

**CONTENT NOTES FROM 12/13/99 MEETING OF  
FLORIDA COMMISSION ON MENTAL HEALTH AND SUBSTANCE ABUSE  
WESTSIDE CONFERENCE CENTER, UNIVERSITY OF SOUTH FLORIDA,  
TAMPA, FL**

Chair David Shern called roll at 9:30 a.m. Present were:

Jeri Cohen  
Patsy Holmes  
Rodney Kang  
Sandra Murman  
David McCampbell  
Mary McKinnon  
Laura Schuck  
Jeremiah Singleton  
Risdon Slate  
Diane Steele  
Bob Williams

Absent were:  
Terry Allen  
Senator Clary  
John Haines  
Daniel Lestage  
Charlie Morris  
Sallie Parks  
Bob Sharpe  
Phyllis Sloyer  
Michael Spellman  
Irvin Williams

**[NOTE TO COMMISSIONERS: For simplicity's sake, minutes and content notes have been written rather informally, without using Commissioners' titles. Please let us know if you feel that this detracts in any way from the work of the Commission and you would prefer a different approach.]**

David Shern announced that a quorum was present.

He then introduced Eric Eisenberg, chair of the USF Communications Department, who facilitated the discussion developing the Commission's sense of its task. Dr. Eisenberg told three short stories that illustrated the importance of pausing to consider perspective and old assumptions. The anecdotes had three points: (1) we want to start somewhere other than where we are; (2) any map will do; (3) and we need to understand what is realistic. What are our assumptions and "sacred cows" regarding the mental health and substance abuse (MHSA) system? All of us become attached to particular perspectives and methodologies. What are we doing now that we could be doing differently and better?

Dr. Eisenberg commented that it is clear that in MHSA we need a better, faster and less expensive way of doing things. The status quo is not working well. Changing will require a breakthrough in thinking. He presented a triangular universal change model. The three points included: (1) understanding the current reality; (2) having aspirations or a vision and (3) aligning these two points.

He asked the Commissioners to consider a question. **If you woke up one morning and the Florida MHSA system was perfect, what would it look like?** Commissions broke up into four groups to answer this question. Their answers were as followed, presented by the group spokesperson, whose name is in parentheses:

1. (David Shern) In an ideal world we would have a simple, universally administered screening test for MHSA problems much like blood pressure, weight and temperature screens for general health. If we had such a brief indicator that was part of every health assessment, this would help with stigma and normalize discussion about mental illness and substance abuse and dramatically improve access to care. Informed consumers would be educated about best practices, alternative treatments, and self-help and demand state of the art care. Systems of care would be varied and appealing to the different groups that comprise our communities.
2. (Diane Steele) People with mental illnesses (MI) would be treated with dignity and respect. Their needs would be met by a broad spectrum of services available round the clock. There would be a belief that people with mental illnesses can and do get better. Resources would be available and there would be a sense of a community effort to help people with MI. Care would be provided by competent, caring providers, and people in rural areas would have access to services equivalent to their urban counterparts.
3. (Jeremiah Singleton) Removing barriers to care is important, as is streamlining access to treatment. We would focus more on the quality of services delivered by qualified providers who exist in sufficient numbers to meet need. There would be a smooth continuum of care and a good case management system so that people don't fall through the cracks between levels of care. Outcomes would reflect clients, not agency, expectations. Sufficient financing would exist to make all this happen. There would also be MHSA evaluation units in the court system and a true partnership between the courts and MHSA providers. Evidence-based knowledge would be used in the courts.
4. (Mary McKinnon) Confirmed the ideas stated by others and added need for:
  - an organized and fully funded system
  - no unmet need
  - Florida would be #1 (versus #49) among the states in providing MH services
  - No stigma would exist about MHSA problems
  - A choice-based system would allow people options about services received, where they were received and access to them
  - Fully implemented outcomes-based services versus decisions made based on how well the provider does
  - System would be organized around primary, secondary and tertiary treatment points.

Dr. Eisenberg then asked the Commissions to choose the most important themes from the above. They chose:

1. Access/integrated system of care
2. No stigma
3. Full and focused funding
4. Outcomes-focused systems

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The second segment of the Commission meeting featured John Petrila, JD, PhD, chair of FMHI's Department of Mental Health Law and Policy discussing the interaction of the legal and MHSA systems. He noted that courts are increasingly operating as gatekeepers to the MHSA system. A single point of entry is an old idea, but no one thought the courts would become such an important and common gateway.

#### Important Issues Affecting Changes in the Public MHSA System

- decreasing importance of state mental health authorities as the responsible agencies for the public's mental health
- increasing importance of state financing authority and legal system

- managed care
- emergence of for-profits as major care providers. This trend has opened up a new market for companies not regulated by government.
- state hospital system has decreased in its overall capacity. Increasingly, more beds are forensic, controlled by judicial system.
- blurring of system boundaries. It's hard to say what the public MHSA system is now because there has been an important diffusion of responsibility.

### Mental Illness and Government Responsibility

1959	1999
State hospitals:	Criminal justice:
559,000 people w/ MISA*	830,000 people w/ MISA
0.3% of population	0.3% of population

\*mental illness/substance abuse

With the same percentage now as 40 years ago, he pointed out the linear relationship between the two statistics. He emphasized that it is simply interesting to note that in 1959, we confined 3/10 of 1% of the population in mental hospitals, and in 1999, the same percentage was confined in jails and prisons. This is not to imply that we moved the population from one setting to another.

### Jail Prevalence Rates

In every major category of mental and addictive disorders, the prevalence rate for individuals in jails exceeds that in the general population. This is particularly true of alcohol and drug abuse. Six percent of those jailed have serious MI, representing 10 million arrests per year. These numbers don't take dual diagnosis into account. In prisons, the numbers are even more dramatic.

### Juvenile Justice Prevalence Rates (even higher than adults)

Psychosis	1 – 6%
Affective Disorders	30 – 75%
PTSD	15 – 40%
Conduct Disorders	> 75%
Substance Dependence	25 – 50%
Learning Disabilities	40%
Mental Retardation	15%

At least 12% of youth have prior psychiatric hospitalization, more than 50% have prior mental health treatment, 25%-33% of children report abuse or neglect, and rates of attempted suicide are 6% - 28%.

### Strategies

Specialty courts – There are now more than 320 drug courts nationally. Florida was the first to create a mental health court, with a special focus on diversion of nonviolent, first-time offenders. The goal is to break the cycle of re-arrests. The courts have become the default way that resources are allocated.

Training of police officers – They make most of the discretionary decisions about what happens to people. Police often book offenders because they can't get access to MHSA treatment, and it's one way to resolve a case quickly, representing another default responsibility.

Privatization – In many corrections settings, MHSA services are contracted out to private vendors for cost containment reasons. Jails and prisons struggle with the same budget pressure and strategies as institutions in the private sector.

Jails as part of service system – We can't ignore the role of jails. They process too many MHSA problems. Also, funding is critical regarding social support. Once people are in jail, they lose their entitlements (SS, SSI, etc.)

### Policy Implications

- Diminished role of state MHSA agencies, both in Florida and other states. State agencies have lost their authority, both formal and informal. The Florida State office has lost a lot of staff. Does the capacity still exist to succeed?
- Local planning is very important among courts, providers and agencies.
- More diverse interests represented in planning. Judges are often key players.
- Importance of state policy framework. Florida has gone too far in this area. It is difficult to know what state policy is because we are now so decentralized.
- Key role of core services such as case management, housing, etc.
- Financing issues – finding ways to pay that get around barriers that categorical funding creates.

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The third segment of the Commission meeting comprised invited testimony from experts, professionals, providers, etc.

**Martha Lenderman, consultant, Lenderman & Associates** . Martha does Baker Act training in Florida and conducted a special study for the Pinellas County Commission on MHSA. Most people with mental illness in Pinellas County courts and jails are there for misdemeanors. They are “mercy bookings” and police hope to help them get treatment by booking them into the criminal justice system. In jails, the booking staff should triage better. We need more CIT police (Crisis Intervention Training). Police are now waiting in line to be trained.

It is important to recognize who does not belong in jail. It's expensive to keep people with mental illness in jail as well as risky in terms of potential injury to self and others.

In any given month, 14% – 16% of inmates are on psychotropic drugs. Length of stay has increased by 24%, especially with changes in sentencing guidelines. There are not more people in jail, but they are staying longer. They usually receive older, less expensive medications with worse compliance [than newer medications]. Incarcerating people with MI costs twice as much as community treatment.

**Bob Dillinger, Office of the Public Defender, 6<sup>th</sup> Judicial District.** He created a mental health unit in Pinellas County with a staff of 10. Previously, an arrested person sat in the county jail for 10-14 months before being committed to a state hospital. With the mental health unit, it is now two to four months. This has saved the Sheriff's Office \$20,000 per

person, places people in the appropriate setting, and has cut down on decompensation. “Cops and nurses simply have different philosophies.”

It is difficult to find placements for persons with mental illness charged with misdemeanors. We scour the state for beds. Different parts of the system don’t always communicate well with each other.

They also created a Juvenile Assessment Center. “In an average of four minutes, we can determine whether to keep a child in custody. (We don’t have this in the adult system. We need a mental health screener in the booking department).”

**Terry Taggart, consumer, Tampa Bay Depression and Manic Depressive Association.**

Terry told the story of her battle with bipolar disorder, including arrest, jail, losing home, her child, firebombing neighbor’s car, etc. She noted that most women she observed while in prison had mental health problems and had no access to drug treatment or social services. She finally was put on the right medications, is stabilized and functional, and runs support group for the association. “It’s clear what could happen [to the system] with funding.”

**Stan Skipper, family member,** father of young man with paranoid schizophrenia killed during a Baker Act procedure several years ago. He and his wife have worked since then to decriminalize mental illness and facilitate 40-hour training for police officers in handling people with mental illnesses (Crisis Response Intervention). “I have seen the mental health system coming together to better equip law enforcement to handle mental illness.” He noted the need for both “top down” and “bottom up” involvement.

**Gayla Sumner and George Hinchliffe, Department of Juvenile Justice.** Provided handouts and overheads summarizing their presentation “Juvenile Offenders in Need of Specialized Services; 5/24/99.”

**Pam Denmark, Department of Corrections Substance Abuse Programs.** We know treatment works, and mandated treatment is important. We are now serving 19% of the prison population. We know that 63% of inmates are substance abusers. We are also trying to expand drug court partnerships. We want to develop after-care and create a seamless system (from community to prison to treatment to after-care and back to the community).

**Judge Don Evans, Drug Court, Hillsborough County** (second largest in the country) He stated that 80% of all crimes are alcohol- and/or drug-related. Forty-three percent of felonies are drug offenses. His drug division handles 5,000 cases a year. Only 15% of these individuals acknowledge their drug problems.

The drug court movement in Florida has government support. They offer a means of getting drug treatment into the criminal justice system. The greatest need in the system is to evaluate people with mental illness who self-medicate with street drugs.

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### **Public Testimony**

The next segment (afternoon) of the Commission meeting comprised public testimony. Speakers were grouped into categories as indicated:

#### **Children and Families**

**Rick Weinberg, Director, Psychology Internship Program, FMHI.** He noted his interest in kids and families, especially the prevention of school violence. He asked the Commission to attend to this area. Since 1992-1993, nationally 257 fatalities have occurred on school sites. This is a well-publicized problem with many facets. A lot of attention is paid to solutions such as metal detectors in schools but not as much to mental health services delivered in schools to at-risk kids. "When fear walks in the school house door, learning stops."

Pediatricians are also concerned about children's mental health problems. Rick wants to incorporate pediatric specialists into the evaluation component of the MHSA system. The primary care pediatrician is usually where kids and parents go first. He said he often sees both parents and kids with problems but has nowhere to send them for immediate help. There is a two- to three-month waiting period for kids who are not in crisis to get help.

Regarding reimbursement, pediatricians can't bill for mental health codes so they often must treat patients without being paid. Other professionals' reimbursement rates are also too low. He pointed to the importance of research-based data and said doctors are not well educated about mental health.

**Dan Cosby, father of children with attention deficit disorder and substance abuse.** He stated that kids with mental health problems are especially at risk for substance abuse. He said his son told him that "marijuana works better than Ritalin, with no side effects." He founded Wake-Up Call, Inc. to educate parents about warning signs and treatment.

### **Serious and Persistent Mental Illness (SPMI)**

**Paula Hayes, Boley Center.** It is essential for people with SPMI to remain in the community with the support of medication, affordable housing, assistance with living skills, and help in getting and keeping jobs. Three areas are lacking: 1) rehab services; 2) job support; and 3) affordable housing. The reasons include: 1) changes in funding; 2) the medicalization of a lot of mental health problems (move from wellness basis to medical model, which has put us back 20 years); and 3) lack of housing. (She cited the statistic that 25% of homeless are mentally ill).

### **Care of the Elderly with MHSA Problems**

**Marion Becker, professor, Dept. of Community Mental Health, FMHI.** Florida's elderly population will increase by 30% by 2010. Deinstitutionalization has been the only mental health policy for elders. It costs \$80,000 - \$85,000 annually to keep an elder in a state hospital. A lot of elders have no access to mental health services. Depression is not a normal consequence of aging and is very treatable. Needs include developing a system of care, local planning, targeted funding for older adults (there is none now), and evaluation of best practices.

**Harvey Landress, Gulf Coast Jewish Family Services.** He said that in 20 years they have diverted 20,000 elders from state hospitals and saved 50% [of expected cost]. A Geriatric Crisis Response team identifies risk and prevents suicide. He noted that funding has been cut drastically for geriatric mental health and asked that elder money not be diverted to other areas.

**Miriam Williams, Gulf Coast Jewish Family Services, a psychiatric nurse practitioners who has worked with elders for 20 years.** She chairs the Florida Coalition for Optimal Mental Health and Aging, which has 30 state agencies and 270 individual members. Their goal is to improve the availability and quality of mental health services for older Floridians. A priority is to develop a comprehensive mental health act for elders modeled after the one for children.

### **Emergency Services/Law Enforcement**

**Dr. Randy Borum, FMHI psychologist and former policeman.** He talked about the role of police in behavioral services. He pointed out that before the courts became the gatekeepers of the MHSA system, that role was filled by the police, for both entries and diversions. Nationally, 7% of all police contact with the public involves mental illnesses. People with mental illnesses are arrested far more often than others. Is this an effective way to handle the situation? Those arrested for minor infractions get caught up in the revolving door of criminal justice.

Less than half of law enforcement agencies nationally have initiatives in place to deal with the problem. When they exist, they include: specialized mental health/crisis response teams; pairing police with mental health professionals to respond to calls; and trained civilians accompanying police to appropriate calls to link individuals to needed social services. These approaches reduce arrests and the use of force and improve outcomes.

**Donald Turnbaugh, NAMI, Pinellas County,** has 35 years experience in law enforcement and drug treatment; with Pinellas County mental health coalition, (made up of consumers, law enforcement, providers, judges, etc.). In July 1997, he learned about the Memphis Crisis Intervention Team. He said that law enforcement is doing a good job with people with mental illnesses but without the proper tools. He now has 95 trained deputies with 40 hours training. They have learned that eight hours training is not enough to learn how to deal with the mentally ill in crisis. This work is also not for every police officer. It depends on their personality and orientation. NAMI is replicating the Memphis model nationwide at no cost. Mental health professionals also volunteer. "How law enforcement reacts to behavior reflects how society views that behavior."

**Darlene Bellant, Suicide Prevention Advocacy Network (SPAN-FL),** a grassroots group of survivors of suicide, is concerned about suicide and the Sunshine Skyway Bridge. Her family has experienced three or four suicides from this bridge. She wants a physical barrier erected to make jumping more difficult. She discussed the aftermath for family survivors of suicide (depression, etc.).

**Pat Scoones, Suicide Prevention Advocacy Network (SPAN-FL),** read a letter written by her depressed son (who later committed suicide) about his long, unsuccessful struggle to get help. She said a primary issue is education because teachers don't understand mental health. Suicide prevention is a complex issue, and one issue can't be addressed without dealing with others.

### **Substance Abuse**

**Richard Brown of the Florida Alcohol and Drug Abuse Association and ACTS of Tampa.** Gave handout. Talked about ways to enter system and local applications for 397.

**Bill Jones of DACCO** talked about the behavioral health delivery system and dual diagnosis. He stated that the stigma of MHSA is real. Parents fear being identified and having their children taken away from them. He said we need accurate identification and assessment of people with problems. We need new protocols for MHSA and dual diagnosis as well as integrated services. The behavioral health system should consider issues from a consumer's standpoint but consider the concerns of counselors, too. For the latter, there should be a balance between accountability and a deluge of paperwork.

**Risdon Slate (Commissioner)** advocated distributing NAMI packets about MI in schools to educate and lessen stigma.

**Ardis Hanson, FMHI librarian,** talked about parity. She explained that a 1996 federal legislative act was passed requiring parity between health and mental health benefits. Each year, the Florida Legislature introduces a bill in both the House and Senate to create a state law, but none has passed. FMHI issues an annual report for legislators on parity issues. With a modest cost increase, parity would result in numerous benefits, including reducing stigma and out-of-pocket expenses for mental health, improved access to services, and improved workforce productivity. She asked the Commission to include the issue of parity in its agendas.

**Doug Jones of the State Mental Health Planning Council** talked about equity regarding developmental disabilities, saying the state system is disparate in not giving enough attention to developmental disabilities as part of the MH agenda. He wants a medications waiver to be considered, better access to newer drugs, and more community and step-down programs.

### **Funding**

**Mark Zwingleberg of Winter Haven Hospital Behavioral Health Unit** asked Commissioners to consider developing new types of funding. The cumbersome and inequitable way it is set up now creates problems for providers. The way many services are categorized precludes some patients from the service mix. We need to integrate funding for MHSA. He also would like to merge ADM and Medicaid.

### **Deaf and Hearing Impaired**

**Jerry Conner and Chris Wagner of Friends of the Deaf Service Center, Inc.** They pointed out that every MHSA issue discussed here also applies to deaf individuals, but there are neither outpatient services for the deaf nor hospital programs. Jerry said that 1.5 million people in Florida are deaf or hard-of-hearing, and 150,000 are profoundly deaf. The unemployment rate in this population is 80%. The hearing-impaired are three times more likely to have mental health problems. Fifty percent of deaf children are suspended from school due to violent behavior, and less than half graduate from high school. He said that only 10% of deaf kids can communicate with their parents, and this alone is a mental health issue. He reminded the audience that most older people lose their hearing and become part of this population. He asked for MH training on the impact of hearing loss and increased access to good programs for deaf individuals.

### **Consumer/Advocates**

**Steve Kersker, executive director of Florida Drop-In Center Association, Inc.** Steve spoke about importance of housing and work. “The best way to recover is to work.” There are jobs in state hospitals but few jobs in the community for people with mental illnesses. Also, often benefits received are not enough to afford housing.

**Joan E. West, consumer.** She told of her own struggle with mental illness and unfair treatment in the system.

**Nelson Kull, consumer with Pathways Drop-In Center,** talked about medications issues and the use of restraints. He said more consumers should be on MHSA boards.

**Gay Hawke, Windmoor Healthcare,** talked about managed care and patient access to services.

**Anita Cape, trauma survivor, of Family Trauma Survivors Network.** She developed associative identity disorder (multiple personalities) after severe trauma. In treatment for 10 years, she has resolved a lot of her issues. She described herself as high functioning. She switches jobs as her identities change Her situation has been complicated by the fact that she cares for her elderly mother, who was one of her abusers. Anita talked about the trouble she has had getting treatment, especially under MediPass. She noted that suicide is a big problem for people like her, especially in terms of “accidental” suicide resulting from self-mutilation. She asked Commissioners to help this population get needed care.

**Barbara Blitz, on advisory board of G. Pierce Woods Hospital and helps with Drop-In Center.** She talked about the importance of family support to hospitalized patients, noting that she sees many patients who don’t have any visitors because their families don’t have cars. She advocates moving to community-based care versus state hospitals.

**Delores Castaldo, advocate with Benedict Haven** Her son with schizophrenia did well on brand name Clozaril but decompensated badly when switched to generic clozapine. His prescription stated “no generics” but the pharmacist would not comply, and Medicaid would not pay for brand name drug. Delores noted that unlike her son, many patients have no family or others to advocate for them. She asked the Commission to help those with mental illnesses retain access to the most effective medications.

**Richard Durstein, NAMI and family member of person with a mental illness.** He talked about parity and observed that mental health is “at the bottom of the totem pole.” Brand name medications can cost \$2,000 a month, and disabled people cannot earn much money and still retain benefits.

**George Thomas, Department of Community Mental Health, FMHI.** He talked about the importance of providers having access to Best Practices. He suggested three issues to consider as a person with a mental illness: 1) learn and take an active role in your own recover; look carefully at the staff of any facility; are state-of-the-art services provided?; and 3) ask “Is this an empowerment-focused system?” He mentioned a need for training and education about mental health issues.

**John Arnaldi, Mental Health Counselors Association.** He talked about the public’s perception that all mental health treatment is equal, but who is really providing the services? It is important to look at outcomes data. Most mental health treatment in Florida is not done by the best-trained people. The more experienced and trained professionals are, the less client

contact they are likely to have. "We need to train everyone who works with clients." He also mentioned the importance of early detection in schools and more trained mental health clinicians based in schools.

The testimony segment ended shortly before 5 p.m. The business meeting of the Commission followed.