Adult Workgroup Report

Report of the Adult Workgroup of the Florida Commission on Mental Health and Substance Abuse

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ADULT WORKGROUP REPORT

Introduction

The Adult Workgroup was established to review and make recommendations to the Florida Commission on Mental Health and Substance Abuse regarding mental health and substance abuse (MHSA) services for adults in the state of Florida. The Adult Workgroup membership is described in Appendix 1.

The Commission and this workgroup are charged with examining issues affecting the health of Floridians as these issues relate to both mental health and substance abuse service delivery in the state of Florida, and then providing recommendations to the legislature to improve the current system of care. In fulfilling this charge, the Commission and this workgroup have chosen to consider issues as they pertain to all Floridians with MHSA problems, rather than just focusing on the services paid for by the Department of Children and Families, Mental Health and Substance Abuse Program Offices or the Agency for Health Care Administration. These services are provided to a much smaller group of persons who tend to experience the most severe MHSA disorders. Some reasons for taking a broad focus include - a) it puts historical decisions concerning funding of public sector services in their full context and allows a better perspective on evaluating those decisions, b) it allows more opportunities for improving the health and reducing suffering for all Florida citizens, and c) changes to one part of the system (public vs. private sectors) are likely to have effects on other parts of the system.

While the areas of mental health and substance abuse have much in common, service provision for individuals with these problems has evolved into two rather separate systems. Thus, while these two areas share many common issues and problems, each area also presents some unique issues and problems. To the extent possible, this workgroup report seeks to discuss mental health and substance abuse problems and services in tandem with appropriate recognition where significant differences exist. Where the two areas are combined, we will use the term 'behavioral health' (or the abbreviation MHSA).

The Surgeon General of the United States recently issued a report on mental health (U.S. Department of Health and Human Services (US DHHS), 1999). This report provides an excellent overview of the state of knowledge about mental health and mental health problems in the United States, and it provides an excellent backdrop for the report of this workgroup regarding mental health issues. Unfortunately, the Surgeon General's report contains very little comparable information specifically regarding substance abuse. However, the Governor's Office of Drug Control has issued a report on the state's drug control strategy (Florida Office of Drug Control, 1999) and the National Institute on Drug Abuse has issued a report, *Principles of Drug Addiction Treatment* (National Institute on Drug Abuse (NIDA), 1999) that together address many of the relevant and specific issues for substance abuse. The workgroup also relied on a number of other sources of data for this report, including a) other scientific literature on mental health and substance use disorders and services, b) testimony received by the Commission, c) the expertise of invited workgroup participants, and d) specific analysis of various data sets available to the Commission (refer to the report of the Data Workgroup - Kip, 2000). Unfortunately, extant data systems regarding mental health and substance abuse services in the Ssate of Florida suffer from multiple problems that limit their usefulness for the purposes of this report. First and foremost, no one data system contains information on the functioning of the entire system. The data system for the Department of Children and Families, Mental Health and Substance Abuse Program Offices has only in the past couple of years begun to yield reliable and reasonably complete data. Moreover, this system only contains data regarding persons who are currently receiving services

from publicly funded MHSA providers; and thus, only pertains to a circumscribed part of the entire system.

Scope of the Problem

The Report of the Surgeon General reached several important conclusions; specifically, that mental health is fundamental to health and that mental disorders are real health conditions that have an immense impact on the quality of life for large numbers of individuals and their families. For example, research by the World Health Organization indicates that in established market economies, having a mental health disorder is the second leading cause of disability and premature mortality. More importantly, such disorders account for over 15% of the overall burden of disease from *all* causes. In addition, substance abuse accounts for more than an additional 6% of the overall disease burden (Murray & Lopez, 1996).

Based on a review of over 3,000 research articles, the Surgeon General's report concluded that the efficacy of mental health treatments is well documented. A range of treatments exists for the symptoms of most mental disorders. Similarly, a range of empirically-validated treatments are available for substance use disorders (NIDA, 1999). Despite the presence of effective treatments, nearly half of all Americans who have a severe mental disorder (and many people with substance use disorders) do not seek treatment due to numerous very real barriers. Foremost among those barriers is the stigma associated with having a diagnosed mental health or substance use disorder and/or receiving treatment (Sussman, Robins, & Earls, 1987).

Furthermore, the Surgeon General's report noted that significant gaps exist between what science has shown to be effective treatment and the treatment that is actually provided to citizens in their community. Left untreated (or treated ineffectively), MHSA disorders can and do worsen. More severe disorders are more likely to be associated with long-term disability due to disruption of education, employment, and social supports at critical times in the person's life. Additional rehabilitative interventions have been developed to address these issues.
The causes of MHSA disorders are attributable to a combination of factors that are described in the biopsychosocial model of disease (Engel, 1977). There is considerable evidence that MHSA disorders such as schizophrenia, substance abuse, and mood disorders (to name a few examples) may be associated with a genetic predisposition to the disease which is more likely to be expressed if the person is subjected to certain psychological conditions (such as trauma or stress) and to certain social conditions (such as lack of social supports). Similarly, the treatment or management of such disorders needs to consider all three types of factors. Treatment may appropriately involve pharmacological interventions (biological), counseling or psychotherapy (psychological), and increasing social supports (social). And finally, progress in treatment is most appropriately assessed by a consideration of all three types of factors, for example, physical health, psychological or emotional health, and social functioning. In recent decades, considerable progress has been made in the treatment of MHSA disorders in all three areas. New medications have been developed that are both more effective and associated with fewer undesirable side effects than those that were previously available. Psychological interventions have been improved and demonstrated to be effective with particular disorders (e.g., cognitive behavioral treatment of depression and anxiety). And additional service components have been developed that address social issues especially for persons with more severe disorders (e.g., supported employment and housing).

MHSA disorders encompass a broad range of disorders that vary considerably in their presentation, course, and severity. The most common types of MHSA disorders experienced by adults include:

Substance-related disorders include substance use disorders, substance dependence disorders, and substance-induced disorders (American Psychiatric Association (APA), 1994). These disorders involve the use of a wide range of substances, both legal and illegal. According to the National Comorbidity Survey (NCS; Kessler, McGonagle, Zhao, et al., 1994), 26.6% of Americans have met the diagnostic criteria for a substance use disorder at some point during their lifetime, and 11% met the criteria during the last 12 months. The essential features of a substance use disorder are a pattern of repeated substance use associated with recurrent and substantial adverse consequences such as repeated failure to fulfill major role obligations, multiple legal problems, recurrent social and interpersonal problems, and a repeated use of substances in situations where it is physically hazardous. Substance dependence disorders involve substance abuse and a pattern of drug usage resulting in tolerance, withdrawal, and/or compulsive drug-taking behavior. Treatment of substance abuse and substance dependence disorders includes behavioral therapy and pharmacotherapy (NIDA, 1999).

Schizophrenia In any given year, about 1.0% of U.S. citizens meet the diagnostic criteria for schizophrenia (Robins & Regier, 1991). While persons of any age may experience symptoms of schizophrenia, onset of a first episode of schizophrenia typically occurs during late adolescence or early adulthood - a time when people are usually establishing autonomy as young adults and entering their first job, starting college, or getting married. The symptoms of schizophrenia vary considerably from case to case. However, to meet the diagnostic criteria a person must experience two or more of the following symptoms for a significant portion of time during a one month period: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (e.g., flattening of affect, inability to initiate and persist in completing tasks, and impoverished speech and language) (APA, 1994). The onset of schizophrenia begins with a "prodromal" phase that consists of a progressive deterioration in functioning preceding one or more episodes of "active" symptoms (described above). The period between "active" episodes is referred to as the residual phase and it is characterized by on-going symptoms of lesser severity than during the active phases. The severity of residual phase symptoms varies widely. The Patient Outcomes Research Team (PORT; Lehman & Steinwachs, 1998) recommendations for the treatment of schizophrenia include pharmacotherapy (anti-psychotic medication) in conjunction with supportive psychotherapy, family treatment, psychosocial rehabilitation and skill development, and vocational rehabilitation. New "atypical" anti-psychotic medications have recently been developed that appear to be more effective with negative symptoms, have fewer side effects, and show promise for treatment of people for whom the older anti-psychotic medications were ineffective (Lieberman, 1996).

Mood disorders Mood disorders include a group of mental disorders that involve episodes of changes in mood that are outside the bounds of normal fluctuations from sadness to elation (APA, 1994). During a year, over 11% of Americans will suffer from a mood disorder (Kessler, McGonagle, Zhao, et al., 1994). The major disorders in this category are major depression which involves episodes of depression, and bipolar disorder which involves at least one episode of mania and may or may not also involve episodes of depression.

Major depression may begin at any age, but the average age of onset is in the mid-20s. Women are twice as likely as men to experience major depression, but the lifetime risk for major depression appears to be unrelated to ethnicity, education, income, or marital status. Approximately 50%-60% of individuals who experience a single episode of depression will have

a second episode, 70% of people who experience a second will have a third, and 90% of individuals who experience a third will experience a fourth (APA, 1994). Depressive episodes involve symptoms such as predominantly depressed moods, loss of interest or pleasure in activities, appetite or weight disturbance, sleep disturbance, fatigue, feelings of worthlessness or guilt, cognition problems, and thoughts of death or suicide (APA, 1994). Depression is treated effectively with anti-depressant medication (Depression Guideline Panel, 1993) and cognitive-behavioral therapy or interpersonal psychotherapy (Elkin et al., 1989).

A manic episode is characterized by an abnormally and persistently elevated, expansive, or irritable mood that lasts at least one week and is accompanied by inflated self-esteem, decreased need for sleep, pressured speech, racing thoughts, distractibility, increase in goal-directed activity or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful or dangerous consequences (APA, 1994). During a manic episode, a person's judgement can be severely compromised. Spending sprees, disinhibited behavior, promiscuity, or other objectively reckless behaviors are commonplace. Both major depression and bipolar disorders can include the presence of psychotic features such as delusions or hallucinations. About 1.3% of the adult population meets criteria for bipolar disorder in a given year (men and women are equally likely to have bipolar disorder) (Kessler, McGonagle, Zhao, et al., 1994). Ninety percent of individuals who have a single manic episode go on to have future episodes. Episodes of mania can occur an average of every 2 to 4 years, although accelerated mood cycles can occur annually or more frequently. Bipolar disorder is typically treated with mood stabilizing medications (APA, 1994).

Anxiety disorders are the most frequently occurring mental disorders among adults, and they often co-occur with mood and substance use disorders. In the United States, 17.2% of persons 15-54 years of age experience an anxiety disorder within a year (Kessler, McGonagle, Zhao, et al., 1994). Anxiety disorders include panic disorder, agoraphobia, obsessive-compulsive disorder, social phobia, and post-traumatic stress disorder (APA, 1994). Panic disorder involves having repeated, unexpected panic attacks which are distinct periods of fear accompanied by symptoms such as heart palpitations, sweating, trembling, shortness of breath, choking, chest pain, nausea or gastrointestinal distress, dizziness, and chills or "hot flashes." Agoraphobia involves anxiety about or avoidance of situations in which escape might be difficult or in which help might not be available in the event of a panic attack. Obsessive-compulsive disorder involves the experience of obsessions (recurrent, intrusive thoughts or impulses that the person sees as inappropriate and uncontrollable) and compulsions (repetitive actions usually geared to reducing the obsessions). Phobias involve irrational fears. (PTSD will be described under trauma-related disorders). Anxiety disorders are generally treated effectively with behavior therapy, psychotherapy, and/or medications (US DHHS, 1999).

Personality disorders involve enduring patterns of perceiving, relating to others, and thinking that are maladaptive and inflexible and that deviate significantly from the expectations of the person's culture (APA, 1994). The onset for most personality disorders is in adolescence or early adulthood, and the disorder is generally stable over time. Some types of personality disorders (e.g., antisocial personality disorder) tend to become less evident or to remit with age, but this is less true with other types (e.g., obsessive-compulsive personality disorder).

Trauma-related disorders Although there is not a separate category for trauma-related disorders in the DSM-IV, several disorders have been identified as being associated with the experience of trauma. These disorders include post-traumatic stress disorder (PTSD), borderline personality disorder and dissociative identity disorder. Such events include experiences such as combat experiences, traumatic accidents, and physical, emotional, and sexual abuse. These disorders

often present with severe symptomatology, and frequently have high financial and social consequences from the significantly elevated rates of hospitalization, suicide attempts and alcohol and drug abuse that occur with these disorders (Rosenberg, Drake, & Mueser, 1996).

Adjustment disorders involve the development of a variety of relatively short-term, but clinically significant emotional or behavioral symptoms in response to an identifiable stressor. Adjustment disorders are relatively common, but reliable epidemiological data are not available in this regard (APA, 1994).

There are other mental disorders that occur primarily among children or older adults that are not discussed here, but we assume these disorders will be discussed by the other workgroups. In addition, there are other, less common mental health disorders that occur among adult Floridians that are not discussed here in the interest of brevity (e.g., eating disorders, sleep disorders, somatoform and factitious disorders, and impulse control disorders).

It is apparent that MHSA disorders vary considerably in their presentation, course, and severity both within and across types of disorders. A common misconception about MHSA disorders is that the disorder affects every person with a particular disorder in the same way. For example, it is commonly (and incorrectly) believed that schizophrenia invariably has a chronic, unremitting, and progressively deteriorating course. Research has shown that this is not the case. In fact, it has been found that the course of schizophrenia is highly variable and that a significant number of persons experience a brief course of the disorder followed by a full recovery. Furthermore, most people with schizophrenia experience at least moderate recovery from the disorder over the course of their lives, and some recover completely (Harding et al., 1992).

Epidemiological studies (Kip, 2000) indicate that about 30% of adult Floridians experienced an MHSA disorder during 1998 (23% had a mental health disorder and 12% had a substance use disorder). Approximately 5.8% of Floridians experienced a mental disorder that could be classified as severe; 2.8% experienced a mental disorder that could be classified as severe and persistent (these figures do not include substance abuse diagnoses).

A significant number of Floridians experienced <u>both</u> a mental health disorder and a substance use disorder. This is referred to as "comorbidity." According to the National Comorbidity Survey (Kessler, McGonagle, Zhao, et al., 1994), for persons aged 15 to 54 nationwide, more than 40% of persons with a substance use disorder within a year also had a co-occurring mental health disorder within that year. Similarly, over 20% of persons with a mental health disorder within a year also had a co-occurring substance use disorder within that year. Lifetime occurrence of comorbidity is even higher. Almost 65% of persons who have had a substance use disorder have also experienced a mental health disorder within their lifetime, and over 40% of persons who have had a mental health disorder have also had a substance use disorder within their lifetime. The NCS also showed that co-morbidity is more of a problem with severe disorders. Nearly 90% of the people with severe disorders experience 3 or more comorbid MHSA disorders in their lifetime (Kessler, 1995). Thus, persons with more severe disorders are much more likely to present with multiple, serious service needs.

Comorbidity can actually involve the co-occurrence of any two MHSA disorders or it can also involve the co-occurrence of one or more MHSA disorders with medical/physical disorders. For example, persons with schizophrenia are much more likely than the general population to experience a substance use disorder, suicide attempts, completed suicides, and a variety of medical problems, including vision and dental problems, high blood pressure, diabetes, and sexually transmitted diseases (Dixon et al., 1999). In fact, mortality rates from a variety of

causes for persons who are diagnosed with schizophrenia are significantly higher than that of the general population (US DHHS, 1999).

Several overall conclusions can be drawn from the information presented above which have implications for MHSA service delivery systems.

1. People who experience MHSA disorders or problems present with highly variable sets of service needs.

2. Effective treatments are available for most MHSA disorders, and effective prevention strategies have been developed for persons with substance use disorders.

3. Left untreated, or treated ineffectively, many MHSA disorders can and do worsen.

4. As MHSA disorders become more severe and/or more chronic, the likelihood of complicating factors such as comorbid disorders or disability increases. When this happens, treatment becomes much more complicated, difficult, and costly.

The Mental Health and Substance Abuse Service System

The "service system" for mental health and substance abuse problems and disorders was not specifically developed, but rather evolved into its current form over many years. As noted above, service systems for mental health and for substance abuse have developed rather independently. Fifty years ago, mental health services were provided primarily in the large state mental hospitals (for persons with severe mental illnesses) and in private practice offices of psychiatrists (for persons with less severe mental illnesses). In the 1960s, the community mental health center approach and the increased use of effective psychotropic medications allowed a shift to the community as the locus of treatment for persons with severe mental illnesses. More recently, community mental health centers have been privatized and the public mental health service system consists of a sizable number of mostly private, not-for-profit corporations that provide services under contract with the state mental health authority (the Mental Health Program Office in the Department of Children and Families). Concurrently, private practitioners and other private agencies have expanded the provision of mental health services that are paid for by individuals or by individual's health insurance policies. Substance abuse services, in contrast, were essentially non-existent fifty years ago. Substance abuse was viewed more as a weakness of character than as a treatable medical condition. Over time, a greater recognition developed that substance abuse is a treatable medical condition and effective treatments were developed. The substance abuse service field has become increasingly professionalized, and substance abuse service provider agencies have been established. Over the past fifty years, dramatic improvements have been made in the technology of mental health and substance abuse treatment and assessment.

The structure of the existing mental health and substance abuse service system was not determined by a set of organizing principles, but rather evolved bit by bit in response to many heterogeneous factors (especially financing incentives). As a result, the system is frequently referred to as being "fragmented" (Regier et al., 1993).

The mental health and substance abuse service system offers services through a wide variety of relatively independent MHSA service settings including:

- Community mental health centers
- Community substance abuse centers
- General hospitals (inpatient and outpatient)
- **Veterans' Administration (VA) hospitals (inpatient and outpatient)**
- Crisis stabilization units
- Addiction receiving facilities
- Private mental health and substance abuse practitioners
- Primary care (medical)
- Self-help
- Criminal justice system

Persons identified as needing treatment and are referred for treatment from a wide variety of settings including:

- Primary care (medical)
- Educational settings
- Employment settings
- Criminal justice settings
- **Human services systems (Welfare, Employment, etc.)**

Services provided in the existing mental health and substance abuse service system are paid for from a wide variety of funding sources including:

- Medicaid
- Medicare
- Department of Children and Families – federal block grants
- Department of Children and Families – general revenue
- Other state funding (e.g. Department of Corrections)
- **Other federal funding (e.g. VA, CHAMPUS, Centers for Disease Control and Substance Abuse and Mental Health Services Agency grants)**
- Local match
- Private insurance
- Self-pay
- Other (charitable foundations)

From the above, it is obvious that the combined service system is complex - there are many (and often competing) provider agencies and multiple funding and regulatory agencies. This complexity has resulted in numerous problems for the system, particularly with regard to organization and planning. Specifically:

1. **There is no overall accountability for outcomes for the system as a whole, since no single entity is responsible for the entire system.**

2. There are no uniform statewide standards for quality of care across all settings.

3. In many areas, services are fragmented especially for people with the most complex illnesses and significant disabilities.

4. Funding mechanisms and regulatory mechanisms for separate funding sources are complicated and often contradictory. This compromises continuity and comprehensiveness of care.

5. There is no integrated information system for the system as a whole to assess system functioning and population health status.

It should be noted that some of these issues are being addressed recently but only for the substance abuse part of the system with the creation of the Office of Drug Control which functions under the Office of the Governor.

Brief Description of a System of Care

The conceptual flow of a system of care may be characterized for mental health and substance abuse problems and treatment. Many MHSA disorders can be prevented before they become health problems. However, it is anticipated that not all mental health and substance use disorders will be prevented. It is highly desirable for persons to be identified early in the process of developing a disorder so that appropriate intervention is provided before the disorder substantially interrupts the person's life. Such early identification can occur within families, at work or school, or in other settings where people naturally find themselves. Upon identification, referral to a service provider could occur and screening, referral, assessment, and/or treatment could be provided on an ambulatory basis. However, it is often the case that such problems are not identified at an early stage, but rather, the problems progress and the disorder becomes more severe. Case identification may still occur in the manner described above, but treatment interventions may need to be more intensive (e.g., delivered in a more restrictive and costly environment) or more frequent. Case identification may also occur in much less desirable ways, such as through child welfare agencies, referral to acute (emergent) care settings, or through law enforcement intervention (e.g., Baker Act or DUI). When MHSA disorders become severe, it is expected that they will be associated with significant disability due to the disruption that these disorders cause in various aspects of a person's life (e.g., vocational, education, social, financial, etc.). At this point, a range of coordinated services is required to address these needs.

Consistent with the conclusions of the Surgeon General's report on mental health and NIDA's report on drug addiction treatment, a wide range of services is available for people experiencing mental health and substance abuse problems and disorders. The workgroup organized its effort by considering the service needs that people have depending on the severity of the symptoms of their disorders. We discuss these needs at several discrete points that occur along a continuum of symptom severity. We refer to these points as "stages" which will serve as the basis for discussion and critique of the MHSA system in this report. First, each of the stages of the model will be discussed, then, issues pertaining to the system as a whole will be presented.

The first part of this model involves all Florida citizens and involves non-treatment MHSA service activities that are targeted to reach persons at risk of developing or being adversely effected by an MHSA disorder. These services include prevention activities and public education about MHSA issues. These efforts are intended to prevent or reduce the occurrence of MHSA disorders and to reduce stigma associated with having MHSA disorders or receiving treatment for such disorders.

The second part of this model involves persons who are developing an MHSA disorder or who are experiencing relatively less severe symptoms of an MHSA disorder. At this stage, people need early recognition of the presence of a disorder, and they need effective treatment for the disorder in the most natural care settings. Early recognition and treatment provides an excellent opportunity to prevent more severe consequences from these disorders.

The third part of this model involves persons who are in more advanced stages of development of an MHSA disorder or who are experiencing relatively more severe symptoms of an MHSA disorder. Persons with such severe disorders are more likely to also experience co-morbid disorders and significant disability. Persons in this stage are likely to need multiple, coordinated interventions (i.e., appropriate treatment, rehabilitation and support) on a consistent, continuing and flexible basis. The fourth part of this model involves persons who are experiencing MHSA crises. People at this stage need immediate emergency assessment and treatment. They also need timely, systematic aftercare in less intensive service settings following discharge.

Persons who are not yet experiencing MHSA disorder, but may be at risk for developing MHSA disorder

Prevention and public education activities related to MHSA disorders involve all citizens and are especially targeted to persons at risk of developing or being adversely effected by an MHSA disorder. These efforts are intended to prevent or reduce the occurrence or severity of MHSA disorders and to increase the likelihood of early detection and effective intervention for persons developing MHSA disorders. We assume that prevention issues will be addressed more thoroughly by the Children's Workgroup, since most effective prevention efforts are targeted to children and their families. However, prevention issues have an important impact on adult behavioral health, and there are a number of very important education issues that pertain to adults.

Prevention interventions are designed to reduce the incidence of MHSA disorders. This has the benefit of reducing suffering, increasing productivity, and reducing the need for (and thus, the overall cost of) MHSA services within our population. Prevention activities have received little attention within the mental health (non-substance abuse) service system. This is probably because little research progress has been made in the identification of modifiable risk factors or protective factors for mental health disorders, and thus, little progress has been made in developing effective prevention strategies for mental health disorders. Experience of trauma is perhaps the most notable identified, modifiable risk factor for mental disorders (Rosenberg, Drake, & Mueser, 1996).

Significant work has been done, however, with regard to prevention of one of the most extreme complications of major mental disorders, namely, suicide. The Surgeon General's office has issued a report entitled *The Surgeon General's Call to Action to Prevent Suicide* (U.S. Public Health Service, 1999) that outlines strategies that the nation and local communities can take to prevent suicide. A significant number of the recommendations of the *Call to Action* are similar to recommendations made by this workgroup (the *Call to Action* can be found on-line at http://www.surgeongeneral.gov/ library/calltoaction/default.htm). The overall rate of suicide in the state of Florida should be considered as an important indicator of the population's mental health status. In 1997, the suicide rate in Florida was 14.3 per 100,000 which was higher than the national average of 13.3 per 100,000.

Due at least in part to federal block grant requirements, much more attention has been focused on prevention activities within the substance abuse service system. These prevention activities focus primarily on reducing risk factors and increasing protective factors for persons at risk of developing substance use disorders. Risk and protective factors have been grouped into six domains of life that include individual factors, peer association factors, school-related factors, community environment factors, family environment factors, and society-related factors. Based on substance abuse prevention research, effective prevention strategies are applied for these risk and protective factors. These include interventions such as information dissemination, education, drug-free alternative activities, early identification and referral, environmental strategies, and community process strategies. The implementation of these strategies occur through information programs, public service messages, internet websites, educational literature, outreach groups, leadership activities, recreation programs, multi-agency coordination and team building, drug and alcohol free events for teens, changing advertising practices, sports outreach to teens, mentoring programs, and involving the faith community, to name a number of specific examples.

Florida's Office of Drug Control and the Department of Children and Families coordinates these prevention efforts. Current efforts are focusing on increasing the overall amount of prevention effort and on increasing interagency collaboration on prevention efforts. Currently, the Department of Children and Families (DCF) has $53.7 million budgeted for substance abuse prevention, and according to the Florida Youth Substance Abuse Prevention Initiative (at DCF) an additional $80.4 million is budgeted for substance abuse prevention efforts across 8 other state agencies. This is compared with $151.3 million budgeted for all substance abuse services (including prevention) through DCF.

Problems regarding Prevention and Public Education

Data presented in the Surgeon General's report indicate that about half of persons with MHSA conditions do not seek treatment. The result is significant cost in terms of suffering and lost productivity. In addition, it is likely that many people who do not receive early, effective treatment continue to experience progressively worsening symptoms of their disorders and develop other comorbid disorders as well. Among the major reasons for people not seeking treatment that might be modified through education are the failure to recognize the presence of an MHSA condition, the lack of awareness of how and where to obtain treatment, the mistaken belief by many that effective treatments are not available, and stigma associated with receiving services for an MHSA condition. Thus, the content of public education efforts should be focused on:

- information on the prevalence of MHSA conditions and how to recognize the presence of an MHSA condition,
- information on the effectiveness of available treatments and on how and where to obtain treatment, and
- reduction of stigma associated with MHSA conditions and treatment.

Public education should be focused on each of these areas to increase the number of persons who receive early, effective treatment for MHSA disorders that they experience.

The interest of state and local government in these activities as they affect the public's welfare should be self-evident. Moreover, the specific rationale for state and local government

involvement in supporting these activities is an issue of cost-benefit. For example, there is evidence to show that comprehensive drug abuse prevention is highly cost effective (Pentz, 1998). There is also good evidence to show that prevention and early intervention with MHSA disorders are effective in reducing disability associated with such conditions. These interventions are far less costly than the more intensive interventions that are required (and that state and local governments pay for) once a person experiences comorbid disorders or disability associated with their MHSA condition.

Recommendations for Prevention and Public Education

1. The state of Florida should increase efforts in the areas of prevention and education.

2. Specifically, prevention and education efforts that are already being implemented in the area of substance abuse prevention and education should be supported and increased.

3. Similar efforts should be implemented for other mental health disorders, and this should be done with new money (not funds taken away from other MHSA services that are already under-funded - see below).

Persons with less severe disorders or in early development of a disorder

The second part of this model involves persons who are developing a MHSA disorder or who are experiencing relatively less severe symptoms of a MHSA disorder. Services that are delivered to persons at this stage are provided primarily on an outpatient, short-term basis; and although their functioning may be significantly impaired by their disorder, these persons are not thought of as experiencing long-term disability associated with their disorder. These services may be provided by traditional (specialty) MHSA providers such as psychiatrists, psychologists, social workers, certified addictions counselors, licensed mental health counselors, free-standing substance abuse providers, and community mental health centers, etc., or these services may be provided by others that are not typically thought of as professional MHSA providers. This would include primary care physicians, clergy, human service agencies, self-help groups, and advocacy and volunteer organizations, etc. We will refer to this stage as "ambulatory care."

At this stage, people need early recognition of the presence of a disorder, and they need effective treatment for the disorder in the most natural care settings. Early recognition and treatment provides an excellent opportunity to prevent more severe consequences from these disorders. However, when persons are not appropriately identified and effectively treated at an earlier stage of their disorder, their condition may continue to worsen until the symptoms are severe enough to warrant treatment within acute (emergent) care settings, or they begin to experience significant disability and become candidates for treatment within the publicly funded continuing care sector, or they become homeless, or come into contact with law enforcement. There is good evidence to suggest that many people are not appropriately identified nor effectively treated at an early stage of their disorder.

Problems with the Ambulatory Care System

A very substantial part of services provided at this stage for mental health disorders are paid for by private insurance or by the service recipient. Services provided at this stage have not been a

focus of the public mental health system because, historically, the state of Florida has prioritized provision of publicly funded services to persons with more severe disorders. Unfortunately, the U.S. Census Bureau's (1999) estimates of the percentage of Floridians under age 65 without health insurance are above the national average with 2.5 million Floridians (21.1 % of the population) uninsured in 1998 (Vogel, Duncan, Garvan, et al., 2000). Furthermore, in 1998 more than 13% of Floridians were below the poverty level. Although, programs do exist to provide health services to persons who are indigent, such programs usually do not offer mental health and substance abuse services. For substance abuse, a higher proportion of services at this stage are paid for with public funds.

Case identification and treatment for people with mental disorders and substance abuse problems at this stage should be improved and increased so that persons are receiving treatment before the symptoms of their disorder become more severe. Effective treatment at an early stage of the disorder can reduce the service demand in the sectors that are responsible for more intensive intervention. Unfortunately, at the national level it has been shown that such early identification and treatment often do not occur (Regier et al., 1993; US DHHS, 1999), and there is no reason to presume that the trend in Florida would be any better than the national trend. Three major problems have been identified:

1. Frequently, persons with disorders are not detected and referred for treatment early enough in development of disorder.

2. Persons with disorders have difficulties with accessing treatment

3. Best practice guidelines are not followed consistently in the community.

Recommendations for Ambulatory Care

Many things could be done to increase and improve MHSA service provision to persons who are in the early stage of development of an MHSA disorder. Four things definitely should be done that would increase access to MHSA services.

1. **Additional resources are needed in this area in both mental health and substance abuse. The state should increase public sector services at this stage for mental health, similar to what is already being done in substance abuse.**

2. Reduce financial barriers to treatment. Specifically, the state should take action to insure equitable and non-discriminatory insurance coverage for MHSA disorders (this would include investigating whether "parity" legislation is called for).

3. Encourage local programs to include MHSA services in programs for the medically indigent.

4. Establish information and referral resources such as a 1-800 number for referral information statewide.

Some additional things that could be done to increase and improve MHSA service provision to persons who are in the early stage of development of an MHSA disorder include:

1. Develop education programs that improve the recognition of MHSA disorders, increase awareness of effective treatments for such disorders, and increase referral information for consumers, families, and providers. Such education programs should target:

    - people at risk of developing a MHSA disorder
    - natural points of contact for people at risk
    - management in employment settings
    - human service personnel
    - families
    - others (e.g., clergy)

    2. Encourage practices in primary medical care that increase detection of cases (e.g., routine behavioral health status screening similar to that done for blood pressure, hearing, vision).

3. Increase support for community support groups, consumer and family organizations, self-help organizations, etc.

4. Establish knowledge development activities to increase implementation of “best practices” in the community.

Persons with more severe disorders or in the later stages of development of a disorder

The third stage in this model involves persons who are in more advanced stages of development of MHSA disorder or who are experiencing relatively more severe symptoms of MHSA disorder. Treatment services for these people are delivered primarily by specialty MHSA providers. Persons with such severe disorders are more likely to also experience comorbid disorders and significant disability, and to have multiple other needs such as medical problems, difficulty maintaining employment, low income, and housing problems, in addition to their specific MHSA symptoms. Persons in this stage are likely to need multiple, coordinated interventions (i.e., appropriate treatment, rehabilitation and support) on a consistent, continuing and flexible basis. Services may be expected to be long-term and may often be intensive (i.e., inpatient treatment). We will refer to this stage as "continuing care."

The overall goal for the system at this stage should be recovery. People with chronic MHSA disorders should have the skills and/or supports to be successful and satisfied in the role or environment of their choice. People receiving services must be treated with respect and given hope for their recovery. The notion of recovery reflects renewed optimism about the outcomes of mental illnesses. Recovery from a major mental illness does not necessarily imply a cure or return to the pre-morbid state. Rather, it means a re-adaptation to an illness that allows life to go forward in a meaningful way. It is not tied to symptom relief. Re-hospitalization, intensive outpatient treatment, etc., are only part of the recovery process. Recovery also includes recovering from stigma; institutionalization; the effects of poor/wrong treatment/interventions; lack of opportunities for self-determination; lack of social and community access and interactions; the effects of unemployment, mis-education about mental illness; and crushed dreams. One of the most prominent professional proponents of recovery, William A. Anthony, summarized consumer writings on recovery with the following: "... a person with mental illness can recover even though the illness is not 'cured' ... [Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new

meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p. 15; Anthony, 1993).

In a system that is recovery-oriented, services - (1) are consumer-centered; (2) empower clients; (3) are racially, culturally and gender appropriate; (4) are flexible; (5) focus on strengths and abilities; (6) normalize and incorporate natural settings; (7) meet special needs; (8) are accountable; and (9) are coordinated (Stroul, 1989). Ideally, the array of services in such a system would be organized into a network that surrounds the client with everything he or she needs to live up to his or her potential. This would include identification of and outreach to persons needing services, mental health treatment, crisis services, medical and dental care, housing, income maintenance, family and community support, rehabilitation services, protection and advocacy, case management, and peer support (Stroul, 1989).

There are extensive discussions of the organization, funding, and activities of publicly funded MHSA services for persons at this stage in Chapter 1 of the Commission's report (Bell & Shern, 2000) and in the Report of the Data Workgroup (Kip, 2000). Thus, we will not reiterate these data here.

Problems with the Continuing Care System

1. **Based on testimony received by the Commission, it appears that there is widespread consensus that the current publicly funded continuing care system is substantially under-funded. The need for service far exceeds the available supply.**

   According to data from SAMHSA, Florida receives less than its proportionate share of mental health and substance abuse block grant funds (specifically, we receive 4.5% of the funds, despite having 5.5% of the nation's population). Several participants on the workgroup suggested that it is likely that Florida similarly receives a lower share of Medicaid "draw down" funds, as well as Medicare, Part B, and Housing and Urban Development funds.

2. Services and funding for services in the continuing care stage are fragmented and this creates barriers to access of services. Persons who would appropriately receive services within the continuing care sector are typically persons who are experiencing significant disability associated with their disorder. This implies that these persons have multiple service needs. Fragmented funding results in multiple agencies designed to address these various multiple needs, each agency having its own set of bureaucratic rules and hurdles. The present system is exclusionary in that programs are often funded for specific groups (i.e., "categorical funding"), and other persons who may have equal or greater need for the services but are not members of the specific group are not included in such programs (e.g., TANF, Medicaid, services offered in correctional system diversion programs, etc.)

3. The current structure of funding thwarts attempts at accountability. With fragmented funding, accountability is also fragmented. For example, an agency may only be responsible for "one piece of the pie" (and that would be with respect to only one funding source). As a result, no entity bears responsibility for the overall outcome for a person receiving services in the continuing care sector. Other particular problems resulting from the current (fragmented) funding structure include:

   - Lack of market forces to force accountability - service recipients have a very limited range of services and service providers from which to choose.

- Conflict of interest potential in case management - case management services are often provided by the MHSA service providers. Thus, case managers may be more likely to steer service recipients to their employer regardless of the appropriateness or desirability of that entity as a provider for that particular case. Additionally, service recipients may be less likely to receive needed services that are not offered by the employer.

- Service mixes are determined by funding contracts rather than the needs of a particular service recipient.

- There are insufficient incentives in service contracts for desired performance.

4. Consumers do not have enough choice in the types of services delivered or enough choice in the specific provider to deliver that service. The system does not currently do enough to empower consumers and their families, nor is there sufficient attention to "recovery" as the major goal for each person receiving services.

5. There is a substantial gap between that which has been identified by scientific research as "best practice" and that which is actually available in the community in the state of Florida. In large part, this is related to the lack of resources available to the system overall. For example, service provision staff in publicly-funded service agencies are lower paid and have less education and training than service provision staff in the private sector (i.e., licensed MHSA professionals). Examples of best practices that have not yet been fully implemented include:

   - Use of the "atypical" medications (especially for persons not eligible for Medicaid).

   - Housing - funding and quality

   - Assertive Community Treatment teams

6. There has been considerable confusion and disagreement about the role of the state mental health hospitals in the current MHSA service system. Treatment technology has improved greatly and large state mental institutions are less necessary than they once were. In addition, when possible, treatment in the service recipient's own community is preferable to treatment in a remote institution. Unfortunately, lawsuits have been a major factor in the state's planning process regarding the state mental institutions.

   On the positive side, the state of Florida has substantially reduced its reliance on the state mental hospitals. Very recently, funding has been made available for Assertive Community Treatment teams to provide services in the community for persons who otherwise would have been at risk for hospitalization in the state mental hospitals. It must be noted that the research indicates that Assertive Community Treatment teams are most effective when they are implemented in strict accordance with the Program for Assertive Community Treatment (PACT) model.

7. There continue to be tremendous problems in service provision for persons with co-occurring substance abuse and mental health disorders. (Recall from above that of all people with MHSA disorders, over 15% have both MH disorder and SA disorder. Also, the proportion of

such dual disorders is higher for persons in the continuing care sector). Research has shown that treatment for such co-occurring disorders must be integrated to be effective. This means that the treatments must be done concurrently and with appreciation for the impact of the other disorder (not necessarily in the same building). Separate systems and separate funding streams (including at the federal level) have resulted in a situation where providers tend to offer only mental health services or only substance abuse services. A small and inadequate number of special programs currently exist that do provide such integrated services for persons with co-occurring mental health and substance use disorders. Additional such programs are needed in many areas of the state.

8. Much more needs to be done with regard to support services for persons at this stage. Currently, there is no clear policy with regard to the role of MHSA service providers regarding housing, transportation, vocational and other support services, and there is no incentive for them to provide such services. For persons who have been hospitalized in state mental health institutions, as the institutions are phased out, all the things that the institution provided for service recipients must be replaced in the community. In addition to MHSA treatment, this includes room and board, medical care and something to do.

   People need a safe, affordable place to live. Furthermore, housing is a critical aspect of services for persons at this stage because, if a person loses their housing, everything else falls apart. People with severe MHSA disorders are definitely at risk becoming homeless (or in too many cases are already homeless).

   Housing options for persons at this stage are inadequate in terms of cost, quantity and quality. Assisted living facilities (ALFs) or other boarding homes are the cheapest (and often the only) housing alternatives available. Unfortunately, many of these facilities offer only a bed and food - they are often in deplorable condition and are not safe nor secure. Furthermore, persons on SSI cannot live in an ALF and survive on their benefits. The ALF receives the person's SSI check and an OSS allotment, and the client receives $43 per month ($1.43 per day) as a personal needs allowance for their remaining expenses (which includes clothing, hygiene, transportation, co-payment for treatment services, entertainment, etc). Persons in this situation may be motivated to become homeless in order to keep their entire SSI checks.

   Public housing money amounts to about $1.6 billion per year, yet virtually no public housing money (from any public source) goes to address housing needs of this group. Mainstream public housing (HUD) is far too expensive for persons with MHSA disorders who are at risk for homelessness. Waiting lists for Section 8 housing are often 2 to 4 years long.

   Many service recipients at this stage cannot afford a car or public transportation (if it is available), making it difficult or impossible to access needed services. This is a particular problem in rural areas. According to DCF data, almost none of the people who receive MHSA services at this stage from publicly funded providers are involved in any meaningful work.

Recommendations for the Continuing Care System

1. The group of adults (ages 18 to 65) to be served should be formally enrolled as continuing care service recipients. Explicit, specific criteria for enrollment should be established. Factors to be considered in the criteria for enrollment should include the diagnosis of MHSA disorder (relatively more severe disorders), level of functioning (significant dysfunction

related to the disorder), expected duration of disorder (requiring ongoing treatment and support), and the presence of other risk factors (such as homelessness, history of incarceration, or lack of social supports). Income criteria should not be applied to enrollment eligibility because of the high long-term costs of continuing care. Explicit criteria for disenrollment from the system must also be established.

Formal enrollment would help to establish a single point of responsibility for the coordination of care to meet all of the service recipient's needs.

2. Services must be delivered through a "system of care" with the following provisions:

a. Care within this system is provided through a limited number of provider agencies that are required to provide (or arrange for) the full array of services specified for the system of care.

b. For each person enrolled, a "lead agency" or an equivalent entity must be identified to serve as the single point of responsibility for the coordination of care. The role of this entity is to assure access to needed treatment and support services while insuring reasonable client choice.

When the system is at full capacity, persons who would otherwise be eligible to receive services should be identified and enrolled. Such persons are at risk for getting worse if they do not receive services. A lead agency should be identified for such cases. The lead agency should track and regularly assess such persons to establish priorities for entry into services as capacity becomes available. Agencies should be paid for such tracking and assessment responsibilities as a part of their contract.

3. The system of care must provide appropriate, flexible, continuous, and comprehensive services.

a. Services must be science-based (i.e., empirically established as "best practices").

b. Services must be based on the recovery model (*see page 12*).

c. Services must include high quality mental health, substance abuse, and medical care including state-of-the-art medications, and evidence-based psychotherapy and substance abuse treatment.

d. Services must also include other rehabilitation and support services such as housing (*see (g) next page*), employment services, therapeutic foster care and case management.

e. Acute care services must be available to the enrolled population and paid for by the lead agency for persons under its contract.

f. Continuity of care is a critical characteristic of this system. The lead agency (particularly the treatment staff, including the psychiatrist) must strive to assure continuity of care for persons under its contract when that person requires services from other agencies. This includes services provided to enrolled participants by state mental

health institutions, acute care facilities, providers outside of the geographic area, criminal justice agencies, and rehabilitative service agencies (e.g., housing and employment), etc. The lead agency must assure appropriate discharge from or transfer between components of the system (e.g., development of a discharge plan, linkage with suitable housing and supports, coordinate with agencies responsible for post-discharge care, and provision of sufficient medication and other basic resources upon discharge).

Lead agencies must have the capacity for providing integrated mental health and substance abuse treatment for persons with co-occurring mental health and substance use disorders.

g. Housing is a critical aspect of services for persons at this stage. Much needs to be done to improve housing conditions for these people, including:

(1) A gamut of appropriate housing options is needed, including the use of models such as "low demand" shelters and "supported housing." Supported housing uses subsidies to make the housing affordable and integrates provision of housing with treatment and other support services.

(2) Standards regarding living conditions in ALFs and other types of congregate living facilities must be strengthened and must provide for monitoring and enforcement of those standards.

(3) State and local programs providing publicly subsidized housing should target more resources to persons with MHSA disorders who are homeless or at risk of homelessness.

(4) The personal needs allowance for persons on SSI living in congregate living facilities must be increased significantly.

4. System financing must be at an adequate level (amount). System resource capacity needs must be based on a systematic assessment of enrolled population needs using data collected from consumers, providers and family members. The needs assessment methods should anticipate long-term availability of formal supports within a system that promotes informal support, consumer independence and community involvement. Local resources should not be required for continuing care services.

   The state needs to do more to maximize support for the system from federal sources. This would include increasing "draw-down" from such federal sources as Medicaid, Vocational Rehabilitation, Medicare, Housing and Urban Development, and Work Incentives Act with Medicaid Buy-in (e.g., Ticket to Work program), etc.

5. The state should contract with the "lead agency" using risk-based case rates with a disease management approach. Contracts must be outcomes-based. Financial incentives (bonuses)

based on outcome data should be utilized to encourage superior performance and continued improvement over time.

The state should also develop innovative financing systems that seek to contain costs, insure appropriate client choice and promote flexibility in tailoring services to client and family needs. One possible such system has recently been proposed as a pilot project in the Jacksonville area (the Self-Directed Care Initiative). Innovative financing may include the use of flexible consumer-controlled vouchers to purchase services.

6. System financing must be integrated (coordinated).

    a. Innovative financing must anticipate the need for treatment, rehabilitative and support services.

    b. Sources of funding (e.g., DCF, Medicaid, local government, and private) should be integrated or coordinated.

    c. An appropriate method of coordinating funding between the continuing care system of care and state mental health institutions needs to be established.

    d. Given that a division will persist between the mental health and the substance abuse service systems, each system should receive additional funds for provision of services for the other area (i.e., the mental health service system should receive funds for the provision of substance abuse services, and vice versa for substance abuse). DCF should earmark some funds from MH and from SA to create pilot projects for fully integrated dual diagnosis treatment programs.

7. A significant part of the reason that there is disagreement about the role of the state's mental health hospitals in the current MHSA service system is that it is not known to what extent persons who would be treated in the state hospital could be treated in the community using state-of-the-art interventions. The Department of Children and Families has recently begun studying the treatment needs of persons in state mental health hospitals, and this is an important first step in resolving this issue. This work should be supported to conclusion.

    Further, the state of Florida should vigorously pursue providing state-of-the-art treatment in the community to persons who are at risk for hospitalization in state mental institutions. After such interventions have been effectively implemented, the need for state mental health institutions should be re-assessed. To the extent that this is part of the current DCF plan with regard to the closing of the G. Pierce Wood Memorial Hospital, it should be supported.

The state of Florida has recently funded Assertive Community Treatment teams to provide services in the community for persons who otherwise would have been at risk for hospitalization in state mental hospitals. This effort should be continued. But it must also be noted that the research indicates that Assertive Community Treatment teams are most effective when they are implemented in strict accordance with the Program for Assertive Community Treatment (PACT) model. This will require maintaining funding at the specified level, and assessing the

implementation of these teams to insure that such implementation is faithful to the PACT model. In addition, more PACT teams will have to be implemented in order to fully provide adequate capacity for treatment in the community.

Persons in crisis with an MHSA disorder

The fourth part of this model involves persons who are experiencing MHSA crises. People at this stage need immediate emergency assessment and treatment (referred to as acute care or emergent care). They also need timely, systematic aftercare in less intensive service settings following discharge from the emergent care setting. Emergency assessment and treatment services are short-term and are typically offered in crisis stabilization units, detoxification centers, hospital emergency rooms, short-term inpatient treatment facilities, and law enforcement/criminal justice settings. Although, in many cases, persons may be initially identified as having a mental health or substance abuse problem when emergent care services are required, this is a very undesirable outcome. In other cases, persons in crisis may have already been receiving services within another venue.

There are extensive discussions of the organization, funding, and activities of publicly funded MHSA services for persons at this stage in Chapter 1 of the Commission's report (Bell & Shern, 2000) and in the Report of the Data Workgroup (Kip, 2000). Thus, we will not reiterate these data here.

Problems with the Acute (Emergent) Care System

1. Overall, there is inadequate capacity for acute (emergent) care services for mental health statewide, and this problem is much more severe in some areas of the state than others. The adequacy of the capacity for substance abuse acute (emergent) care services is not known (a lack of capacity was not apparent in the information made available to the workgroup). There are very few resources available for appropriate acute (emergent) care for persons with co-occurring mental health and substance use disorders.

   Two factors likely contribute to the overall lack of capacity for mental health acute care. One is that over the past decade funding for such services has decreased by 50% (in constant dollars for general revenue Baker Act funds), and many considered the level of funding a decade ago to have already been inadequate. Second is that demand for such services has increased due to steadily increasing state population, down-sizing of the state mental hospitals, and inadequate capacity (or access) to early intervention for mental disorders in the ambulatory sector. This latter problem affects the acute care sector in two ways. First, in some cases emergency situations could be prevented by adequate case identification and early intervention. Second, acute care facilities have very few options for referral for post-discharge treatment in less restrictive environments for persons who are discharge-ready from acute care. Length of stay for these cases is inappropriately prolonged and the beds that are occupied are unavailable for other cases. This is apparently less of a problem for substance abuse than for mental health. In the substance abuse system, acute care facilities often serve as the "front door" for the ambulatory care sector.

2. Much testimony was taken by the Commission on problems with accessing acute (emergent) care facilities for persons with mental health disorders. Frequently cited problems were lack of information about facilities (particularly changes in location), lack of bed availability, and "turfing" of cases to hospital emergency rooms.

3. There is inadequate planning for acute care. Local planning is required by law, but plans apparently often do not exist or are not used. Plans that do exist are reportedly vague and do not focus on day-to-day operations. Planning groups are not required, appropriate persons often are not involved, and/or there is not enough consumer involvement in planning. There is no clear connection between state plans and local plans.

4. There is no consistent standard of care for acute care services.

5. Law enforcement personnel are frequently involved in getting people into acute care. Law enforcement personnel are often not adequately trained to handle these responsibilities.

6. There is no integrated data system available for decision-making on cases admitted to acute care. This impedes the accessing of data that may be available elsewhere. Many emergency events occur outside of regular business hours, and in such cases, it is often not possible to obtain information in a timely fashion from providers who have already been involved in the person's care.

7. Medicaid funding / provider payment systems do not match up with the acute care system. Many third party payers do not cover voluntary acute services. Psychiatrists are often not paid for evaluating and/or treating involuntary patients, especially indigent patients.

Recommendations for Acute (Emergent) Care

1. Eligibility for acute care services should be based solely on service need. Specifically, all persons ages 18 to 65 who are in need of acute care services for mental health or substance abuse problems in the state of Florida should be provided with such services. The service recipient's ability to pay is a factor in how the provider agency is paid only after services are provided. (This should already be the case, but apparently is not being done in all cases.)

2. Level of funding for acute care services within each geographic area should be based on objective indicators of the need for such services within that area (e.g., population characteristics, numbers of out of area visitors, and other circumstances, as appropriate). DCF, in conjunction with the Agency for Health Care Administration (AHCA), should contract with an organization that can establish actuarial estimates of the cost of delivering acute mental health and substance abuse services including services to all individuals who do not have insurance coverage for these services. The state should pay for those who are uninsured and cannot pay for services. Funds should then be provided to that geographic area to support that level of capacity. Included within the funding should be funds to pay for medical clearance for persons being evaluated for admission to the acute care service system. The Legislature should appropriate funds adjusted on a yearly basis based on factors established from the findings regarding actuarial estimates. Funding decisions should consider the effect of such decisions on incentives that may be created (e.g., when funding is tied only to a set capacity, i.e., number of beds, disincentives may be created for agencies to admit new patients). Local match should be expected for funding of acute care services.

3. Within each geographic area, there should be a single focus of responsibility for administering the acute care system. This party is responsible for providing or procuring services, for assuring that persons in need of acute care services have ready access to such services, and that within the geographic area, acute care services are of good quality and

properly coordinated with one another and with other appropriate agencies. This includes the coordination of mental health acute care and substance abuse acute care for persons with co-occurring mental health and substance use disorders.

4. Acute care providers in the community will work with a local planning body composed of other health and human service providers, law enforcement, the judiciary, family members and consumers which will be responsible for planning and monitoring the system and reporting and tracking problems to their resolutions. The local planning body should be given the authority and responsibility for decisions about the configuration and capacity for acute care services and contracting with provider agencies in the local area.

5. Localities should consider establishing alternative crisis services including:

   - Crisis support telephone lines
   - 24-hour walk-in crisis clinics
   - Consumer-run crisis residences and services
   - Mobile crisis services
   - Pre-booking and post-booking arrest diversion strategies
   - Family respite services
   - Alternative dispute resolution techniques
   - Use of advanced directives
   - Mediation services
   - Educational programs in crisis management

6. There should be statewide standards for access and quality of acute care services. As a part of this standard, the acute care system must have the capacity to provide acute mental health care and acute substance abuse care, and these must be integrated when appropriate. The acute care services system includes at a minimum the following: (1) emergency psychiatric evaluation and assessment, (2) licensed medical hospital services, (3) crisis stabilization, short-term residential treatment or other non-hospital residential care to individuals in acute distress, and (4) medical and non-medical detoxification. As a part of the standards of care, the following must be included with regard to post-discharge treatment planning:

   - Discharge planning should occur in every case.
   - Discharge planning must make provision for satisfactory arrangements for room and board, continuing medications, and making timely follow-up appointments.

- The discharge plan must be written and must include information on treatment history.

- The written discharge plan must be made readily available to other providers with appropriate release consent.

- These standards must be part of the provider's contract and there have to be appropriate contingencies placed upon compliance.

- These standards apply to acute care cases in crisis stabilization units, emergency rooms, jails, inpatient treatment units, etc.

Minimal use of restraints is imperative for people with MHSA disorders. People that have suffered abuse often have exacerbation of their symptoms with the loss of control experienced through the forced use of restraints. The state of Florida should re-assess the adequacy of extant standards for the use of seclusion and restraint against national standards and modify the existing state standards as appropriate.

7. The acute care system must be linked to a full array of credentialed service providers to which it can refer for immediate post-discharge care. Acute care patients should be given a choice of providers within that array.

8. Baker Act and Marchman Act:

a. The Baker Act and Marchman Act should be formally evaluated specifically regarding provisions of these Acts for involuntary commitment of persons to evaluation and treatment, including issues of:

- Need for treatment standard
- Continuity of commitment orders
- Language regarding etiology
- Involuntary outpatient commitment

b. There needs to be more training for everyone who is involved in implementing the Baker Act and Marchman Act processes - especially law enforcement personnel.

c. There needs to be language added to the Baker Act to make provision for additional accountability under the act. Psychiatric patients should have the same rights as nursing home residents (Chapter 400) to remedy violations of their rights. There needs to be something comparable to the COBRA requirements that pertain to medical treatment in emergency rooms.

d. There needs to be some provision for less restrictive involuntary examination procedures (e.g., mobile crisis teams)

9. Persons in need of acute care who are involved with the criminal justice system may receive treatment in a mental health/substance abuse treatment facility or in a criminal justice facility, as appropriate, based on their criminal justice status. However, the acute care provided to such persons must be held to the same standard regardless of the locus of treatment.

10. There needs to be an integrated data system available to support clinical decision-making on cases admitted to acute care. The state should have the appropriate entities work with the Attorney General to determine what is allowable under the law to facilitate access to information concerning the treatment of persons being admitted for emergency evaluation and treatment.

System Failures

Failures of the previously described system of care can and do affect other social venues in the state of Florida. Persons with MHSA disorders are clearly over-represented in the homeless population and the criminal justice system. Other venues (for example, the child welfare system) are affected as well but are not discussed here.

Homelessness

According to the Data Workgroup Report (Kip,2000), it is estimated more than 150,000 Floridians are homeless at any given time during a year and nearly 71% have a diagnosable MHSA disorder. Of the approximately 109,000 homeless Floridians with MHSA disorders, 84% have an alcohol or drug dependence/abuse disorder, 4% have schizophrenia, 4.5% have bipolar disorder, 17% have major depression, and 17% have post-traumatic stress disorder during any given year. Clearly, people with MHSA disorders are over-represented in the homeless population relative to the general population in the state of Florida.

There are several reasons why a person may be homeless and have an MHSA disorder. First, MHSA disorders would be expected to appear in the homeless population at the same rate that such disorders occur in the general population. Second, persons with severe MHSA disorders are at risk of becoming homeless as a direct result of their MHSA disorder (for example, a person may be unable to hold a job due to their disorder and because of that they are unable to pay rent). Third, being homeless can be very stressful and may exacerbate or cause the expression of an MHSA disorder.

Despite the fact that such a large percentage of homeless persons experience MHSA disorders, data from the DCF database suggest that only about 3% of these individuals receive publicly funded MHSA services. Clearly, there exists a large unmet service need in this group. Several reasons may exist for this. For example, homeless persons with MHSA disorders may have difficulty accessing services for a variety of reasons, but particularly due to problems with transportation. Also, homeless persons are frequently disenfranchised from MHSA service systems (i.e., they feel that they are not treated with respect and/or that the services do not meet their needs).

Recommendations

More MHSA services need to be delivered to persons with MHSA disorders who are homeless.

1. Persons who are homeless or at risk of homelessness who have an MHSA disorder should be prioritized for eligibility for state-supported MHSA treatment services (including case management).

2. For persons who are homeless and who have become disenfranchised from the MHSA service system, more intensive efforts are needed with outreach and with individualizing services in terms of goals, methods, and location of services. One method for increasing efforts in this regard is to provide incentives in contracts with providers for providing services to persons in this group.

3. As a part of the services provided to this group, priority needs to be given to housing and transportation services (*see items 3.d. and 3.g. regarding continuing care services on pages 15, 16*).

Many persons who are homeless and who have MHSA disorders come into contact with the criminal justice system - an area to which we now turn.

Criminalization of MHSA Disorders

To an increasing extent, persons with MHSA disorders have come in contact with the criminal justice system. Large percentages of persons incarcerated in jails and prisons in the state of Florida have MHSA disorders, and thus, the criminal justice system and become a very substantial component of the MHSA service system. Considerable work has been done recently documenting these problems and examining the issues of police response to persons with MHSA disorders, court jurisdiction over misdemeanor offenders with MHSA disorders, and MHSA services in the jails in the state of Florida (Borum, 1999a and Borum, 1999b). Some re-analysis of data from those reports is also summarized in the Report of the Data Workgroup (Kip, 2000). We will not reiterate all the findings and recommendations of these reports, but instead, refer the reader to these original reports.

The workgroup recommends that these reports be incorporated into the recommendations of the Commission. Further, the workgroup wishes to emphasize some of the findings and recommendations from these reports and to note additional impressions and recommendations regarding this area.

Police Training

Police play a critical role in implementing the Baker Act. Indeed, they are sometimes referred to as the "gatekeepers" for the acute care MHSA service system. However, many people involved in this process, including police officers, feel that officers do not receive adequate training to carry out these responsibilities. Police officers need more training in MHSA issues in their academy training and as continuing education. In addition, specialized training is needed. Crisis Intervention TEAM (CIT) training has been shown to be most effective (Borum, 1999b).

In order to be effectively implemented, such training should be mandated by the Florida Department of Law Enforcement (FDLE). If the FDLE does not have the authority to mandate this, then it should be given the authority to do so.

As noted earlier regarding the acute care service system, there needs to be more training for everyone involved in implementing the Baker Act and Marchman Act processes, especially police officers who play a critical role in implementing them.

Pre and Post-booking diversion

There are numerous practical reasons to reduce the number of misdemeanants with mental illnesses in the criminal justice system. However, it seems that it is also a good general principle for our legal system that people should not be incarcerated for minor, non-violent criminal behaviors that result from MHSA disorder, but rather should be incarcerated only for committing actual crimes.

To that end, we need to continue to improve pre-booking and post-booking diversion efforts (e.g., pre-trial release for treatment with charges still pending, and linking homeless people to shelters). The substance abuse service system has emphasized this by developing the drug courts. This movement needs to continue to be developed. Similar efforts need to be developed for mental health (initial efforts have been made on implementing mental health courts with some mixed reviews).

Various models have been adopted in establishing methods to improve diversion - drug courts and mental health courts involve primarily having a judge who has special expertise in this area. In other areas of the state, special units have been developed within the public defender's office for handling MHSA cases (e.g., Miami and St. Petersburg). Regardless of the model employed, it is important that all parts of the system-judicial (including public defenders and prosecutors), law enforcement, and MHSA service providers work together to integrate service provision.

One problem that has been introduced in some diversion efforts pertains to the issue of categorical funding in this area. For example, if services are funded only for people who have been arrested who need treatment, then this encourages the inappropriate arrest of people who need treatment so that they will qualify for treatment. Services should be available based on need rather than on legal status.

MHSA Treatment in the Jails

Given the large percentage of inmates with MHSA disorders in Florida jails and prisons, the issue of treatment for these disorders in an important one. As a general principle, the workgroup feels that persons in the jails who are in need of MHSA treatment must receive such treatment and that such treatment services should be held to the appropriate standard that would pertain to such treatment if provided outside of the criminal justice system.

The quality of MHSA treatment provided in the jails varies a lot (Borum, 1999b). For substance abuse, the substance abuse system has emphasized providing treatment in the jails and treatment services in the jails are working well in some areas. However, jails in rural areas are ill-equipped to deal with persons with substance abuse (and mental health) problems. The capacity for substance abuse treatment needs to be increased overall, but especially in rural areas.

For mental health services, there are problems in many areas for treatment of mental health disorders (for example, there is reportedly no access to "atypical" medications in the St. Petersburg jail unless the person comes from the state hospital). Little or no treatment occurs for persons with co-occurring mental health and substance use disorders. For example, only 30% of Florida jails have specialized services for such co-occurring disorders. Under Chapter 394, mental health receiving facilities are required to provide acute care mental health treatment in the

jails, but they do not have the budgets to do this. Counties have little incentive to provide treatment in the jails, except to control problem behavior.

One issue that contributes to this problem is that the state no longer holds the jails to any standard for MHSA treatment. This needs to be changed. One possible solution would be that the state provide oversight of MHSA treatment in the jails (perhaps through the Correctional Medical Authority).

An additional problem with MHSA treatment in the jails is that little or no discharge treatment planning occurs when persons with MHSA disorders leave correctional facilities. These persons are at high risk for relapse during their transition to community living.

System-Wide Issues

There is wide-spread consensus that the MHSA service system is under funded. Since the state of Florida has not been in a position to provide full funding for the entire MHSA treatment system, decisions have been made about how to fund the system. For mental health services, the current arrangement funds services from the "back end" or "deep end." That is, the state seeks to provide funding for services for persons with the most severe needs. To the extent that service needs go unmet for persons with less severe disorders, these persons may very well continue to experience worsening symptoms and may then swell the numbers of persons requiring "deep end" services that are paid for by the state of Florida. It is in the state's interest for the entire MHSA service system to function well.

With regard to the mental health services sector, there is considerable opinion that the current arrangement tackles the problems in a piece meal fashion. Problems are often dealt with in isolation from the "big picture," and are often dealt with after the situation has reached crisis proportions. Categorical funding has often been used to deal with these situations and this has resulted in further fragmentation of the system.
The situation in this regard has improved recently with the establishment of the Office of Drug Control under the Office of the Governor. The Office of Drug Control is taking the lead in planning to improve substance abuse services statewide, including integration of effort across agencies.

Numerous recommendations have been made in this report for monitoring and accountability actions. MHSA providers already spend large amounts of time and effort in compliance activities which are imposed by the various funding sources and regulatory agencies. Any new requirements for monitoring and accountability activities need to be accompanied by actions that minimize redundancies in monitoring and accountability requirements.

System-Wide Recommendations

1. A single entity such as a Behavioral Health Authority (BHA) needs to be established to take statewide responsibility for planning and accountability for the entire MHSA service system. The BHA would be responsible for:

a. Planning and evaluating the adequacy of the MHSA system.

b. Assuring quality of services throughout the system.

c. Assuring coordination among all elements of the system

d. Providing a monitoring and accountability system:

- developing benchmarks for each component of the system
- integrating existing data bases to enable accountability and planning
- assessing population MHSA status through the development of a population behavioral health monitoring system

e. Reporting to the Governor, Speaker, and President of the Senate annually.

f. Representing all elements of the system including the secretaries of the relevant state agencies, service providers, and service recipients and their families.

g. Coordinating/integrating activities and planning with the Office of Drug Control.

2. Establish local planning and accountability structures that parallel the state Behavioral Health Authority. The local structures should:

- Represent all of the key local stakeholders
- Serve as a forum for local problem solving
- Conduct planning and evaluation of the local system
- Develop appropriate blended funding mechanisms that are responsive to local needs
- Develop local information systems to facilitate planning, accountability and, perhaps, clinical services

3. Rewrite Chapter 394, part 4 to accommodate the changes implied by the recommendations of this Commission.

4. Support the recommendations of the Drug Control Strategy that has been prepared by the Office of Drug Control.

5. The state should pursue the strategy of having all MHSA providers accredited by an appropriate national accrediting agency, and then all other monitoring requirements should be evaluated to minimize redundancies in monitoring requirements.

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