healthcare System Community Youth Services
- Best Small Program – Home Detox, Inc., Home Detox, Inc.
- Best Rural Program – Project K.I.C.K., (Kids in Cooperation with Kids), Florida State University
- Best Innovative Program – FACE IT, School District of Palm Beach County

A synopsis of each of The Best Practices Awards Program recipient's program is in the 2007 Best Practices Recognition Program Manual and a list of recipients is available on Florida Alcohol and Drug Abuse Association's website, www.fadaa.org, 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[1] require that states receiving SAPT block grants funding conduct a "Peer Review" of 5 percent of Block Grant supported treatment programs. During FY 2006-2007, seven substance abuse treatment programs were reviewed.

A significant finding of these reviews indicated that although therapists reported using therapeutic approaches only one therapist was actually using the treatment per protocol. Another finding indicated that clinical documentation, treatment planning and treatment implementation were in need of improvement. Findings such as these will be addressed through interventions identified as a part of the Florida Learning System. Eight peer reviews are planned for FY 2007-2008.

THE SOUTHERN COAST ADDICTION TECHNOLOGY TRANSFER CENTER (SCATTC)

The Department contracts with the Southern Coast Addiction Technology Transfer Center (SCATTC) on many training initiatives related to substance abuse treatment and prevention. In FY 2006-2007, the SCATTC:

- Provided training to providers participating in the Florida Access to Recovery Program. Providing an overview of a specific treatment planning utilizing the Addiction Severity Index as the basis for comprehensive treatment plan development;
- Developed a training manual and conducted five trainings statewide; and
- Developed a training package, *The ABC's of Documentation: How to Chart and Still have Time to Help* People and provided three hours of clinical documentation training to approximately 66 participants.

[1] [1][45 CFR part 96, §96.136]

PREVENTION EVIDENCE-BASED PROGRAM

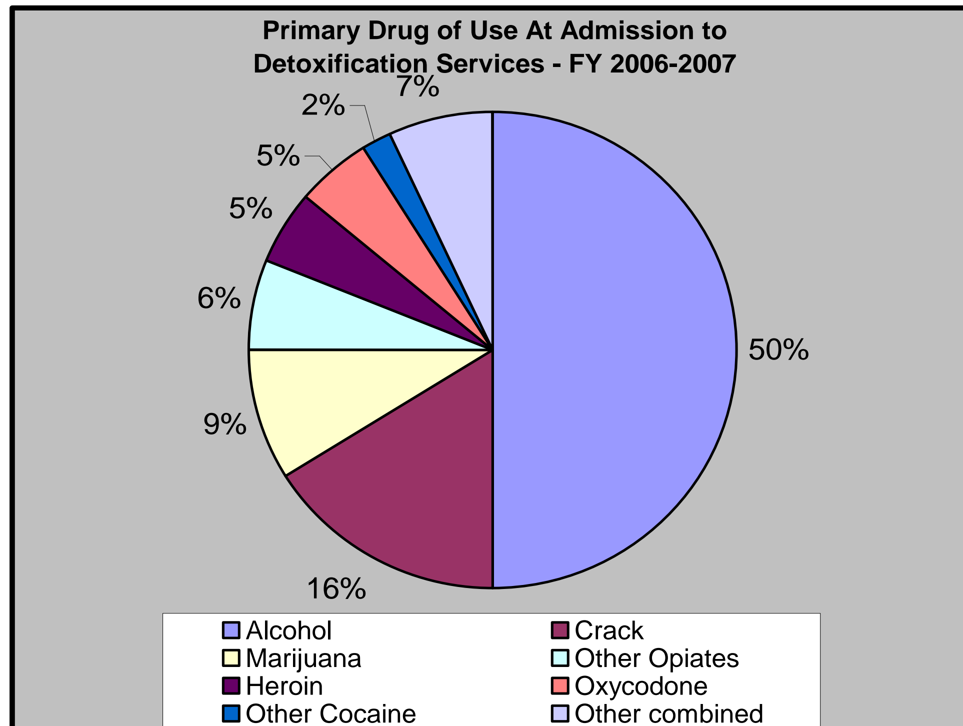
In October 2007, the Department certified that the Center for Drug-Free Living successfully met the requirements for validating the effectiveness of the New Horizon's Program. This program targeted services towards middle and high school youth that were particularly high risk of alcohol or other drug use or are experimenting with alcohol or other drugs. The program was found to be effective in increasing children's school attendance, improving academic performance, as well as reducing alcohol, marijuana, and other drug use and related risk factors.

SUBSTANCE ABUSE DETOXIFICATION AND TREATMENT SERVICES

Detoxification

Detoxification programs serve individuals on a residential or an outpatient basis and use medical and clinical procedures to assist children and adults in their efforts to withdraw from the physiological and psychological effects of substance abuse. Detoxification services are a critical part of the substance abuse services continuum and are appropriate for individuals that need medical assistance and oversight while withdrawing from substance use. However, it is not a necessary precursor to participation in treatment for most individuals.

During FY 2006-2007, contract agencies provided detoxification services to 21,819 adults (1,557 fewer than in FY 05-06) and 2,364 children. Alcohol was reported as the primary drug of choice for 50% of the individuals admitted followed by Crack (16%), Marijuana (9%) and Heroin (5%).



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 illnesses, families involved in the child protection system and persons at-risk of or having the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (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 individual outcomes. Combined, the grants will serve an additional 28,000 adults, adolescents, and their families.

Adolescents

The Adolescent Treatment Infrastructure grant (3 years/$1.2 million) created several collaborative partnerships at the state and local levels to reduce barriers to treatment for adolescents and their families. The grant supported a series of training events on cognitive behavioral therapy and motivation enhancement to promote certification for addiction professionals working with substance abusing adolescents. The grant also supported the development of a series of monographs on evidence-based treatment practices for adolescent assessment, family engagement, and service funding resources.

Drug Courts

Drug courts are a 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. Florida has the second largest drug court system in the United States and the system is continuing to grow.

In May 1999, only 34 operational drug courts existed in Florida. By 2006, the courts have expanded to 110 operational drug courts, and an additional six programs are in the planning stages of development. Despite its size, the system only has the capacity to serve a small portion of offenders who could benefit from the program.

Budget reductions occurring during the 2006-2007 FY have negatively affected the drug court program. For example, funding cuts for Department of Corrections' residential beds has resulted in reduced access to beds for adults. In some areas, county funding was also reduced.

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,

circuit/regional offices and providers is exploring ways to direct funding that will sustain these valuable programs.

Special Populations and Initiatives
The Access to Recovery (ATR) Program, a Presidential initiative, began implementation in 2005. The federal Substance Abuse and Mental Health Services Administration funds ATR through a three-year, 20.4 million dollar grant from. This individual 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 Circuits 5, 6, 9, 13, 15, 19, and 20. Through the end of November 2007, the program had committed over $17 million dollars to vouchers and expended 99 percent of these funds, serving more than 12,400 individuals. Effective December 31, 2007, direct services provided by this grant will end.

In order to help sustain the gains experienced through the ATR Program, the Department has begun purchasing recovery support services through its traditional system of care. Recovery support services allow for a combination of services related to substance abuse education, life skills, medical or health education, employment and educational skills, support counseling and anger/stress management coping skills, and family/marital/parenting relationship skills to be obtained by the individual. Additionally, these services allow for "individual choice" in the development of natural supports from of non-traditional treatment service providers. The Florida Certification Board is developing a certification designation for Recovery Support Specialists, modeling the requirements for experience, training, and credentialing after the recovery support service provision begun through Access to Recovery. The new certification will be available in January 2008.

The Florida Brief Intervention and Treatment for Elders (BRITE) Program was expanded to include the Center for Drug-Free Living in Circuit 9 (Orlando) for FY 2005-2006. For FY 2006-2007, Circuit 13 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 18 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 (emergency rooms, family/gerontology physicians, and public health clinics). The primary goals for the grant include:

- Enhancing outreach services and improve access to care;
- Identifying and alleviating systemic barriers to intervention and treatment;
- Improve linkages with primary care system;
- Increasing the level of cultural competence among professionals and providers; and
- Enhancing treatment capacity for older adults.

In October 2006, the Department received a three-year Strengthening Treatment Access and Retention-State Implementation (STAR-SI) grant from the Substance Abuse and Mental Health Services Administration to improve individual 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 included participation from five provider agencies that implemented the Network for the Improvement of Addiction Treatment (NIATx), rapid cycle process improvement, model to continuously identify and reduce barriers that impede timely entry of individuals into treatment, and increase the number of individuals who complete detoxification services that transition to outpatient services.

During the first year of grant implementation, the provider agencies experienced a number of successes. These successes included increasing the number of individuals who received outpatient services, reducing individuals waiting time to begin treatment, and increasing the number of persons completing detoxification who began outpatient treatment.

The key state goals include:

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

Implementation of this project will help 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.

In October 2006, the Department received an Advancing Recovery grant from the Robert Wood Johnson Foundation to identify and address clinical and business practices that impede the use of evidence-based practices within the alcohol and other drug treatment system. The Department serves as the lead statewide agency for the Foundation’s, Advancing Recovery Project. During the first year of implementation, medication-assisted treatment was introduced as an evidence-based practice at three provider agencies. Since implementation of this project, more than 300 staff persons have received education regarding the use of Vivitrol as a treatment for alcoholism. Vivitrol has been shown, through research, to be effective for individuals who are chronic abusers of alcohol and have been otherwise unsuccessful through traditional treatment programs (without medication). Through December 2007, more than 40 individuals have begun treatment with Vivitrol. 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

Approximately half of the adults and children receiving publicly-supported substance abuse services in Florida have some level of involvement with the criminal or juvenile justice systems. 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 in a variety of settings: community-based provider agencies, in local jails or detention facilities, or commitment facilities. These services are offered through a Treatment Alternatives for Safer Communities (TASC) program which has been shown to be an effective alternative to incarceration. This program allows substance-involved offenders to receive needed treatment and support while being supervised in the community. The TASC programs monitor individuals' progress and compliance with court stipulations for substance abuse services and communicate individual results to designated criminal justice agencies.

As a part of the STAR-SI grant, during FY 2006-2007, a workgroup consisting of members from provider agencies, the Department of Juvenile Justice (DJJ), and the Department met to identify areas of the program which needed improvement. This group identified the need to update the TASC manual (its requirements are out of date), decrease the amount of time that it takes for assessment recommendations to be provided to DJJ, and to improve the standardization of the assessment component of the process. This workgroup will continue in the upcoming year and work to implement the needed improvements.

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. At the program's peak, there were 165 faith-based organizations participating in the 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 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 2006-2007, with a funding contribution of about $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. Additionally, the SAMH Programs assist with the Department's development and implementation of the federal Strengthening Families initiative through its Temporary Assistance to Needy Families (TANF) program.

Persons with Human Immunodeficiency Virus (HIV) and Intravenous Drug Use (IDU)
The Florida Department of Health reports that Florida ranks third in the nation for AIDS cases and second for pediatric AIDS cases. 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 offer voluntary HIV/AIDS education and testing for all individuals in treatment and to provide outreach services to intravenous drug users and minority populations. The Substance Abuse Prevention and Treatment Block Grant requires the state to provide HIV Early Intervention Services to individuals who receive substance abuse services and IDU Outreach. Services are provided in each of the circuits/regions.

The major focus areas of the Substance Abuse Treatment System include: HIV Early Intervention Projects offering services for individuals in treatment; IDU/HIV Outreach Programs; the HIV Rapid Testing Initiative; and collaborative efforts with the Florida Department of Health for planning, evaluation, and training.

HIV Early Intervention Projects
In FY 2006-2007, there were 39 service providers under contract with the Department to provide HIV Early Intervention Services. The goal of the Substance Abuse Program is to have HIV Early Intervention Services provided in all major substance abuse treatment agencies under contract with the Department.

During FY 2006-2007, 17,572 individuals in substance abuse treatment received some HIV services and 13,494 received HIV Early Intervention Services, with 5,243 of these reported as receiving HIV tests. All individuals in treatment are required to receive HIV education, even if an HIV Early Intervention Project is not funded at the site.

IDU/HIV Outreach Projects
Additionally, substance abuse treatment providers provide a network of IDU/HIV outreach services to case find and facilitate entry into treatment by HIV high-risk substance abusing individuals. In 2006, 40 IDU/HIV Substance Abuse outreach programs received funding from a mix of state substance abuse, state health, federal, and other partners. Formal outreach programs provide services to both the community at large and to individuals.

In addition to outreach funded through state contracts, Florida substance abuse providers aggressively and successfully pursued resources from the SAMHSA HIV/AIDS minority grants. This funding initiative resulted in much needed support for substance abuse/ IDU/ HIV outreach in Florida. In 2006, there were 22 SAMHSA Grants to Florida providers totaling approximately $7.4 million.

HIV Rapid Testing
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 using the latest HIV testing technology. For FY 2006-2007, the Department selected 17 providers to participate in the project. These providers participate in mandatory HIV testing reporting to the Florida Department of Health.

Homelessness

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 has a substance abuse disorder and another three percent are dually diagnosed with mental health and substance abuse problems. During FY 2006-2007, the Substance Abuse Program served 8,716 individuals who were homeless at the time of admission to services, representing 5.9 percent of all admissions.

The Access to Recovery grant enabled the Department to purchasing short-term transitional housing for adult individuals 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 other potential funding sources in order to continue transitional housing as a service option when the grant expires in January 2008.

Prevention

The Department provides a wide array of substance abuse prevention services to the citizens of Florida. Prevention services are in 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 FY 2006-2007 a total of 141,731 children and 14,265 adults were provided Level 1 prevention services, and 4,509 children and 1,139 adults received Level 2 prevention services. These services are congruent with the federal Center for Substance Abuse Prevention's six prevention strategies.

Some strategies occur via direct service programs or prevention practices 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.

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 to help 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 alcohol and/or drug experimentation. These individuals require the most direct and intense form of prevention strategies.

Children
The emphasis of prevention activities targets 12 to 17 year old youth and their families. Strategies to improve program operations and outcomes for children include an increase in the use of rigorously evaluated program models; support for community anti-drug coalitions; coordination with other state agencies; and

establishment of reliable data sources for assessing children's needs and provider performance.

According to the Florida Youth Substance Abuse Survey, the alcohol, tobacco and other drug use among youth has generally declined since 2000. This statewide survey is 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 as boys.

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 shows 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 FY 2000-2006, and reflects a slight increase from FY 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 FYs 2000-2006 & 2005-2006					
		% Change			
	%	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 of alcohol, tobacco and other drug use among middle and high school students in Florida. Table 2 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 FYs 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 for adults. The primary emphasis during the next three years will be on 18 to 24 year old youth 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

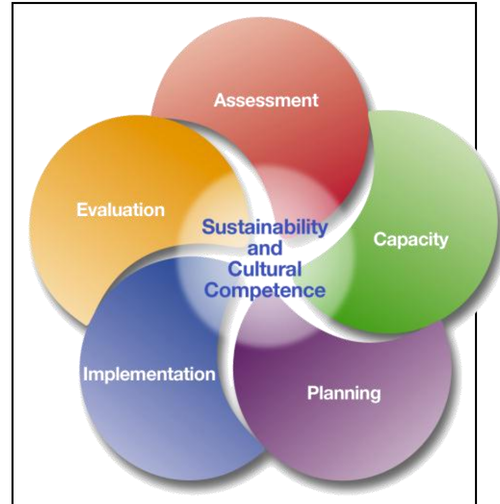
through the "Coalition Mini-Grant Program". The "Coalition Mini-Grant Program" awards grants to prevention coalitions to strengthen the organizational structure of local anti-drug coalitions and provides for training on environmental strategies. These environmental strategies give Florida's local community 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 circuits/regions and community-based organizations. Funding is disbursed through two-year contracts, which are competitively bid, and the coalitions are held to a high standard of evaluation 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 substance abuse treatment 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[2], 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,* is 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 intends to conduct an adult epidemiological survey during the next three years.

[2] 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.



The Performance-Based Prevention System (PBPS) is a web-based data system to track the performance of the Department and its contracted prevention service providers. Data coming in or going out of the system are electronically encrypted to prevent outside sources viewing the information (similar to coding used by banking systems). All contracted prevention service providers use this web-based, secure, real-time reporting system. The system contains information needed to evaluate contracted performance measures, preliminary invoice verification, as well as 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 that allows a prevention provider to track key system elements.

Strategic Planning

In March 2007, as part of the Federal Strategic Prevention Framework Grant, the Department, in partnership with the Governor's Office of Drug Control, released a statewide "Call to Action" for communities to identify and respond to their priority alcohol or other drug issues. Community anti-drug coalitions from 48 communities responded; 44 identified underage alcohol use and four chose to work on issues related to adult heavy alcohol use.

Coalitions consist of representatives of various community sectors. The "Community Wheel" *(pictured on next page)* of the Community Anti-Drug Coalitions of America guides the Department in assessing the representation on a coalition.

Community Wheel

The coalitions agreed to implement the Outcome-Based Prevention (OBP) Process, which operationalizes the assessment and planning elements of the Strategic Prevention Framework. All coalitions received training in the OBP Process and Florida State University's Center for Prevention Research (FSU-CPR) developed a cadre of "coalition coaches" to assist coalitions as they proceed through the OBP Process.

In order to address local substance abuse issues, these coalitions started with county-level information produced by the State Epidemiology Workgroup and gathered additional local information. This information is used to assess alcohol consumption behaviors in their communities, the health, social, economic, legal consequences of those consequences, and to identify local conditions supporting that community risk profile.

In the course of FY 2007-08, each coalition will develop an action plan which will be carried out by local organizations and institutions. Community coalitions will track progress on the implementation of their plans. Additionally, the FSU-CPR is developing a web-based resource assessment and strategy selection guide. A prototype of that planning tool will focus on alcohol-related issues and be on-line in 2008.

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 circuit/regional offices prioritize model prevention programs in their contracts. Additionally, through the SPF Grant, the Substance Abuse 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. The Substance Abuse 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.

Outlined below is a listing of agencies with which the Department and the Substance Abuse Program Office have formal written agreements, as well as those agencies where there is substantive collaborative relationships.

- A workgroup has been meeting for several months to discuss possible changes to Chapter 397, F.S., as well as, Chapter 65D-30, F.A.C. This workgroup consists of staff from the Substance Abuse Program Office, various substance abuse service providers (public and private), Florida Alcohol and Drug Abuse Association, the Departments of Juvenile Justice and Corrections, Florida Council for Community Mental Health, and the Florida Psychiatric Society. The purpose of the workgroup is to update language to promote recovery and resiliency, increase use of evidence-based practices and continuous quality improvement practices. Furthermore, the group is working toward identifying potential areas to be revised or deleted to streamline the monitoring process and to ensure that the statute/rule accommodates serving individuals with co-occurring substance abuse and mental health diagnoses.
- Personnel from the Substance Abuse and Mental Health Program Offices regularly participate on a Co-occurring Workgroup convened by the Florida Alcohol and Drug Abuse Association and the Florida Council for Community Mental Health. The purpose of the workgroup is to increase capability to serve individuals with co-occurring substance abuse and mental health needs within provider agencies.
- The Adolescent Treatment Grant was awarded to the Office of Drug Control in 2005. The three-year federal infrastructure grant was awarded for the primary purpose of increasing evidence-based substance abuse treatment services for adolescents and their families. The grant is also used to expand access to treatment through increased use of Medicaid and other third-party billing resources. Successes in service improvements and increased use of available funding sources are being achieved through interagency collaborations, partnerships with providers and provider associations, and partnerships with individual advocacy organizations. These partnerships include: The Office of Drug Control, The Department of Children and Families, The Department of Health, The Department of Juvenile Justice, Agency for Health Care Administration (AHCA), The Department of Education, The University of Miami, The

Florida Certification Board, The Florida Alcohol and Drug Abuse Association (FADAA), Florida Council for Community Mental Health, Florida Children Health Insurance Program (S-CHIP) and the Florida Network of Youth Family Services, Florida Coalition for Children, and the Substance Abuse and Mental Health Corporation. Additional partnerships for the Adolescent Treatment Grant include judges, treatment professionals, researchers, parents, medical professionals, individuals, and private citizens.

- The Substance Abuse Program is working with the Departments of Corrections and Juvenile Justice and the Agency for Health Care Administration to develop a Unified Monitoring Tool. The purpose of this project is to reduce monitoring visits of provider agencies jointed funded by the various departments and prevent duplication of functions.
- The Substance Abuse Program is actively involved with the Department of Health's Bureau of Infectious Diseases, HIV/AIDS Office to address issues associated with HIV. Future goals are to extend HIV services to individuals in areas where the greatest identified needs exist.

CHAPTER 3: MENTAL HEALTH PROGRAM

INTRODUCTION

This chapter contains updates to the Mental Health program plan, projecting those activities and initiatives that will, in part, address the needs of the persons we serve. The plan reflects the Department's continued commitment and ongoing efforts to develop an individual-driven and integrated system of care that promotes recovery (restoration of function) and resiliency (ability to cope with life stressors). The transformed, individual-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 an individual-driven system of care, with the goal of enabling individuals 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:

- Adequate and equitable funding across the 20 service circuits/ 6 regions;
- Timely access to a continuum of care ranging from routine outpatient to acute residential care;
- Integrated record-keeping and data-sharing systems to facilitate continuity of care when individuals move between care levels or providers, and to accurately track provider performance and individual outcomes;
- Increased use of technology to enhance individual access to information and services, to enhance cost-efficiencies, and to expand service delivery in remote and rural areas;
- Reduced individual involvement in the juvenile and criminal justice systems;
- Increased use of evidence-based and promising treatments;
- Increased individual access to stable housing, employment, and transportation;
- Comprehensive workforce development to ensure availability of sufficient numbers of skilled, culturally competent service providers;
- Promotion of the use of recovery services and supports through Medicaid Purchased Services and amendment to the Medicaid State Plan to include Recovery Services; and
- Inclusion of families and youth as full partners in the development and implementation of individual recovery plans and ensuring they have a prominent voice in designing supports and services.

THE MENTAL HEALTH PROGRAM STATUTORY FRAMEWORK

The Department has statutory responsibility for:

- 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 chapter 394, Part V, F.S.; and
- 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 (chapter 985, Part IV, F.S.).

Section 20.19(4), F.S., creates a Mental Health Program Office within the Department of Children and Family Services. While s. 394.453, F.S., provides guidance for the Mental Health Program: "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."

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 20 circuits/six regions and one region around the state, and nine 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 nine state mental health treatment facilities are operated by the state, and the other six are outsourced using contracts managed from the central office and local circuit staff.

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:

1. 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);

2. 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; and
3. Civil and Forensic State Mental Health Treatment Facilities – which comprise the most intensive and costly level of care available to adults. Three of the facilities serve persons civilly committed to the Department as needing inpatient care beyond that available in the community, one serves persons committed as sexually violent predators, four serve persons forensically committed (as not guilty by reason of insanity or incompetent to proceed), and one serves both civil and forensic individuals.

THE DEPARTMENT'S STRATEGIC PLAN

The Department's FY 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. Authorized is provided by ch. 394, F.S., to the Mental Health Program Office to serve both adults and children who reside in the community and who are in need of mental health services.

The adult target populations include:

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

The children's target populations include:

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

In addition to the above target populations, the Mental Health Program Office also serves three target populations who reside 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
  - Suicide rate per 1000 individuals served. The strategy to achieve this objective is to establish a uniform, system-wide procedure for reporting, analyzing, and following-up on significant events, including suicide.
- 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; and
  - 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
  - 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 percent of school days children with serious emotional disturbance attend 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 children continued access to substance abuse and mental health services; and implement substance abuse and mental health prevention partnerships.

Local Participation in Planning, Organizing, and Financing
The Department is directed to "Involve local citizens in the planning of substance abuse and mental health services in their communities" by s. 394.66(3), F.S. Additional requirements are specified by s. 394.75(1)(e) F.S., which state that 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; individuals 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 local planning.

Individual Involvement
During FY 2006-2007, the Mental Health Program Office staff actively sought direct input from individuals receiving services and supports through the public mental health system. 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 included:

- housing;
- transportation; and
- 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 individuals. Each circuit/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 individuals, 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.

Adult Community Mental Health Services
Florida's Adult Community Mental Health Program serves individuals 18 years of age and older who meet one of the legislatively-mandated priority service populations.

Priority Service Populations
(The language below reflects Florida Statute.)

Adults with serious and persistent mental illnesses (SPMI):
The Public Health Service Act {Section 1912(c)}, provides a definition for adults with serious mental illness. These persons must be age 18 or older; and currently have, or at any time during the past year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV[3] or their ICD-9-CM[4] equivalent (and subsequent revisions). The DSM-IV "V" codes are exempt, substance use disorders, and developmental disorders, are excluded, unless they co-occur with another diagnosable serious mental illness. Additionally, as a result of the mental illness, the individual:

- Experiences functional impairment which substantially interferes with or limits one or more major life activities (e.g., personal hygiene, dressing, nutrition, housekeeping, etc.);
- Receives disability income for a psychiatric condition (e.g., Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), veteran's benefits); or
- Is at risk of institutionalization or incarceration for mental health reasons.

Adults experiencing an acute mental or emotional crisis:
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 SPMI and forensic involvement:
This group includes persons 18 years and older who have a serious and mental illness as defined above, and are involved in or at serious risk for involvement in the criminal justice system. Priority is given to individuals subject to criminal proceedings under Chapter 916, F.S.

In FY 2006-2007, 168,683 adults received mental health services in community programs around the state. These individuals included: 136,665 persons with

[3] *DSM-IV is the Diagnostic and Statistical Manual, Fourth Edition.*
[4] *CD-9-CM is the International Statistical Classification of Diseases, Ninth Edition, Clinical Modification.*

SPMI (81%), 28,820 persons experiencing an acute mental or emotional crisis (17%); and 3,198 individuals with Chapter 916 forensic involvement (2%).

Program Priorities
Mental Health Transformation – Changing the current system of care to promote recovery and resiliency is a major area of focus for the Adult Community Mental Health Program. 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. Our priorities have not changed dramatically in the last year, as we continue to address the needs of the mental health system in the State of Florida.

- Adequate and equitable funding - During FY 2006-2007, we estimate that approximately 337,000 adults with narrowly defined serious mental illnesses needed to access Florida's public mental health system. In contrast, only 168,683 adults (50%) received services in the public mental health system during that state FY, indicating significant unmet need. Moreover, current funding for adult community mental health services remains inequitable across districts, as 8 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 for the duration of this plan.

- Use of evidence-based practices - Evidence-based practices has 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 during the period covered by 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 Psycho-education;
5. Assertive Community Treatment; and
6. Integrated co-occurring treatment (substance abuse & mental illness).

The use of evidence-based practices will increase over the next three years through:

- Involvement in the juvenile and adult criminal justice systems - The GAINS[5] 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, 5% of adults served by the mental health system are in county jails.

  In Florida, up to 23% of county jail inmates and 16% of state prison inmates have serious mental illnesses.[6] These individuals frequently come to the attention of the criminal justice system due to circumstances related to their mental illness. Because of untreated or under-treated mental illnesses, many commit minor or non-violent crimes that result in being 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 individuals (persons committed to the Department as incompetent to proceed or not guilty by reason of insanity) are by far the fastest growing mental health individual group in the state. Forensic commitments have increased by 72% since 1999, including an unprecedented 16% increase between FY 2004-2005 and FY 2005-2006. At the same time, prison sentences of a year and a day have increased by 25%. As the criminal justice population has increased, so has the number of individuals committed to the Department. This has led to an increasingly large number of persons waiting in county jails for long periods for the next available bed at a state forensic mental health treatment facility.

  Approximately 60% of these forensic commitments reflect individuals who are new to the mental health treatment system, and many require ongoing treatment after release. This data suggests that the unfunded cost of a significant amount of needed community based treatment and support for persons with serious mental illnesses is being shifted, albeit inadvertently, to 'the deep end' - county jails, state prisons, and state forensic treatment facilities. The Department has worked and will continue to work collaboratively with interested parties and stakeholders to reduce individual involvement in the criminal and juvenile justice systems.

  Solutions to the mental health forensic crisis experienced in FY 2006-2007 required aggressive action on three fronts. First, through additional and current appropriations, the Department converted or added 410 new secure forensic beds, increasing capacity from 1,339 to 1,749. Secondly, 70 new community forensic beds were created, and third, every district was awarded

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[5]GAINS is an acronym for Gathering information, Assessing what works, Interpreting facts, Networking, and Stimulating change.

[6] Florida Partners in Crisis 2007 data.

new funds with which to create community-based diversion services, e.g., community competency restoration; forensic court liaisons; Crisis Intervention Team (CIT) Training support; development of mental health courts. As a result of these measures, the forensic waiting list was reduced to zero in June 2007, and no one has approached the statutorily required 15-day limit since that time.

Communities must continue to work together in order to develop local community intervention strategies for persons committed to, or who are at-risk of being committed to the Department. Excellent examples of this approach are Broward, Dade, Orange, Escambia, Pinellas and Duval counties. Stakeholders must include, at a minimum, mental health individuals 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, must 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 illnesses in the criminal justice system.

The Department developed the following Comprehensive Six Point Plan to address the needs of persons with mental illnesses who are involved in the criminal justice system.

1. **Prevent persons with mental illnesses 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 services;
    - Increase access to appropriate, safe, and affordable housing for persons with mental illnesses;
    - 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; and
- Expand use of Assertive Community Treatment Teams.

2. Increase the diversion of persons with mental illnesses 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 (CCSTs) that will direct services and supports to persons in/or at risk of entering the criminal justice system;
- Support the development of Crisis Intervention Teams in all county law enforcement agencies, to divert people with mental illnesses into 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, and community mental health providers; and
- Increase availability of long-term supervised housing, residential facilities, assisted living facilities, and adult family-care homes with adequate mental health support services.

3. Expand basic mental health services to individuals in jail

- Work with County governments to improve the provision of screening, assessment, and mental health services, and to assure that individuals have adequate access to appropriate medications;
- Facilitate continuity of services, including medications, for persons receiving community services upon admission to and discharge from jails;
- Expand access to services designed to treat individuals with co-occurring mental health and substance abuse disorders;
- Expand community and in-jail competency restoration and maintenance services;
- Expand community residential treatment and housing options for forensic individuals; and
- Work with the Agency for Healthcare Administration to create a mechanism for suspending, not terminating Medicaid enrollment, for persons who are jailed.

4. Manage the use of state treatment facility beds

- Assure effective and timely competency restoration services;

- 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 prompt notification to courts of an individual's readiness to return to court; and
- Work with circuit/regional forensic coordinators to develop approved discharge plans for persons who can be safely treated and supported in community placements.

5. Work with Courts to Enhance Court Processes 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 mental illness;
- Assure that evaluations to determine and individuals' mental health competency meet all statutory requirements; and
- Convene community leaders and stakeholders to develop strategies to divert individuals with mental illnesses from the criminal justice system.

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

- Negotiate and maintain an interagency agreement with the Department of Corrections on the facilitation of aftercare referrals for prisoners with serious mental illnesses who are reaching the end of their sentences;
- Request funding for a contracted aftercare system, to include case management, assessment, and medication management for eligible individuals upon their release from the state prison system;
- Improve processes for restoring Social Security and Medicaid benefits for eligible persons upon discharge from prison;
- Increase availability of long-term supervised housing, residential facilities, assisted living facilities, and adult family-care homes; and
- Provide access to employment services.

Legislative Recommendations

- Continue to support incentives for community planning or community coalitions to address the issues of persons with mental illnesses and the criminal justice system, as provided in 2007 through Senate Bill

542/House Bill 1477 through the Criminal Justice, Mental Health and Substance Abuse Community Reinvestment Grant Program;
- Support the recommendations of the Workgroups led by Judge Steve Leifman, as presented to the Governor and the Florida Supreme Court in December, 2007; and
- Promote the expansion of Crisis Intervention Teams and mental health courts in each judicial circuit.

➢ Adequate continuum of care - We must recognize that the unmet treatment, social, and economic needs of individuals who have serious and persistent mental illnesses have effects across systems. The increased demand for forensic mental health services is related to the failure of the public mental health and substance abuse systems to advance - in both quality and quantity - in response to the growing needs of Florida's residents. In FY 06-07, we faced the results of ongoing challenges to accurately convey the extent of Floridians' needs for public mental health services. The demand for more and better forensic interventions has been partially addressed, but continued efforts are needed to address broader systemic deficiencies.

Perhaps our greatest need is for safe, affordable and accessible housing resources. Crisis stabilization units (CSU) around the state are typically full, while large numbers of individuals wait in general hospitals for the next available bed. Significant numbers of mental health treatment facility residents remain hospitalized after they are discharge-ready because of the lack of suitable community placements. Similarly, significant numbers of persons are committed to state mental health treatment facilities who could have been diverted to less restrictive settings, and were not due to lack of suitable community living alternatives.

In addition to housing, our individuals and national experts have identified transportation and employment support as unmet needs. For the legislative session in 2008, the Department submitted budget requests related to housing supplements and clubhouse development (employment venue), but have not addressed transportation issues.

A final area of concern is the availability of medical / psychiatric services. Community mental health providers have received no system rate increases for over a decade and the recruitment and retention of qualified medical staff has become a challenge. Individuals are sometimes not receiving the type or amount of clinical oversight required and recommended for 'best practice' prescription and medication monitoring. People most often stop taking prescribed medications because of aversive side effects – not because they do not acknowledge that they're 'sick'. Lack of timely access to a qualified medical professional with whom you can discuss and resolve these potentially serious issues sometimes leads to discontinuance of medications. Lack of medication, in turn, leads to a variety of familiar social problems, including arrest and incarceration.

As previously described, growing numbers of persons with serious mental illnesses are becoming involved in the criminal justice systems. The Mental Health Program Office regularly receives calls and complaints about individuals who cycle in and out of crisis stabilization units and jails due to lack of suitable community treatment alternatives.
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 (Chapter 394, F.S., Part I), 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 harmonized Florida's laws with precedent established by the US Supreme Court, and 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).

Medicaid Reform and Medicaid Managed Care Initiatives in Florida -The continuum of care available to priority individuals of the public mental health system has been impacted by Florida's Medicaid Reform and Managed Care initiatives. Several studies sponsored by major universities found problems with the implementation of Medicaid Reform in the State of Florida. Based on these studies, a decision was made by the Agency for Healthcare Administration (AHCA) to halt the continued spread of Medicaid Reform beyond the current five Areas. At this point the Department will continue to work closely with AHCA to monitor the impact of Medicaid Reform in these five Areas. The Department will also be an active participant in the continued development of the public mental health system funded by Medicaid.

Individual 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 individuals and other stakeholders during statewide meetings seeking input on the mental health system in Florida.

Some 8,000 persons with severe and persistent mental illnesses reside in Assisted Living Facilities with Limited Mental Health licenses. Particularly in rural areas, these individuals have only limited access to our broad array of mental health services and supports (typically case management and psychotropic medications).

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, as well as clinical and other support services.

For housing to be 'affordable' in accordance with standards set by Housing and Urban Development (HUD), the cost of housing 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 mental health and substance abuse needs.

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). The Department has submitted a Legislative Budget Request (LBR) for this issue to the Governor's office.

Individual Access to Transportation - Inadequate transportation is another significant barrier for individuals to recovery from mental illnesses and full participation in one's community. Transportation problems make it difficult for individuals to shop for food and other essential goods, keep mental health appointments, and 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 individuals during statewide forums conducted in the spring and summer of 2006. This was especially salient for individuals residing in remote or rural areas. During the duration of this plan, the Department will work collaboratively with individuals, providers, and other community stakeholders to increase individual access to reliable transportation. If necessary, funding support will be requested through the legislative budgeting process.

Individual Employment and Other Meaningful Community Involvement - Unemployment among people with serious mental illnesses is estimated to be as high as 85%. Current data indicates that the outpatient mental health population reports approximately 40 days per year paid employment, which is equivalent to

only 16% of full time employment, making this population the single largest unemployed disability group in the country. Despite this estimate, approximately 75% of these individuals express a desire for increased 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 delivered in an integrated work setting, and 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 FY 2006-2007, 2,590 adults with severe and persistent mental illnesses received supported employment services. Supported employment is now available in each of the Department's service areas, and is helping the Department to meet its employment performance measure: 40 average annual days worked for pay. In FY 2006-2007, the statewide target was exceeded, averaging 44.24 days of paid employment for individuals with severe and persistent mental illnesses.

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; and
- 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.

Fountain House, the first mental health clubhouse, was established in New York City during 1974. There are now 196 Clubhouses in 32 states, serving approximately 37,500 people. Approximately 150 of these 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. Experience so far indicates that model clubhouses provide a vital element of hope for people working toward recovery from the effects of mental illnesses.

There are seven Clubhouses in Florida, and two have achieved ICCD certification – Vincent House, in Pinellas Park, and Club Success, in Lakeland. There are 11 more communities that have actively planned for several years, but have been unable to get their Clubhouses started without new funds. For all, maintaining operations is a daily struggle, because DCF funding levels are 'short', and financial participation the Department anticipated from Medicaid managed care companies has not materialized. The Department's Mental Health Program staff will work to: 1) assist new Clubhouses with start-up funds; 2) expand the capacity of Clubhouses already in existence; and 3) provide ongoing technical assistance to all Clubhouses pursuing certification through the International Center for Clubhouse Development (ICCD). The Department has submitted a Legislative Budget Request to the Governor's Office on this issue for FY 2008-2009.

Peer Specialist Certification - In addition to increased use of supported employment and mental health Clubhouses, the Mental Health Program Office will also facilitate employment of individuals through continued development of the Peer and Family Peer Specialist certifications. The Mental Health Program has worked with the Florida Certification Board during FY 06-07 to create and establish these certifications, which are now approved. The Mental Health Program staff encourages contracted providers to employ certified peer specialists in appropriate capacities, and have ad hoc evidence that peer support may be especially effective in forensic settings. The Mental Health Program will also employ certified peer specialists to help perform ongoing evaluation of program process and effectiveness.

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 was crafted to ensure that persons with disabilities can reside in the least restrictive settings, and receive appropriate therapeutic services. Thanks to additional legislative budget authority granted in the 2007 session, the Mental Health Program Office has been able to enter into a contract with APS Healthcare, Inc., for PASRR Level II screening services. A 75% federal match is available for all PASRR screenings conducted, and in

combination with funds carved out of the existing adult mental health budget, there is enough to start a system. Systems design has been underway for 3 months – statewide screenings will begin in mid-January. In partnership with DCF's Adult Services program, AHCA, the Department of Health and the Department of Elder Affairs, are crafting a system that meets both federal requirements and the needs of our constituents. The Department has submitted a Legislative Budget Request (LBR) to the Governor's office for the additional $317,000 in budget authority required to meet the projected need, including $80,000 in additional general state revenue funds.

Status of Self-Directed Care

Self-Directed Care (SDC) Program is an innovation in the delivery of mental health care by which the individual receiving care has a central role in choosing the services they need to effectively deal with their mental illness and live as productive and rewarding a life as possible. Self-directed care was initiated in District 4 (Jacksonville) in 2004, and has rapidly expanded in size.

During FY 2005-2006, the SDC Program expanded to District 8 (Sarasota) while the District 4 program implemented a peer specialist initiative. The introduction of peer specialists led to an increase in gainful employment among individuals receiving self-directed care services from 42% the previous year to 88%.

The Department received the Transformation Transfer Initiative grant was in late 2007. This award supports the expansion of the peer specialist training program across the state. Improvements, similar to those experienced by districts with the SDC Program, should result from this expansion.

The further, statewide, expansion of the SDC Program is under consideration. A legislative budget request (LBR), pending legislative action, has been submitted to fund the expansion of this program.

Family Directed *Care* - In our efforts to transform the children's mental health system to a more child focused and family-driven system, the Mental Health Program staff understands that children must be seen in the context of their social environments - family, peers, and physical and cultural surroundings. Children's Mental Health staff recognize that family involvement is critical to achieving positive outcomes for the children we serve. To provide an opportunity for this interaction, Children's Mental Health staff conducted Family Forums across the state. These Forums provided the Department 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 have become a priority list to address. Steps are being taken to increase the voice of children and their families through the following activities:

- Florida developed, with family input, a curriculum for certification of Family-to-Family Peer Specialists. This certification program is for families of children with emotional disturbances and was coordinated with the Florida Certification Board in developing the standards;

- A contact list, which includes a statewide listing of all of Florida's family organizations targeting families of children with emotional disturbances, was developed. Since January 2007, the Substance Abuse and Mental Health Corporation has sponsored monthly calls to support the continued development of family organizations and support networks for families;
- Children's Mental Health provided support for families to meet in December 2006. The purpose of this meeting was to develop local strategic plans to promote the 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 services and supports;
- A statewide Family Network Leadership Team was developed to establish family-run organizations throughout the state, to effectively provide leadership, technical assistance, and capacity building. There is a youth component to this team which will develop a data-base of services, resource tools, and advocacy services. The goal is to help youth formulate strategies and techniques to address the issues in their communities and help find resources to reduce problems and move toward recovery;
- In May 2007, a Child Welfare and Substance Abuse/Mental Health Collaboration Forum was held, "Stronger Collaboration for Stronger Families." The conference was well attended and was an opportunity to develop linkages with family organizations and improve collaboration efforts for Florida's families; and
- Children's Mental Health and the Department of Education/SEDNET (Severely Emotionally Disturbed Network) program staff jointly funded the development of materials designed to improve professionals' understanding of the need to work more closely with families. These materials were distributed to schools throughout the state.

CHILDREN'S MENTAL HEALTH

There were several challenges for Children's Mental Health. The first was capitation of Medicaid-funded mental health services for children involved with the child welfare system in February of 2007 for all levels of service except residential treatment. The second was uncertainty about the funding and eligibility level for the State Children's Health Insurance Program (SCHIP), and the third was growing recognition of the high level of therapeutic needs of children involved with the Juvenile Justice system present both opportunities and challenges for Children's Mental Health. In addition, other challenges include identifying funding for infrastructure to provide technical assistance and quality assurance activities that support the ability to build on existing programs to maximize available knowledge and resources, communicate effectively with all stakeholders in order to increase and coordinate funding and services effectively, and expand programs to include more effective prevention programs

There were also several opportunities. The first was an ability to focus on efforts to advance promotion and prevention programs for children and youth. The

second was to increase family and youth involvement in program and treatment planning, and the third was to develop methods to increase dissemination of information regarding evidence- based assessment and treatment options.

Priority Service Populations
Florida's publicly-funded children's mental health system serves over 80,000 eligible children with serious emotional disturbances, children with emotional disturbances, and children at risk of emotional disturbances. Services are also provided for children found incompetent to proceed due to mental illness, which prevents them from participating in their defense.

Children with serious emotional disturbances:
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 circuit; 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 disturbances:
A child under the age of 18 who meets one of the following criteria:

- Currently classified as a student with an emotional handicap by a local school circuit; 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 disturbances:
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. Children's Mental Health staff remain committed to:

- Increasing provider and family knowledge regarding what therapy and medication practices work for what diagnosis;
- Ensuring that families are full partners in the design of individual recovery plans and have a prominent voice in designing services and supports;
- Ensuring that culturally competent care is a reality for the children and families we serve;
- Continuing 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 transition, early intervention and prevention programs, and to avoid duplication of effort;
- Increasing the number of children and youth at risk for mental health and substance abuse disorders who receive prevention services;
- Ensuring 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;
- Reducing the time to access treatment and training services for juveniles found incompetent to proceed by the courts; and
- Ensuring that children and youth with co-occurring mental health and substance abuse disorders receive services and supports that address both of these needs.

Recovery and Resiliency-Based System of Care - Florida's Mental Health Program strives to develop coordinated systems of care for children that provide services and supports that promote recovery and resiliency as envisioned in Chapter 394, Part III by being:

- community-based;
- culturally competent;
- strength-based;
- evidence-based;
- individualized, child-focused, and child and family driven;
- inclusive of early intervention with the child and family; and
- coordinated across agencies and time lines.

To achieve this vision, the Department Mental Health Program 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.

Evidence-Based Practices - The knowledge base in the Children's Mental Health Program is rapidly expanding. 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.

Children's Mental Health staff is working to secure funding for a web-based directory of evidence-based practices that is available to funding sources, practitioners and families. Based on the Hawaii Evidence-Based Practice Guidelines, the web-based format will provide information that matches diagnoses to components in each evidence-based practice.

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. The Department's Mental Health Program goal 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 disturbances, 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 disturbances is based on Florida's Peer-to-Peer Specialist Program. The Family-to-Family Peer Specialists Certification will provide a basis for funders and providers to expand the use of this evidence-based practice.

Children's Mental Health staff will continue to be involved in initiatives that help to identify best practices. Some of the areas that are of particular focus include: the

use of psychotherapeutic medication; reducing the need for seclusion and restraint in settings which serve children and youth; increasing family and youth involvement in all levels of planning and evaluation of service delivery; and decreasing the need for children to be admitted to residential placements.

Cultural Competency - The population of Florida consists of people from all countries and cultures. The Children's Mental Health Program must develop a culturally competent system of care to guarantee that children and their families receive adequate and appropriate services. Failure to take into account a person's attitudes and beliefs about the causes and appropriate treatment for mental health issues, their beliefs about child rearing, and an appreciation for what is considered "normal," can often interfere with the development of a collaborative working relationship with children and families. Children's Mental Health staff endorses the Georgetown University's viewpoint on culturally competent organizations.

"Cultural competence requires that organizations:

- *Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.*
- *Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.*
- *Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities."* [7]

The Department will ensure that our contracts, policies and programs promote and support culturally competent care by adhering to the principles outlined above.

Collaborative Efforts - Collaborative partnerships have been crucial in meeting the challenges faced by Florida's publicly funded 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 staff 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 staff members are involved in the juvenile justice system on several fronts. Past and current collaborative efforts include:

[7] http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html

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.

In August 2007 the Department of Children and Families (DCF), the Department of Juvenile Justice (DJJ) and the Agency for Persons with Disabilities (APD) entered into an interagency agreement to coordinate services and supports for children in the State of Florida who are incompetent to proceed or youth who are multiagency involved;

In an effort to develop a systems approach and promote the local coordination the DCF regional directors DJJ circuit coordinators, and APD area administrators created local interagency teams to meet in each circuit;

The Circuit Teams will focus on resolving issues related to systems problems and case specific issues; and

The agreement also requires that DCF, DJJ, and APD establish a Rapid Response Team to receive referrals from the Local Review Teams. The Rapid Response Team will be available to resolve placement issues as well as review and amend practices and policies that may impede the ability to meet the individual needs of the multi-agency children by the Local Review Teams.

Headquarters Multi-Agency Meeting (Tallahassee)
DCF, DJJ, and APD meet on a regular basis to develop inter-agency strategies and initiatives to enhance the coordination and quality of service provision for youth involved in the Juvenile Justice system. Activities include the joint development of substantive or budgetary legislative requests, and targeting resource development responsive to the unique needs of this population of children.

The Department continues to collaborate with the Department of Juvenile Justice in their efforts to ensure services are trauma informed, and evidence based. 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.

- Behavioral Health Overlay Services (BHOS)

  Services are 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 towards 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. The Juvenile Justice, Medicaid, and Children's Mental Health staff jointly monitor services to ensure compliance.

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 Circuit 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. During FY 2006-2007 Children's Mental Health staff along with the Department's Legal staff closely monitored the length of time between the determination of competency and the child's court date. This has assisted in reducing the time spent by some youth waiting for admission to the secure training program;

- 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 circuit/regional levels has increased cooperation between the Department of Juvenile Justice and the Juvenile Incompetent to Proceed Program; and

- The Department obtained $469,291 in new funding to meet the growing needs of the community competency restoration program. Our total FY 2007-2008 budget of $1,849,023 ($939,732 original base, new funding of $469,291, and a journal transfer of $440,000 from the Agency for Persons with Disabilities, should allow the Department to serve approximately 260 juveniles before a waitlist for service begins in April 2008.

Department of Education

Children's Mental Health circuit/regional staff are members of the circuit multi-agency Service Network for Students with Emotional Disturbance (SEDNET) boards and maintain a good working relationship 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 multidisciplinary teams include educational services, although 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 FY 2006-2007. These relationships, at both the state and local levels, facilitate open communication between programs, and provide opportunities to improve outcomes for children.

Staff participated in a Department of Education workgroup in FY 2006-2007 aimed at developing guidance for the use of seclusion and restraint in educational settings.

Department of Health

The Federal Child Abuse Prevention and Treatment Act amendments (CAPTA) requires referral of children under age 3, in a substantiated case of abuse or neglect, to early intervention services funded under Individuals with Disabilities Education Act (IDEA Part C. A first draft of an agreement between the Department of Health, Early Steps, Part C IDEA Program and the Department is being circulated for review and comment. This agreement between state agencies will assist Florida to meet Federal requirements and be utilized as a guideline for local communities to draft their own agreements to meet their local needs.

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 for the children's physical health needs. Behavioral health benefits are delivered through a consortium of providers contracted with Substance Abuse and Mental Health circuit/region offices. A liaison is located in each circuit/region 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 staff is also active on the Florida Kid Care Coordinating Council.

The Behavioral Health Network uses a capitation payment methodology that provides considerable freedom for its contracted providers to tailor services to the specific needs of individuals. The program is popular with the families who benefit from its services as well as the Substance Abuse and Mental Health

circuit/region staff who help coordinate it locally. The program is small and has experienced slow growth, until recently. The size of the program makes it difficult, statistically, to show its effectiveness relative to other programs. Additionally, the capitation rate has remained unchanged since FY 2000. Self-reported data collected from all the contracted lead agency providers indicated substantial variation in operating results with several large providers operating the program in the red. Others have reported unacceptably low expenditures. There is a need for more specificity in terms of program requirements and acceptable operating results, as well as the need to identify and formalize the use of best practices. Children's Mental Health will focus in the next year on specific program requirements embodied in the Behavioral Health Network rule and initiate changes necessary to ensure both the program's clinical effectiveness and its cost effectiveness. Staff will also provide technical assistance to plans identified as falling outside the norm for plan operating results, and will reinvigorate a process for identifying and disseminating best practices in existing plan operations.

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 ten 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.

This grant will allow the Department and Medicaid to pilot an intensive community based system of services and supports for children who meet the level of need for residential treatment but whom otherwise would not be eligible for Medicaid. Children enrolled under the pilot will be considered as "families of one." This will enable children who otherwise would not meet Medicaid income eligibility due to their family's income to access necessary services and supports

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 activities across public and private agencies and providers. Partners in Transition is a statewide group consisting of individuals, parents of individuals, 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 enhancing 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 is difficult. Youth with serious emotional disturbances or emotional disturbances 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. Section 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 include:

- Children’s Mental Health staff collaborated 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.
- Children’s Mental Health staff also attended the Partners in Transition conference in October 2007, as another way to collaborate with other state agencies, educators, and families. The conference served as an avenue for our staff to share information on how children and families may access mental health services throughout the state and to assist youth as they transition from one system to another.

Prevention, Early Identification and Intervention - The Department’s Children’s Mental Health Program 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 disturbances. Special project funding has been provided to each of the Department’s districts for the past four 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.

To help promote community capacity the Children’s Mental Health Program Office supported the seventeen local chapter affiliates to the Florida Association of Infant Mental Health (FAIMH) throughout the state. The program office provided funds to FAIMH for local distribution to the chapters to help with outreach and training in the communities. These funds were provided on a

matching basis with FAIMH approval and documentation of need. Some examples of what chapters invested in include the following:

- Brochures on infant mental health for pediatrician offices, families, and child care settings;
- Community training including: Understanding the Impact of Family Violence on Young Children; Understanding Infants and Toddlers in the Child Welfare System; and Working with Families Who Have Severe Mental Health Issues; and
- Promotional marketing items and display boards for conferences and presentations.

Additional funding will be identified in the coming year to continue providing support to the Association at the community level and through sponsorship of the association's statewide annual training conference.

Children's Mental Health staff has been participating with the Department of Health and other state agencies in a planning grant provided by the Federal Bureau of Maternal/Child Health to develop an early childhood strategic plan for the state. As part of the plan to provide cross-system training, the participating agencies recently completed four, one day, regional trainings on the Georgetown University's "Bright Futures in Practice: Mental Health Guide and Toolkit and What to Expect and When to Seek Help".

The trainings focused on the application of Bright Futures to assist parents, families, and communities to identify and assess the mental health needs of children and families and ways to address those needs in a collaborative manner. Children's Mental Health staff sponsored the funding for a parental training component and the printing of the toolkit for the community agencies participating in the trainings. Additional training will be in the coming year at four more sites in the state to provide a shared understanding of early childhood social/emotional development and aid in the building of community systems of care for young children and their families.

A recent study conducted on the rate of expulsion in pre-kindergarteners indicated that students are expelled three times more often that their older peers in grades Kindergarten through grade 12. Florida falls in the median, with four to seven expulsions per 1,000 Pre-Kindergarten students. To respond to this situation, Children's Mental Health contracted with the Florida State University Center for Prevention, Early Intervention and Policy, to complete a nation wide search on sites that have successfully implemented early childhood mental health consultation services within Pre-Kindergarten centers. The research paper describes models in other states and is a ready guide for Florida in developing early childhood consultation for child-care programs. Work continues on identifying funding sources to implement a pre-kindergarten pilot program that builds the capacity of pre-kindergarten staff to enhance early emotional development and to identify treatment needs of young children.

Medications - The Department continues to partner with the Agency for Health Care Administration to monitor the use of psychotherapeutic medication for children we serve.
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; and
- A PreConsent line service was added in 2005 for the review of plans for psychotherapeutic medication for children in out-of-home care 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

Children's Mental Health staff will continue to monitor psychotherapeutic prescribing practices and support best practices by monitoring HomeSafeNet Data, looking for unusual practices affecting children in Departmental custody. The Department's Children's Mental Health Program staff 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 substance abuse and mental health disorders were treated in parallel systems. Individuals with 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 substance abuse and mental health 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:

- 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 received training on the integration of mental health and substance abuse services. Providers are encouraged to develop memoranda 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 Child Welfare /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 placement in a more intensive, restrictive level of care;
- Mental health and substance abuse services (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; and
- 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. These staff 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 maintain these efforts, Children's Mental Health will continue to partner with substance abuse to develop services that recognize and treat youth with co-occurring substance abuse and mental health 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. During 2008, plans are underway to expand the focus on creating trauma-informed systems for not only our residential providers, but all child serving systems in order to ensure that children receive appropriate care and are not further traumatized by the system meant to help them.

Circuit Children's Mental Health staff participates in monitoring seclusion and restraint use, policies, and procedures in contracted facilities. The Department and Agency for Health Care Administration also provide technical assistance.

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" presented a two day train-the-trainer program to a three-person training group from each of the Statewide Inpatient Psychiatric Programs

in January 2007. 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 for 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's 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 designed to specify licensure standards for admission, length of stay, program and staffing, discharge and discharge planning, seclusion, restraints, and timeouts, rights of residents under s. 394.459, F.S., use of psychotropic medications, and standards for the operations of such centers. The promulgation of ch.65E-9, F.A.C., in July 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 ch. 395, F.S., are not included. The majority of facilities affected by this rule have become licensed under this rule.

STATE MENTAL HEALTH TREATMENT FACILITIES
The Department of Children and Families directly operates or contracts for the operation of nine 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 mental health 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; and
- Individuals civilly committed under the Jimmy Ryce Act as Sexually Violent Predators.

Three of the nine state facilities are managed by the state and four are currently operated under contract with GEO Care, Inc., and one is operated under contract with the GEO Group, Inc., a commercial vendor. A ninth 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 2,750 beds statewide. Five hundred and seventeen of the civil beds are currently designated as “step-down” capacity, to treat individuals committed under the forensic statute who no longer require the security of a forensic facility.

The table below shows the state mental health treatment facilities and bed capacities a at the end of FY 06-07:

Facility/Location	Type	Bed Capacity	Operated by	Number Served FY 2006-07
Florida State Hospital - Chattahoochee	Civil and Forensic	180 civil 310 forensic step-down 528 forensic 1,018 total beds	DCF	806 civil 1,242 forensic
Northeast Florida State Hospital –Macclenny	Civil	461 civil 152 forensic step-down 613 total beds	DCF	833
North Florida Evaluation and Treatment Center - Gainesville	Forensic	216	DCF	435
South Florida Evaluation and Treatment Center - Miami	Forensic	213	GEO Care, Inc.	535
South Florida Evaluation and Treatment Center – Annex - Miami	Forensic	100	GEO Care, Inc.	Opened February 2007
South Florida State Hospital – Pembroke Pines	Civil	280 civil 55 forensic step-down 335 total	GEO Care, Inc.	560
Treasure Coast Forensic Treatment Center – Indiantown	Forensic	175	GEO Care, inc.	Opened April 2007
West Florida Community Care Center - Milton	Civil	80	Lakeview Center	236
Florida Civil Commitment Center (FCCC) - Arcadia	Sexually Violent Predators (SVP)	580	GEO Group	592
TOTAL		3,330		5,239

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 five 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 individuals’ 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.

Criteria for Admission
Adults who are committed into a civil commitment state mental health treatment facility must be 18 years of age or older and meet the following criteria:

- Committed in accordance with the provision of services provided in Chapter 394, Florida Statutes;
- 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; and
- Admitted on either a voluntary or involuntary basis.

Adults who meet forensic commitment criteria for placement in a state mental health treatment facility must be 18 years and older or a juvenile adjudicated as an adult and meet the following criteria:

- Committed in accordance with the provision of services provided in Chapter 916, Florida Statutes;
- Has a felony charge;
- Adjudicated either Incompetent to Proceed through the judicial system or Not Guilty By Reason of Insanity; and
- 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 who are civilly committed under the Jimmy Ryce Act pursuant to Chapter 394, Part V, Florida Statutes are served in the Sexually Violent Predator Program must:

- 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:

- Basic Support Services - include provision of the basic requirements for survival such as shelter, food, clothing, and a sense of personal safety.
- Healthcare Services - are intended to identify and treat resident's physical and mental illness and promote good health. The priorities of health

services include: 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.

- Recovery Services - consists of psychiatric evaluation, diagnosis, holistic recovery planning with the individual and interdisciplinary team, stabilization of the resident's 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.
- 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 circuits/regions to facilitate continuous services and supports for people transitioning from the facility to the community.
- 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); and
- 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 indicate, 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 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 increase self-confidence, hope, and motivation to recover.

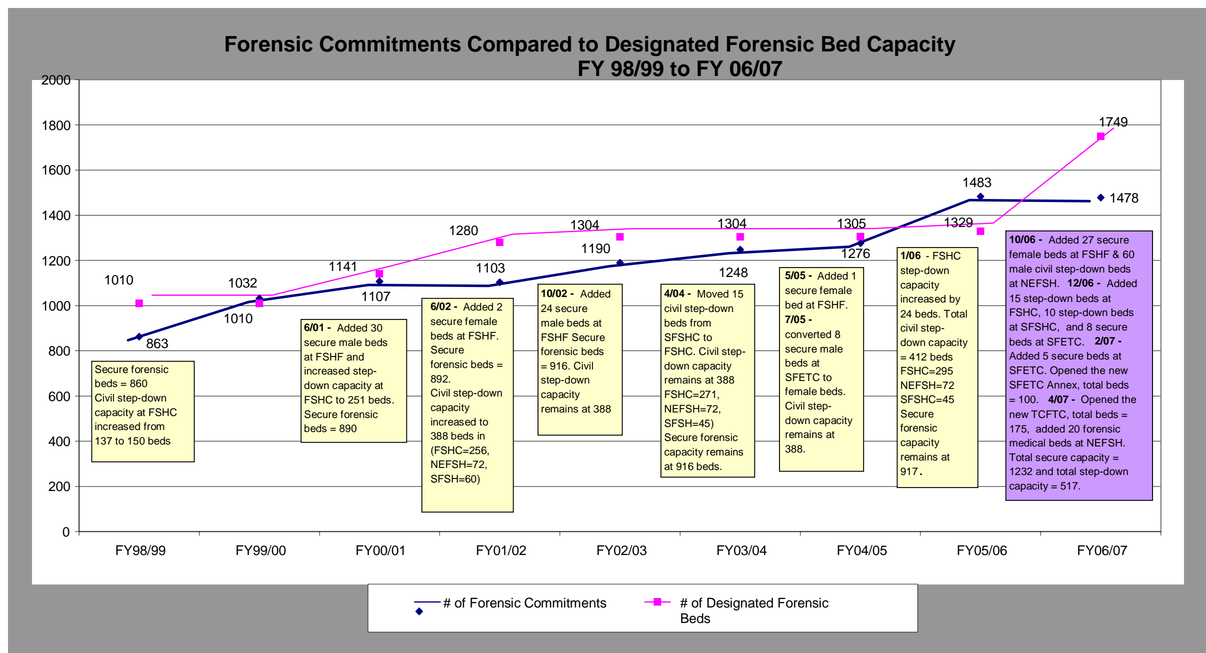
Each of the facilities offer at least some degree of services for residents with co-occurring substance abuse and mental illnesses. However, the amount of services, that are available, for these individuals varies by facility.

Executive Summary - Priorities and Future Directions
The following issues are priorities for the state mental health treatment facilities, and will establish direction for future improvements:

- Maintain Adequate Forensic Capacity to Meet an Increasing Need for Forensic Beds

The Department is currently admitting every individual committed with a mental illness pursuant to Ch. 916, F. S., within the required 15 days from receipt of a complete commitment packet. As of November 13, 2007, there were 17(16 males and 1 female) individuals on the forensic waiting list with 0 waiting in excess of the statutory 15 days to admit. Through October 2007 of FY 2007-2008, the Department admitted 496 individuals who were committed pursuant to Ch. 916, F.S. On average, these individuals were admitted within 3.57 days.

The graph below depicts increases in forensic capacity relative to the increased number of commitments.



Often, adults with mental illnesses come to the attention of law enforcement due to 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. Many of the individuals committed to forensic facilities could be more appropriately served in the community. The Department has increased community resources to provide alternative community treatment services for individuals not requiring a secure treatment facility environment.

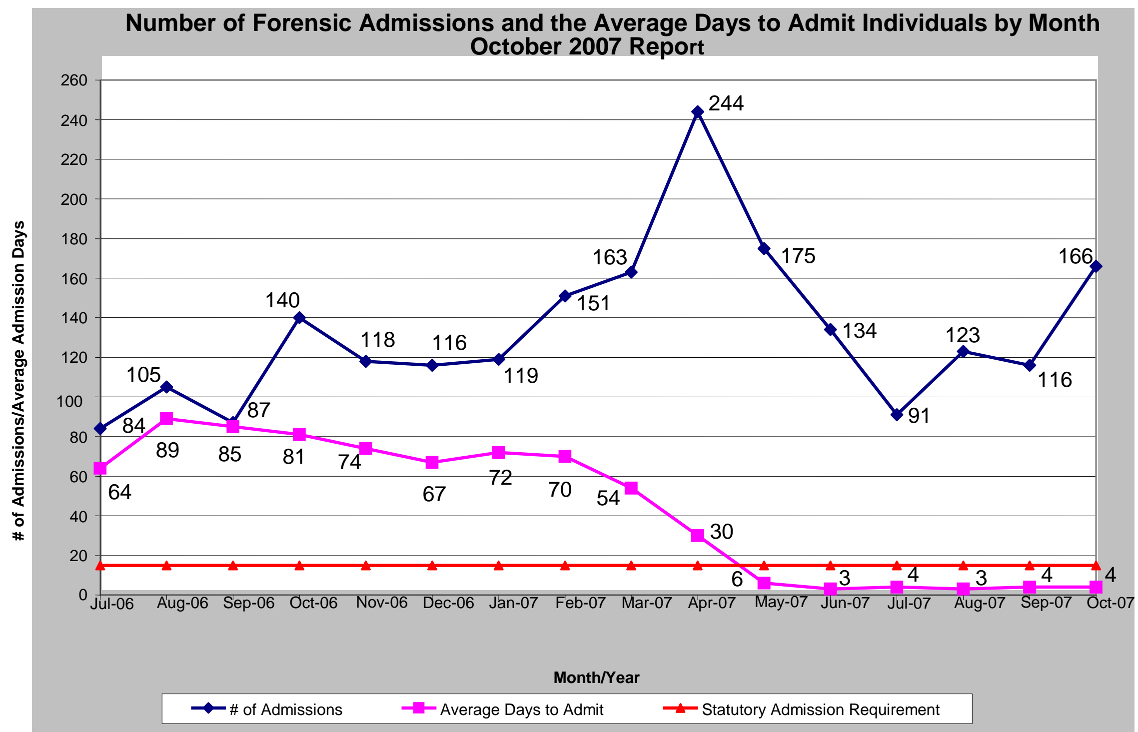
Actions Taken:

- In 2007, a total of $22,164,081 was directed toward decreasing the number of people waiting for forensic admission to a state treatment facility by increasing community forensic residential beds, community competency restoration services, expanding wrap around services to support individuals diverted to the community and increasing the number of forensic state treatment facility beds. A total of 318 state treatment facility beds and 70 forensic designated community residential beds were added to serve individuals in the forensic system.
- In FY 2007-2008, a total of $53,092,297 (annualized) was designated to continue the forensic beds and community services that were added during FY 2006-2007.
- The Department has partnered with the court and jail officials to ensure rapid pick up of individuals who are found competent at our facilities and need to be returned to their local jail for the court proceedings. Through October 2007 of FY 2007-2008, 406 competent individuals have been picked up for return to court in an average of 17 days.
- The Department's Mental Health Program has arranged to provide 30 days of medications for individuals returned to jail to maintain their competency while awaiting court action.

- Initiate competency restoration in counties allowed by the jail for every individual awaiting placement in a state mental health treatment facility.

Impact of Current and Planned Actions:

The following chart shows the impact of actions this year to reduce the time individuals must wait in jail prior to admission to a state mental health treatment facility. The Department has admitted all individuals committed pursuant to Chapter 916, F.S., within 15 days since May 2007. Funding in FY 2007-2008 should allow the Department to continue to meet its statutory obligation to place individuals within fifteen days of commitment.



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 FY 2004-2005, a 63 percent increase in one year. The higher workload is expected to continue, 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 “sexually motivated.”

Another major issue is the projected shortage of bed capacity at the Florida Civil Commitment Center (FCCC). Based upon the increasing census over the past three years (nine percent), it is likely that by July 2007, the program capacity (580 beds) for confinement and treatment will be exceeded. Since FY 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 conduct quality improvement activities; and
- Seek contract services funding to increase the bed capacity of the Center to 660 beds.

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 individuals 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 individuals 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. Currently, direct care staff performs security functions, such as escorting and transporting residents into the community for medical appointments, de-escalating violent and potentially violent situations, and perform continuous supervision of residents in acute care areas. The direct care staff perform these functions due to an insufficient number of certified security officers. The performance of security functions by direct care staff significantly reduces their ability to perform essential

care and support services. Therefore, the Department has requested additional 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, re-traumatization 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 is indicated for use 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 continue to decrease the use of seclusion and restraint events. The total number of seclusion or restraint events decreased by 51% between FY 2003-2004 and FY 2006-2007.

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; and
- 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, and require the Department 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; and
- 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 facility staff 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. Highlights include the following:

- Florida State Hospital is recognized nationally for their role recovery program, implemented in 1998;
- Florida State Hospital and GEO Care, Inc./South Florida State Hospital use recovery models from the Boston Center for Psychiatric Rehabilitation;
- Northeast Florida State Hospital's recovery approach is modeled after Robert Lieberman's work; and
- 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 staff 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; and

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

- Significant Incident Tracking and Reporting

The Mental Health Program Office continues to work closely with Operations and Information Systems staff to finalize the Department-wide Incident Reporting and Analysis System (IRAS). The program will be piloted this year and refinements made to ensure reporting, tracking, and trending of significant incidents by Region and Statewide. With the improved data collection and analysis, the Department's risk management program will be able to identify areas of fragility and initiate corrective actions, education, and service improvement to reduce the risk of morbidity and mortality for individuals in the state with mental illnesses. A module that will attach to the IRAS program that will allow for the collection of restraint and seclusion data statewide is under development. The new module will allow for monitoring of the statewide initiative to reduce the use of restraint

and seclusion. It will also provide immediate notification to Department administrative staff of any significant injury or death related to restraint or seclusion.

- Additional Initiatives

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 anti-psychotics, 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 individuals' functional skills, the state treatment facilities use 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 used 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 Mental Health Central Program Office, circuits/regions, and facility staff successfully developed and are implementing a community needs assessment (CNA) tool and operating procedure, which allows for ongoing, electronic communication between state mental health treatment facilities and the community. This tool, when fully implemented, will provide constant communication between facilities, circuits/regions, and providers, so that communities are aware 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 offered by Florida State Hospital which identifies of potential living environments in the community. Individuals in state facilities, facility staff, family members, circuit/regional staff, and providers can access this site. The website provides admission criteria, community resources, and programmatic information on living environments in all circuits/regions and regions so that individuals will be able to make an informed choice regarding preferred community placements and services.

Emerging Issues -

Improved Alignment between Mental Health and Criminal Justice
Judge Steven Leifman is special advisor to the Florida Supreme Court on mental health issues and chair of the Mental Health Subcommittee of the Steering Committee on Family and Children in the Court. He has been collaborating with the Department and other agencies to develop and present a comprehensive

plan to address the mental health needs of individuals who are at risk for forensic commitment. Judge Leifman presented this plan to the Senate Committee on Criminal Justice in December 2007.

The plan calls for diversion of the significant number of individuals who have legal charges with low-level crimes, like resisting arrest with violence and cocaine possession, and creation of a robust preventative community-based approach to reduce the need for expensive hospitalization of individuals found incompetent to proceed on such low-level charges. The plan recommends that we create a competent mental health system to handle people with this very acute level of mental illness. Timely and appropriate treatment for these individuals will avoid the mental health treatment burden currently experienced by Florida's county jails. The Department, in conjunction with AHCA, are working to identify ways to operationally address the issues identified in Judge Leifman's plan and have submitted a LBR for 21.6 million dollars to support this initiative.

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 illnesses 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.

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 using 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.

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), F.S., includes "any criminal act" that may be determined

"beyond a reasonable doubt" to have been sexually motivated. The statute requires the determination of whether a crime was sexually motivated at the time of sentencing for the crime in question, or subsequently during the trial. During 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. Although the statute requires the consideration of "sexually motivated" offenses during the screening process there is no mechanism to systematically label or flag such offenses for later consideration. Without such a mechanism, some sexually violent predators will go undetected.
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 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) - The parameters for use of force against persons, civilly detained or committed, who reside in the Florida Civil Commitment Center is unclear. 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 would contribute to a safer and more secure facility for residents, staff, and the community at large.

Placement and Treatment of Department of Corrections Inmates with Mental Health Needs - The Department has proposed statutory language regarding two distinct issues related to serving Department of Corrections (DC) inmates. The first situation involves DC inmates who sentenced to death and are and need restoration of competency under Florida Rules of Criminal Procedure 3.851(g). In three recent cases, the Courts committed the inmates to the Department of Children and Families (DCF) for competency treatment and training but ordered that they continue to remain in a DC facility. DC retains physical custody of the inmates and remains responsible for all aspects of the custodial care for the inmates, except for the aspect of, "treatment and training necessary to restore competency" which was specifically carved out by the Committing Courts as the responsibility of DCF. It is expected that DCF will go into the DC facility to provide competency restoration treatment and training to these individuals on Death Row. The Department has significant concerns about providing treatment to persons who are in the custody of another department.

The second situation involves DC inmates who are Incompetent to Proceed to Trial or Not Guilty By Reason of Insanity on new charges acquired while in prison. These inmates go to a DCF forensic facility for treatment which presents a safety issue. Many of these individuals have very little incentive to cooperate

with treatment (because once competency has been restored and the new charge has been resolved, they will likely return to prison to face their prior charge) and, more importantly, have nothing to lose by injuring staff or other residents at the facility. The treatment options are limited by lack of incentive, and the safety options are severely limited by the forensic rules and statutes regarding proper treatment of individuals with mental health needs within a mental health facility.

Chapter 916, F.S., does not contain specific language regarding commitment of individuals who are active DC inmates. Therefore, the Mental Health Program Office has proposed a statutory language change to Ch. 916, F.S., to provide clarification regarding DC's responsibility for providing treatment and/or training to inmates who are determined to be ITP or NGI, have incurred additional charges while in the facility and or who sentenced to death. The proposed language clarifies that these inmates will remain in the custody of DC at a DC facility. It also indicates that any necessary treatment to restore competency or for mental health services will be provided to these individuals by DC.

<u>Timely Transportation to Court and Jail</u> – Currently, Chapter 916, F.S., does not reference language related to returning a forensic individual to court within a certain number of days or requiring a hearing date within a certain number of days. Florida Rules of Criminal Procedure (Rule 3.211 (a)(6)) indicate the court shall hold a hearing within 30 days of the receipt of a report from the administrator of a facility; however this language is not in statute and it is not being consistently followed. Therefore, people who have restored competency or who no longer meet criteria for commitment in a forensic facility may wait in the state mental health treatment facility, for an extended time, until they return to court and continue their court proceedings. Without a requirement to ensure timely pick up and transport of these individuals, the person may remain in the treatment facility without receiving any continuing benefit and they occupy a bed needed by persons awaiting admission into the forensic facility. Although Ch. 916, F.S., requires admission of a committed individual within 15 days, there is no similar requirement for the pick up of individuals who have completed treatment within a specified amount of time.

The Mental Health Program Office has proposed a statutory language change to Chapter 916, Florida Statutes, to establish a time frame for an individual to be returned to jail and to be seen in circuit court when the court receives a report indicating that competency has been restored or that a decision has been made indicating the individual no longer meets commitment criteria. The proposed language indicates an individual will be transported by the sheriff back to jail within 15 days of receiving such a report from the Department and have a hearing within 30 days of receiving such report. The proposed language will help the forensic system increase the number of people served and it will help forensic individuals to continue with their judicial proceedings, many times resolving their charges, in a more timely manner.

Mental Health Disaster Response Team

The Mental Health Program Office sponsored Project H.O.P.E. (Helping Other People in Emergencies), a federally funded crisis counseling project, to assist individuals in the emotional recovery from Hurricanes Charley, Frances, Jeanne, Ivan, Dennis, Katrina, and Wilma. The Federal Emergency Management Agency and the U.S. Department of Health and Human Services provided this funding. The project provides outreach activities, information and referral services to facilitate disaster survivors resuming their normal patterns of living. More than 1.5 million individuals received services during FY 2005-2006 in response to Hurricanes Katrina and Wilma.

Additionally, Project Recovery, a supplementary grant from the U.S. Department of Health and Human Services, provided more intense recover 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 issues. 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 the 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 between the Departments of Health and Children and Families. The Florida Domestic Security Taskforce has adopted this plan which will be an appendix to the Comprehensive Emergency Management Plan.

CHAPTER 4: FINANCIAL MANAGEMENT

Substance Abuse and Mental Health Contracting System

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 Substance Abuse and Mental Health staff may evaluate the performance of the providers. 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 contracts require that provider agencies achieve a quantifiable level of performance relative to a specific measure. Measures of performance include outputs (direct counts of program activities and individuals served) and outcomes (results of program activities in the lives of those served).

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, individual-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 is 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, the Department's data system does not capture billings. 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.

IMPROVEMENTS

Work is underway to address these issues. A number of improvements to the contracting system began on July 1, 2006, including 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 individual, as opposed to the necessary contract service unit.

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

PROCESSES AND CHALLENGES
Shrinking administrative resources, coupled with additional legislative requirements, has proven challenging. The Department is constantly seeking new ways to streamline administrative business practices in order to meet these challenges. A data system for billing purposes, along with improved financing mechanism, is necessary to enable the Department to tie funding directly to individuals and their clinical outcomes.

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.

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. There are limitations to the frequency of on-site monitoring visits by Department to accredited facilities. This limits, in many cases, the scope and frequency of provider reviews. The development of systems that integrate these reviews with information available from other sources such as: accrediting bodies; licensing bodies; independent audits; other funding sources; internal quality assurance; and improvement activities is essential.

FUTURE DIRECTIONS
In an effort to promote a more flexible person-centered and directed system of care, the Substance Abuse and Mental Health Program will continue to review alternative financing strategies, including prospective case rates. During 2006, a workgroup explored the possibility of implementing case rates for methadone treatment services. However, this option was not feasible at the time.

The Department will engage the services of a fiscal agent for person-directed purchasing programs. This will allow for greater expansion of these programs, as well as will streamline and economize business practices.

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 2007-2008

In FY 2007-2008, the Substance Abuse Program Office (PDSA) was appropriated $217.6 million for Children and Adult Substance Abuse Services and Program Management and Compliance (administration). The table below depicts state and federal funding for Children's and Adult Substance Abuse Services and administration.

	PROGRAM MANAGEMENT and COMPLIANCE	CHILD SUBSTANCE ABUSE	ADULT SUBSTANCE ABUSE	TOTAL
General Revenue	$2,783,651	$41,352,230	$36,590,930	$80,726,811
Other State Funds	$7,329	$5,220,907	$7,682,199	$12,910,435
Total State Funds	$2,790,980	$46,573,137	$44,273,129	$93,637,246
Federal Trust Funds				
ADAMH TF (SAPT BG)	$1,915,740	$28,959,758	$63,819,958	$94,695,456
Welfare Transitions Trust Fund (TANF)		$640,000	$14,097,500	$14,737,500
Federal Grants Trust Fund	$5,607,980	$211,066	$7,602,824	$13,421,870
Social Services Block Grant Trust Fund			$901,616	$901,616
Total Federal Funds	$7,523,720	$29,810,824	$86,421,898	$123,756,442
Other Grant Funds				
Grants and Donations Trust Funds	$180,000			$180,000
Other Grant Funds	$180,000			$180,000
Total	$10,494,700	$76,383,961	$130,695,027	$217,573,688

Determination of Service and Funding Needs

The Substance Abuse program uses the Florida Youth Substance Abuse Survey (FYSAS) to calculate the number of children and adolescents in need of substance abuse services in each circuit/region. On an annual basis, middle school and high school students throughout Florida respond to the FYSAS. Their responses are used to determine the prevalence/rate of alcohol, illicit drug, tobacco, and prescription drug use. The derived alcohol and drug use rates are compared to population figures by county to derive local service need figures. The service needs figures are used for determining funding allocations. Based on this analysis, it is projected that 332,355 children and adolescents in Florida will need substance abuse services during FY 07-08.

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 this 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

circuit/region. For FY 2007-2008, 1,297,336 adults in Florida are in need of substance abuse services.

Children's Substance Abuse Prevention, Evaluation and Treatment
The Children's Substance Abuse Prevention, Evaluation and Treatment Services budget was allocated based on FY 2006-2007 Approved Operating Budget using the base funding for each circuit/region. Recurring internal budget amendments between circuits/regions and/or Other Cost Accumulators (OCA) that were approved by the Program Office, Budget Office, Zones, Circuits, Region and Performance Resource Teams (PaRTs) were allowed to be continued in the FY 2007-2008 approved operating budget. New special projects are added into specific circuits/regions to arrive at a total allocation for FY 2007-2008 with a statewide per capita rate of $212.61. All of the Special Projects are non-recurring for FY 2007-2008.

Children's Substance Abuse Funding Per Person

District	District Budget	Target Population	Allocation Per Target Population
1	$3,188,821	14,684	$217.17
2	$3,164,001	12,835	$246.51
3	$2,217,165	10,490	$211.35
4	$5,663,712	27,508	$205.89
7	$8,259,606	38,104	$216.76
8	$3,559,593	17,780	$200.20
9	$4,353,002	22,772	$191.16
10	$6,023,004	28,894	$208.45
11	$10,683,886	53,923	$198.13
12	$2,617,277	10,317	$253.68
13	$3,292,422	16,368	$201.16
14	$2,757,955	11,627	$237.21
15	$2,300,639	10,178	$226.04
SC	$12,579,656	56,875	$221.18
Total	$70,660,739	332,355	$212.61

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 $212.61.

The table below reflects the amount of funding needed to bring these circuits/regions up to the current statewide average.

Districts/regions	Additional Resources Needed
3	$ 13,178
4	$ 184,739
8	$ 220,711
9	$ 488,474
10	$ 120,239
11	$ 780,621
13	$ 187,489
Total resources needed to bring the seven under-funded districts to the state average of $212.61.	$ 1,995,452

Adult Substance Abuse Prevention, Evaluation and Treatment

The Adult Substance Abuse Prevention, Evaluation, and Treatment Services budget was allocated based on FY 2006-2007 approved operating budget (AOB) using the base funding for each circuit/region. Reductions in funding ($629,406) were taken within each region proportionate with their level of funding. Recurring internal budget amendments between circuits/regions and/or OCAs that were approved by the Program Office, Budget Office, Zones, Circuits, Region, and PaRTs were allowed to be continued in the FY 2007-2008. approved operating budget. New special projects are included into specific circuits/regions to arrive at a total allocation for FY 2007-2008 with a statewide per capita rate of $90.88. All of the special projects are non-recurring for FY 2007-2008.

Adult Substance Abuse Funding Per Person FY 07-08

District	Disctrict Budget	Target Population	Allocation Per Target
1	$4,567,398	50,758	$89.98
2	$4,996,473	57,106	$87.49
3	$4,004,572	45,639	$87.74
4	$8,073,882	91,415	$88.32
7	$14,050,494	160,097	$87.77
8	$6,696,915	76,919	$87.06
9	$7,870,442	89,990	$87.45
10	$10,587,308	121,827	$86.90
11	$17,382,752	178,912	$97.15
12	$6,407,065	42,552	$150.57
13	$5,636,011	66,487	$84.76
14	$4,306,103	47,120	$91.38
15	$3,434,258	39,268	$87.45
SunCoast	$20,168,676	229,247	$87.97
Total	$117,905,173	1,297,336	$90.88

Note: Totals include special projects.

As the table on the previous page shows, all but three circuits/regions have per capita funding rates that are lower than the statewide average of $90.88. The amount of funding needed to bring each of these circuits/regions up to the current statewide average is below:

Districts	Additional Resources Needed FY 07-08
1	$ 45,489
2	$ 193,320
3	$ 143,100
4	$ 233,913
7	$ 499,121
8	$ 293,484
9	$ 307,849
10	$ 484,330
13	$ 406,328
15	$ 134,418
Suncoast	$ 665,291
Total resources needed to bring the 11 under-funded districts to the state average of $90.88 per person	$ 3,406,644

Legislative Budget Requests (LBR)

The PDSA has submitted the following LBR issues for FY 2008-2009:

- Substance Abuse Treatment Access for Child Welfare Clients
- Infrastructure Development for Co-occurring Disorders
- Strategic Investment in Determining Treatment Needs for Adults and Cost of Substance Abuse Services
- Fetal Alcohol Spectrum Disorders (FASD) Prevention and Intervention
- Convert Other Personnel Services (OPS) positions to Full Time Equivalent (FTE) positions – 20 FTEs

Mental Health Program Funding for FY 2007-2008

FY 2007-2008 mental health funding appears in Table 3 below. A total of $803.5 million was appropriated: $305.8 million in Adult Community Mental Health; $91.2 million in Adult Community Mental Health, $368.7 million in Mental Health Treatment Facilities; $26.1 million in the Violent Sexual Predator Program; and $11.3 million in Program Management and Compliance.

Table 3: FY 2007-2008 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	$7,850,271	$242,904,605	$75,105,559	$276,690,918	$26,140,529	78.24%	$628,691,882
Alcohol, Drug Abuse & Mental Health Trust Fund	$712,927	$15,534,012	$8,464,303	$0	$0	3.08%	$24,711,242
Tobacco Settlement Trust Fund	$0	$21,240,092	$1,662,772	$0	$0	2.85%	$22,902,864
Federal Grants Trust Fund	$2,756,269	$14,353,053	$6,254,760	$64,875,030	$0	10.98%	$88,239,112
Operations & Maintenance Trust Fund	$0	$450,002	$0	$27,100,702	$0	3.43%	$27,550,704
Grants & Donations Trust Fund	$0	$2,030,000	$0	$0	$0	0.25%	$2,030,000
Administrative Trust Fund	$9,715	$0	$0	$0	$0	0.00%	$9,715
Welfare Transitions Trust Fund	$0	$7,693,789	$0	$0	$0	0.96%	$7,693,789
Social Services Block Grant Trust Fund	$0	$1,617,750	$24,831	$63,137	$0	0.21%	$1,705,718
TOTAL	$11,329,182	$305,823,303	$91,512,225	$368,729,787	$26,140,529	100.0%	$803,535,026

Note: Mental Health Treatment Facilities appropriation includes $20.3 in Operations and Maintenance Trust Fund budget authority only. Spending authority was provided 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.

The need for acute care beds is determined based on a formula of ten Crisis Stabilization Unit (CSU) beds per 100,000 persons in the 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.

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

In FY 2007-2008, the Legislature appropriated $280,358,450 to provide community mental health services to an estimated population of 346,045 adults with severe and persistent mental illness (SPMI). This appropriation includes $11,479,585 million which was distributed in accordance with the following 2007 Proviso: In accordance with Senate Bill 2802, Section 3: "In order to implement Specific Appropriation 388 of the 2007-2008 General Appropriations Act, and notwithstanding s.394.908(3)(a) and (b), Florida Statutes, funds appropriated for forensic mental health treatment in Specific Appropriation 388 shall be allocated to the areas of the state having the greatest demand for services and treatment capacity. This section expires July 1, 2008."

CHILDREN'S MENTAL HEALTH

The Children's Mental Health Services budget is allocated based on FY 2006-2007 approved operating budget. An additional $469,281 was appropriated for Community Juvenile Incompetent to Proceed Program; $7.4 million was reduced in the Therapeutic Services for Children category and transferred to the Agency for Healthcare Administration. Therapeutic services for Medicaid-eligible children under 21 are now capitated under the Child Welfare Prepaid Mental Health Plan as of February 1, 2006.

MENTAL HEALTH TREATMENT FACILITIES

The Mental Health Treatment Facilities budget is allocated based on FY 2006-2007 Approved Operating Budget. The Legislature appropriated an additional $41.6 million to continue operation of 343 forensic beds. This allocation was based on cost per bed. In addition, the Legislature appropriated $1 million for cost of living Increase for South Florida State Hospital as well as annualized forensic funding of $987,000 from FY 2006-2007.

VIOLENT SEXUAL PREDATOR PROGRAM

The Violent Sexual Predator Program budget is allocated based on FY 2006-2007 approved operating budget. No new dollars were appropriated for Fiscal 2006-2007 for this budget entity.

Funding Differences Between Circuits/Region:

Adult Mental Health:
After the allocation of the $11,479,585 million in FY 2007-2008, the statewide average funding per person with SPMI is $810.18.

Funding Allocated for SPMI by District FY 2007-2008

Districts	FY 2007-2008 Appropriation	SPMI Population	Amount Per SPMI	% Over/Under Statewide SPMI
1	$9,598,431	13,439	$714.22	(13.44%)
2	$14,775,470	14,812	$997.53	18.78%
3	$8,428,694	11,398	$739.49	(9.56%)
4	$17,332,498	25,840	$670.76	(20.78%)
7	$28,056,454	45,370	$618.39	(31.01%)
8	$20,645,944	19,396	$1,064.44	23.89%
9	$15,841,333	23,371	$677.82	(19.53%)
10	$23,988,888	34,121	$703.05	(15.24%)
11	$35,093,025	49,188	$713.45	(13.56%)
12	$7,794,529	10,806	$721.31	(12.32%)
13	$11,183,699	16,442	$680.19	(19.11%)
14	$13,221,933	12,016	$1,110.36	26.37%
15	$11,907,384	9,905	$1,202.16	32.61%
SC Region	$62,490,168	59,941	$1,042.53	22.29%
Statewide Total	$280,358,450	346,045	$810.18	

As the table above shows, nine districts have per capita funding rates that are lower than the statewide average of $810.18. The amount of funding needed to bring these circuits/regions up to the current statewide average is below.

Funding Needed to Achieve Statewide Average by District FY 2007-2008

District	Average Amount Per Adult in Need	Additional Resources Needed
1	$714,22	$1,289,578
3	$739.49	$805,738
4	$670,76	$3,602,553
7	$618.39	$8,701,413
9	$677.82	$3,093,384
10	$703.05	$3,655,264
11	$713,45	$4,758,109
12	$721.31	$960,276
13	$680,19	$2,137,281
Total resources needed to bring nine districts/region up to the state average of $810.18 per person.		**$29,003,596**

Children's Mental Health:
The average funding spent for per Severely Emotionally Disturbed (SED) individual statewide is $177.99. Eight districts have per capita funding rates that are lower than the statewide average of $177.99. In order for each area to achieve the statewide average, additional resources are needed.

Average Funding for SED by District/Region
FY 2007-2008

District	FY 2007-2008 Appropriation	SED Population	Amount Per SED	% Over/Under Statewide SED
1	$2,471,172	12,899	$191.58	7.09%
2	$2,266,134	12,276	$184.60	3.58%
3	$2,244,724	9,356	$239.92	25.81%
4	$4,625,320	26,245	$176.24	(1.00%)
7	$7,738,271	45,127	$171.48	(3.80%)
8	$3,127,037	18,059	$173.16	(.79%)
9	$3,622,028	22,378	$161.86	(.97%)
10	$5,990,195	33,566	$178.46	0.26%
11	$8,540,053	49,347	$173.06	(2.85%)
12	$1,564,900	9,351	$167.35	(6.36%)
13	$3,264,171	14,850	$219.81	19.02%
14	$2,179,630	12,775	$170.62	(4.32%)
15	$2,189,147	9,441	$231.88	23.24%
Suncoast	$9,179,852	55,825	$164.44	(8.24%)
Statewide Total	**$59,003,634**	**331,495**	**$177.99**	

Funding Needed to Meet State Average
FY 2007-2008

District	Average Amount Per Children in Need	Additional Resources Needed
4	$176.24	$45,028
7	$171.48	$293,884
8	$173.16	$87,284
9	$161,86	$361,032
11	$173.06	$243,220
12	$167.35	$99,484
14	$170.62	$94,193
SC	$164.44	$756,440
Total resources needed to bring the eight under-funded districts to the state average of $177.99		$1,980,564

Budget Policies:
Chapter 216, F.S., mandates budget procedures for transferring budget and establishing positions for all state agencies. Due to Departmental Reorganization, effective July 1, 2007, the Substance Abuse & Mental Health

(SAMH) Program Office no longer has direct line authority over the circuits/regions. In order to coordinate the utilization of Substance Abuse and Mental Health Program funding, a bi-weekly conference is scheduled with administrative staff in the circuits/regions to discuss spending plans and legislative updates.

Legislative Budget Requests

The Mental Health Program has submitted the following LBR issues for FY 2008-2009.

- Substance Abuse and Mental Health Information System (SAMHIS)
- Convert Mental Health Program Other Personal Services Positions to Salaried Positions – Add
- Convert Mental Health Program Other Personal Services Positions to Salaried Positions – Deduct
- Enhancing Public Safety and Improving Outcomes for Persons with Serious and Persistent Mental Illnesses With or at High Risk for Criminal Justice Involvement: Florida's Sequential Intercept and Redirection Program
- Medicaid Administrative Claiming for Mental Health & Substance Abuse Providers
- Restoration of Florida Substance Abuse and Mental Health Corporation Grant Funding
- Violent Sexual Predator Program
- Adult Mental Health Preadmission Screening and Resident Review Workload Increase
- Adult Mental Health Self-Directed Care Expansion
- Adult Mental Health Orange County Central Receiving Center System
- Adult Mental Health Housing Rental Supplement Program
- Adult Mental Health Criminal Justice Re-entry Aftercare Support
- Adult Mental Health Clubhouse Expansion and Development
- Adult Mental Health Florida Assertive Community Treatment Team Expansion
- Children's Mental Health Juvenile Incompetent to Proceed-Secure Additional Beds
- Children's Mental Health Intensive Prevention/Early Intervention Services
- Children's Mental Health Early Childhood Consultation
- Children's Community Action Teams
- Children's Mental Health Juvenile Incompetent to Proceed Community-Based Program
- Children's Mental Health Juvenile Incompetent to Proceed Secure Per Diem Rate Increase
- Children's Mental Health Family-to-Family Support Network Demonstration Project
- Continue Increase in Federal Grants Trust Fund Behavioral Health Network in Children's Mental Health Services
- Realign Positions and Budget to Reflect the Correct Funding Source and Organizational Structure – Add

- Children's Mental Health Psychiatric Residential Treatment Facilities
- Mental Health Federal Trust Fund Authority for Crisis Counseling
- Establish Circuit Peer Specialist Positions for Mental Health
- Guaranteed Energy Performance Savings Contracts – Add
- Guaranteed Energy Performance Savings Contracts – Deduct
- Enhanced Security Staff for Forensic Mental Health Treatment Facilities
- Special Risk Class for Mental Health Treatment Facilities staff
- Annualization of the Conversion of Contracted Services to Salaries for Additional Forensic Capacity
- Contracted Mental Health Institution - Cost of Living Adjustment

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 20 circuits/Five regions 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 state's growing needs. A new business model that addresses growth and other issues is needed. In order to address these needs, the Substance Abuse and Mental Health Program plans to continue exploring financing options such as community-based networks or managing entities at the sub-state circuit or regional level.

Two major activities are scheduled that will affect the Department and the Substance Abuse Program's managing entity initiative. First, the South East Florida Region is in the midst of procurement for managing entity services. The "Request for Proposals" will be issued in January 2008 with the selection of and contracting with a selected provider occurring prior to July 1, 2008.

Secondly, the Substance Abuse and Mental Health Program Office held a public meeting to accept stakeholder and public comment on the role and functions of a managing entity. The specifications of the role, functions, governance, and financing of managing entities may be modified because of that public input. The results of the public meeting will be incorporated into the Department's specifications for the managing entity procurement.

CHAPTER 5: INFORMATION TECHNOLOGY

DESCRIPTION OF THE CURRENT SYSTEM

The goal of the Substance Abuse and Mental Health 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:

- Section 394.9082(4)(d)(5), F.S., requires the Department and AHCA to establish or develop data management and reporting systems that:
    - Promote efficient use of data by the service delivery system;
    - Address the management and clinical care needs of the service providers and managing entities; and
    - 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, of each year describing 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:
    - Improve the integration, accessibility, and dissemination of behavioral health data for planning and monitoring purposes; and
    - 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:
    - Health Insurance Portability and Accountability Act (HIPAA) standards for security and privacy;
    - Block Grant data, including substance abuse and mental health data infrastructure requirements;
    - National Outcome Measures (NOMS) data;
    - Data Infrastructure Grant tables for Uniform Reporting System;
    - Decision Support 2000 uniform data reporting standards; and
    - Treatment Episode Data System (TEDS) requirements.

The Substance Abuse and Mental Health (SAMH) Program Offices use the SAMH Information System (SAMHIS) 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 SAMH Information System is managed by the SAMH Program Offices' Data Section staff who, in collaboration with regional, circuit, and provider staff, are responsible for the following activities:

- Developing business data requirements based on user needs assessment;
- Testing, accepting, and implementing computer programs based on approved business requirements;
- Maintaining and updating system documentation, including data policies and procedures;
- Training system users and providing on-going technical support;
- Data processing and validation of data quality;
- Analyzing data and producing ad hoc and standard reports; and
- Conducting special studies in response to stakeholder needs.

The DCF Office of Information Systems staff 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 used for hosting the SAMH Information System.

Need for a Comprehensive Behavioral Health Management System

In the absence of requested LBR funding, the SAMH Program Office has taken the following steps in FY 2007-2008 to improve the capability of the current data system:

- 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;
- The FMHI contract for data analysis and reporting functions has been outsourced using the Request for Quote (RFQ) process to select a vendor who will be responsible for developing a web-based application, including hardware and software needed to perform these functions more effectively and efficiently, using fixed cost contracts for professional services. The Acclaims Systems, Inc., is the information technology vendor who was

awarded the contract to complete the development of this web-based application by June 30, 2008. The SAMH Program Office will use existing resources, including funds from the State Outcomes Measurement and Management System (SOMMS) grant and from the Data Infrastructure Grant (DIG) to cover the costs of this contract; and
- FY 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.

SYSTEM REFINEMENTS AND ENHANCEMENTS
The migration of the SAMH Information System from CACHE platform to JAVA/Oracle database environment began in FY 2005-2006, and became effective September 15, 2006. The refinements and enhancements implemented:

- Improved the data validation process to minimize or eliminate existing system defects;
- Redesigned the input screens to improve online data entries;
- Improved 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;
- Increased data security by implementing a dual sign-on process;
- Improved the data analysis and reporting capabilities by revising the user views of the Query Facility data tables;
- 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);
- Created online Crystal reports for tracking data submission status; and
- Created online exception reports used by staff at the state, circuit and local levels for data quality assurance and improvement activities.

To enhance functionality of the current data system, the Department submitted a LBR for funding to acquire and implement a comprehensive and person-centered behavioral health management information system (BHMIS) in FY 2008-2009. This new system will significantly improve the current data system by integrating clinical, social, financial, and administrative information in the following areas:

- Electronic medical records, including but not limited to, information related to clinical evaluation, diagnosis, recovery goals/plans, individual outcomes, medication management, and emergency information;
- 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; and

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

DATA FOR PROGRAM PERFORMANCE AND INDIVIDUAL OUTCOME EVALUATION

The SAMHIS 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. The data collected within the SAMHIS will be used for future NOMs reporting.

Data is used to evaluate the individuals' outcomes include a number of different mechanisms. These mechanisms include: (a) Functional Assessment Rating Scales (FARS) for adults; (b) Children's Functional Assessment Rating Scales (CFARS); (c) individual satisfaction surveys; (d) mental health and substance abuse admission and discharge records; such as employment status, days spent in community, days worked and income earned; school days attended, and involvement in criminal justice system.

Finally, in addition to these individual-based outcome data, the SAMH Program Offices' plan to use the Recovery Oriented System Indicators (ROSI) measures to advance the transformation of the mental health system of care. Teams of peer support specialists are collecting data on the ROSI using stratified samples of individuals per circuit.

CURRENT PERFORMANCE AND FUTURE PLANS

The SAMH Program Offices used the feedback and input from various stakeholders to identify the strengths and weaknesses of the current system and to propose strategies needed to resolve pending problems. External audit reports have identified a number of areas for concern. For example, 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 cited the SAMH Program Offices for the following data issues:

- Insufficient data to correlate provider invoice payments with services provided;
- Inability to provide reasonable assurance that overpayments and erroneous billings do not occur;
- Inability to use data to perform quality assurance and quality improvement activities; and
- Lack of timely resolution for system defects or implementation of system enhancements.

Recommendations have made to address these concerns:

- 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;
- Improve technical skills of individuals responsible for system development activities to reduce system defects and time needed to implement new system enhancements;
- Improve the existing data system to analyze 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; and
- Modify existing data system to implement a billing data module for tracking and approving invoice payments based on actual services provided and documented in SAMHIS.

In the future, the SAMHIS must develop the capacity to comply with the NOMs reporting requirements. Grant funding was used to capture data on the majority of the NOMS measures. However, to become operational, additional financial resources may be needed.

CHAPTER 6: QUALITY IMPROVEMENT - PERFORMANCE MANAGEMENT

Performance management is an essential tool to for the management of program resources and to assess effectiveness of delivered services. Timely and accurate measurement of performance level and trends enable organizations to meet the needs of customers. The Substance Abuse and Mental Health Program Offices utilize quality improvement activities to meet these objectives.

OVERVIEW

Beginning in August 2005, Performance and Resource Management Teams (PaRTs) were chartered to integrate management of performance outcomes and decisions regarding expenditures. These PaRTs Teams were given responsibility for identifying performance and resource gaps, providing corrective action strategies and monitoring implementation impact. Core team membership consisted of representatives from all sectors of the Department in the central office, regions and circuits.

Program performance measures and resource use are linked to the Department's strategic and business plans and support service delivery in the community. The SAMH PaRTs team meets on an ongoing basis to address SAMH issues. Performance reports are provided to the Assistant Secretary for Substance Abuse and Mental Health as a part of the Substance Abuse and Mental Health Steering Team.

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 status of 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. The team reviews data posted to the Dashboard as well as, compares current performance to prior performance and trends to Departmental targets. Based upon data results, the team then contacts Circuit/regional staff and provider agencies to continue the analysis at the local level. Countermeasures are developed and initiated to improve performance related to specific outcomes. PaRTs reports reflect the periodic assessment of the data as well as the design and implementation of identified countermeasures. The team monitors the impact of selected countermeasures on an ongoing basis.

State Measures

Certain performance measures are of primary importance to the Department due to the criticality of the services they measure. These are the "Critical Few," and identified as such on the Department's Dashboard. Other measures (not included in the critical few, or reviewed as frequently), appear in the Department's strategic and business plans, the Long Range Program Plan or in the SAMH state master plan. Some of these measures appear in several documents. These measures are reviewed monthly and results are reported on an as needed basis.

National Outcome Measures

Both the Substance Abuse and Mental Health Program Offices 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 substance abuse issues or mental illnesses include:

- 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).

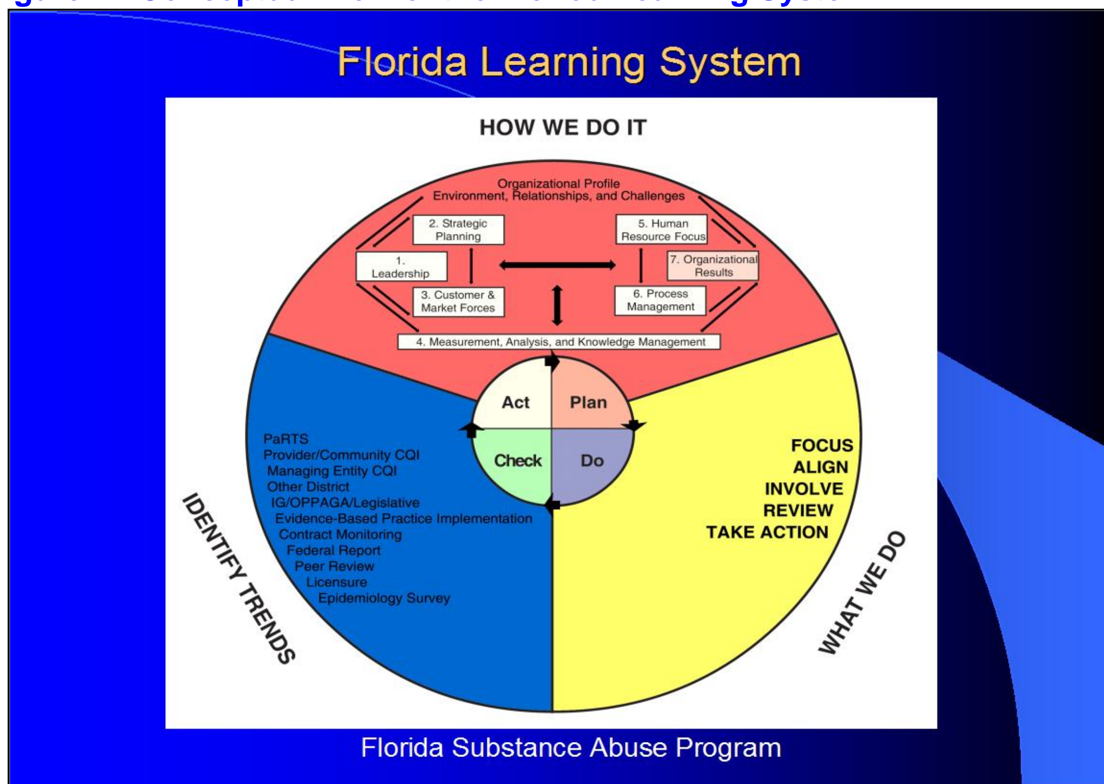
- Use of Evidence-Based Practices: the measure is the same as for cost effectiveness. The outcome is the use of evidence-based practices.

Each of the program offices have implemented a process to develop measurement algorithms and reporting capacity for the NOMs measures by 2008. During the next year, additional steps will be taken to transition from the current state measures to the federally required NOMs.

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 enables 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 ensures that the systems of care and administrative oversight process operate efficiently and effectively.

Figure 7: Conceptual Flow of the Florida Learning System



Central to the continuous quality improvement function of the Florida Learning System is use of the Plan, Do, Check, Act cycle. Two grants acquired by the Substance Abuse Program Office, i.e., Strengthening Treatment Access and Recovery - State Implementation (STAR-SI), and Advancing Recovery, have assisted in directing the focus of the Florida Learning System.

During the past year, members of the Learning System have met in conjunction with the STAR-SI learning sessions and acted in an advisory capacity to that grant. Members of the Learning System will begin meeting on a quarterly basis in 2008.

During the upcoming year, the Substance Abuse and Mental Health Programs will strive to meet its strategic challenges as well as continue to initiate strategies and action steps that contribute to meeting the Program's objectives. In addition to the objectives and strategies identified in the triennial master plan, the programs will introduce initiatives to meet new Legislative direction.