



**Commission on Mental Health and Substance Abuse
Legislative Report
January 1, 2023**

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Message from the Chair

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social, and economic cost, resulting in incarceration, devastation, homelessness, and death. When people are in a mental health crisis, what to expect at the basic level of treatment and services before, during and after the crisis should not be a mystery.

Many individuals are unable to access care in the community. Some are unable to access care due to financial limitations, travel time and distance to available services, and/or no available space. There are not enough resources (services) for all who need it, and many find themselves on a waiting list for services (see Appendix 6).

Not only is there a shortage of MH professionals, but community-based organizations cannot attract MH clinicians and compete with the private sector. The only option is to access care through some of the most costly and inefficient points of entry into the health care delivery system including emergency rooms, acute crisis services and, often, the juvenile and criminal justice systems.

There is an equally if not more compelling need to invest in prevention and treatment at the front end so that the demand for more inefficient services will be reduced.

- Programs to prevent individuals from inappropriately entering the justice and forensic mental health systems.
- Programs to stabilize these individuals and link them to recovery-oriented services in the community that are responsive to their unique needs.
- Mechanisms to quickly identify individuals with mental illnesses who do become inappropriately involved in the justice system.
- Lack of community-based care for reentry. It is imperative that the efforts being undertaken to enhance community re-entry from jails and prisons include the establishment of comprehensive and competent services in the community targeted toward the needs of this high-risk population.

18% (1 in 5) of the population in the U.S. has a diagnosable mental illness. 1 in 17, or 6% of the population, suffer from a serious mental illness (Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2020). An estimated 20 million Americans have a substance use disorder and 8 million suffer from both Mental Health and Substance Use disorders.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), last year alone, more than 56% of all adults living with serious mental illness and about 62% of all children living with severe emotional disturbances in need of treatment in the public mental health system had no access to care. Our geriatric population is also lacking in providers, needed care, and medication.

It is estimated that somewhere between 13%-20% of adolescents suffer from a mental health disorder, most starting around age 14. It is said that 37 out of 100 children suffer from Acute Childhood Experiences (ACE's). Trauma affects the brain. It is important that those who work

with children, such as school officials, have training in ACEs, calming techniques, and de-escalation. The earlier the diagnoses, and treatment is provided, the better the outcome for the individual.

As identified in the Marjory Stoneman Douglas High School Public Safety Commission, there are issues transitioning from the juvenile system of care into the adult system. Many reaching adulthood are left out on their own and/or now can just choose to stop treatment, which can have devastating effects. Those who find themselves in the criminal justice system will receive services through the Department of Juvenile Justice (DJJ), but once released from their supervision, there are no referrals and/or follow up care.

There are six state mental health hospitals and three private facilities in Florida. In fiscal year 2021 the Department of Children and Families (Department) funded 2,677 beds through the state mental health treatment facilities. Additional beds are contracted annually through the managing entities, including residential programs, inpatient programs and psychiatric hospitals. The number varies and only represents patients paid for by the Department. Using the 2020 provisional population numbers for adults in Florida, 17,358,504, the ratio of beds per 1,000 adults is 0.154. There are just not enough long-term and short-term residential treatment beds in the State to address the need. In addition, counties in the State are not created equal and lack access to care for their residents.

In FY 2021, the Department's clients presented with 997 different mental health diagnoses in FY2021. These were the top 10 most common.

ICD10	Dx	Number of clients
F32.9	Major depressive disorder, single episode, unspecified	14,923
F33.1	Major depressive disorder, recurrent, moderate	14,055
F11.20	Opioid dependence, uncomplicated	10,389
Z91.89	Other specified personal risk factors, not elsewhere classified	10,336
F41.1	Generalized anxiety disorder	9,919
F31.9	Bipolar disorder, unspecified	9,724
F43.10	Post-traumatic stress disorder, unspecified	9,554
F25.0	Schizoaffective disorder, bipolar type	9,236
F20.9	Schizophrenia, unspecified	9,147
F10.20	Alcohol dependence, uncomplicated	8,624

Below is a breakdown of Department clients served in FY2021 by program area. This only represents the clients paid for through Department funding and does not represent the entire population of individuals with mental health and substance abuse disorders.

Program Area	Number of clients
Adult Mental Health	152,565
Adult Substance Abuse	43,470
Child Mental Health	34,595
Child Substance Abuse	6,976

Here are the number of admissions meeting criteria for Baker Act and Marchman Act for the last five years.

	Baker Act Admissions	Marchman Act Admissions
FY 2020-2021	14,043	1,125
FY 2019-2020	27,576	2,235
FY 2018-2019	37,722	2,907
FY 2017-2018	38,385	2,995
FY 2016-2017	36,676	2,639
Note: FY 2016-2017 and 2017-2018 are from SAMHIS; FY 2018-2019, 2019-2020, and 2020-2021 are from FASAMS.		

It is not possible to go to one specific source to obtain this data. There is no interoperability between various systems (public providers, private providers, primary care, DCF, DJJ, DOH, DOE, DJJ, VA, criminal justice system). Deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, and systems; leaving enormous gaps in treatment and disparities in access to care.

Individuals can and do, move through community-based providers, the criminal justice system, private providers, emergency rooms, schools, etc., receiving a diagnosis, treatment, and medications in each without anyone being the wiser. Not even our state organizations (DFC, AHCA, DOH, DOC, DJJ, DVA, etc.) share information. We must connect the dots between all the service providers, both public and private, to make sure everyone is sharing information about a single client and preventing silos of information from existing.

While a portion of crises are unpredictable and unavoidable even in the perfect overall behavioral health delivery system, many behavioral health crises are a direct result of inadequate performance by the rest of the behavioral health delivery system and other human service systems such as justice, housing, immigration and child or adult protective services. Common behavioral health system causes of behavioral health crises include inadequate access to routine services, premature discharge from treatment programs and inadequate attention to patient engagement.

In many communities, it is difficult for individuals to flow smoothly to higher or lower levels of service intensity as their needs change. Even more problematic, many individuals in crisis, their families and support systems, experience multiple disjunctions and transitions in care during the crisis episode at a time when they are most vulnerable and distressed. These transitions are often associated with multiple repetitive assessments, changes in diagnosis and variations in treatment plan from one day to the next or one program to the next. This lack of continuity through the crisis episode results not only in diminished experience of care for primary customers but can lead to poorer outcomes because the information often does not flow efficiently as the client moves through the continuum.

For these reasons, continuity of care through the crisis episode and facilitation of smooth transition through different levels of service intensity in the crisis continuum are both essential elements of an ideal crisis system. In Florida's system of care, the money follows individual

programs and not the individual. As the needs of the individual change, protocols and funding should be in place that make it easy for them to be transitioned through the appropriate levels of care in the crisis continuum. These vertical transitions through the continuum should occur as smoothly as possible to meet individual needs and be associated with continuity of care by a crisis intervention team or crisis intervention coordinator that is usually based in the crisis hub and has a care coordination function throughout the continuum of services.

In addition, we separate mental health and substance abuse disorders (SUD). SUDs are included in the DSM V manual as a mental health disorder. There is a need for seamless flow between various types of co-occurring capable mental health and SUD services for individuals with co-occurring mental health and SUD. Many crisis programs and crisis systems create distinct detox capacity and crisis bed capacity. This often results in impediments to both individual client flow and flexible utilization of limited resources. Individuals with co-occurring conditions in crisis who need help with withdrawal management can receive such support in a crisis bed. Individuals who present with requests for assistance with SUD often have co-occurring mental health conditions as well.

Further, individuals with active SUD who need a safe place to stop using, to address mental health and social concerns and to consider the next steps in recovery should not be required to present with intoxication to access the support services labeled as detox. Therefore, within the bounds of state regulations, efforts in the ideal crisis system should be made to eliminate the artificial distinction between crisis beds and detox beds in favor of a more fluid system that meets the needs of all individuals with any combination of mental health and substance use needs.

Our system is complicated and administratively burdensome, not just for the individual and their families, but the providers. MH/SUD clinicians are inundated with paperwork for various funding sources and programs. Where does this paperwork go and what is it used for? Hours of paperwork equals time a MH/SUD professional could be working with clients. Reporting is necessary in tracking outcomes but can be streamlined to what data is necessary for treatment and for guiding the system of care throughout the State of Florida.

Community providers often find it difficult to meet mandatory performance standards. These high standards disincentivize providers from taking on those high-risk individuals, who are harder to treat, and are more likely to provide services to those not requiring acute care. There are financial deterrents for programs to take on those requiring acute care services. Behavioral health systems cannot meet the mandatory performance standards by taking on those who need the services the most. There are also no protections for the community-based providers and all liability falls on them and premiums continue to rise.

A continuum of services is needed as an individual navigates through the MH/SUD system. Case workers and peer support members are also paramount to keep the individual on track and circumnavigate through this very complex system, assuring they receive the care they need and the funding to support the treatment. The individual should navigate through the system based on their needs not by what the funding source dictates.

In the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community, Florida is often ranked near the bottom. In 2021, \$769,723,025 was allocated to the managing entities. \$61,483,010 was unexpended due to unused **program** funds. This is just funding provided through the managing entities. There are also funds from other local and private entities that are returned for this same reason.

The Funding is not flexible. Rules are very strict and cannot be used universally. It was indicated that there is not enough funding, but if funding was more portable, it might address the areas where funding is short, making the system more effective and efficient.

In this first report, you will find recommendations the Commission believes will begin to make the system better. But we still have much work to do as we continue to take a deeper dive into all aspects of our system of care. We are tracking the funding, where it's going, how it's being expended, and the reporting and accountability requirements. We are looking at data collection and sharing, how to make this happen among all stakeholders, and most importantly, how to make Florida's system of care work for all.

[William Prummell, Sheriff](#)

Commission on Mental Health and Substance Abuse, Chair

Executive Summary

In 2021, the Florida Legislature passed legislation, which Governor Ron DeSantis subsequently signed into law, to establish the Commission on Mental Health and Substance Abuse (Commission). Composed of 19 members, the Commission's tasks are to review and evaluate the current effectiveness of such services in the state, identify barriers to care, and make recommendations regarding policy and legislative action to implement improvements. In addition to conducting a review of the State's behavioral health and substance abuse systems of care, the Commission is also responsible for assessing priority population groups that can benefit from publicly funded care and proposing recommendations for the creation of a single, permanent State agency that will manage the delivery of these services. Other tasks the Commission must perform include identifying gaps in behavioral health care and assessing current staffing levels and availability of services across Florida. Also, the Commission is responsible for submitting two reports to the Governor, President of the Senate, and Speaker of the House of Representatives. The first, which is due on January 1, 2023, is an interim report that precedes a final one due on September 1, 2023. This is the Commission's interim report on the status and recommendations for Florida's mental health and substance abuse services.

To complete its review, the Commission established four subcommittees and tasked them with evaluating specific aspects of the State's behavioral health and substance abuse systems of care. In addition to holding regular meetings, each prepared reports proposing recommendations. Focusing on their assigned areas, the following subcommittees developed strategies and ideas based on their assessments of how Florida delivers behavioral health services:

- **Subcommittee on Business Operations:** This team dedicated itself to evaluating how Florida's State agencies approached behavioral health services and where they could implement improvements to streamline delivery and reduce wasteful practices.
- **Subcommittee on Criminal Justice:** Tasked with reviewing the Baker and Marchman Acts, this subcommittee worked on recommendations to improve services related to restoring competency, jail diversion, and reducing recidivism.
- **Subcommittee on Data Analysis:** All State agencies and entities engaged in delivering behavioral health services perform data collection. This team focused on methods to improve and enhance data collection and reporting, and devised strategies for alignment and storage.
- **Subcommittee on Finance:** Funding for behavioral health services comes from myriad payers, including Medicaid, federal grants, private insurance, and state and local revenues. This subcommittee explored current obstacles to funding, in addition to identifying potential new sources.

These recommendations correlated to the subcommittees' respective areas and included proposals to improve access to care, divert those with behavioral health needs from the criminal justice system, gather and report data, and discover novel means to fund these services. Each recommendation builds upon existing State programs and will enhance behavioral health care across Florida, if implemented. It is important to note that while the recommendations in this report were agreed upon by the majority of the Commission members, there are some recommendations for which there was not consensus, specifically in the Access to Care section.

As the Commission continues its work, these subcommittees will refine their proposals in the final report.

Focusing on how to improve access to behavioral health services, the Subcommittee on Business Operations identified several approaches that can connect individuals to appropriate care when necessary. These consist of the following measures:

- Establishing a master client index that will collect demographic and diagnosis information: If implemented, such an index can identify those who would benefit the most from enhanced care coordination to reduce the likelihood of utilizing higher levels of services (e.g., crisis stabilization units, inpatient hospitals).
- Conducting an explorative study to better understand the perceived gaps in behavioral health care to determine if modifying Medicaid eligibility criteria would make a difference.
- Initiating uniform quality metrics for all publicly funded behavioral health and substance abuse care in Florida: Currently, programs such as Medicaid and the Department use similar but varying metrics that can prevent accurate measures of performance. A uniform set will provide a more accurate account on the effectiveness of services delivered statewide.
- Creating a coordinated community behavioral health approach for public school students utilizing a single organization, and amending Section 1006.05, F.S

The above recommendations can increase access to behavioral health care for individuals of all ages. Having the ability to see the right provider at the right time can help reduce overutilization of intense services, as well as mental health and substance abuse crises. Among the most intense behavioral health services in Florida that result in heavy costs for the State are involuntary examinations conducted under the Baker and Marchman Acts. In addition, competency restoration following arrest and indictment compounds these costs. Furthermore, the State's jails and prisons have become residences for those who would be better served by behavioral health and substance abuse service providers. To improve these issues, the Subcommittee on Criminal Justice proposed modernizing the Baker and Marchman Acts, making improvements to how Florida approaches competency restoration, and implementing jail diversion programs. Regarding the two acts, the subcommittee recommended legislative action that will amend the existing statutes to better serve the populations that require them and reduce unnecessary involuntary examinations. For competency restoration, proposed actions consist of reducing the number of offenses where such action is necessary for an individual to stand trial. This is needed to alleviate the burden on state mental health hospitals, which have insufficient capacity to meet this demand. The subcommittee also cited jail diversion programs as critical in reducing the number of inmates contending with serious mental illness who would benefit from behavioral health interventions. All of these recommendations can contribute to reducing costs by lowering recidivism rates and utilization of intense levels of care.

Measuring the outcomes of new measures and programs is impossible without data. To determine actions to improve this area, the Subcommittee on Data Analysis proposed the following three goals that will align and centralize Florida's behavioral health and substance abuse data:

- Goal One: Create a coalition of key stakeholders to identify the best data sources across the state and determine outcomes for their use.
- Goal Two: Establish a single repository for behavioral health and substance abuse data which can allow for accurate collation and reporting. The subcommittee proposed establishing one point for all state agencies to submit their data.
- Goal Three: Use collected data to provide information on behavioral health provider availability to aid individuals with the highest risks.

These improvements can aid the State in increasing access to services, achieving better outcomes, and ensuring appropriate levels of care are utilized. Regarding funding opportunities, the Subcommittee on Finance is in the process of reviewing whether there are untapped sources of revenue or areas that could generate additional funds. As the subcommittee completes its evaluations, it will prepare its recommendations for the final report in September 2023.

Data Transparency

Having data available upon which to make informed decisions and address persistent behavioral health problems is critical to having a robust and effective system of care. On that basis, the Commission has composed several recommendations to improve data collection, storage, and transparency that will improve how the State uses information when evaluating performance, individual outcomes, and identifying issues. The Commission proposes the development of a master client index to reduce duplication of effort and better integrate delivery of care between various public funders of behavioral health services. The Commission further proposes the development of a de-identified data warehouse to analyze trends, prevalence, and outcomes in behavioral healthcare in Florida. The following outlines the Commission's proposed actions to make these improvements.

Recommendation 1

Develop a pilot Master Client Index to yield the following results:

1. Public Funders of Behavioral Health Services would be required to upload limited scope, client specific information and service type or program into a non-transactional data warehouse/repository at a specified frequency.
2. The data would be submitted in a universal file format
3. The data fields would be limited to the most commonly collected information. For example:
 - a. First Name
 - b. Middle Initial
 - c. Last Name
 - d. Date of Birth
 - e. Social Security Number
 - f. Procedure code or Healthcare Common procedure coding system
 - g. DSM-5 Diagnosis
 - h. First date of behavioral health service or entry into a treatment program
 - i. Setting of service – i.e., jail, school, Department of Juvenile Justice (DJJ) commitment program, provider facility, state psychiatric hospital, etc.
 - j. Last day of a publicly funded behavioral health service or exit from a treatment program
4. The Master Client Index would sort/match records based on a combination of the demographic fields, including partial matches, so that a significant level of confidence is achieved when two distinct individuals are identified as actually the same person.
5. Access to a patient's record in the repository would be limited to matches between the specific public funder's roster and a corresponding demographic record match from another public funder's submission. Access will be guided by adherence to federal and state privacy protections.

Rationale

Individuals whose behavioral health care needs go unmet become the high utilizers of acute care and encounters across systems. They are frequently bounced between social service systems, including the Department of Education (DOE), the Department of Juvenile Justice (DJJ), the Department of Children and Families (DCF), law enforcement agencies, the Agency for Persons with Disabilities (APD), and the Agency for Health Care Administration (AHCA), Department of Housing and Urban development (HUD). By developing a standard methodology for building a Master Client Index that cross-checks certain demographic values with an advanced algorithm to include partial matches, the potential for a truly integrated and informed behavioral health care system is attainable. The effects of successfully identifying those who would most benefit from a targeted care coordination strategy would be a reduction in duplicative or conflicting services, more effective resource allocations by informed funders of behavioral health services, and better outcomes for the complex individuals served.

Recommendation 2

Create a Florida behavioral health data repository or comparable effective data system that includes data harmonization and cleaning of identified data sources.

Following creation of a statewide data collaborative and development of information sharing guidelines, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to):

- Department of Children and Families (DCF)
- Agency for Health Care Administration (AHCA)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Department of Housing and Urban Development (HUD)
- Florida Department of Law Enforcement (FDLE)
- Agency for Persons with Disabilities (APD)

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Secure the administrative authority and commitment from stakeholders/agencies (DCF, AHCA, etc., to establish the state-wide Florida Behavioral Healthcare Data Repository (FBHDR)).
2. Due to the sensitivity of this data, the legalities of Health Information Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and SAMHSA must be addressed.
3. Determine structure of the repository (centralized, federated, etc.), as well as policies and protocols for data standardization, security, and access.
4. Determine a process to identify and partner with parties responsible for creation and maintenance of a data repository.
5. Implement innovative technology to address privacy concerns and make the data more accessible with fewer data sharing consequences (e.g., personally identifiable information and protected health information).
6. Incorporate technological and data science innovations to improve data collection, upload, cleaning, harmonization, and statistical analyses.

7. Budget appropriate initial funding for the initiative, including a fiscal analysis of elements/components (associated costs) of establishing and maintaining the repository and the possible addition of a qualitative component and analysis.

Rationale

The overall goal is to provide information on access, prevalence, quality, costs, and outcomes of the behavioral health system in Florida. Key questions have been developed based on national standards and guidance relating to understanding and improving statewide health systems aimed at effectiveness, efficiency, and fairness. In addition, states that have embarked on characterizing and optimizing behavioral health care and outcomes have provided guidance on initial questions that inform policy, spending, and clinical capacity. Initial research questions will evaluate major behavioral health outcomes and evaluation of current performance metrics to provide detailed information defining what they are and what outcomes they are achieving.

Recommendation 3

Provide information on behavioral health data sources in Florida for high-risk individuals. The Commission's Data Strategy for improving outcomes is included in [Appendix 2](#).

In order to mobilize this recommendation, the Commission proposes the following steps:

1. Establish an FBHDR oversight steering committee that will identify appropriate behavioral health data sources and will guide and prioritize analytic direction and initiatives. Membership should include representatives from major stakeholders.
2. Initially, this level of research will focus on people served by public-funded services and supports. Specifically, the research will descriptively report on people served within each public service and across departments (e.g., DCF, AHCA, DOJ, etc.). Specific research questions will include, but not be limited to:
 - Demographic and diagnostic characteristics.
 - Prevalence of specific psychiatric and medical diagnoses.
 - Specific behavioral health and medical services.
 - Client outcomes, using available direct and proxy outcome measures, based on the above client and service characteristics.

In a later exploration, comparisons of the above outputs will be made among people covered by Medicaid versus Medicare versus private insurance versus uninsured. Some recommendations for additional analyses may be proposed.

3. Additional considerations:
 - a. Implement a mixed-method or qualitative component to inform/contextualize the data:
 - i. Focus on the following questions: (1) what services are being provided, (2) how services are being provided, and (3) how effective services are for different populations.
 - ii. Prioritize consumer voices (e.g., advocacy groups focusing on housed individuals, individuals with a criminal record, etc.).

For more information on national data frameworks, refer to [Appendix 3](#).

Rationale

States that have embarked on integration of behavioral health information from multiple agency sources have found significant improvements in accuracy of information on:

1. Personal characteristics (e.g., age, sex, gender, race, ethnicity, geographic location).
2. Diagnoses, including co-morbidities (e.g., DSM-5 ICD-10 dx, multiple diagnoses, screening tool results, medical dx).
3. Service use types and intensity/frequency (e.g., visit types- assessment, intake, medication management, psychotherapy and counseling, crisis intervention, individual, group treatment, provider type).
4. Person outcomes and health care quality (e.g., clinical severity scores, such as PHQ9, functioning outcomes, outcome measures, such as follow up with care, medical screening for patients with psychotic disorders, etc.).
5. Collect data on individuals receiving services and start collecting a 'catalogue' of mental health and behavioral health resources that are available.
 - a. Identify all existing statewide behavioral health service directories (e.g., Hope for Healing and 211 services).
 - b. Compare county level resource differences (i.e., organizations, providers, practitioners, etc.) between DCF and AHCA systems.
6. Identify information that is not being collected through publicly funded care that should be collected for outcomes.

Recommendation 4

Develop a workgroup to establish a statewide core set of metrics that will provide a comprehensive, standardized, and transparent approach to assessing and evaluating quality of care and health outcomes. These metrics will address the following domains:

- Preventive care and screening.
- Referrals and care coordination.
- Treatment and follow up.
- Risk factors and health outcomes.

Rationale

Health surveillance is the process of continuously monitoring attitudes, behaviors, quality of care, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. Standardized and comprehensive data to accurately assess and monitor substance abuse and mental health related metrics are currently not available at a state level. Development of a comprehensive approach to substance abuse and mental health quality metrics will provide a source of reliable and valid information for use in developing, implementing, and evaluating efforts to improve the health and safety of all Floridians and visitors. A detailed collaboration roadmap is provided in [Appendix 1](#).

Access to Care

Considering that Florida's population is rapidly expanding, timely access to behavioral health services when needed is critical to preventing crisis situations that result in admissions to crisis stabilization units or inpatient facilities. As one of the State's main priorities, improving access to care is not only essential to improving individual outcomes, but also to reducing the financial and human costs of behavioral health crises that involve intense levels of care or law enforcement. Because of this need, the Commission has made several recommendations that will improve access to behavioral health care so that more individuals will have their first encounter with a provider at the community level rather than the emergency department or local jail.

Recommendation 5

In partnership with AHCA, conduct an explorative study to assess the potential impact of adjusting the Medicaid income eligibility criteria for young adults ages 18-26 years, in the coverage gap whose parents are not insured. The results of this study will be used to meet the following goals:

- Assess the data to ascertain the behavioral health needs of uninsured or underinsured youth
- Identify evidence-based interventions to address their specific needs and increase access to care (e.g., pilot)
- Develop a strategic, data-driven approach to addressing behavioral health care access and costs for a targeted population at risk that will benefit from early intervention.

Rationale

An estimated **415,000 Floridians** are in the **coverage gap**. They do not have health insurance through an employer, possibly because they work at a small business, work part-time or seasonally, or they are self-employed. They earn too much to qualify for Medicaid, but not enough to qualify for subsidies to purchase health insurance in the Marketplace.

Coverage for Behavioral Health

In 2019-2020, over 1,000,000 adults in Florida reported needing, but not receiving, mental health treatment, and 51.9% cited cost as the barrier.

In Florida, behavioral health care can be covered by commercial insurance, Medicare, Medicaid, state or federal funding, or self-pay. An estimated 14.9 percent of adults in Florida who reported a mental health disorder were covered by Medicaid, while 54.9 percent were covered by private insurance. Because the Managed Medical Assistance (MMA) plans are paid on a capitated basis, determining how much is spent specifically to treat mental or substance use disorders is difficult and requires analysis of encounter data for each plan.

However, it is worth noting that behavioral health care costs are not limited to behavioral health treatment. A recent 2020 study found that people with behavioral health disorders also had higher utilization and costs for physical health care. This study included 21 million individuals covered by employer health plans. The study also found that 27 percent had a behavioral health diagnosis or treatment but accounted for **56.5 percent of the total health care costs** for the entire study population. More than 95 percent of their health care spending was for physical treatment and only 4 percent was used

for behavioral health. Better care coordination and integrated services would appear to be important tools to reduce health care costs, regardless of payer source. ([Davenport et al, 2020](#))

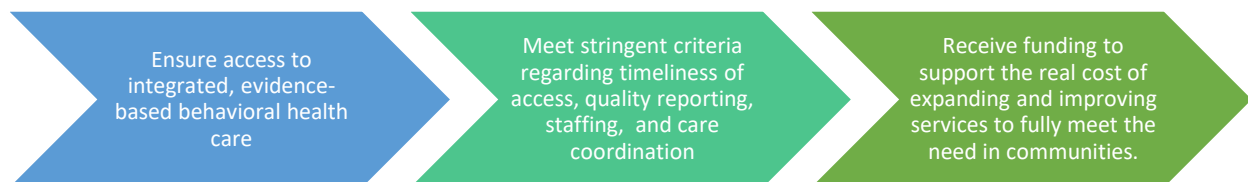
Young adults ages 19 to 26 account for 8.3 percent of Florida’s total population, but 14.1 percent of the uninsured population. This percentage has improved since young adults up to age 26 became eligible to remain on a parent’s health insurance plan. Youth ,who age out of foster care are also permitted to remain on Medicaid until age 26, if income requirements are met. Adjusting the income eligibility criteria for Medicaid for young adults in the coverage gap whose parents are not insured would improve access to care for behavioral health and for primary and preventive care that could promote better long-term physical health outcomes. The study would include a comprehensive system of qualitative and quantitative data analysis to assess utilization and results. This approach allows for a better understanding of gaps in behavioral health services that exist for young adults whose families are not able to afford health insurance, and for youth pursuing technical education without access to college health clinics and those who are living independently and working, but in jobs that do not offer affordable health coverage.

Recommendation 6

Implement a three-year pilot in which one agency level entity manages all public, behavioral health funding in a geographic area, minimally including:

- Department of Children and Families (DCF) safety net funding.
- DCF child welfare prevention funds related to substance use and mental health.
- Criminal justice funding (Department of Corrections and DJJ).
- Medicaid managed care funding.
- Private Insurers.
- Medicaid fee-for-service funding (including Florida Assertive Community Treatment).
- Local funding (county, city, Children’s Services Councils, independent tax districts, etc.).
- Department of Education and Local School Boards mental health funding.

To ensure the community has access to timely, quality, and comprehensive services, it is further recommended that the pilot must provide a minimum of nine types of services through contract with partner organizations, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with community partners, integration with physical health care, and provider payment through a prospective payment system or other payment systems, regardless of the patient’s payer source.



Based on a comprehensive assessment, individuals would have access to the entire service array. The agency level entity would be responsible for billing the responsible entity, blending and braiding funding to ensure comprehensive, equitable care for all. The following topics will require development and definitions.

- Independent care coordination.
- Prospective payments based on cost.

- CCBHC certification criteria in addition to the federal minimum standards.
- Contracts with the various funders.
- Uniform performance measures to satisfy federal Medicaid and Substance Abuse and Mental Health Services (SAMHSA) reporting requirements.
- Coverage policies for individuals who have commercial or federal coverage (i.e., Medicare, Tricare, etc.), but are not able to access the services they need under these plans because the service is not covered, or co-payments/deductibles are so high that the individuals cannot afford care.

Rationale

Florida's current payment structure for publicly funded behavioral healthcare has resulted in a fragmented and siloed service system. The services a person with mental health and/or substance use disorders receives is often dependent on how their services are funded, rather than their individualized needs. The system of care is a patchwork of programs, care delivery, and oversight that is complex, disjointed, and inequitable. Because each payor has differing covered services, reporting requirements, and eligibility, it is challenging to provide individualized care or maintain needed service levels when insurance/fund source changes occur. The recommended approach would allow providers of behavioral healthcare to serve individuals with the flexibility necessary to provide person and family-centered care. Provider time would be spent on what they do best – provision of prevention, recovery, and treatment services instead of complicated billing processes and reporting that differs for each funder. A predictable, stable payment structure based on actual costs will allow providers to hire and retain the workforce necessary to manage the challenging needs of the target population. The entity would function as the single point of accountability for payment, oversight, and care-system management with the ability to leverage resources and reduce duplication. Another advantage to this approach is that one entity would have all the behavioral health care history for the person served in one place, including service encounters, assessments completed, multiple provider involvement, and service intensity. This will allow the agency level entity to identify high utilizers, duplication of care, and care coordination needs through data surveillance. The agency level entity would also have the necessary data on service provision, cost, and performance outcomes across the system of care to effectively identify gaps, scale best practices, and plan system improvements.

Recommendation 7

Create a coordinated community behavioral health approach for public school students utilizing a single organization and amend section 1006.05, F.S., as indicated in [Appendix 4](#).

The need for a uniform system to assure access to care, reduce fragmentation caused by siloed systems of care, care coordination, and uniform reporting of outcomes was identified by the Marjory Stoneman Douglas Commission.

A successful model has been replicated by three major school systems (Broward, Hillsborough, and Pasco) to assure the appropriate identification, referral, and care coordination of children and families with complex and co-occurring behavioral health needs. The model standardizes the process for referral, care coordination, feedback, and outcomes through contracts with Managing Entities, and will be evaluated for potential replication across the State.

Multi-Tier Approach



School staff, District Clinician and the School Project Manager identify children and assess using a Multi-Tier approach

Services are delivered at the lowest possible level that meets child and family needs to prevent progression into higher, more intensive levels of service

Reporting outcomes include:

- ✓ Days in school
- ✓ Pre and Post functioning level
- ✓ Screening and assessments
- ✓ Statutorily required children's mental health measures

Source: PREP4RE School Crisis Prevention and Intervention Training Curriculum. Adapted with permission from Cherry Creek School District. (2008). Emergency response and crisis management guide. Greenwood Village, CO: Author.



Merging school and community behavioral health process

Similar to the model above, the single organization will contract with the school district to assess student needs and gaps in services, identify providers and additional services needed, and report needs and outcomes. The entity will also organize a system of care to ensure mental health services are delivered to all children and families, regardless of insurance type, identified by the school system.

The single organization would be responsible for ensuring there is an expansive network of providers with both the expertise and capacity to provide timely access to services for these high-risk children and their families. The model would include a Care Coordinator within each district to ensure students are receiving necessary services and to assure that appropriate funds are used to support the cost of treatment (including Medicaid and private or commercial insurance) prior to accessing school based mental health funding to purchase community-based services. In addition, school districts may choose to contract for the management of onsite community-based services designated to meet the students' needs in high needs schools within the district.

Single organization responsibilities include the following:

- Identification of gaps to expand and enhance services.
- Provide onsite services for high-risk schools (upon request).
- Track and report outcomes.
- Ensure community education about the availability of wraparound services.
- Identification of unique behavioral health needs for students.
- Assure that the provider network has the capacity to meet the need.
- Maintain and enhance relationship building and communication with school districts and community providers.
- Collaborate with public and private funders.

- Develop or utilize youth at risk staffing when necessary for children involved in multiple systems (Child Welfare, DJJ, students with three or more admissions to a crisis unit within 90 days, etc.).

Rationale

School districts' expertise is in the delivery of high-quality education and services to maximize each student's potential. The single organization would possess expertise in the delivery and coordination of behavioral health services (mental health, substance use, and recovery supports) for children and their families with complex and severe behavioral health needs. School districts utilize a variety of methods and services within the school system to offer mental health well-being, screen and identify youth with behavioral health needs. The majority of students identified with behavioral health services can be appropriately served within current school-based prevention and counseling services to support the student's well-being. However, there is no uniform system in place throughout Florida to assure timely access to the appropriate level of community based behavioral health services and care coordination for children identified at the highest level of risk that cannot be mitigated with school-based counseling and supports. Although school systems may have referral agreements and/or contracts with community providers, there is no mechanism to assure that linkage and care coordination feedback loops are in place to assure students' unique needs are addressed across the various systems providing services to high-risk youth and their families, or uniform reporting of outcomes for children referred to community services.

Gaps in Care

To better ensure access to care, the Commission recognizes the need to identify and fill the gaps in behavioral health services. Many of the gaps exist due to outdated processes that will require systematic change. Currently in the system, there are wait lists for services that are highly utilized. In [Appendix 6](#), wait list data by Managing Entity is presented. This section puts forth recommendations that will improve the State's capacity to address behavioral health comprehensively.

Recommendation 8

Limit the use of Competency Restoration process to cases that are inappropriate for dismissal or diversion using the following:

- 1) Divert cases inappropriate for competency restoration (misdemeanor/low level felonies) from the criminal justice system through the expansion and funding of specialty courts and programs.
- 2) Restrict which cases are referred for competency evaluations.
- 3) Expand and fund [section 916.185, F.S.](#) – Competency Alternative Programs

Rationale

Competency to stand trial (CST), refers to the constitutional requirement that people facing criminal charges must be able to assist in their own defense. A criminal case cannot be adjudicated unless this requirement is met. The U.S. Supreme Court considers someone competent to stand trial if that person is rationally able to consult with an attorney and holds a clear understanding of the charges against him or her. Some people view competency restoration as a way to connect a person with mental health treatment. The reality, however, is that competency restoration services have a narrow focus on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and treatment services with the goal of long-term recovery and rejoining the community.

In Florida, once an individual is adjudicated incompetent to stand trial on a felony charge, DCF must transfer the individual from jail to a competency restoration facility within 15 days of the finding. Individuals adjudicated incompetent to stand trial on a misdemeanor charge may be restored in the community, but more likely would be released to the community without access to treatment. If they remain incompetent to stand trial after one year, the charges are dismissed. Florida spends nearly 20 percent of all adult mental health dollars and half of all state mental health treatment facility dollars (approximately \$198 million) annually on 1,600 forensic and forensic step-down beds serving roughly 3,300 individuals under forensic commitment. Admissions for competency restoration in state forensic treatment facilities last almost six months, at a cost to taxpayers of over \$50,000 per admission. Roughly 70 percent of people restored will have their charges dropped, or they will accept a plea to credit time served or probation and will be released back to the community; in many cases there is no provision for follow-up services or access to basic necessities such as food, clothing, housing, or medication.

Individuals subject to forensic commitments are now the fastest growing segment of mental health consumers. Forensic commitments have increased by 72 percent since 1999, including an unprecedented 16 percent increase between 2005 and 2006, far exceeding existing forensic treatment bed capacity. At the same time, prison sentences of a year and a day have increased by 25 percent. On November 30, 2006, a judge in West Florida fined the Secretary of DCF

\$80,000, and found her in criminal contempt of court for failing to comply with an order to transfer inmates with mental illnesses adjudicated incompetent to proceed to trial from the Pinellas County jail to state forensic hospitals in a timely manner, as required by law. This ruling followed months of controversy and high-profile media attention surrounding DCF's inability, due to lack of resources, to abide by statutory requirements to place defendants, who were found incompetent to proceed to trial or not guilty by reason of insanity, in forensic mental health treatment facilities within 15 days of adjudication.

Recommendation 9

Modernize the Baker and Marchman Acts statutes by including proposals that include the following changes in the existing laws: The recommendations represent a comprehensive modernization of Florida's civil commitment system for mental health and substance abuse treatment. The changes reflect case law and scientific developments and will conserve state resources while ensuring that care is more efficiently provided.

Baker Act Changes (Involuntary Mental Health Care):

- Defines the elements of the law's "self-neglect" criteria.
- Allows DCF to establish rules regarding a person's care after post-discharge and make recommendations to reduce high utilizer readmission based on facility data.
- Further protects minors from being forced into "voluntary treatment" by requiring they have a mental illness and be suitable for treatment.
- Grants the police same discretion the courts and medical professionals have to initiate Baker Act examinations, which should reduce number of unnecessary Baker Acts.
- Streamlines procedures to allow the court the opinion of ordering inpatient or outpatient treatment depending on individual's needs. Outpatient is less costly and respects individual liberty more than inpatient hospitalization, and grants court continuing jurisdiction to enforce its treatment orders.
- Modernizes Baker Act's Dangerousness Criteria and conforms Florida law to majority of other states which address harm on a "totality of the circumstances" basis and not just the threat of serious bodily harm.
- Enables witnesses to appear remotely if there is good cause.
- Grants State Attorney limited record access & continuance; allows appointment of public defender, regardless of respondent's indigency status.

Marchman Act Changes (Involuntary Substance Abuse Treatment):

(Note: given the overlap between mental illness and addiction, many of the above changes are made to the Marchman Act so that the laws mirror each other as much as possible.)

- Updates definition of substance abuse impaired so that Marchman Act can better address prescription drug abuse and substance abuse disorders and requires DCF to create annual reports on Marchman cases statewide.

- Makes the State Attorney the real party of interest except if private counsel retained.
- Streamlines Marchman procedures by eliminating the need to file two separate petitions (assessment and treatment).
- Modernizes Marchman Court's authority to incorporate drug court best practices, which are scientifically proven to be more effective at treating addiction.

Rationale

In 1971, the Florida Legislature passed into law the Florida Mental Health Act, which went into effect July 1, 1972. This Act brought about a dramatic and comprehensive revision of Florida's 97-year-old mental health laws. It substantially strengthened the due process and civil rights of persons in mental health facilities and those alleged to be in need of emergency evaluation and treatment.

The Act, usually referred to as the "Baker Act," was named after Maxine Baker, former state Representative from Miami, who sponsored the legislation after serving as chairperson of the House Committee on Mental Health. When the Baker Act was passed, it created a legal process to involuntarily hospitalize individuals primarily in state psychiatric hospitals. At the time, Florida had significantly more psychiatric hospital beds than it has today, serving a state population of approximately 6.8 million people. Today, there are a little over 2,600 state hospital beds. Two-thirds of admissions are forensic and 69 percent of bed capacity is occupied by individuals, with forensic involvement serving a state population of approximately 21.3 million people. In a study by three authors affiliated with the Department of Mental Health Law and Policy at the University of South Florida, they found that involuntary examinations under the Baker Act "are associated with increased risk of arrest." They concluded that "an involuntary examination" is a significant signal that individuals with serious mental illness are at risk of arrest. In fact, each involuntary examination was associated with a 12 percent increase in the risk of arrest. An individual who is Baker Acted four times in a year has almost a 50% chance of being arrested in the near future.

Based on data from the Florida Mental Health Institute at USF, there were over 205,000 involuntary examinations under the Baker Act in 2019. Involuntary Baker Act examinations more than doubled (115.31 percent increase) in the last 17 years. More than 50 percent (106,327) were initiated by law enforcement. More than half (55.84 percent) of all involuntary examinations were based on evidence of *harm to self only*. One in five (21.52 percent) were based on *both harm to self and harm to others*. *Harm to others only* was the evidence for 5.55 percent of all involuntary examinations. In a one-year period, it is typical for 21 percent of people with an involuntary (Baker Act) examination to have two or more. While the people with two or more involuntary exams in a year account for 21 percent of the people with involuntary exams in that year, their involuntary exams account for 44% of the total involuntary exams for the year. While the people with five or more involuntary exams account for two percent of people with exams in that year, their exams account for 12 percent of the total involuntary exams. Florida ranks 43rd nationally in access to mental health care and has the 4th highest rate of adults with mental illnesses who are uninsured. At \$39.55 per capita, spending for community-based treatment ranks 49th among all states and the District of Columbia. However, Florida is spending inordinate resources on acute mental health services. Improving access to treatment under this proposal will help Florida avoid unnecessary acute care spending and will afford those with serious mental illnesses an opportunity for hope and recovery.

Modernizing the Baker Act will prevent individuals from entering the justice system, and will respond quickly to individuals who do become involved in the justice system to effectively link them to appropriate services and prevent recidivism. By designing an appropriate and responsive system of care for individuals with serious mental illnesses, severe emotional disturbances, and/or co-occurring substance use disorders, people who otherwise would continue to recycle through the justice system will be served more effectively and efficiently. Public safety will be improved and the rate of individuals accessing more costly services in forensic mental health and criminal justice systems will be reduced.

Recommendation 10

Establish pre and post diversion programs in every circuit throughout Florida for individuals with serious mental illnesses who are at risk of an arrest or charged with a non-violent offense.

Rationale

Pre-Arrest Diversion Program

Over the last several years, mental health units have been developed by law enforcement agencies across the nation to address MH/SUD calls for service. Crisis Intervention Teams, co-responder models, or MH response teams help redirect individuals with mental illness from the judicial system and other high-cost health care systems to lower cost health care interventions. The purpose of these programs is to address the growing issues surrounding mental health, homelessness, and substance abuse challenges each community faces. To deliver quality professional services to the community while minimizing the abuse of 911 and diverting emergency services response. The target population are people who contact 911, or by other means come in to contact with law enforcement and are presenting with a mental health or substance use concern. Teams will assist persons and families in crisis in the community and attempt to restore the person to a pre-crisis level. They will be able to provide direct follow up until the crisis is diverted or resolved. Outcomes of such interventions include:

1. Improving officer and client safety.
2. Redirecting clients with mental health or substance use crisis from the judicial system and other high-cost healthcare systems to lower cost of health care interventions.
3. Improve outcomes of police interactions with people with mental health or substance use concerns.
4. Reducing the number of repeat calls for service for persons with mental illness.
5. Reduction in arrests, reducing contact with an already over-burdened criminal justice system.
6. Reducing emergency room visits, thus reducing costs and drain to an overworked healthcare system.

These response teams are often funded through local county or municipal budgets and are often found in counties and cities that are able to afford to budget for such a team. There are mobile response teams divided among regions, but often response times are much too long, and law enforcement is left to handle the case, often resulting in arrest of a subject suffering from a MH and SUD. All counties and cities should have access to a response team that can respond quickly.

Post-Arrest Diversion

Florida Statutes 394.47891, 394.47892, and 397.334 all provide the ability for each jurisdiction to create a veteran's court, mental health court, and drug court. The issue is that it is optional, and counties must secure funding from sources other than the state to operate. This is achievable by those jurisdictions that can afford to operate them but is often unachievable for those fiscally constrained counties.

Misdemeanor Diversion

All defendants booked into jail should be screened for signs and symptoms of mental illnesses. Individuals charged with misdemeanors who meet involuntary examination criteria should be transferred from the jail to a community-based crisis stabilization unit, as soon as possible. Individuals that do not meet involuntary eligibility should be screened, assessed, and, if necessary, provided with treatment while incarcerated. Eligible defendants who voluntarily agree to participate in a diversion program, should have their legal charges dismissed or modified upon successful completion, in accordance with treatment engagement. Individuals who agree to services should be assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. Program participants should be monitored for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. Eligible participants are likely to be homeless at the time of arrest and are likely to be the most severely psychiatrically impaired. Assisted Out-Patient Treatment (AOT) should be expanded to every circuit and county court criminal division in Florida.

Assisted Out-Patient Treatment (AOT)

Florida Senate Bill 12 went into effect July 1, 2016, and it provides the authority for County Court Criminal Judges to use AOT for individuals charged with misdemeanor offenses. AOT serves to identify individuals with histories of repeated admissions to mental health treatment services in the criminal justice and acute care treatment systems that may benefit from court ordered outpatient treatment services. These individuals will have histories of treatment noncompliance and/or refusal to engage in treatment and are unlikely to survive safely in the community without supervision. Individuals that complete AOT can be transitioned into misdemeanor jail diversion to resolve misdemeanor cases. In Miami-Dade (detailed in [Appendix 5](#)) the misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants have decreased from roughly 75 percent to 20 percent annually.

Felony Diversion

Participants in a felony jail diversion program should be referred for mental health treatment and should meet diagnostic and legal criteria. When a person is accepted into the felony jail diversion program, the State Attorney's Office should inform the court of the plea the defendant will be offered, contingent upon successful program completion. The State Attorney weighs all of the equities involved in a case and determines whether a charge is dismissed, pled to a lesser offense, or will utilize some other appropriate sanction. Like the misdemeanor program, upon successful completion, legal charges should be dismissed or modified based on treatment engagement. All program participants should be assisted in accessing community-based services and supports, and their progress should be monitored and reported back to the court

by program staff. In Miami-Dade, individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved Miami-Dade County over 31,000 jail days, more than 84 years in jail bed days.

Conclusion

The Commission is honored to serve in the capacity to address the needs of the people of Florida. The ultimate goal is to ensure individuals facing behavioral health issues have access to high quality, affordable, person-centered care. To effectively and efficiently meet the most pressing needs currently facing the mental health system in Florida, it is recommended that the state invest in a redesigned and transformed system of care oriented around ensuring adequate access to appropriate prevention and treatment services in the community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across levels of care and treatment settings. In order to have sustainable and pervasive impact, the Commission recognizes that this work cannot happen overnight, and will require systematic changes and improvements. The Commission stands ready to partner with stakeholders across the state in order to achieve the aforementioned recommendations and utilize data to reach those most in need.



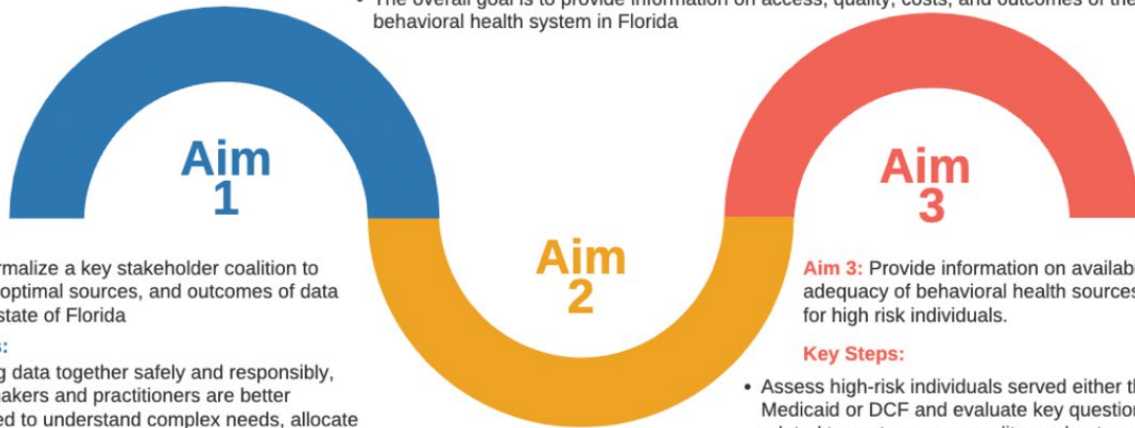
Recommended Data Collaboration Roadmap

The Data Analysis Subcommittee of the Commission on Mental Health and Substance Abuse have designed the following phased approach roadmap for data sharing, collaboration, and analysis in the state of Florida.

Aim 2: Create a Florida behavioral health data repository or comparable effective system that includes harmonization and cleaning of identified data sources for analyses.

Key Steps:

- Once a statewide data collaborative has been created and information sharing guidelines have been developed, then a behavioral health repository can be formed to include various data from organizations such as (but not limited to) DCF, AHCA, DJJ, and FDLE.
- The overall goal is to provide information on access, quality, costs, and outcomes of the behavioral health system in Florida



Aim 1: Formalize a key stakeholder coalition to determine optimal sources, and outcomes of data within the state of Florida

Key Steps:

- Bringing data together safely and responsibly, policymakers and practitioners are better equipped to understand complex needs, allocate resources, measure impacts of policies and programs, engage in shared decision-making about data use, and institutionalize regulatory compliance.
- Assess county- and state-level data collaboratives to account for specified approaches related to the creation of Memorandum of Understanding (MOU) documents, linking resources across agencies, and assignment of unique identification numbers.

Aim 3: Provide information on availability and adequacy of behavioral health sources in Florida for high risk individuals.

Key Steps:

- Assess high-risk individuals served either through Medicaid or DCF and evaluate key questions related to cost, access, quality, and outcomes.
- Integration of behavioral health information from multiple sources have significant improvements in accuracy of personal demographics, diagnoses (including co-morbidities), service use types and frequency of use, and personal outcomes and health care quality
- Establishing a Florida Behavioral Health Data Repository (FBHDR) oversight steering committee can identify appropriate data sources and can guide and prioritize analytic direction and initiatives.

Appendix 2

Improving Outcomes

The Commission's Data Strategy for improving outcomes will include the following aims aligned to statute direction (§394.9086, F.S.):

Outcome 1: Describe the continuum of services available for Floridians' mental health and substance use disorders. Descriptive statistics will be used to report on the number of people and rates of utilization for the continuum of mental health and substance use services spanning from disease prevention to screening and detection, and from treatment to recovery support services that maintain sobriety and prevent relapse. Comparisons will be made among geographic areas, payers, Managing Entities, health systems, facility, or provider classifications. Claims-based methods will be used to estimate health care expenditures per service and per sub-classification. Particular emphasis will be made to quantifying the utilization of telehealth services for people with mental illnesses and/or substance use disorders. The number and trend of prescribing providers for medication-assisted therapy (MAT) will be reported, with respect to changes in certification requirements and clinical sub-specialty (e.g., primary care, obstetric, addiction medicine). The number and trend of mental health providers will be reported, including, but not limited to, psychiatrists, nurse psychiatrists, licensed certified social workers, licensed mental health counselors, and psychologists. The number and trend of certified community health workers as peer supports or targeted case managers for mental health will be presented. Trend data will be presented spanning before 2020, when available, to compensate for exacerbating effects of COVID-19 on mental health and substance use.

Outcome 2: Quantify the effectiveness of mental health care in Florida. The Commission will define a list of benchmarked performance measures that the Commission should use to evaluate the quality of mental health care delivery (process measures) and mental health outcomes (outcome measures). We recommend the development of a statewide behavioral health dashboard. For example, the percentage of children in a clinical practice who have documented evidence of mental health screening using the PSC-17 survey or similar instrument is measured and indicative of high-quality practice. The number of suicides or near-suicides would be a late-stage disease outcome measure. Employment or housing would be positive outcome measures of interest. Descriptive statistics will be used to show the trends of these performance measures. These performance measures, when possible, will be analyzed by subgrouping according to geographic distribution, payer, Managing Entity, intervention, health system, facility, or attributable provider classification.

Outcome 3: Identify barriers and deficiencies in the delivery of mental health services in Florida. Performance measures from Recommendation 8 that fall below national medians will be highlighted as opportunities for improvement, and will indicate either ineffective programs, systems of programs, or lack of programs. In addition, the Subcommittee will identify data sources to inform the Commission's examination of prevention services; hotline access and utilization; integration of mental health services within settings of physical health care delivery; telehealth access and reimbursement to providers; workforce training sites, faculty number, and trainee slots; access to MAT providers for pregnant women with substance use disorder; number and variety of school-based programs for preventing bullying, promoting mental health, and diverting from need for involuntary examination; number and rate of drug court utilization and referrals; and number, funding, and outcomes of community re-entry programs for justice-involved people with mental illness and/or substance use disorder.

Outcome 4: Modeling of proposed service changes. Modeling and sensitivity analyses will be performed for the Commission on programs or rule changes, with impacts calculated at least on expected health outcomes and expenditures.

Outcome 5: Surveillance of Mental Health. The Commission will develop and maintain a directory of currently available data sources related to the status of population mental health in Florida. This directory will include national, state, and local data sources. The primary purpose of this directory is to make data sources readily accessible to the Commissioners and other policy decisionmakers. To protect privacy and confidentiality, the specific datasets will still be housed and maintained by the respective data sources. The directory itself does not contain specific datasets but instead provides the Commissioners and other policy decisionmakers information on: (1) the appropriate data sources that can potentially address research questions and policy concerns, and (2) how to access those relevant datasets. The directory, at a minimum, will include the following information about the data sources: a brief description of the source, what specific type of data is included in the source, who owns and/or maintains the source, when the source is updated (i.e., its periodicity), how it is benchmarked, and how to access the data.

Appendix 3

National Frameworks

There are many national frameworks that may provide useful guidance in developing core categories or domains of quality care metrics. The following represent just a handful of examples that the workgroup may consider:

- Institute of Medicine (IOM) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Outlines the six aims of high-quality health care: (1) Safe, (2) Effective, (3) Patient-centered, (4) Timely, (5) Efficient, and (6) Equitable, and provides recommendations on improving the quality of health care for mental and substance use conditions. <https://www.ncbi.nlm.nih.gov/books/NBK19823/>
- National Committee for Quality Assurance (NCQA) Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care. Provides a potential framework encouraging a shift from administrative metrics to quality focused metrics and focuses on three levels of management: (1) State & Federal (Macro level) to set priorities and direct resources through regulations and financial support, (2) Managed Care (Meso level) – manage delivery of evidence-based care, and (3) Facility/Provider (Micro level) – provide evidence-based treatment and services to support whole-person care. https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf
- American Society of Addiction Medicine (ASAM) Standards of Care for the Addiction Specialist Physician. The Standards identify six practice domains: (1) Assessment and Diagnosis, (2) Withdrawal Management, (3) Treatment Planning, (4) Treatment Management, (5) Care Transitions and Care Coordination, and (6) Continuing Care Management. Reference: <https://www.asam.org/docs/default-source/advocacy/performance-measures-for-the-addiction-specialist-physician.pdf>
- Centers for Disease Control and Prevention (CDC) Four Domains of Chronic Disease Prevention. These key areas are: (1) Epidemiology and Surveillance, (2) Environmental Approaches, (3) Health Care System Interventions, and (4) Community Programs Linked to Clinical Services. Reference: <https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm>
- Association of State and Territorial Health Officials (ASTHO) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) Preventing Opioid Misuse and Overdose in the States and Territories: A Comprehensive Public Health Framework to Address the Opioid Crisis. This framework recognizes the need for a comprehensive, cross-sector response to the opioid crisis leveraging leadership and cross-sector partnerships across four strategies: (1) Training and Education, (2) Monitoring and Surveillance, (3) Treatment, Recovery and Harm Reduction, and (4) Primary and Overdose Prevention. Reference: <https://my.astho.org/opioids/home>

There are also existing national standards for tracking quality of care and health outcomes that should be considered for inclusion in the Florida substance abuse and mental health metrics. This section references metrics that would provide a national reference for benchmarking and monitoring improvement at the state and local levels. Sample topics and measures are listed below, but the list is not exhaustive. Please note that some measures are included in more than one national standard described below.

- NCQA Healthcare Effectiveness Data and Information Set (HEDIS): <https://www.ncqa.org/hedis/>

Domain	Sample Measures
Effectiveness of Care	<ul style="list-style-type: none"> • Follow-Up After Emergency Department Visit for Mental Illness. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. • Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder. • Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Pharmacotherapy for Opioid Use Disorder.
Access/Availability of Care	<ul style="list-style-type: none"> • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.
Utilization	<ul style="list-style-type: none"> • Identification of Alcohol and Other Drug Services. • Mental Health Utilization.
Measures Reported Using Electronic Clinical Data Systems	<ul style="list-style-type: none"> • Depression Screening and Follow-Up for Adolescents and Adults. • Depression Remission or Response for Adolescents and Adults. • Unhealthy Alcohol Use Screening and Follow-Up.

- Centers for Medicare and Medicaid Services: Core Quality Measures Collaborative (CQMC) Behavioral Health Dataset: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures>

Topic	Sample Measures
Depression	<ul style="list-style-type: none"> • Depression Response at Six Months. • Depression Response at Twelve Months.
Serious Mental Illness	<ul style="list-style-type: none"> • Adherence to Antipsychotic Medications for Individuals with Schizophrenia. • Metabolic Monitoring for Children and Adolescents on Antipsychotics. • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

Tobacco, Alcohol, and Other Substance Use	<ul style="list-style-type: none"> • --Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. • --Pharmacotherapy for Opioid Use Disorder.
Other	<ul style="list-style-type: none"> • --Follow-Up After Hospitalization for Mental Illness. • --Follow-Up After Emergency Department Visit for Mental Illness.

Healthy People 2030: <https://health.gov/healthypeople>

Domain	Sample Indicators
Addiction	<ul style="list-style-type: none"> • --Increase the proportion of people with a substance use disorder who got treatment in the past year. • --Reduce the proportion of people who had drug use disorder in the past year. • --Increase the proportion of people who get a referral for substance use treatment after an emergency department visit.
Mental Health and Mental Disorders	<ul style="list-style-type: none"> • --Increase the proportion of people with substance use and mental health disorders who get treatment for both. <ul style="list-style-type: none"> ■ Increase the proportion of primary care visits where adolescents and adults are screened for depression. ■ Increase the proportion of children and adolescents with symptoms of trauma who get treatment. ■ Increase the proportion of adults with serious mental illness who get treatment. • -- Reduce emergency department visits related to nonmedical use of prescription opioids

Section 1006.05, Florida Statutes, Amendment to Recommendation 6

1006.05 Section 1. Subsection (1) to be added. Pursuant to section 394.491 and to further promote the effective implementation of a coordinated system of care pursuant to 394.4573 and 394.495 each school district that provides mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance use diagnosis and students at high risk of such diagnoses shall be guided by and adhere to the principles of the child and adolescent mental health treatment and support system.

1006.05 Section 1. Subsection (2) (a) to be added. School districts shall contract with Managing Entities to provide children’s care coordination for students with complex behavioral health needs who continue to experience adverse outcomes due to their unmet needs or inability to engage. Care coordination is as defined in 394.573(1)(a).

1006.05 Section 1. Section (2) (b) to be added. School districts shall address recommendations from the Managing Entity children’s care coordinator whenever a student is identified as having experienced an involuntary admission to an acute care psychiatric facility upon the return of the student to the school setting.

1006.05 Section 1. Subsection (2) to be added. Pursuant to s. 394.494(1) Each school district shall meet the general performance outcomes for the child and adolescent mental health treatment and support system.

(This recommendation would connect school districts with the mental health system of care and reads:

394.494 General performance outcomes for the child and adolescent mental health treatment and support system.—

(1) It is the intent of the Legislature that the child and adolescent mental health treatment and support system achieve the following performance outcomes within the target populations who are eligible for services:

(a) Stabilization or improvement of the emotional condition or behavior of the child or adolescent, as evidenced by resolving the presented problems and symptoms of the serious emotional disturbance recorded in the initial assessment.

(b) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the family, so that the child or adolescent can function in the family with minimum appropriate supports.

(c) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to school, so that the child can function in the school with minimum appropriate supports.

(d) Stabilization or improvement of the behavior or condition of the child or adolescent with respect to the way he or she interacts in the community, so that the child or adolescent can avoid behaviors that may be attributable to the emotional disturbance, such as substance abuse, unintended pregnancy, delinquency, sexually transmitted diseases, and other negative consequences.)

Revise 397.96 Case management for complex substance abuse cases.— Change case management to care coordination as defined in 394.573(1)(a).

397.96 Section (1) Replace case management with care coordination.

397.96 Section (2) Replace case manager with care coordinator.

397.96 Section (3) Replace case management with care coordination.

397.96 Section (4) Replace case manager with care coordinator.

397.96 Section (5) Replace case manager with care coordinator.

MIAMI-DADE FORENSIC ALTERNATIVE CENTER (MD-FAC) PROGRAM

Since August 2009, the Miami-Dade Criminal Mental Health Project has been diverting individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic facilities to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies that do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity.

Unlike individuals admitted to state forensic treatment facilities, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state facility. To date, the project has demonstrated more cost-effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings. Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35 percent) sooner than individuals who complete competency restoration services in forensic treatment facilities and spend an average of 31 fewer days (18 percent) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32 percent less expensive than services provided in state forensic treatment facilities.

- 4) Revise restoration protocols.
- 5) Address operational inefficiencies.
 - a. Evaluator training, availability, and speed.
 - b. Evaluation templates.
 - c. Limit multiple evaluations
 - d. Case managers and court liaisons.
 - e. Court case management – centralized calendars, frequent reviews, and teams.
 - i. Centralized calendars
 - ii. Frequent reviews
 - iii. Teams
- 6) Address training, recruitment, and retention of staff.
- 7) Coordinate and use data.
- 8) Develop robust community-based treatment and supports for diversion and re-entry.

Appendix 6



FISCAL YEAR 20-21 Individuals Served Each Month – Unduplicated Monthly

Row Labels	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
AMH	51,207	50,373	49,769	49,854	46,511	47,316	48,441	48,222	49,600	50,698	49,929	49,345	591,265
CSU/Inpatient	2,852	2,898	2,784	2,733	2,556	2,575	2,715	2,611	2,883	2,725	2,789	2,517	32,638
Outpatient	47,106	46,251	45,736	45,855	42,708	43,422	44,454	44,273	45,363	46,653	45,636	45,343	542,800
Residential	1,249	1,224	1,249	1,266	1,247	1,319	1,272	1,338	1,354	1,320	1,504	1,485	15,827
ASA	22,699	23,014	23,060	23,563	22,474	21,490	22,628	22,512	23,125	23,140	24,273	23,500	275,478
Inpatient Detoxification	1,216	1,330	1,282	1,359	1,294	1,218	1,317	1,266	1,313	1,320	1,470	1,247	15,632
Outpatient	19,715	19,899	19,903	20,260	19,310	18,449	19,507	19,517	19,900	19,885	20,597	20,040	236,982
Residential	1,343	1,340	1,430	1,486	1,456	1,427	1,471	1,426	1,552	1,559	1,837	1,774	18,101
Detox	425	445	445	458	414	396	333	303	360	376	369	439	4,763
CMH	9,094	8,981	9,485	9,556	8,619	9,132	9,425	9,817	10,457	10,440	10,657	10,379	116,042
CSU/Inpatient	358	418	549	531	478	494	596	697	631	589	496	362	6,199
Outpatient	8,689	8,524	8,900	8,996	8,122	8,614	8,792	9,082	9,803	9,832	10,143	9,999	109,496
Residential	47	39	36	29	19	24	37	38	23	19	18	18	347
CSA	2,447	2,419	2,520	2,572	2,520	2,684	2,597	2,691	2,840	2,935	3,235	2,757	32,217
Inpatient Detoxification	2						2	1		1			6
Outpatient	2,303	2,277	2,375	2,427	2,373	2,533	2,461	2,552	2,713	2,810	3,097	2,620	30,541
Residential	142	142	145	145	147	151	134	138	127	124	138	137	1,670
Grand Total	85,447	84,787	84,834	85,545	80,124	80,622	83,091	83,242	86,022	87,213	88,094	85,981	1,015,002

FISCAL YEAR 20-21 Individuals Added to the Waitlist

Clients added to wait list	Sum of Added To Wait List
AMH	1,315
CAT	27
CCT	204
CSU/Inpatient	70
FACT	222
Outpatient	382
Residential	388
Forensic MT	22
ASA	5,117
Care Coordination	8
Inpatient Detoxification	21
Outpatient	411
Residential	4,677
CMH	809
CAT	681
Outpatient	128
CSA	9
Residential	9
Grand Total	7,250