Commission on Mental Health and Substance Abuse

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Sheriff William Prummell
Chair

Ann Berner
Speaker of the House Appointee

Representative Christine Hunschofsky
Speaker of the House Appointee

Clara Reynolds
Governor Appointee

Senator Darryl Rouson
President of the Senate Appointee

Doug Leonardo
President of the Senate

Jay Reeve, PhD
Governor Appointee

Dr. Kathleen Moore
President of the Senate Appointee

Dr. Kelly Gray-Eurom
Governor Appointee

Larry Rein
Governor Appointee

Chief Judge Mark Mahon
Governor Appointee

Melissa Larkin-Skinner
Speaker of the House Appointee

Ray Gadd
President of the Senate Appointee

Shawn Salamida
Speaker of the House Appointee

Secretary Shevaun Harris
Florida Department of Children and Families

Secretary Simone Marstiller
Florida Agency for Health Care Administration

Dr. Uma Suryadevara
Speaker of the House Appointee

Judge Ronald Ficarrotta
Governor Appointee

Minutes

December 15, 2021 - 9:00 a.m. to 1:00 p.m.

Note: The following is a summary of the highlights of the proceedings and is not intended to be construed as a transcript. For information on the Commission, please visit the Commission website:
https://www.myflfamilies.com/service-programs/samh/commission/index.shtml

Attendance Summary

Members in Attendance

Chair, William Prummell
Ann Berner
Representative Christine Hunshofsky
Clara Reynolds
Doug Leonardo
Dr. Jay Reeve
Dr. Kathleen Moore
Dr. Kelly Gray-Eurom
Larry Rein
Chief Judge Mark Mahon
Ray Gadd
Chief Judge Ronald Ficarrotta
Shawn Salamida
Secretary Shevaun Harris
Dr. Uma Suryavevara
Wes Evans

Staff in Attendance

Pat Smith

Proceedings

Call to Order and Welcome

Chair William Prummell called the Commission on Mental Health and Substance Abuse meeting to order at 9:00 a.m. and welcomed commissioners.

Roll Call

The roll was called by Pat Smith and a quorum was confirmed.

Approval of October Meeting Minutes

Approved by Commissioner Ray Gadd and seconded by Commissioner Jay Reeve. All in favor, minutes were passed.

The Foundation of Lifelong Mental Health in Early Childhood

Dr. Mimi Graham, Director, FSU Center for Prevention & Early Intervention Policy, spoke about the trajectory for mental health. She shared a presentation that showed past cases from news sources. Brain science shows that 80 percent of the adult brain is developed by age three and 90 percent by age five. Stress derails child development. Attachment Science shows that

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the cornerstone for all development and future relationships is a healthy attachment to a primary caregiver. Trauma and Adverse Childhood Experiences (ACEs) Science shows that adverse childhood experiences as well as adverse community environments influence children and impacts their trauma. Resiliency Science shows that even one healthy relationship can buffer adversity. Use positive factors to outweigh the negative. Infusing the science across systems creates opportunities to change the trajectory.

Dr. Reeve question – Speak to schizophrenia and bi-polar disorder.

Dr. Graham response – There is a genetic component, and the environment can exacerbate it and with social support lessen the impact – healed trauma. All should have access to trauma treatment.

Dr. Reeve response – Interventions are good across the board. Note that we are not talking about a cure for serious mental illness but mitigating adverse factors in that realm.

Dr. Hunshofsky question – What would be your recommendations to capture these issues early on? What would that look like in a practical, day to day scenario?

Dr. Graham response – Early identification before the Mother gives birth is very important. There is a crisis of not having enough mental health providers. Families need more support than what is being provided.

Dr. Hunshofky question – We need to drill down and give real-world recommendations. What are practical recommendations?

Dr. Graham response – Crisis intervention, trauma informed practice, training for judges, integrating behavioral health into the healthcare system, involving the faith-based community, universities offer training, access for providers and parents, prevention, etc. When we see problems, we need to know what to do.

Reynolds question – Have you been able to present your information to the Medicaid Managed Health plans?

Dr. Graham response – Yes. Child/Parent Psychotherapy is a Medicaid reimbursable therapy which is widely used with the Early Childhood Courts. Can we change the criteria? Need to take advantage of funding that is available. More can be done. When the root problem is identified it can be treated more appropriately and effectively.

Dr. Gray-Eurom comment – Actionable items. Also, awareness of successful programs throughout the state would help to pilot in other areas. The conversation about diagnosis, as an Emergency physician, there is a challenge in getting people, especially children, early interventions without a diagnosed ICD-10 illness. The ability to access proactive interventional services earlier would be incredibly helpful.

Dr. Graham response – There is “Diagnostic DC 0-5” where a crosswalk was done with ICD-9 codes. “Disorders of Infancy Not Yet Specified” allows children to get services

early. If trauma is addressed, children are much less likely to be in the criminal system. If physicians knew what to do and where to send them, they could refer as needed.
Dr. Gray-Eurom comment – A state-wide electronic Geo Map would be a good product to come from this committee. Finding services currently is difficult.

Dr. Reeve comment – There is education needed for providers on how to bill Medicaid.

Salamida question – What legislation exists that pertains to infant childhood development and attachment? Capitalize on data, practice – is it in legislation to address?

Dr. Graham response – In 2021 (SB80) verbiage was added about attachment. There's language that could be added. There's no leading group/agency pushing the trauma informed agenda. There's no statewide authority or legislation.

Chair Prummell comment – One of our responsibilities under the law is to potentially make recommendations for a statewide agency that oversees mental health and substance abuse. How is ACEs scored? How does it work?

Dr. Graham response – Dr. Graham explained how ACEs scoring works. Will share study and slides.

Chair Prummell question – There are signs, but people are hesitant to speak up. *Shared scenario of child/family.* What is the likelihood that the child at four years old, still in diapers, can't speak might live a normal life?

Dr. Graham response – Having Grandparents or anyone in their corner would help with resiliency. If you aren't speaking by age three it will be harder to overcome that barrier.

Gadd question – 1. Is it possible to make recommendations to the Legislature such as "if we do these five things" Statewide it would make a significant difference? 2. What is the likelihood that we could look at blueprint programs that could be implemented statewide and funded over time?

Dr. Graham response – Yes, we could have a statewide plan and we should invest in it. Spoke of various scenarios.

Heather Allman comment – Regarding payment for services for those without ICD-10 behavioral health clinical disorder. The Department of Children and Families is statutorily authorized to fund services for children at risk for emotional disturbance.

Reeve comment – Confirmed what Heather Allman stated. Noted that in most Regions the budget is fully dedicated through the Managing Entities. New dedicated funding is needed.

Harris comment – Emphasized the priority of the First Lady. Think about a no wrong door approach. There are challenges, but a desire at the highest levels of leadership to help families navigate the system.

DRAFT

Salamida comment – Protective factors and research. Ex: Parental resilience, social connections, concrete support, education for parents, social and emotional knowledge of children.

Mental Health Services Overview from the Department of Juvenile Justice (DJJ)
Dr. Tracy Shelby, Acting Director of the Office of Health Services and Joy Bennink, Acting Director of Mental Health and Substance Abuse Treatment Services with the Department of Juvenile Justice, presented on DJJ Mental Health Services program.

Evans question – In what ways does DJJ mitigate the impact of trauma and try to avoid traumatization to those in your care and custody?

Bennink response – Arrest is a trauma in and of itself. We take that seriously. We have trauma informed care as a base requirement. We use a reward base.

Evans question – Psychological assessment – do you feel you have the adequate resources to meet those needs or are there opportunities that you have identified to build the capacity?

Bennink response – We make smart and efficient use of the dollars we have. There's always room for expansion. More robust aftercare is needed. Shortage of counselors, Psychiatrists, etc. effects our population who already have attachment problems.

Reynolds question – What percentage of children are already in clinical treatment when they come to DJJ?

Bennink response – Not currently known but will be once DJJ has an electronic health record. Forms needed by their office will be able to be created.

Reynolds question – Electronic health record would somehow be shared with local providers?

Shelby response – Every youth has screening, assessment, and psychological evaluation. During the screening and evaluation phase the data is collected and uploaded. A health record is different from a medical record in that you can run data.

Reynolds question – When you identify that they have had outside treatment how do you continue that while they are in your care?

Bennink response – That varies depending on where the youth is in the system. Explained via scenarios.

Shelby response – Spoke of release form and importance.

Chair Prummell question – When a child is in your (DJJ) care, and then released, does DCF take over care?

Bennink response – I was speaking of Foster children, or cross-over children, that are dually served by DJJ/DCF – there is room for more information sharing.

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Chair Prummell question – You make recommendations for them and/or appointments when they are released from your custody. Is there anything in place assuring that they go to these appointments? Any follow-up?

Bennink response – That depends if the youth is on probation or committed. That would become part of their supervision plan with their Juvenile Probation Officer. There are also DJJ contracted therapy providers throughout the State.

Shelby response – Once they are no longer on probation DJJ no longer has legal control and then it is up to the parent.

Berner question – Clarification – residential program that DJJ funds is a commitment program based on criminal activities and not their behavioral health needs?

Bennink response – It is court ordered – 20 to 50/60 beds. School and therapy every day, etc. We do not have general offender programs.

Shelby response – There are two things considered when DJJ places a youth – 1. Security level, 2. Treatment type.

Berner comment – Having a successful diversion would depend on children receiving a behavioral health assessment. Gang violence has been focused on in relation to the trauma – have used Mobile Response Teams (MRTs) and lived experience to help with younger children being recruited. Reexamine the civil citation opportunities.

Bennink comment – TASC providers are through DCF.

Salamida comment –We need coordinated care when integrating back into the community. Make sure gains were made while in DJJ.

Bennink response – Explained current process to request records, treatment discharge summary, etc.

Ficarrotta question – Does DJJ interact/work with the school systems?

Bennink response – DJJ has a Director of Education – will discuss with her and get back with the Commission.

Shelby response – The educators in the detention facilities and residential programs are Department of Education teachers.

Leonardo question – Is DJJ able to give the number of youths receiving substance abuse or mental health services?

Shelby response – If they are not in DJJ's care or custody, or on probation with sanctions for continued services within the community, no.

Bennink response – Part of a State Review Team under an MOU with other Agencies. Will provide link from DCF website. There are local, regional, and state review teams. All work together to find resources, placements, etc. for most challenging placements.

Prummell comment – The commission will be looking closer at the sharing of information. It is allowed under Florida Statute 163.62.

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Seniors and the Elder Care Behavioral Health System

Dr. Luis Vinuela, Chief of Medical Staff for Circles of Care in Brevard County presented. There are over 600,000 people living in Brevard. Circles of Care is a non-profit organization providing psychiatric services. Geriatric population is considered 65 and older. A concern is what will happen 10 years from now regarding treating the elderly population. People are living longer. Statistics state that by 2030, 20 percent of the population will be over 65. One current challenge is placement after a patient is stable and ready to be discharged into the community. Many come from other residential facilities. Many problems cannot be solved in an in-patient facility. Many behavioral issues stem from medical issues and should not be admitted to a psychiatric facility. Medications have a higher percentage of side effects in the elderly population. Many patients are not able to give consent for treatment, thus we petition the mental health courts in the meantime. There is a severe shortage of out-patient providers and when referrals are made there is a waiting list. The lack of nursing staff has become a major issue.

Chair Prummell question – ACLFs are not allowed to use chemical restraint on a client. What is the reason?

> Dr. Vinuela response – There is a law that does not allow injections. The rationale is possibly due to the side effects. They can be controlled in a hospital setting but not an ACLF or ALF.
> Chair Prummell quest – Have you heard of Leading Age?
> Dr. Vinuela response – No.
> Dr. Suryadevara comment – Every year nursing homes must show a percentage decrease of psychotropic medications. Nursing homes do not want to take Baker Act patients based on bringing their percentage up.

Dr. Gray-Eurom comment – The medication formulary issue – medications required for substance abuse or mental illnesses are more and more being removed from formularies. Patients who need medications need to have access to them.

Evans question – Are there any assertive prevention type approaches?

> Dr. Vinuela response – Many are on their own. Connection to family is always attempted. Case management visits patients as able, day treatment programs are used, etc. The lack of providers is an issue.

Road Map Discussion

Sheriff William Prummell, Chair

Full Commission meeting every other month, sub-committee meetings in between. Four sub-committees have been created – Data, Finance, Business Operations, and Data Sharing. There will be additional sub-committees created (Judicial, Youth, Geriatric). Google is developing a

program in Miami-Dade for Data Sharing. Chair Prummell will be requesting the developer give an in-sight to the Commission on this program.

Next Steps/Action Items

- Chair Prummell will finalize the roadmap and share with Commissioners once complete.
- If anyone is interested in serving on any of the sub-committees, please contact Pat Smith and she will share that information with the Chair.

Closing Remarks

Gadd question – When can we expect to get the Roadmap? Pat, is it possible to call and ask a few questions about the Roadmap?

Pat Smith response – Yes, calls are welcome.

Chair Prummell response – The document will be complete in the next week.

Salamida question – A presentation/overview by the Agency for Persons with Disabilities is suggested.

Chair Prummell response – This will be scheduled for a future meeting.

Meeting was adjourned.

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