

CHAPTER 2

Introduction

Florida's services system for mental and addictive disorders has undergone significant and far-reaching changes. During the past 30 years, a diverse collection of MHSA programs has evolved outside the boundaries of the traditional DCF system. These service settings range far beyond what was originally conceived by legislators. In addition to the Department of Children and Families, MHSA services are now delivered by other departments and agencies of state and local government in an array of settings including health, education, child welfare, corrections and juvenile justice (*see Figure 1.2, page 3*). Although service delivery was not part of their original missions, each of these departments is now, in fact, in the business of providing MHSA services.

Increasingly, we believe that if they cannot successfully address MHSA problems, these agencies will be unable to achieve their primary objectives effectively. However, these additional responsibilities can strain existing resources and compromise the ability of these departments to meet their essential obligations to the populations they serve.

"We need to structure our mental health systems to better respond to individuals' actual needs, creating mechanisms for multiple systems to work together."

Martin Cohen, President and CEO,
Metro West Community
Healthcare Foundation,
Framingham, MA.

Additionally, all components of this combined system interact in ways that are not fully understood. They share an ecology of sorts in that the actions of each one separately - and all collectively - influence the others. In other words, problems and failures in one part of the system inevitably have an impact on other parts of the system. For example, when clients' mental health or substance abuse treatment needs are not met in the traditional DCF system, they may end up in jail, a setting ill-equipped to treat such problems. Or when individuals cannot access services through primary care providers, mental illnesses or addictive disorders may worsen, necessitating admission to a state treatment facility in an already overburdened traditional system.

Key Findings

The Commission's research and the testimony we heard throughout the last year highlight several important points:

Parts of the traditional MHSA system's enabling legislation are out of date and out of step with the combined system that has evolved. Though incremental steps have been taken to update the legislation, the statute is nonetheless inadequate to address the diverse nature of existing services. The legislation must be modified to reflect the service settings, providers and clients in Florida's current system.

The current combined system is complex, fragmented, uncoordinated and often ineffective. Multiple programs, numerous and often conflicting funding streams, and bureaucratic barriers frustrate access for many Floridians needing care.

We must do a better job of understanding the combined system, capitalizing on the strengths of its components and the commitment and expertise of the professionals who work within it. It is critical that we differentiate the roles of all the players in the system and establish clear priorities for both the specialized DCF system and other providers outside the traditional system. We must better delineate the roles of agencies, helping orchestrate their interaction and establishing clear points of responsibility, particularly for the most vulnerable Floridians.

The non-DCF mental health system lacks a clear overall strategy and identified leadership. (This is not true of substance abuse). No one is attending to the workings and ongoing development of this diverse collection of mental health treatment venues.

The data needed to make important treatment and funding decisions are either unavailable or cannot be integrated to the degree necessary to understand the full impact of the current system. While great progress has been achieved in assessing performance in the DCF programs during the last five years, we still cannot reliably estimate the magnitude of unmet need for mental health and substance abuse services, evaluate the relative value of individual treatment programs alone or in combination, and systematically monitor accountability for treatment outcomes across the combined system.

Although a substantial amount of money is spent throughout the combined system, additional resources - and a better system for allocating them - are needed in many core areas. We must be sure that available money is spent wisely and is allocated based on need, optimal performance and outcomes.

The purpose of the remainder of this chapter is to identify Commission findings regarding major strengths, problems and crisis areas; specify implications for components of the combined system; and point to reasons for optimism as well as foundations for planning and positive change.

“Honest, comprehensive and quality reform will require a commitment by the Legislature, the administration, and the public to fully fund what is truly needed...Helping individuals with psychiatric disabilities is a statewide challenge, not a localized crisis. While implementation of any system should be flexible enough to accommodate local idiosyncrasies, the system itself must be the product of state policy, planning, funding, technical assistance and monitoring.”

Brent Taylor, Director of Policy
Advocacy Center for Persons with Disabilities, Inc.

Identified Problems

Prevalence and Unmet Need

Mental and addictive disorders constitute significant problems in Florida.

Prevalence

Mental illness is the second leading cause of disability and premature mortality in the United States and other established market economies (behind cardiovascular diseases). Due to numerous barriers, nearly half of all Americans with serious mental illnesses do not seek treatment.

Important among these barriers are a failure to recognize the symptoms of mental disorders, lack of awareness regarding how and where to obtain help, the belief that effective treatments are not available, financial barriers to receiving care, and stigma associated with having a mental health or substance abuse problem.¹

Mental and addictive disorders are significant problems in Florida, with a prevalence and impact far beyond what the average citizen might assume. Over the course of a year, one in three Florida adults and children will meet diagnostic criteria for a mental or substance abuse disorder. Among adults, approximately 23% will meet diagnostic criteria for a mental disorder, 12% will meet criteria for substance abuse/dependence; and 5% (1 in 20 Floridians) will meet criteria for co-occurring mental illness and addictive disorders.^{2,3}

Similar high prevalence rates occur in both children and the elderly, and exceptionally high rates occur in Floridians detained in the criminal justice system (juvenile and adult), persons who are homeless, and among assisted living facility and nursing home residents.^{2,4}

Unmet Need

Since not all persons who meet diagnostic criteria for a mental or substance abuse disorder experience significant impairment, an issue is how many Floridians each year actually need treatment services, and how many receive them. If we conservatively limit the need for treatment to persons with substance abuse/dependence and/or severe mental illness, between 1 in 12 to 1 in 14 Florida citizens will need mental health and/or substance abuse services at some time during a given year. These estimates comport with the recent finding that 1 in 10 Floridians rates his or her own mental health as “not good” for one or more weeks during the previous month.^{2,5}

Despite limitations in our current information management system, we can reasonably estimate that annually only about 20% of all children and adults with need for MHSA services receive treatment from DCF providers. We cannot estimate, however, what percentage of the state’s population in need is not served by DCF but by other state agency service providers (e.g., education programs). We suspect that within Florida jails and nursing homes, about 1 in 4 persons in need of MHSA treatment actually receives services from at least one non-DCF provider.^{2,6}

As illustrated by statistics, from a public health perspective, mental and addictive disorders are prevalent and disabling conditions confronted by Floridians. Given limited public health resources, the frequent occurrence of mental and addictive disorders and the variability in their severity suggest a special role for the traditional system in preferentially serving people with the most severe and disabling disorders.

Overall, however, most people with mental and addictive disorders (or who are at risk of developing disorders) are not seen in the traditional MHSA system but in other treatment and community settings. The frequency of these problems has important negative consequences for both the individuals who experience them and the settings in which they live, work and are served. Many persons, including employers and family members, do not recognize that behavioral health problems can significantly reduce productivity, and that they often respond extremely well to treatment. In essence, therefore, routine coordination is needed among all the components of the combined system to promote prevention, early recognition of problems and effective treatment.

Prevention Versus Deep End Crisis Services

Prevention is currently a low priority in mental health, although it is a priority in substance abuse. Instead, the traditional mental health system emphasizes deep end services and crisis interventions.

Research shows clearly that prevention and early intervention strategies can be effective in reducing illness and disability in both mental and addictive disorders. Crime and delinquency, drug use, child abuse, and HIV infection are all specific outcomes that respond well to prevention efforts. For example, controlled studies have shown that preventative interventions with disruptive classroom behaviors (which are predictive of later problems) in first grade children, significantly reduce arrests later in life. These interventions even reduce smoking rates in adolescence.¹⁴ However, prevention benefits are not widely understood, and proven strategies are not widely utilized. There is a wide gap between what has been identified by scientific research as “best practice” and what is available in educational and other settings throughout Florida.

“...there is a unique disconnect between the scientific facts and the people’s perception about drug abuse and addiction. We need to overcome this disconnect if we are to make any real progress. We now have the science base, but it isn’t being used. Science can replace ideology as the foundation for drug abuse and addictive prevention, treatment, and policy strategies.”

Dr. Alan Leshner, Director
National Institute of Drug Abuse

In substance abuse, on the other hand, Florida’s Office of Drug Control has taken a strong role in aggressively pursuing science-based prevention efforts and is attempting to develop a state prevention plan involving all state agencies that fund prevention of substance abuse disorders.¹⁵ DCF has implemented the federally-funded Florida Youth Initiative for Substance Abuse Prevention, a science-based prevention program in 23 communities throughout the state. A statewide Advisory Council to this project is also developing a prevention plan to coordinate effective state prevention strategies. Such initiatives are based on a new understanding that alcohol and other drug dependence is a primary, chronic and progressive disease. Substance abuse and dependence are, in fact, treatable and subject to preventive measures.

Funding for substance abuse prevention, however, has not kept pace with research knowledge. Federal dollars are the primary source of funds for prevention through research grants and direct block grants to states. State agencies administer these funds, largely at the local level. A recent survey of state agency support for substance abuse prevention suggested that prevention accounts for less than 10% of most agency operating budgets. Only about one third of prevention activities have a primary substance abuse prevention focus, representing approximately \$73.2 million, an

amount that appears large but is spread across all prevention programs statewide, including schools.¹⁶

In mental health, services within the traditional system have focused primarily on persons with more severe illnesses and disability. The lack of prevention in mental health -- and under-funding of these services in substance abuse -- mean that some individuals become more severely ill and disabled than they might have had they received proven preventative intervention measures. Thus it is possible that the demand for deep end, specialty services provided by DCF could be substantially reduced through the provision of effective prevention and early intervention strategies, as well as support for consumer-run community programs, including drop-in centers and consumer-operated businesses. Throughout the combined system, understanding where and how preventative interventions are implemented requires a coordinated leadership function and collaboration with experts.

Diagnosis and Treatment Have Improved Dramatically

The diagnosis and treatment of mental and addictive disorders have improved dramatically.

Science has made tremendous strides in the last 20 years in understanding how the brain interacts with biological, psychological and social factors to influence thought, behavior and emotion. This knowledge has given rise to remarkably effective new medications, therapies and rehabilitation techniques that allow persons with even severe illness to function in society and lead productive lives. Schizophrenia, depression and anxiety disorders are all good examples.

We also know that people with mental and addictive disorders recover most effectively when they participate in their own treatment. Their care should be based on a philosophy of self-determination; respect for privacy; and informed choices by consumers, family members and caregivers.

Stigma and Education

Mental and addictive disorders are still stigmatized to a great extent. Education is a critical part of the solution.

Professionals, consumers and family members throughout the state have consistently indicated a significant need for better, more extensive education about mental and addictive disorders. Many myths and misunderstandings about mental health and substance abuse are a consequence of a lack of education regarding the causes, symptoms, treatment and potential for recovery from these disorders. These in turn result in stigma and discrimination that create perhaps the most important barriers to timely and effective care. Education for all Floridians about mental and addictive disorders, effective treatments, and the potential for recovery is critically important. Education on the biological bases for some mental illnesses could be included in primary and secondary school curricula.

“Only my immediate family knew I suffered from manic-depressive illness. I paid for my medication and doctor’s visits out of my own pocket, as I didn’t want to establish a paper trail. I was worried about the stigma associated with mental illness.”

Consumer

Multiplicity

Multiple service settings, funding sources, funding streams, resource use expectations, and constraints regarding resource flexibility have created a fragmented, conflicting, and frequently ineffective MHSA system of care.

Multiple agencies and treatment settings address multiple client needs. Many agencies have their own regulations and requirements, which may conflict or duplicate the efforts of others. Inconsistent standards and expectations exist among numerous funding sources. Consumer-operated programs are often subject to inappropriate rules and regulations that negatively impact the services they provide. Treatment providers labor under a huge burden of required (and often redundant) documentation. Most importantly, no one entity has responsibility for treatment outcomes for persons receiving care in multiple programs.

Persons seen throughout the non-DCF system often have great difficulty obtaining the services and supports they need because of difficulty accessing resources and a pervasive lack of knowledge regarding the symptoms of mental and addictive disorders. For example, individuals with depression seen in primary care settings may not be diagnosed quickly or correctly by their primary care physicians. Even if mental health or substance abuse problems are recognized, fear of stigmatization and financial barriers may preclude access to effective specialty services.

Persons with the most severe disorders who are served in the traditional system often have difficulty obtaining the support and rehabilitative services (such as housing, transportation, etc.) that they need to recover. Their complex needs cannot be well met in a system that is restricted by categorical funding requirements and an absence of parity between physical health and mental health insurance benefits. This disparity in insurance status creates a cascading host of additional problems, including barriers to access, discontinuity of care, fragmented services, and stigma and discrimination. Similarly, it is difficult if not impossible to hold agencies accountable for client outcomes when they do not have access to a full range of resources to meet the complicated needs of persons with significant disability.

Lack of Overall System Coordination

There is a marked lack of coordination among the components of the combined system of care for Floridians with mental and addictive disorders.

Florida does not have a comprehensive, coordinated system for providing services for mental and addictive disorders across health, human services, educational and correctional settings. In non-DCF service settings, a fragmented assortment of treatment venues has evolved among agencies, all of which have a primary mission that is distinct from treating MHSA disorders. Persons with mental and addictive disorders in these settings may not be quickly and accurately diagnosed. Even if their problems are recognized, they may not receive timely, effective treatment due to limited expertise in MHSA issues and constraints on resources.

For example, research shows that parents wait an average of two years from the first signs of MHSA problems in their children before seeking help. The primary health care setting in which children are initially seen, however, is ill equipped to respond more quickly. Earlier intervention might significantly alter the problem trajectory for these children.¹⁷

With a lack of integrated information about systemic functioning across these diverse settings, we do not understand the interaction among service settings and the impact that this lack of coordination has on Florida's citizens. For example, the Commission's analyses indicate that difficulties in the mental health emergency response and community care system underlie the increased presence of persons with severe mental illness - and often substance abuse - among jail and prison inmates. Addressing these problems requires a systemic perspective, as well as data systems, that allow us to observe relationships among the various components of the entire system.

"The shame of it all is that we know how to effectively treat most people with mental illnesses. We just don't make these treatments available to people. De-institutionalization has become "trans-institutionalization." Today, we institutionalize people with severe mental illnesses in jails and prisons instead of hospitals."

Consumer

Lack of Strategic State Policy and Leadership Across the non-DCF System

Each of the state agencies that serve people with mental and addictive disorders has planning, quality assurance and accountability functions related to its primary mission. However, there is no governmental entity responsible for state strategy, policy and leadership across the combined system in mental health.

The Florida Office of Drug Control, on the other hand, has been effective in developing a statewide strategy for reducing substance abuse in Florida. The Governor's Drug Policy Advisory Council includes representatives of state agencies and communities throughout Florida who work together to affect a coordinated law enforcement, prevention and treatment approach to substance abuse.

As described in Chapter 1, across the combined system, no governmental entity is responsible for the definition of boundaries of responsibility; accountability and performance measurement; information collection and management; and public education across the system. No one is measuring overall outcomes, helping to frame statewide policy questions, and suggesting collaborative strategies based on these data. Beyond the individual efforts of service sectors, no one is asking if the current investment of resources across systems is achieving the desired policy effect overall, even when each of the individual components of the system is meeting its own primary objectives.

The lack of a recognized leadership function has important implications for both the traditional and non-DCF systems. Without it, policies and practices within individual agencies are designed to optimize performance relative to that particular agency's mission, without considering the implications of these decisions for other parts of the system - or more importantly, the individuals and families who need help. Knowledge about effective practices in treatment and rehabilitation is slow to influence practice in the traditional system. Given the multiple missions in the non-DCF service sector network, knowledge about effective practices is even less likely to influence practice than in the traditional system.

An excellent example is the role conflict that schools are experiencing about dispensing medications to their students. While drug therapies for addressing children's health and behavioral health needs have improved, schools are not well equipped to administer or monitor

medications. Nonetheless, they are expected to serve this function because of their extensive contact with children. Thoughtful leadership focusing broadly on the overall system would increase the likelihood of identifying problems like these and suggesting more comprehensive and effective solutions.

Expenditures for treating mental and addictive disorders

Florida's current services system for mental and addictive disorders involves enormous financial investment from federal, state, local and private sources.

While the exact amount of expenditures cannot be directly calculated due to limited data, it is estimated that nearly \$5 billion is spent annually across all public and private expenditure sources in Florida in the combined traditional and non-DCF system (leading payer sources include private insurance, Medicaid, Medicare, general revenue and out-of-pocket payment for services)^{2, 18}, (see Table 2.2, page 28). Nearly \$3 billion (58%) of this total (which includes in-hospital, outpatient/residential, prescription drugs, and insurance administration expenditures) is public money. Eighty-six percent is allocated for mental health services. Prescription drugs account for over three fourths of a billion dollars in annual expenditures. Surprisingly, annual expenditures for the traditional DCF system and state-hospital system combined amount to less than 20% of all expenditures. Thus, it is clear that the traditional DCF system is an important -- but by no means the only -- provider of mental health and substance abuse services. State funding may also not be sufficient to meet the needs of mental health consumers. Yearly per capita expenses for mental health in Florida are \$43.80, giving Florida a national ranking of 37th, with less than half the per capita expenditures of states including Maine, Massachusetts, New York and Michigan.¹⁹

Although the trend has clearly been toward outpatient treatment, a high percentage of mental health treatment costs still occur in inpatient facilities. On an aggregate level, more than one billion dollars is spent annually (1/5 of total expenditures) on inpatient MHSA care (mostly mental health), compared to about \$500 million for community-based DCF MHSA services. The inpatient total does not include state hospitals, which treat 4,300 individuals yearly (.03% of Florida's population). In state hospitals, the average annual cost per bed is \$100,000, and \$275 million (or roughly 5% of total expenditures) is spent annually.²⁰ Current data indicate that much inpatient care could be avoided if competent community-based services were available.

Medicaid, a federal program administered by the Agency for Health Care Administration, has emerged as an important payer of public mental health expenses, though not of substance abuse services. Commission testimony, however, indicated that Florida may not be optimally leveraging federal Medicaid funding and taking advantage of all available federal funding sources. It is imperative that all available federal funding opportunities be utilized.

Problems identified with Medicaid include the fact that it is a highly prescriptive program with strict eligibility criteria, and its fee-for-service reimbursement mechanism may create provider incentives for inappropriate service provision. Additionally, disparities exist in the ability of providers to access Medicaid reimbursement as well as in the amount of reimbursement available and the availability of licensed professionals through public insurance programs.

A goal of focused funding requires that we be able to catalogue our expenses and understand their effects. Given the lack of overall information about services in the non-DCF system, it is not possible to separately identify the MHSA expenditures for each state agency outside the Department of Children and Families. Without these data, as well as data related to performance

in each component, it is impossible to estimate the efficiency and effectiveness of our resource expenditures.

Additional Resources Are Needed

Many essential MHSA services need additional resources - and a better resource allocation system - in order to effectively serve all those who need care.

While a great deal of money is spent in the aggregate to treat MHSA problems, each of the workgroup reports appended to this Commission report describes specific areas in which resources are not available in order for the combined system to function effectively. All age groups need more effective and assertive case management and outreach services to assist persons with severe disabilities in negotiating our fragmented system.

Outreach, in particular, is key to serving Floridians who experience difficulty in accessing public services and in supporting these individuals in their natural settings. A lack of transportation services further frustrates access. Since many adults with severe mental illnesses become impoverished due to their disorder, they need assistance in finding and keeping safe and affordable housing. Enhanced vocational rehabilitation and educational services are desired by most adult clients and hold promise for significantly improving their rates of employment. The latest medications can also be very expensive, and many persons with severe illnesses need help in obtaining them.

“We must be in the business of helping people cope with their disabilities in terms of housing, transportation, etc. [Persons with mental illnesses] usually have multiple needs and are often poor, so they may need financial assistance. Systems of care should respond to all these issues.”

Martin Cohen, President and CEO,
Metro West Community
Healthcare Foundation,
Framingham, MA.

While the Commission heard consistent testimony throughout the year on the desperate need for expanded services, the lack of any systematic needs assessment data frustrated efforts to be more specific. Without these data, for example, it is impossible to confidently estimate the degree to which service capacity should be expanded to adequately meet need, or the degree to which existing resources could be shifted to be more responsive to client needs. This lack of system-wide data significantly undermines effective, targeted planning.

Additionally, the Commission collected data indicating that we may not appropriately participate in all of the federal programs that are available for MHSA problems. In 1998, Florida's population made up 5.5% of the total U.S. population, yet the state received only 4.5% of the community MHSA block grant funds from the Substance Abuse Mental Health Services Administration. This relative difference of 1% is not trivial, as it amounts to about \$16 million in available public funding. Moreover, this relative under-funding has been observed each year since 1993, contributing to a cumulative under-funding effect.

Deficient Data System

Data at both the state and local levels are unavailable or poorly integrated.

No single data system contains information on the overall MHSA system. Consequently, it is difficult, and in many cases impossible, to link individual client data across service sectors. Because data and collection methods are not standardized, treatment strategies, costs and outcomes cannot easily be tracked over time.

The absence of an integrated information management system has numerous adverse consequences. Despite today's technology, the true magnitude of unmet need for MHSA services cannot be determined; aggregate costs of treatment by diagnosis and other case mix variables cannot be calculated; the relative value of different combinations and sequences of treatment programs across service systems cannot be evaluated; weak links in the system cannot be pinpointed; and accountability for treatment outcomes cannot be systematically monitored. Thus, like most other states, Florida currently lacks the capacity on a system-wide basis to evaluate which MHSA treatment strategies result in favorable client outcomes, as well as their corresponding cost effectiveness.

Major progress has occurred, however, during the last five years in the development of data systems within the traditional DCF system. DCF Program Offices routinely track the number of persons being served by contracted providers, the types of MHSA services being provided, the costs of these services, and client outcomes. Nevertheless, there are limitations with the current DCF data system, which currently cannot link the patterns of services received to the characteristics of persons served. We, therefore, know how many persons were enrolled in care, and how many services were provided, but not how many services were received by which individuals or the outcomes that these individuals achieved.

Quality And Performance Management

Although great progress has been made in developing performance management systems across state government in the last several years, more work is needed in this important area.

The traditional MHSA system was among the first in state government to begin implementation of performance based budgeting systems, and much has been learned about the success of MHSA programs in improving treatment outcomes. However, much is yet to be done. Measurement must be improved, indicators refined, and better methods used for estimating change. Although well intended, some of the performance measures actually provide incentives to preferentially serve individuals who are relatively less impaired. For example, client outcomes and the performance of DCF-contracted providers tend to be evaluated by societal indicators such as average days spent in the community. These societal indicators often lack clinical relevance, and they also tend to create a perverse incentive for providers to shun persons most in need of treatment.

However, because MHSA services are provided in multiple service settings and data are not standardized and integrated, currently we can neither estimate the percent of unmet treatment need for Florida's citizens with MHSA disorders (other than within DCF) nor evaluate on a system-wide basis both how and why individual treatment "successes" and "failures" occur. For example, we strongly suspect that the fact that many Floridians with mental health and substance abuse disorders are detained in criminal justice settings reflects an overall lack of early recognition and coordinated care across the entire system. Unfortunately, the architecture of the

current information management system is inadequate to rigorously study the real world experiences of Floridians with MHSA disorders.

“Drug courts are the ‘crown jewel’ in the current treatment system. Coercion works; no one volunteers for treatment through the courts. We need incentives to get people into treatment.”

James McDonough, Director
Florida Office of Drug
Control Strategy

Specific Crisis Areas

Emergency Services

Emergency behavioral health services are in crisis throughout Florida.

During Commission meetings, we repeatedly heard testimony about the serious problems in Florida’s emergency response system, particularly for persons with mental illness. (The Commission did not hear extensive testimony regarding emergency substance abuse services and the Marchman Act). Problems described in testimony include inadequate capacity for emergency mental health care; pressures to shift responsibility for emergency care between hospital emergency rooms and crisis stabilization units (CSU); inconsistent standards of care; inadequate training for law enforcement personnel; a lack of knowledge regarding the statutory requirements in the Baker Act; and a lack of integrated data systems.

Under the Baker Act, a person in crisis can be held involuntarily for 72 hours for examination by a mental health professional. The Commission heard testimony that the Baker Act is frequently used inappropriately throughout Florida. Hospital emergency departments have patients who are often held for days at a time without treatment, according to a number of emergency physicians. There is a severe shortage of available crisis intervention services, beds and trained caregivers, and there is too little after-care follow up. Diffuse responsibility for emergency services within a service region often contributes to these problems in the delivery of emergency care.

Funding is an important part of the problem. Per capita Baker Act funding has decreased by 13% in the past five years²¹ and many experts say it was inadequate five years ago.

Mental Health and Substance Abuse in the Criminal Justice System

The fact that many persons with mental illnesses and/or substance abuse problems end up in jail or prison can be seen as a marker of barriers within the traditional system, in particular, to identifying and treating MHSA problems.

Lacking early intervention, responsive emergency services and appropriate, affordable follow-up care (including help with finding affordable, decent housing and other psychosocial supports), many individuals guilty of minor infractions find themselves in criminal justice settings rather than treatment settings. In fact, in every major category of mental and addictive disorders, the prevalence rate for individuals in jails dramatically exceeds that in the general population.

The following data exemplify the large MHSA treatment burden being placed on Florida's correctional system (as previously referenced). Throughout the state, we estimate that 335,000 persons are detained in a jail or prison at some time each year (2% of the state's population), and that 218,000 of these individuals (65%) will meet diagnostic criteria for a mental health and/or substance abuse disorder. The prevalence of substance use/abuse is exceptionally high among jail and prison inmates. In addition, about 100,000 Florida youths between the ages of 10 and 17 (or 7% of the juvenile population) are referred for juvenile delinquency each year. Of these youth, 60% or more have emotional, mental, and/or substance abuse problems. A recent survey among Florida county jails reveals that less than 25% of jail inmates with a mental illness or substance abuse disorder receive MHSA services, and that jails in general have limited effectiveness in providing adequate services to inmates with MHSA treatment need, especially the smaller rural jails in Florida.²²

"Of all crime, 60% to 80% is related to substance abuse."

James McDonough, Director
Florida Office of Drug
Control Strategy

It is important to note that we are not concluding that most persons in jail or prison should not be incarcerated. When untreated MHSA problems contribute to the illegal behaviors of some individuals, however, early identification and treatment is appropriate and important. Incarcerating individuals with mental and addictive disorders for minor offenses as a substitute for adequate care is neither sensible nor morally defensible.

Law enforcement personnel testified that they are frustrated with emergency services that either release clients following minimal stabilization or that require officers to wait for hours in hospital emergency rooms until clients are admitted to care. Police officers and sheriffs report having to transport individuals from crisis stabilization units to hospital emergency departments and back again. Their testimony indicated that no one wants to accept responsibility for individuals with mental and addictive disorders. Frustrated, the police may pursue incarceration as a way to assure the safety of the individual and the community and, possibly, to access treatment.

Jail diversion (both pre-arrest and post-arrest) is the name given to efforts to redirect individuals with MHSA disorders who commit minor offenses away from incarceration and into community-based treatment. Crisis Intervention Teams (CIT) and response models originating, variously, with the police and mental health professionals are used increasingly around the country (including Florida) with success. Research shows that these programs are effective in keeping people with mental illnesses out of jail, minimizing police time, and maintaining community safety.²³

Florida has been among the pioneers in jail diversion efforts. The second drug court established in the United States originated in Broward County. Drug courts, as an alternative to incarceration, have been demonstrated to be effective in reducing re-arrest and improving the recovery of individuals diverted from jail. Broward County also led the nation in establishing the first mental health court.

There are numerous models available to divert persons from punitive settings into emergency and community treatment. However, local resources and existing diversion programs, as well as mental health and substance abuse assessment and treatment services within correctional and juvenile justice settings, are far from sufficient to meet current demand.

The Commission has concluded that the lack of emergency response capacity and adequate follow-up services are important contributing factors to the incarceration of persons with MHSA disorders. Persons with both substance abuse and mental illness are particularly difficult to serve and, as will be discussed below, require special integrated treatment programming that is largely unavailable in Florida.

Adults with Serious Mental Illnesses (SMI) And Co-Occurring Disorders

Floridians with serious mental illnesses, as well as those with and co-occurring mental and addictive disorders, are under-served by the traditional system. Integrated services to address multiple needs are almost nonexistent.

Among Florida adults and older adults, the estimated annual rate of serious mental illnesses (SMI) (not including substance abuse/dependence) is 5.5%.^{2, 25} According to Commission testimony, Floridians with serious mental illnesses such as schizophrenia, bipolar disorder, major depression and trauma disorders may be particularly under-served by the current DCF system. Individuals with these severe disorders are more likely to experience significant disability and have multiple needs such as medical problems, low income, and difficulty maintaining employment and accessing affordable housing.

Many individuals who are most in need of services are not identified. Assessment, access, and flexible, consumer-driven funding and services are lacking. In Florida, of the estimated 610,000 adults (ages 18 to 64) with SMI, less than 25% receive services from the Department of Children and Families^{2, 24, 25} although some may be served in other settings.

While we suspect that the overall needs of persons with severe mental illness are not being adequately met, individuals with both mental illness and substance abuse or addiction (also called co-occurring disorders, co-morbidity, or dual diagnosis) may be particularly poorly served. Persons with co-occurring disorders are classic examples of individuals who fall through the cracks in the traditional system of care.²⁶ Research clearly indicates that these individuals have greater treatment success when they receive integrated care. Although models of integrated care exist, they are rarely used in Florida. Both capacity and resources for persons with co-occurring disorders are grossly inadequate to meet current need.

“Addiction is a brain disease expressed as compulsive behavior. Both developing it and recovering from it depends on behavior and social context. People can’t ‘just stop’ because they’re in a different brain state. That’s why treatment is so essential.”

Dr. Alan Leshner, Director
National Institute of Drug Abuse

Nationally, among persons age 15 to 54, more than 40% of those with a substance abuse disorder also had a mental disorder within a given year. Similarly, more than 20% of individuals with a mental disorder also had a co-occurring addictive disorder within a year. Lifetime occurrence of co-morbidity is even higher, as is substance abuse among individuals with severe mental illness.^{27, 28} Five percent of Floridians meet criteria for both mental and addictive disorders each year. However, only 12% of these individuals receive MHSA services from DCF providers.^{2, 29} While we do not know how many of these persons are served in other treatment settings, it seems unlikely that they are well represented in the non-specialty sector. Recent attempts to implement integrated services in some Department of Corrections facilities is one example of attempts

outside the DCF system to better meet the needs of this population.³⁰ Given the prevalence of these problems and the marked functional difficulties that individuals with these disorders confront, it is imperative that we work to better understand where they are seen and to implement integrated models of care for their treatment in these settings.

Specific Findings

According to the Commission's Adult Workgroup, in addition to findings described elsewhere in this chapter, the following problems also occur in the public adult MHS system:

- No uniform, statewide standards for quality of care exist.
- Consumers are not empowered to recover through programs that focus on individual's strength and abilities, promote accountability and coordination, and demonstrate sensitivity to special needs.
- The need for mental health services exceeds current supply. Funding must be sufficient to meet needs and must be adjusted for inflation and population changes.
- Community-based treatment is currently insufficient to meet the expected demand if state hospitals are closed and patients are released to community care.
- Florida not only does not receive an appropriate share of Medicaid, HUD and other federal funds, but most HUD dollars are diverted to individuals with modest incomes rather than to persons with psychiatric disorders. This creates a severe shortage of safe, affordable housing for some of Florida's most vulnerable citizens.
- Clients in assisted living facilities (ALF) must relinquish their SSI and OSS allotments. The monthly stipend of \$43 they receive is not nearly adequate to cover clothing, hygiene, co-payments for treatment services, transportation and other expenses.
- Individuals with histories of abuse often experience an exacerbation of symptoms when they are placed in restraints, further traumatizing them and potentially necessitating further treatment.

Children's Mental Health and Substance Abuse

Many of Florida's children with mental health and substance abuse problems cannot access coordinated, individualized, affordable services.

Current estimates indicate that 10% of Florida's children have serious emotional disturbances, and 20% have a diagnosable mental disorder. Nine percent of preschool-age children between ages two to five already have serious mental health problems. Many are not identified and treated.³²

"For 1 in 5 children and adolescents, the criminal justice system is the gateway to mental health treatment."

Alberto de la Torre, M.D.,
Medical Director,
Renaissance Behavioral
Healthcare Systems
Jacksonville, FL

The substance abuse situation is hardly more encouraging. A recent study suggested that within the previous 30-day period, 31% of Florida high school students have used alcohol, and 35% report the use of alcohol or an illicit drug. More than 23% report binge drinking during the preceding two weeks. Among middle school students, 8% report the use of an illicit drug during the preceding 30 days.³²

Many youngsters have both mental health and substance abuse problems. Of those treated for substance abuse, 80% to 85% also have a mental disorder.³³ Florida's troubled children find themselves in a variety of settings. Seventy five percent of children in foster care have mental health and/or substance abuse problems. About 100,000 Florida youth ages 10 to 17 are referred for delinquency each year in the juvenile justice system.^{2, 35}

Children with troubled parents are at extremely high risk for problems. Fifty percent of adults involved in the state's substance abuse system are parents, and 80% of children in the child welfare system have parents with mental and addictive disorders. Approximately 70,000 cases of maltreatment of Florida children are documented annually. (This translates to one of every 50 children and adolescents in the state but is likely an underestimate, as many cases of maltreatment are neither reported nor investigated).²

According to the Commission's Children's Workgroup, many of Florida's children with mental and addictive disorders have serious difficulty accessing coordinated, affordable treatment services. The Department of Children and Families estimates its unmet need for its target population groups at 77% for children and 86% for adults. In particular, many children who are being seen in the juvenile justice or child welfare systems are not being treated for their substance and mental health issues.

Specific Findings

According to the Commission's Children's Workgroup, problems with the current children's MHSA system include:

- The prevalence of MHSA problems appears to be increasing, with problems developing at earlier ages. Numerous public agencies are involved in treatment, but there is little integration or coordination of services. Planning, funding and service delivery are extremely fragmented.
- Inadequate resources to implement mandated programs exist in numerous areas.
- There is no coordinated, comprehensive, integrated prevention program for children's mental health.
- Adequate insurance coverage is lacking for many children and families.
- Medicaid funding potential is under-utilized.
- Little routine screening is conducted to identify problems.
- There is too little family involvement and family choice in treatment.
- Some aspects of the residential treatment system are characterized by questionable care, a poorly trained workforce and lax oversight.
- Racial and ethnic diversity are not adequately considered in planning and delivering services.
- A critical need exists for public education (particularly for parents seeking help) and stigma reduction.

Older Adults

Tremendous unrecognized and unmet need exists for MHSA services among older adults, and Florida has no system in place to address this need.

Nationally, but particularly in Florida, MHSA issues in elders will soon become a major public health problem due to the changing demographics of our state and nation. Florida is already the "oldest" state in the nation, and all projections indicate that this trend will continue.

A significant percentage of older adults have mental health and substance abuse needs. Dementia, depression and schizophrenia all present special problems in elders. Depression in elders is particularly prevalent and under-diagnosed, both in epidemiological studies and in treatment settings.^{2, 36} Nationally, geriatric depression is projected to affect up to 15 million elders by 2030.³⁷

“We should be sending professionals out to places where elders live or gather, rather than expecting them to come to professionals or seek help, which is often contrary to their habits and long-standing approach to dealing with problems.”

Dr. Gema Hernandez, Secretary
Florida Department of Elder Affairs

While little Florida-specific data are available, nationally it is estimated that 22% of persons older than 60, and more than half of all nursing home residents, have mental or addictive disorders. We estimate that one in five Florida elders may have MHSA needs. Substance abuse in elders is especially under-recognized and under-treated. Many symptoms mimic physical disorders in the elderly, and health professionals lack understanding of the problem as well as appropriate screening tools.

Specific Findings

According to the Commission’s Older Adult Workgroup, specific findings regarding the crisis in Florida MHSA elder care include:

- Elder care is currently not a priority for state and local governments.
- The availability of mental health and substance abuse services has dramatically decreased during the past decade.
- The MHSA service utilization rate for Florida’s elders is among the lowest in the United States.
- There currently is no unified, integrated system of care to respond to elder’s needs, nor is there a statewide policy for MHSA care for older adults in Florida.
- Programs that do exist are scarce, of variable quality and under-funded.
- Ageism and stigma are significant problems.
- Little outreach is undertaken to identify elders in need of help.
- There is a shortage of caregivers, and few receive adequate training.

Conclusion

The Commission has concluded that we must acknowledge and better understand the realities of the combined MHSA system. We must design leadership and information systems that will help us more fully understand the implications of decisions made in one component of the system on service settings in other components. We must work to improve the relationship between our science and our practice and move our interventions “up stream” to identify problems earlier in normalized settings and effectively intervene to either prevent or ameliorate the symptoms of illness before the onset of disability.

For persons who have developed significant disabilities from a mental or addictive disorder, we must establish single points of responsibility for their care, integrated services, and flexible funding approaches that allow them to get what they need to recover or improve. We must hold ourselves accountable for the outcomes of these individuals and for all our state’s citizens. In the next chapter we will outline a set of proposed solutions to address both the problems of the traditional DCF system and the broader challenges inherent in the combined system.