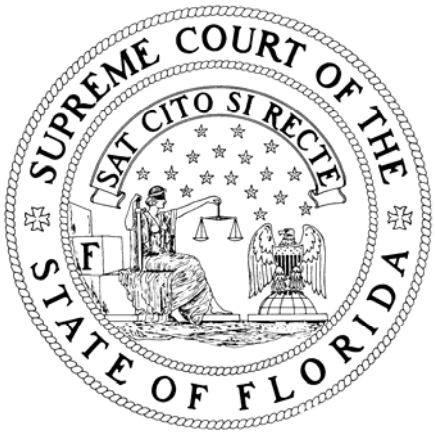
CONSTRUCTING A COMPREHENSIVE AND COMPETENT CRIMINAL JUSTICE/MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT SYSTEM:

Strategies for Planning, Leadership,
Financing, and Service Development



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EXECUTIVE SUMMARY

200 years ago, people with severe and disabling mental illnesses in the United States were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent mental health treatment existed. During the 1800's, a movement known as *moral* treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them. The first state psychiatric hospitals were opened in the United States during the 1800's, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staff, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Furthermore, physical and mental abuses became common and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

By the mid-1900's, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the *community mental health movement.*

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed a $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the *deinstitutionalization* of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

The fact that a comprehensive network of community mental health services was never established following deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illness.

Lack of strategic funding and programming, and adherence to treatment guidelines that do not necessarily reflect current best practices have affected certain segments of the population in particularly devastating ways. For many individuals unable to access care in the community, the only options to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways. First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstituionalized from state psychiatric hospitals to jails and prisons. Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses. In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses.

On any given day in Florida, there are approximately 16,000 prison inmates, 15,000 local jail detainees, and 40,000 individuals under correctional supervision in the community who experience serious mental illness (SMI). Annually, as many as 125,000 people with mental illnesses requiring immediate treatment are arrested and booked into Florida jails. The vast majority of these individuals are charged with minor misdemeanor and low level felony offenses that are a direct result of their psychiatric illnesses. People with SMI who come in contact with the criminal justice system are typically poor, uninsured, homeless, members of minority groups, and experience co-occurring substance use disorders. Approximately 25 percent of the homeless population in Florida has an SMI and over 50 percent of these individuals have spent time in a jail or prison.

A 2006 report by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute reported that the State of Florida ranked 12th in the nation in spending for forensic mental health services. Today, this estimate is likely to be considerably higher as this ranking did not take into account the state's investment earlier this year of more than $16 million in emergency funding allocated by the Legislative Budget Commission and the addition of $48 million in annual funding to add 300 desperately needed treatment beds to the overflowing forensic system. Individuals ordered into forensic commitment are now the fastest growing segment of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006.

To put this in a more acute perspective, the State of Florida currently spends roughly a quarter of a billion dollars annually to treat roughly 1,700 individuals under forensic commitment; most of whom are receiving services to restore competency so that they can stand trial on criminal charges and, in many cases, be sentenced to serve time in state prison. Furthermore, the treatment provided in Florida's forensic hospitals is funded entirely by state general revenue dollars, as Federal law prohibits Medicaid from providing payment for psychiatric services rendered in such institutional settings. As a result, the state is investing enormous sums of

taxpayer dollars into costly, back-end services that may render a person competent to stand trial, but will do nothing to provide the kind of treatment needed to facilitate eventual community re-entry and reintegration.

While expenditures in the area of forensic mental health services place Florida near the top of list nationally, the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community place the state near dead last. According to the NASMHPD Research Institute, the State of Florida ranks 48th nationally in overall per capita public mental health spending. Difficult to navigate and inefficient points of entry have resulted in barriers to accessing preventative, routine, and competent care. Last year alone, more than half of all adults with SMI and about a third of all children with severe emotional disturbances (SED) in need of treatment in the Florida's public mental health system had no access to care. Furthermore, despite recent research which has lead to the identification and development of increasingly effective, evidence-based interventions for serious mental illnesses, such treatments have yet to be adequately implemented by many service providers in the public mental health system. Consequently, increasing numbers of people experiencing acute episodes of mental illness are becoming involved in the justice systems.

Roughly 150,000 children and adolescents, under the age of 18, are referred to Florida's Department of Juvenile Justice (DJJ) every year. Many of these youth have been impacted by poverty, violence, substance abuse, and academic disadvantage. Over 70 percent have at least one mental health disorder, with females experiencing higher rates of disorders (81%) than males (67%). Of youth diagnosed with a mental health disorder, 79 percent meet criteria for at least one other co-morbid psychiatric diagnosis, the majority of whom (approximately 60 percent) are diagnosed with a co-occurring substance use disorder.

The problems currently facing Florida's mental health and, consequently, criminal justice systems relate to the fact that the community mental health infrastructure was developed at a time when most people with severe and disabling forms of mental illnesses resided in state hospitals. As such, the community mental health system was designed around individuals with more moderate treatment needs, and not around the needs of individuals who experience acute and chronic mental illnesses. People who would have been hospitalized 40 years ago because of the degree to which mental illness has impaired their ability to function are now forced to seek services from an inappropriate, fragmented, and unwelcoming system of community-based care.

The justice system was never intended to serve as the safety net for the public mental health system and is ill-equipped to do so. Florida's jails and prisons have been forced to house an increasing number of individuals who are unable to access critically needed and competent care in the community. The consequences of the failure to design and implement an appropriate system of community-based care for people who experience the most severe forms of mental illnesses have been:

- Substantial and disproportionate cost shifts from considerably less expensive, front end services in the public mental health system to much more expensive, back-end services in the juvenile justice, criminal justice, and forensic mental health systems
- Compromised public safety

- Increased arrest, incarceration, and criminalization of people with mental illnesses
- Increased police shootings of people with mental illnesses
- Increased police injuries
- Increased rates of chronic homelessness

To effectively and efficiently address 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 this report, recommendations are made for the development of a comprehensive and competent mental health system which will prevent individuals from entering the justice system to begin with and will respond to individuals who do become involved in the justice system quickly and effectively to 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.

Under this redesigned system of care, which will serve both adults with SMI and children with SED there will be 1) programs incorporating best-practices to support adaptive functioning in the community and prevent individuals with SMI/SED from inappropriately entering the justice and forensic mental health systems, 2) mechanisms to quickly identify and appropriately respond to individuals with SMI/SED who do become inappropriately involved in the justice system, 3) programs to stabilize these individuals and link them to recovery-oriented, community-based services that are responsive to their unique needs; and 4) financing strategies which redirect cost savings from the forensic mental health system and establish new Medicaid funding programs.

Key elements of the proposed plan include:

- Adoption of innovative financing strategies, designed around principles of managed care, that create incentives to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice system.
- Establishment of a multi-tiered level of care classification system targeting individuals at highest risk of institutional involvement in the criminal justice, juvenile justice, and state mental health systems to ensure adequate services in times of acute need when at risk of penetration into institutional levels of care and maximizing limited state resources during periods of relatively stable recovery.
- Creation of a statewide system of limited enrollment, Integrated Specialty Care Networks (ISCNs) under a newly authorized Medicaid state plan option targeting Home and

Community Based Services (HCBS) and specifically tailored to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care.

- State certification of local providers and communities for participation in the proposed ISCNs, who demonstrate:
    - The ability to deliver effective, high-quality services across systems of care to individuals at highest risk of becoming involved in the criminal justice system or other institutional levels of care.
    - Ongoing, collaborative relationships with state and local criminal justice and community stakeholders that will facilitate early intervention and continuity of care across systems.
- Implementation of strategies targeting community readiness and individuals at highest risk for institutional involvement.
- Establishment of a partnership between DCF and AHCA to maximize funding streams and opportunities to serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not covered.
- Programs to maximize access to federal entitlement benefits by expediting the application process and increasing initial approval rates for individuals prescreened to be eligible for benefits.
- Strategic, phased in implementation over a six year period to ensure adequate infrastructure development and sustainability.
- Strategic reinvestment of general revenue appropriations currently allocated to the state forensic system into community-based services targeting individuals at risk of criminal justice system involvement.
- Establishment of a Statewide Leadership Group to provide administrative oversight and facilitate technical assistance with the development of state and local plans.
- Implementing strategies and promising practices to maximize enrollment in federally supported entitlement benefits such as Medicaid and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI).
- Expansion of the Criminal Justice/Mental Health/Substance Abuse Reinvestment Grant Program to build local and statewide infrastructures.
- Development of local and statewide collaborations.

TABLE OF KEY RECOMMENDATIONS

Creating a redesigned and transformed system of care will require the provision of community-based services and supports which ensure that people with mental illnesses and/or co-occurring substance use disorders are able to access care that is effective, efficient, safe, and appropriate to individual needs and circumstances. In addition, services and supports must be available in the community when and where they are needed. Services offered should be those that are most likely to contribute to adaptive and productive life in the community, while minimizing unnecessary or inappropriate involvement in the criminal justice system or other institutional settings. While the needs of each community will be different, potentially producing significantly different priorities and objectives, the efforts of each community must be guided by a common vision and current knowledge regarding evidence-based and promising practices. Table 1 lists key recommendations addressed in this report.

Table 1. Key recommendations

Recommendation area:
Phased-in implementation of a redesigned system of care targeting the provision of enhanced services to individuals involved in or at risk of becoming involved in the criminal and juvenile justice systems, with the provision of reasonable start up costs.
Creation of a statewide system of limited enrollment, Integrated Specialty Care Networks (ISCNs) which maximize state funding, along with new Medicaid programs to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care.
Development of financing strategies that creates incentives to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice system.
Certification of local providers and communities for participation in ISCNs, who demonstrate the ability, commitment, and readiness to deliver effective, high-quality services, across systems of care to individuals at highest risk of becoming involved in the criminal justice system or other institutional levels of care.
Establishment of a classification system based on risk of institutional involvement in the criminal justice, juvenile justice, and state mental health systems to target enhanced services based on necessary level of care.
Establishment of a partnership between DCF and AHCA to maximize funding streams and opportunities to serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not covered.
Implementation of strategies to maximize enrollment in federally supported entitlement benefits such as Medicaid and SSI/SSDI.

Recommendation area:
Establishment of a Statewide Leadership Group to provide administrative oversight and facilitate technical assistance with the development state and local plans.
Development of comprehensive and competent community-based mental health systems based on evidence-based and promising practices.
Development of comprehensive and competent interventions targeting adults involved in or at risk of becoming involved in the criminal justice system based on evidence-based and promising practices.
Development of comprehensive and competent interventions targeting youth involved in or at risk of becoming involved in the criminal or juvenile justice systems based on evidence-based and promising practices.
Recommendations to promote and sustain a more effective, competent, and sustained mental health/substance abuse treatment workforce.
Recommendations for oversight of psychotherapeutic medication prescribing practices in the dependency system and child-protective services.
Recommendations for best practices in screening and assessment in the juvenile justice system.
Recommendations for educating judges and other professionals in the courts.
Recommendations for judicial leadership and the development of community collaborations.

Part 1: The Crisis of Community Mental Health Care in Florida and the United States: 1800-2007[1]

The current problems and weaknesses of the community mental health system can be traced to historical events that have shaped public policy and attitudes toward people with mental illnesses over the past 200 hundred years. From the time the United States was founded until the early 1800s, people with mental illnesses who could not be cared for by their families were often confined under cruel and inhumane conditions in jails and almshouses. During the 19th century, a movement known as moral treatment emerged which sought to hospitalize rather than incarcerate people with mental illnesses. Unfortunately, this well-intentioned effort failed miserably.

The first public mental health hospital in the United States was opened in Massachusetts in 1833 by the Boston Prison Discipline Society, a group of reformers seeking an alternative to incarceration for people with mental illnesses (Goff & Guderman, 1999). The institution contained 120 beds, which was considered by experts at the time to be the maximum number of patients that could be effectively treated at the facility. By 1848, the average daily census had grown to approximately 400 patients, and the state was forced to open additional public mental health facilities. A similar pattern was seen across the country as more and more states began to open public psychiatric hospitals.

During the early part of the 19th century, Floridians with serious mental illnesses requiring hospitalization were sent to Georgia State Hospital in Milledgeville and South Carolina State Hospital in Columbia, and the State of Florida was charged $250 per person annually for care. In 1876, Florida State Hospital was opened in a former civil war arsenal in Chattahoochee, two years after the state first enacted statutes governing people with mental illnesses. With little effective treatment available, the institution functioned primarily to provide a custodial environment where patients would not injure themselves, staff, or other residents, and to ensure public safety. In 1947, two years after the end of World War II, Florida's second state institution, G. Pierce Wood Hospital was opened in Arcadia on the site of a former military training grounds and air field. Because of tremendous population growth in the state following the war, overcrowding quickly became a significant problem at both facilities. By the late 1950s two additional hospitals were opened in Pembroke Pines and MacClenny.

Meanwhile, nearly 350 state psychiatric hospitals were in operation across the United States by the mid-1900s. However, overcrowding, inadequate staff, and lack of effective programs resulted in facilities providing little more than custodial care. Physical and mental abuses were common and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom.

With the introduction of the first antipsychotic medications in the 1950s, combined with the fact that many large and aging state institutions were becoming increasingly inefficient to operate, the

[1] Portions of this review adapted from DCF report: *Mental Health and Substance Abuse Services Plan: 2003-2006.* Retrieved October 26, 2007 from: http://www.dcf.state.fl.us/mentalhealth/publications/stateplan2003.pdf

idea that people with serious mental illnesses could be treated more effectively and humanely in the community began to take hold.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed a $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by advances in psychotherapeutic medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the deinstitutionalization of public mental health care by the Courts. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

Much like the rest of the country, the early days of community-based mental health care in Florida consisted primarily of individual clinics, funded by local governments, charitable organizations and other voluntary sources. However, no organized system of publicly funded community-based care existed. In 1968, the Florida Constitution was revised and health and social services were assigned to the Department of Health and Rehabilitative Services (DHRS). This newly-created agency was notable in that it represented one of the first attempts nationally to integrate health and human services, and was intended to address the emerging realization that many individuals accessing publicly funded programs and service often had complex health and social needs that weren't adequately served through categorically distinct programs.

In 1970, the Florida Legislature enacted the Community Mental Health Act to establish ways and means for the distribution of federal funds through the state to community mental health centers. Under this legislation, the State of Florida committed to funding mental health services for the first time, requiring that local governments participate in the cost by providing a match of one local dollar for every three state dollars.

To assure local participation in funding, the legislature created Mental Health Boards in each service area identified by the Division of Mental Health within DHRS for planning and allocating state and federal funds for services. The boards, funded by the state but independently staffed, were to be comprised of local citizens appointed by local governments. The role of the boards was to assess service needs, evaluate programs in the community, and contract with local providers to allocate funds from public and private sources based on district plans. With the exception of state hospitals, all mental health services were provided through board contracts with private providers.

In 1971, the State Legislature passed the Florida Mental Health Act, which became better known as the Baker Act, to provide due process in involuntary civil commitment proceedings and to establish uniform criteria for people being admitted to state hospitals. Considered model

legislation at the time, the Baker Act built on case law that established the requirement of due process for people being committed involuntarily and defined the concept of least restrictive environment. The history of this legislation is addressed in the next section.

One of the most influential cases in defining the rights of people with mental illnesses and the deinstitutionalization movement in the United States came out of Florida. In 1971, Kenneth Donaldson, a patient at Florida State Hospital for almost 15 years, filed suit against the hospital's administrator and other staff members, alleging that they had intentionally and maliciously deprived him of his constitutional right to liberty. Over the years of confinement, Donaldson's frequent requests for release had been rejected despite there being repeated offers, both from a halfway house in Minneapolis and a friend of Donaldson's in Syracuse, New York, to provide a home and supervision for him. The evidence showed that during the course of his hospitalization, Donaldson had refused all treatment, denied that he had an illness, and was neither dangerous to himself nor others. Furthermore, even if he had a mental illness, the evidence indicated he had not received treatment.

In 1975, the United States Supreme Court ruled in O'Connor v. Donaldson[2] that the state had no right to confine an individual "without more." The Courts decision read, in part, "A finding of 'mental illness' alone cannot justify a state's locking a person up against his will and keeping him indefinitely in simple custodial confinement… In short, a state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

During the same year, the Florida Legislature mandated the first of many re-organizational efforts within DHRS. Eleven geographically defined service districts were created to better plan, contract, and integrate services at the local level. Each district had staff assigned to programs under the purview of the Department, and the old division structure was eliminated and Alcohol, Drug Abuse, and Mental Health (ADM) Program Offices were created. ADM program offices were responsible for establishing and monitoring program standards and performance objectives, evaluating programs, and developing funding allocation methods. Over time, the ADM program offices took over many of the functions of the local Mental Health Boards, eventually replacing them all together.

In 1984, the legislature made sweeping changes to the Florida Mental Health Act revising the Baker Act and eliminating the mental health boards, which were replaced with planning councils that had similar planning and evaluation duties but did not allocate funds. The district program offices were vested with the responsibility for contracting directly with providers for services consistent with district plans.

As federal funding became less generous and with the advent of block grants in the 1980s, pressure mounted to develop alternative mechanisms for funding services to people with serious mental illnesses. The 1980s marked the beginning of a shift in funding for community mental health programs through Medicaid Community Mental Health Services Rehabilitation and Targeted Case Management programs. The 1990s saw the continued expansion of Medicaid

[2] O'Connor v. Donaldson 422 U.S. 563, 95 S. Ct. 2486 (1975, Florida)

funding for mental health services. The Agency for Health Care Administration (AHCA), through its role as the state's Medicaid authority, became a critical funding and planning partner for community-based mental health services. Medicaid now accounts for over half of all state expenditures for the public mental health system.

The late 1980s and 1990s brought significant changes in many of the legal and social assumptions upon which the mental health service delivery system had evolved. Rapid advancement in the fields of neurobiology and pharmacology saw unprecedented success in the treatment of the most intractable forms of mental illness. At the same time, class action suits increased the pressure on states to provide appropriate community-based services. As a result, state mental health treatment facilities became smaller and demand on community resources increased. People with mental illnesses and their families became increasingly articulate advocates for the need for system reform and for their inclusion as full participants in the planning and delivery of services. Overwhelming evidence that recovery from serious mental illnesses was possible generated new energy and required a complete rethinking of the design of the service delivery system.

In 1989, another significant lawsuit, Sanbourne v. Chiles,[3] was filed in Federal court on behalf of Deidra Sanbourne, who had resided at South Florida State Hospital in Pembroke Pines for most of her adult life. The class-action litigation lead to further deinstitutionalization of Florida's state hospitals and required ongoing monitoring of conditions at South Florida State Hospital, particularly discharge planning for residents and services received in first 30 days after discharge to the community. While Deidra Sanbourne was released from the confines of the state hospital after 20 years of institutionalization, she later died at the age of 57 after being neglected in a boarding home (Early, 2006).

The 1990s were also a period in which accountability became a driving principle in mental health policy development. The passage of the Government Accountability Act and increasing demands on state resources required that the DHRS and providers be accountable for measurable outcomes. The legislature established target populations that were the priority groups to receive services funded by the state. The collection of outcome data on the services provided became a required element in contracts with providers. This focus on accountability was also fueled by escalating health care costs. As demands on state resources increased, restructuring payment mechanisms for mental health services became increasingly important.

In 1996 the Legislature reorganized DHRS, creating a separate Department of Health and creating the Department of Children & Families (DCF). This reorganization also created separate program offices at the state level for Alcohol, Drug Abuse and Mental Health, although the separation did not extend to the district level. Due to the explosive population growth since the 1975 reorganization, the original eleven districts were expanded to fifteen.

In 2003, the legislature enacted changes that represented the next step in the evolution of Florida's human services delivery system. In response to concerns that the mission of the mental health and substance abuse programs was not a high priority within the department, the legislature created a Deputy Secretary for Substance Abuse and Mental Health within DCF, with

[3] Case 89-6283-CIV-NESSBITT, (S.D. Fla. 1993)

accountability directly to the Secretary. In an effort to elevate the importance of services to people with mental illness and substance abuse problems, the Legislature established the Florida Substance Abuse and Mental Health Corporation, independent of the department, to review the service delivery system, assess needs for services, staff and resources, and provide a forum for direct advocacy with policymakers.

During the 2007 regular session, the Florida Legislature again took up legislation relating to the public mental health system, authorizing DCF to modify its organizational structure to improve the effectiveness and efficiency of the agency. Under this reorganization, which is currently in progress, DCF is working to integrate substance abuse and mental health programs into the Department's overall structure and priorities and to realign the service districts to conform with judicial circuits.

Also during the 2007 session, the Florida Legislature passed HB 1477, the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program. This legislation allocates $4 million in funding with a match from counties to be used for a statewide competitive grant program, enabling communities to plan and/or expand joint problem-solving initiatives aimed at responding more effectively to people with mental illnesses in the justice system. Similar to Federal legislation passed under the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), the grant program requires the establishment of collaborative partnerships between the judiciary and other traditional and nontraditional stakeholders serving the needs of people with mental illnesses.

History of the Baker Act:[4]

In 1971 the Florida Legislature passed into law the Florida Mental Health Act, which went into effect July 1st of the following year. 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 heath 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. According to Representative Baker, the intent of the Act was to encourage voluntary commitments as opposed to involuntary (when the person was incompetent to consent), to separate the process of hospitalization from the process of legal incompetency, to increase community care of persons with mental illnesses, and to facilitate persons' return to normal community life. Referring to the treatment of persons with mental illness before the passage of her bill, Representative Baker stated "In the name of mental health, we deprive them of their most precious possession – liberty."

Before the Baker Act was enacted, a person could be placed in a state hospital if three people signed affidavits and secured the approval of a county judge. The law stated that the committing

[4] Parts of this review adapted from: *History of the Baker Act – It's Development and Intent.* State of Florida Department of Children and Families Mental Health Program Office Website. Retrieved from: http://www.dcf.state.fl.us/mentalhealth/laws/histba.pdf

judge was required to have any destitute person with mental illness committed to the sheriff for safekeeping until transferred to the hospital. Children as young as 12 years old could be placed into state hospitals with adults. Payment could be required from friends, parents, or guardian for the person's care. Persons hospitalized in private or public hospitals were allowed only one individual with whom he or she could openly and privately correspond. There was no specific period of commitment before a person's confinement would be reconsidered by a judge.

The Baker Act prohibited the indiscriminate admission of persons to state institutions or the retention of persons without just cause. The Baker Act mandated court-appointed attorneys to represent each person for whom involuntary placement was sought and provided for independent reviews of all involuntary placements every six months. The new law established a patients' bill of rights, protecting persons' rights to communicate with whomever they wished, to receive and send unopened mail, to use their own possessions, and to vote, among many other rights. The law also prohibited the placement of persons with mental illnesses in jails, unless they had committed criminal acts.

Since the Baker Act became effective in 1972, a number of legislative amendments have been enacted to further protect persons' civil and due process rights. The most substantial reform occurred in 1996 when greater protections were extended to persons seeking voluntary admission, informed consent and guardian advocacy provisions were strengthened, notice requirements were expanded, and suspension and withdrawal of receiving and treatment facility designations was specified, among many other revisions.

The Baker Act was considered by many persons around the country as landmark legislation at the time of its enactment. The movement to deinstitutionalize persons from large mental hospitals back to their home communities became prominent since the 1970s and many newer psychiatric medications have made it possible for persons to avoid or reduce the need for long-term hospitalization. Since the passage of the Act, there has been increasing public awareness and understanding that the rights and liberties of people with mental illnesses are no different than those bestowed to the rest of the general population.

In 1999, the Commission on Fairness of the Supreme Court of Florida conducted the first comprehensive review of the judicial administration of the Baker Act since its enactment nearly 30 years earlier. The commission concluded that that this legislation effected certain populations, particularly elders, in detrimental ways; and that the Baker Act was in need of overhaul, including statutory reforms, improvements in court procedures, and increased funding (Commission on Fairness, 1999).

The commission found that the number of Florida residents with mental illnesses and cognitive disorders such Alzheimer's disease (roughly one million individuals) was greater than the entire populations of some individual states. They also found that an alarmingly large number of Floridians were undergoing involuntary examination and civil commitment hearings every year. They noted that, because of inadequate funding, hearings on petitions for involuntary placement were not always held within the time frames required by law, resulting in lengthier detentions. In addition, they recommended more funding for community-based mental health services to avoid unnecessary institutionalization or criminalization of individuals with mental illnesses. It

was found that the Baker Act had sometimes been used maliciously for financial gain or personal retribution, often against elders in nursing homes. Some people detained under the Baker Act were found to have received inadequate legal help and some Baker Act hearings were so informal that detainees did not understand their liberty was at stake, and in some instances, state attorneys were not fully participating in the process. The Commission also concluded that judicial and executive agencies that should have a role in preventing abuses of the Baker Act were too poorly funded to be effective. Furthermore, they did not receive adequate training and education to prepare them to participate effectively in Baker Act proceedings. Although the Commission on Fairness published a list of recommendations addressing legislative, financial, training, and procedural issues relating to the Baker Act, few corrective actions were implemented.

In 2005, changes to the Baker Act were enacted that provide for involuntary outpatient placement (IOP), or outpatient civil commitment. The intention of this legislation is to provide for a less restrictive alternative to court-ordered hospital treatment for individuals with mental illnesses who have demonstrated substantial difficulty with adhering to treatment and who, as a result of treatment noncompliance, have experienced repeated, recent institutional involvement in mental health or criminal justice systems. Considerable controversy relating to IOP has emerged, in Florida and across the country, surrounding the appropriateness and value of court-ordered outpatient care. In addition, this legislation was passed without providing consideration for funding of services, or for the impact on the judiciary and the legal system. As a result, IOP has yet to be fully implemented in many communities across Florida. In the handful of jurisdictions where it has been implemented, it is reported to be yielding promising results.

During the fall of 2006, DCF convened a workgroup of key stakeholders from around the state to address the increasing demands on the acute care system (particularly among individuals involved in the criminal justice system), review and recommend alternative treatment/intervention options, and make recommendations regarding the need for statutory changes in the Baker Act. In their final report, the workgroup echoed many of the recommendations made by the Commission on Fairness, as well as other recommendations relating to judicial procedure which were recently referred to the Steering Committee on Families and Children in the Court of the Supreme Court of Florida.

Children and Families:

In addition to criminal justice and judicial system related consequences, untreated mental illnesses also contribute to non-justice system related consequences that are not only equally tragic, but imminently avoidable. A recent study by a branch of the Department of Health and Human Services, found that almost one-quarter of all stays in public hospitals in the United States for patients ages 18 and older in 2004 (roughly 7.6 million of nearly 32 million total hospital stays), involved mental illness and/or substance use disorders. Of all hospital stays involving these disorders, 25 percent (1.9 million, or 6 percent of total hospital stays) involved a principal psychiatric diagnosis, with the remaining 75 percent (5.7 million, or 18 percent of total hospital stays) documenting a secondary psychiatric diagnosis on the discharge record (Owens, Myers, Elixhauser, & Brach, 2007).

An estimated 30-40 percent of Florida children in out-of-home care have a serious emotional disturbance (DCF, 2006). The National Resource Center on Homelessness and Mental Illness estimates that 25.5 percent of people in Florida who are homeless have mental illnesses. About 2,000 individuals discharged from Florida's civil commitment facilities every year have no source of income and are reliant upon state resources for housing and services. Florida's suicide rate ranks 13th in the nation, and is the 9th leading cause of death in the state among the general population and the 3rd leading cause of death among individuals aged 15 to 24. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined (Florida Suicide Prevention Coalition).

To the extent that changes are undertaken to reform the mental health system and to minimize the unintended consequences of conventional policies and practices, it is imperative that issues relating to pregnancy and infant care and development be given prominent attention. Among the more compelling recent research on underlying causes of behavioral and emotional difficulties is the contribution of prenatal, neonatal, and early childhood development on later expression of mental illnesses and behavioral disorders. Research has demonstrated that poor maternal nutrition, health, and prenatal care, along with exposure to illicit drugs and other toxic substances in utero, have strong relationships with later development of behavioral and emotional difficulties (Institute of Medicine, 2003).

Similarly, research now shows definitively that insecure and inconsistent patterns of attachment to key caregivers during the first years of life are associated with development of psychiatric difficulties, and can have profound effects on an individual's ability to develop and maintain meaningful relationships later in life. While risk factors associated with disorganized infant-caregiver attachment include parental trauma, maternal depression, maternal alcoholism, and other substance-use problems and illnesses, they are also associated with infants who are placed in environments that do not provide an adequate opportunity to develop stable, secure relationships with one or more key caregivers (Lederman, Osofsky, & Katz, 2001). Such impermanence in relationships may occur, for example, when infants enter into the foster care system and move from one placement to another without having the opportunity to developed meaningful attachments.

Another trend which has raised concerns involves the off-label prescribing of psychotherapeutic medications to preschoolers and older children (Rawal, Lyons, MacIntyre, & Hunter, 2004; Zito, Safer, dos Reis, Gardner, Boles, & Lynch, 2000). In the absence of formal standards and clinical guidelines, the off-label use of these medications, usually in response to behavioral problems, has been questioned for both its safety and efficacy. To complicate matters, judges in dependency courts are now required to provide signatures authorizing the administration of psychotherapeutic medications to children in foster care, which may present further legal and ethical concerns that are worthy of review.

Traditionally, prevention and intervention strategies have focused on mental illnesses in adults with the apparent presumption that the development of serious mental illness is something that, by and large, cannot be predicted prior to the onset of symptoms in early adulthood. It is only recently that the popular belief among policymakers and the public have entertained the notion

that events in early childhood development may foreshadow more significant impairments later in life.

The emerging research on infant and childhood development suggest that attending to issues of early human development, particularly on the part of service providers, policymakers, and the courts by way of the dependency system, may not only respond more effectively to the needs of children, but may also serve as a critical first line of defense against preventable and irreversible consequences that may lead to future disability, institutionalization, and criminal justice system involvement.

Trends in Service Organizations, Services Provided, and Funding:

To put in perspective current challenges facing the public mental health system, it is useful to consider historical issues relating to the financing and delivery of mental health care services in the United States and in Florida. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (DHHS) recently released *Mental Health, United States, 2004* (Center for Mental Health Services, 2006), the latest in a series of reports published biennially that address policies and practices in mental health care service delivery in the United States. The latest compendium includes detailed information on both aggregate and service-sector specific system capacity, service delivery, and expenditures.

The types of mental health organizations covered are state and county psychiatric hospitals, private psychiatric hospitals, non-Federal general hospitals with separate psychiatric services, Department of Veterans Affairs (VA) medical centers, residential treatment centers (RTCs) for children with severe emotional disturbances (SED), and "all other mental health organizations," which include multi-service mental health organizations, freestanding psychiatric outpatient clinics, and partial care psychiatric organizations.

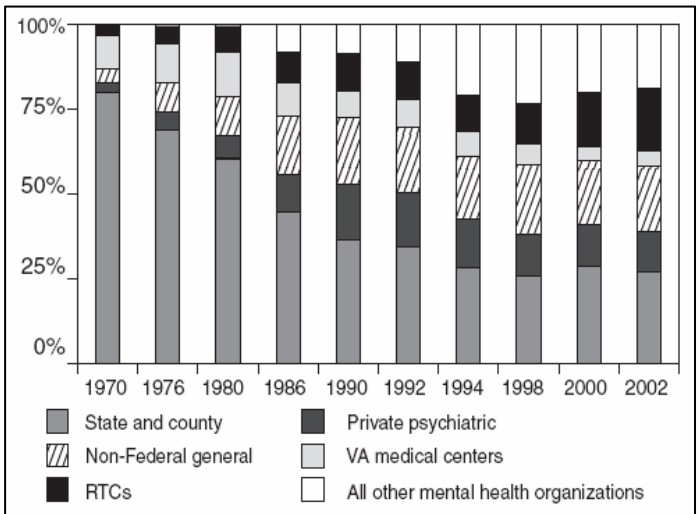


Figure 1. Percent Distribution of 24-Hour Hospital and Residential Treatment Beds, by Type of Mental Health Organization: United States, Selected Years, 1970–2002. Source: Foley et al., 2006.

Services:

Between 1970 and 1998 the total number of mental health organizations in the United States increased from 3,005 to 5,722. Between 1998 and 2002, the number of organizations decreased from 5,722 to 4,301. Similarly, the total number of mental health organizations in Florida between 1992 and 1998 increased from 177 to 223. Between 1998 and 2002, this number decreased from 223 to 152. The majority of the increases in services were among organizations providing less than 24-hour care and in non-federal general hospitals and RTC for children with SED (Foley, Manderscheid, Atay, Maedke, Sussman, & Cribbs, 2006).

Although the total number of service organizations in the United States providing inpatient and residential treatment care increased between 1970 and 2002, the number of treatment beds declined dramatically. In 1970, 524,878 beds existed across all service sectors. As of 2002, this number had dropped to 211,199, a decrease of 60 percent. State hospitals and VA medical centers closed nearly 400,000 beds combined, resulting in decreased inpatient and residential bed capacity of 86 and 81 percent respectively (see Figures 1 & 2).

A similar trend has occurred in Florida where the number of community hospital psychiatric beds decreased from 6,467 in 1994 to 4,021 in 2006, despite the increase in the state's population during that time. This is a drop from 45.8 beds per 100,000 total population in 1994 to 21.8 beds per total 100,000 population in 2006. There are currently a total of 3,823 beds for adults and 556 for children that provide 24 hour care in a community setting. Beds in Florida's civil state psychiatric hospitals have decreased from 1,926 in 1997 to 921 in 2007, placing greater pressure on community-based facilities (DCF, 2007).

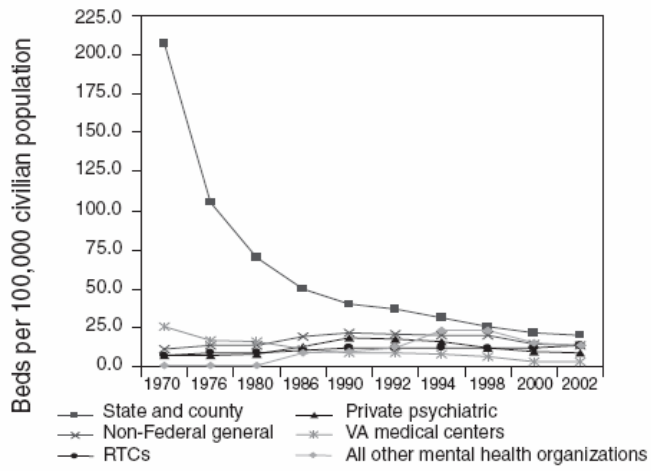


Figure 2. Rate of 24-Hour Hospital and Treatment Beds, by Type of Mental Health Organization: United States, Selected Years, 1970–2002.
Source: Foley et al, 2006

In 1969, state hospitals served slightly more than 78 percent of all residents of psychiatric facilities, whereas private psychiatric hospitals and non-Federal general hospitals accounted for just over 6 percent of all residents. As of 2002, state hospitals accounted for roughly 29 percent of all residents of psychiatric facilities, whereas the percentage of combined residents in private psychiatric hospitals and non-Federal general hospitals had grown to over 25 percent (Foley et al., 2006).

Along with the shift in patient care episodes from 24-hour hospital and residential treatment care to less than 24-hour services, a shift also occurred across organization types within these two services. For example, state hospitals accounted for 63 percent of hospital and residential treatment episodes in 1955, compared with only 13 percent in 2002. Also in 2002, the majority of hospital and residential treatment care episodes were in private psychiatric hospitals (22 percent) and non-Federal general hospitals (48 percent).

Expenditures:

Total expenditures by mental health organizations in the United States increased from $3.3 billion to $34 billion between 1969 and 2002. However, when adjusted for inflation, total expenditures (in 1969 dollars) rose by only $700 million, or 21 percent (see Figure 3). By contrast, the estimated United States population increased by roughly 87 million people, or 43 percent, during this same period of time. Only 2 percent of the $31 billion increase in

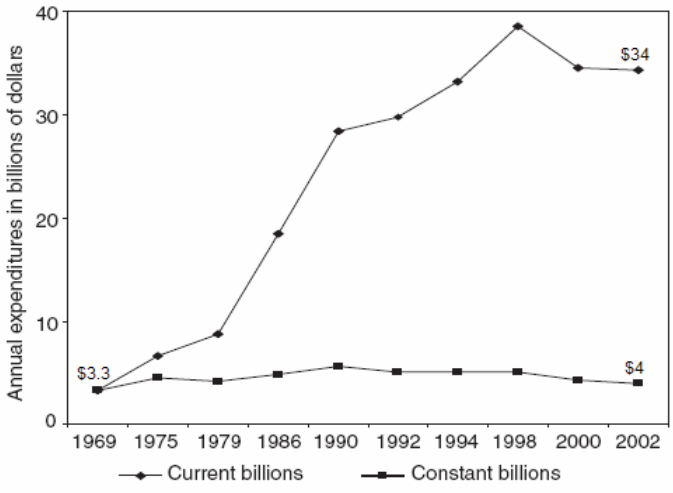


Figure 3. Annual Expenditures in Current and Constant Dollars, All Mental Health Organizations, United States: Selected Years, 1969–2002. Source: Foley et al., 2006.

expenditures between 1969 and 2002 represented an increase in purchasing power. The remaining 98 percent was due solely to inflation. Trends in per capita expenditures followed similar patterns between 1969 and 2002. When expressed in constant dollars, total per capita expenditures had an inconsistent net decline of $2.97 between 1969 and 2002, from $16.53 to $13.56.

In Florida, total state mental health appropriations increased from $219 million to $370 million between FY96-97 and FY06-07, an increase of $151 million. When adjustments are made for inflation, total expenditures rose from $219 million in FY96-97 to $248 million in FY06-07, an increase of $29 million (see Figure 4). Trends in per capita state appropriations indicate an increase in funding between FY96-97 and FY06-07 from $14.90 to $20.10; however when adjusted for inflation, per capita state appropriations increased from $14.90 to $17.27 between FY96-97 and FY01-02 and then decreased to $13.47 in FY06-07, a net loss of $1.43 per capita across the prior decade (see Figure 5).[5]

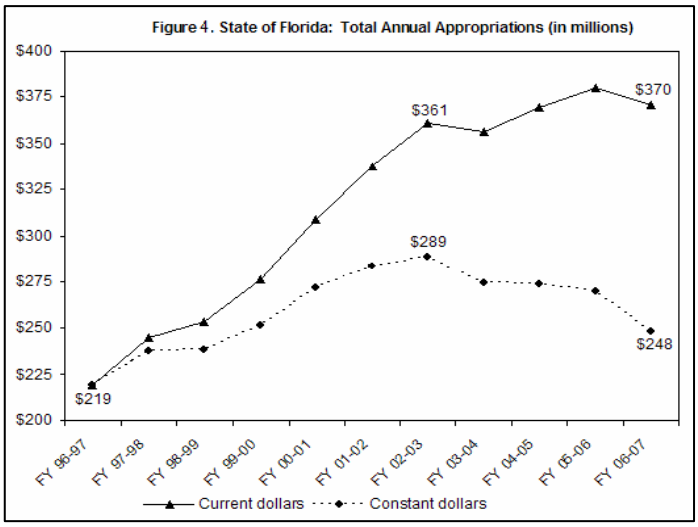
Medicaid is the largest source of public funding for mental health and substance abuse (MHSA) treatment in the United States, accounting for roughly 44% of all MHSA spending (Kaiser Commission on Medicaid and the Uninsured, 2007). Furthermore, Medicaid accounts for roughly 18 percent of total United States healthcare spending, 60 percent of all acute care costs, and more than one-third of all operating revenues for community health centers and public hospitals.

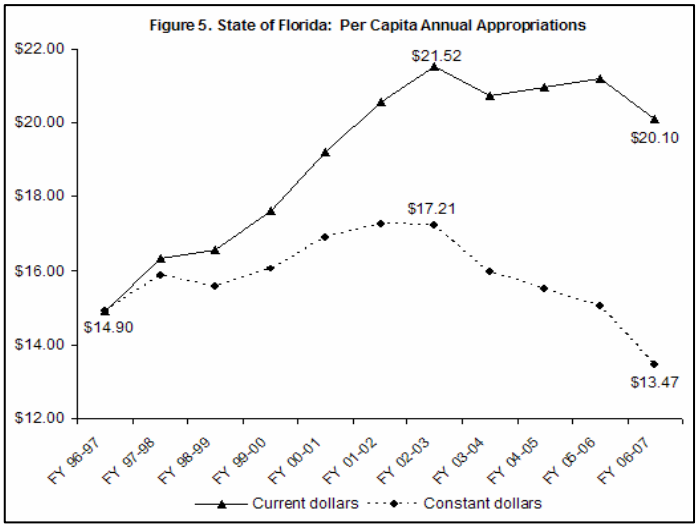
Medicaid is jointly financed through federal and state matching funds; and accounts for roughly 8 percent of total federal outlays and an average of 18 percent of state general revenue spending. Behind elementary and secondary education, Medicaid is the second largest item in most state budgets. The federal share of spending is determined by the *federal medical assistance percentage (FMAP)*, which varies by state based on per capita state income relative to per capita national income. In Florida, the FMAP for FY2007 is 58.8 percent federal dollars to 41.2 percent state general revenue dollars, resulting in $1.42 in federal funding for each dollar of state Medicaid spending.

Of the roughly 55 million Americans covered by Medicaid, 11 percent receive MHSA services. Expenditures associated with enrollees accessing MHSA services, however, tend to account for a substantially larger proportion of Medicaid spending. Schizophrenia (and related disorders) and affective disorders (depression and bipolar disorder) rank as the 4th and 5th most expensive conditions billed to Medicaid for hospitalization services, totaling 316,000 hospital stays

[5] Figures 4 & 5 are based on data provided by the Florida Council for Community Mental Health.

annually at a cost of more than $5 billion annually (Russo and Andrews, 2006). In many states, Medicaid is relied on to pay for mental and behavioral health services that are not covered under other sources of health insurance.





While the Florida Department of Children and Families (DCF) is responsible for coordinating programs and contracting for services with local providers, the Agency for Health Care Administration (AHCA) is responsible for overseeing the administration of Medicaid funds for the state. Although Florida has seen consistent and substantial growth in demand for mental health services across all service segments in recent years, growth in funding for services has been relatively nominal or flat (Legislative Committee on Intergovernmental Relations, 2005). In some areas, funding levels have even declined.

Mental illness in state prison systems

To illustrate the impact of mental illnesses and lack of access to community-based care on individuals entering the justice system, consider the following example from the state prison systems. According to the Bureau of Justice Statistics (BJS, 2006), more than half of all inmates in state prisons across the United States experience mental health difficulties, with one in six diagnosed with a serious mental illness (BJS, 1999). Because of lack of community resources and inadequate pre- and post-release service planning and coordination, many individuals with mental illnesses who are released from prisons are unable to access basic supports needed for successful community re-entry, such as housing and medications. As a result, substantial numbers of individuals with mental illnesses, unable to successfully re-integrate into the community are eventually re-arrested and returned to jails and prisons. Ironically, as many as half of these individuals are re-arrested not for committing new offenses, but for violating conditions of their probation or parole, such as failing to report to treatment or to maintain stable housing or employment (Council of State Governments, 2002).

Over time, and in conjunction with a decrease in the availability of residential and community-based services and supports, this has resulted in a substantial increase in the number of inmates in Florida prisons who experience mental illnesses, along with significant burdens and costs to

the state prison system to respond to the needs of these individuals. According to the Florida Department of Corrections, between 1995 and 2007 the percentage of inmates receiving ongoing mental health services in state prisons increased from 10.6 percent to 18.1 percent, an overall proportional increase of more than 70 percent. Among inmates with mental illnesses, the percentage with severe and persistent mental illness (SPMI), requiring the most acute and costly levels of care, increased from 17.3 percent to 39.1 percent between 1995 and 2006, an overall proportional increase of 126 percent. Similarly, the number of inmates housed in inpatient mental health settings within the Department of Corrections more than doubled between 2000 and 2006.

Providing appropriate levels of care to this rapidly expanding subpopulation has meant a substantial increase in investment in costly acute care services and treatment infrastructure. The Department of Corrections now provides ongoing mental health treatment to more than 18,000 inmates annually, with roughly 13,000 identified as requiring intensive levels of care. Currently, mental health services are provided in all major correctional facilities, with 9 facilities providing inpatient levels of mental health care. The Department of Corrections operates roughly 1,150 inpatient mental health treatment beds, which is more beds than currently exist across the state's entire inpatient civil commitment system. While many inmates with mental illnesses are housed in the general population, this is not without added cost. In addition to requiring ongoing medication and other treatment services in many cases, as these inmates are nearly twice as likely to be placed in confinement settings as compared to inmates without mental illnesses.

It should be noted that the Florida Department of Corrections, in collaboration with various community stakeholders, has undertaken commendable efforts to more effectively address continuity of care and effective re-entry among inmates with mental illnesses released from the state prison system. This has included creating an Interagency Agreement between the Department of Corrections and the Department of Children and Families, coordinating with the Social Security Administration to facilitate the application process for federal entitlement benefits, establishing community partnerships with key stakeholders, creating administrative processes and roles to oversee the coordination of re-entry and post-release services, and creation of additional staff positions solely dedicated to coordinating aftercare services. While these re-entry strategies markedly improve pre-release planning and continuity of care, they are of little value in the absence of an effective and informed system of community-based care to receive individuals exiting the justice system. As such, 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.

Unintended Consequences:

The fact that a comprehensive network of community mental health services was never established following 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. Years of inadequate funding and adherence to dated legislation and policies that don't necessarily reflect the current demands and priorities of the mental health system has effected certain segments of the population and the community in

particularly devastating ways. But for lack of adequate and appropriate sources of care in the community many individuals experiencing episodes of profound and acute mental illness, particularly those most economically and socially disadvantaged, are increasingly finding their way into the criminal and juvenile justice systems.

According to DCF (2007), 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 found incompetent to proceed to trial or not guilty by reason of insanity in forensic mental health treatment facilities within 15 days of adjudication. [6]

At the time, roughly 300 inmates in jails across the state were awaiting transfer to the state's roughly 1,400 forensic treatment beds. More than 240 of these individuals had remained in local jails beyond the 15 day limit, with an average waiting time of nearly three months. Judges in Miami, Fort Lauderdale, and Jacksonville had issued similar court orders demanding that DCF comply with state law, and threatened additional sanctions if the Department failed to promptly move individuals in need of treatment out of local jails and into state facilities. The day after the contempt ruling in Pinellas County, the Secretary of DCF submitted her letter of resignation to the state's outgoing Governor.

In subsequent months the state was forced to allocate an additional $16 million in emergency funding and, later during the regular legislative session, $48 million in recurring annual funding to create 300 desperately needed forensic treatment beds. In total, the State of Florida has committed to spending roughly a quarter of a billion dollars annually to treat 1,700 individuals under forensic commitment, many of whom are destined to be tried on criminal charges and moved on to the state prison system.

To make matters worse, the urgency with which the state needed to add these additional beds has meant that state hospital beds previously designated for the civil mental health system had to be converted to serve the forensic population. This has resulted in a reduction in the already scarce supply of civil state hospital beds intended as the proper safety net for individuals experiencing severe and persistent mental illnesses who, as a result of their illnesses and <u>not</u> criminal behavior, are judged to be an imminent risk of harm to themselves or others and in need of court-ordered, long-term care in a hospital-based setting.

[6] Chapter 916.107, Florida Statutes, Rights of Forensic Clients, *"a jail may be used as an emergency facility for up to 15 days following the date the department or agency receives a completed copy of the court commitment order"*

The loss of such critical civil infrastructure increases the likelihood that individuals in need of care, at times when they are least likely to be able to care for themselves, will eventually find their way into the criminal justice system. Such indirect thinning of resources is a prime example of the unintended consequences of a mental health system in which lack of adequate front-end investment and planning has resulted in the further diminishment of the separation between acute and chronic mental illnesses and entry into the criminal justice system.

Inadequate funding of community-based services has meant that more than half of all adults with SMI and about a third of all children with SED in need of treatment in the Florida's public mental health system have no access to care (Department of Children and Families, 2007). Because Florida is a state that does not require parity for mental health coverage with general medical benefits, access to care becomes further restricted for many individuals, placing increased demand on the public mental health system.

Although various legislatures in the state have taken up the issue of community mental health over the past 40 years, the reality is that the system in place today, particularly as it relates to areas such as the provision of involuntary treatment, is largely built on the philosophies, assumptions, and best-practices of more than a generation ago. In an era of huge institutions that warehoused people with mental illnesses, subjecting them to cruel and inhumane conditions, it was necessary to have in place laws which protected individuals' civil liberties and rights. While protection of these same civil liberties and rights are no less relevant today, access to services for individuals with SMI/SED in times of critical need are often met with roadblocks and impediments that raise questions about the extent to which laws designed to protect the safety and well-being of people with mental illnesses have resulted in consequences that effectively block or obstruct access to care. There is a need to review the adequacy of current legislation permitting court-ordered treatment on an inpatient or outpatient basis to ensure that not only does the law provide protections to guard against civil rights abuses, but also that the law does not function as a barrier to treatment for people who may need it the most.

It should also be noted that the consumer population accessing crisis services and the community mental health system today, along with our scientific and social understanding of mental illnesses, are in many ways quite different from the consumer population and conventional wisdom of a generation or more ago. Whereas 40 years ago, individuals were much more likely to reside in long-term hospital settings, today individuals are faced with the challenges of living with illnesses that, if not properly treated, can be profoundly disabling and result in maladaptive behaviors and functioning that make it all but impossible to reside independently in the community. While the diagnoses and underlying disorders are the same, individuals with serious mental illnesses and/or co-occurring substance use disorders today are much more likely to have experienced life events such as criminal justice system involvement, incarceration, and chronic homelessness. In addition, our current understanding of serious mental illnesses and the prevalence of accompanying difficulties such as substance use disorders, trauma histories, and incarceration histories means that interventions and treatment considerations must be informed and responsive to a broader array of needs.

There is a need to ensure that the mental health system is organized and financed in such a way as to provide appropriate levels of care when and where they are needed. The current system

provides inherent disincentives to the appropriate utilization of cost-effective, less intensive community-based services; which in turn contributes to an increase in demand for significantly more expensive acute care and hospitalization services. Because the community-based system to which the individual returns upon discharge from crisis stabilization or hospitalization episodes is the same one which was unwelcoming and overburdened to begin with, the entire process is reset to begin anew contributing to a revolving door of discrete acute care episodes and subsequent psychiatric decompensation, all too often interspersed with periods of criminal justice system involvement and incarceration. Despite scientific advances that have lead to increasingly effective treatment of serious mental illnesses, routine and efficient access to such evidence-based interventions in the public mental health system remains beyond the reach of many seeking care.

The unintended, but nonetheless undeniable consequences of this system have been increased homelessness, increased police injuries, increased police shootings of people with mental illnesses, critical tax dollars wasted, and the reality that we have made mental illness a crime; or at the very least a significant risk factor for criminal justice system involvement. Our jails and prisons have become the unfortunate and undeserving "safety nets" for an impoverished system of community mental health care, and some of the most vulnerable and disadvantaged individuals in our society are allowed to unnecessarily suffer from horrific and imminently treatable illnesses.

Consider the following: In 1955, some 560,000 people were confined in state psychiatric hospitals across the United States. By the year 2000, only about 56,000 remained in such facilities (Manderscheid & Hutchins, 2004). By some estimates, this figure may be as low as 40,000 today. Over this same period of time, the number of psychiatric hospital beds nationwide has decreased by more than 90 percent, while the number of people with mental illnesses incarcerated in our jails and prison has grown by more than 400 percent. Figure 6 illustrates this dramatic shift in service delivery from inpatient to outpatient care between 1955 and 2002. Today there are more than five times as many people with mental illnesses in jails and prisons in the United States than in all state psychiatric hospitals combined (Ditton, 1999). Over the last ten years, we have closed more than twice as many hospitals as we did in the previous twenty and, if this weren't bad enough, some of the hospitals that were closed were actually converted into correctional facilities which now house a disproportionate number of inmates with mental illnesses (Krauth & Dickerson, 1984).

The National GAINS Center estimates that more than 1.1 million people diagnosed with serious mental illnesses are arrested and booked into jails annually (Steadman, 2007). Furthermore, roughly three-quarters of these individuals also meet criteria for co-occurring substance use disorders (Abram & Teplin, 1991; National GAINS Center, 2001). As of mid-year 1998, the Department of Justice estimated that almost 300,000 people with mental illnesses were incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses were on probation in the community (Ditton, 1999). Today, these numbers are likely to be significantly higher.

In Florida alone, roughly 125,000 people with serious mental illnesses requiring immediate treatment are arrested and booked into jails annually. Up to 23 percent of county jail inmates and 17 percent, or more than 16,000, of Florida's state prison inmates experience serious mental illnesses. On any given day, the Miami-Dade County Jail houses between 800 and 1200 defendants with SMI, making it the largest psychiatric facility in the State of Florida. Inmates designated as having a mental health problem in the Orange County Jail are more likely to be repeat offenders, stay in jail 67 percent longer than other inmates, and are more likely to return within three years of being released (Council of State Governments, 2007). Since 1999, 19 individuals experiencing acute episodes of serious mental illness have died as the result of altercations with law enforcement officers in Miami-Dade County alone.

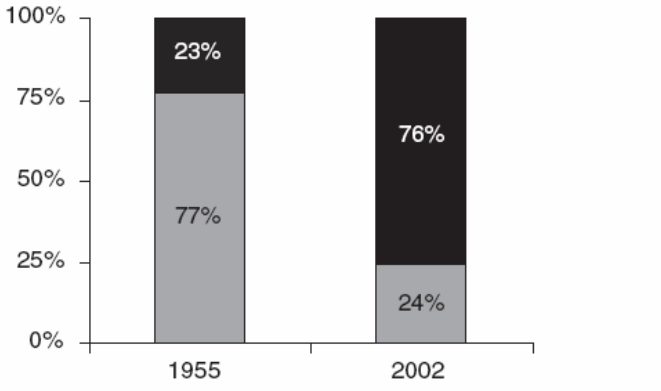


Figure 6. Patient Care Episodes in Mental Health Organizations in 1955 (1.7 Million Patient Care Episodes) and 2002 (9.5 Million Patient Care Episodes). Source: Foley et al., 2006.

From 2001 to 2005 total involuntary examinations under the Baker Act increased 35.2%, while total population increased 9.4% during this time period. The number of involuntary examinations for children 4 through 17 increased 32.5% during this time period, in contrast to 7.8% population growth for this group (Christie & McCranie, 2006). In 2005, the number of examinations under the Baker Act initiated by law enforcement officers exceeded the total number of arrests for robbery, burglary, and motor vehicle theft combined.[7] Moreover, during this same year, judges and law enforcement officers accounted for slightly more than half of all involuntary examinations initiated. Also in 2005, there were at least 82,759 people with Baker Act involuntary examinations initiated. Twenty percent of these individuals had more than one involuntary exam initiated during the year (Christie & McCranie, 2006).

The sad irony is that we did not deinstitutionalize mental health care. We allowed for the trans-institutionalization of people with mental illnesses from state psychiatric facilities to our correctional institutions, and in the process, made our jails and prisons the asylums of the new millennium. In many cases, the conditions that exist in these correctional settings are far worse than those that existed in state hospitals. In 200 years, we have come full circle, and today our jails are once again psychiatric warehouses. To be fair, it's not honest to call them psychiatric institutions because we do not provide treatment very well in these settings.

[7] Based on data published by the Louis de la Parte Florida Mental Health Institute retrieved November 2, 2007 from: http://bakeract.fmhi.usf.edu/Document/BA_Annual_Report_2005.pdf and the Florida Department of Law Enforcement *2005 Annual Crime in Florida Report.* Retrieved November 2, 2007from: http://www.fdle.state.fl.us/FSAC/UCR/2005/ CIFAcomp_annual05.pdf

What is clear from this history is that the current short-comings of the community mental health and criminal justice systems did not arise recently, nor did they arise as the result of any one stakeholder's actions or inactions. None of us created these problems alone and none of us will be able to solve these problems alone. As a society, we all must be a part of the solution.

Borrowing from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Federal Action Agenda,[8] the strategies for planning, leadership, financing, and service development contained in this report are guided by the following five principles:

- Focus on the desired outcomes of mental health care to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Follow the principles of federalism, and ensure that (The New Freedom Commission on Mental Health's) recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the states and Indian tribes.

[8] Accessed at: http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx

Part 2: Organizing Framework for Criminal Justice/Mental Health/Substance Abuse Initiatives: The Policy, Financing, and Administrative Content

Background:

In recent years, there has been an alarming increase in the number of adults with serious mental illnesses (SMI) and children with severe emotional disturbances (SED) involved in the criminal and juvenile justice systems because of behaviors related to untreated mental illnesses or, on occasion, because it is the only means of accessing mental health services or basic life needs. The justice system was never intended to serve as the safety net for the public mental health system and is ill-equipped to do so; however, this is exactly the role that Florida's jails, detention centers, and prisons have been forced to assume as increasing numbers of individuals are unable to access critically needed care in the community. Failing to adequately respond to the needs of people with SMI/SED in the community has resulted in a myriad of avoidable, unnecessary, and costly consequences for individuals, communities, and the State of Florida as a whole. These include:

- Substantial and disproportionate cost shifts from considerably less expensive, front end services in the public mental health system to much more expensive, back-end services in the juvenile justice, criminal justice, and forensic mental health systems
- Compromised public safety
- Increased arrest, incarceration, and criminalization of people with mental illnesses
- Increased police shootings of people with mental illnesses
- Increased police injuries
- Increased rates of chronic homelessness

The fact that a comprehensive network of community mental health services was never established following deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Lack of strategic funding and programming, and adherence to treatment guidelines that don't necessarily reflect current best practices have impacted certain segments of the population in particularly devastating ways. For many individuals unable to access care in the community, the only options to receive treatment is by accessing care through the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

On any given day in Florida, there are approximately 16,000 prison inmates, 15,000 local jail detainees, and 40,000 individuals under correctional supervision in the community who experience SMI. Annually, as many as 125,000 people with mental illnesses requiring immediate treatment are arrested and booked into Florida jails. The vast majority of these individuals are charged with minor misdemeanor and low level felony offenses that are a direct result of their psychiatric illnesses.

People with SMI who come in contact with the criminal justice system are typically poor, uninsured, homeless, members of minority groups, and experience co-occurring substance use disorders. Approximately 25 percent of the homeless population in Florida has a SMI and over 50 percent of these individuals have spent time in a jail or prison.

A 2006 report by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute reported that the State of Florida ranked 12th in the nation in spending for forensic mental health services. Today, this estimate is likely to be considerably higher as this ranking did not take into account the state's investment earlier this year of more than $16 million in emergency funding allocated by the Legislative Budget Commission and the addition of $48 million in annual funding to add 300 desperately needed treatment beds to the overflowing forensic system. Individuals ordered into forensic commitment are now the fastest growing segment of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006.

The following figures, taken from testimony provided before the Legislative Budget Commission prior to the approval of emergency funding for additional forensic beds, demonstrate just how economically inefficient it is to invest in costly back-end services. The same $48 million invested in the community would be enough to:

- Fund mental health care for more than 260,000 children or 60,000 adults at current spending rates
- Fund substance abuse services for 238,000 children or 372,000 adults annually
- Pay for psychotherapeutic medications for nearly 15,000 individuals for a year
- Fund 37 new FACT teams, more than doubling the state's capacity to provide 24-hour community supports for individuals with SMI living in the community
- Provide annual housing subsidies for nearly 15,000 individuals/families (at $300 per month)

To put this in a more acute perspective, the State of Florida currently spends roughly a quarter of a billion dollars annually to treat roughly 1,700 individuals under forensic commitment; most of whom are receiving services to restore competency so that they can stand trial on criminal charges and, in many cases, be sentenced to serve time in state prison. Furthermore, the treatment provided in Florida's forensic hospitals is funded entirely by state general revenue dollars, as Federal law prohibits Medicaid from providing payment for psychiatric services rendered in such institutional settings. As a result, the state is investing enormous sums of taxpayer dollars into costly, back-end services that may render a person competent to stand trial, but will do nothing to provide the kind of treatment needed to facilitate eventual community re-entry and reintegration.

While expenditures in the area of forensic mental health services place Florida near the top of the list nationally, the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community place the state near dead last. According to the NASMHPD Research Institute, the State of Florida ranks 48th nationally in

overall per capita public mental health spending. Difficult to navigate and inefficient points of entry have resulted in barriers to accessing preventative and routine care. Last year alone, more than half of all adults with serious mental illnesses and about a third of all children with severe emotional disturbances in need of treatment in the Florida's public mental health system had no access to care. Furthermore, despite recent research which has lead to the identification and development of increasingly effective, evidence-based interventions for serious mental illnesses, such treatments have yet to be adequately implemented by many service providers in the public mental health system. Consequently, increasing numbers of people experiencing acute episodes of mental illness are becoming involved in the justice systems.

Overview of Recommendations:

Although a shortage of funding for community-based mental health services and supports is not solely responsible for the significant increase in the number of people with mental illnesses becoming involved in the juvenile and criminal justice systems and the escalating numbers of referrals to the state's forensic mental health system, it is clearly a prevailing cause in Florida and across the country. It would be short-sighted to suggest that concerted and sustained efforts from local or regional stakeholders toward solving these problems could be achieved without explicitly responding to financial resource needs.

Given the level of fragmentation, inefficiency, and wastefulness in the current system, it is recommended that that the state focus on investment in a redesigned and transformed system of care geared toward ensuring access to qualified and competent prevention and treatment services in the community and prevention of the unnecessary and costly criminalization of people with mental illnesses. Under the redesigned system of care, which will serve both adults with SMI and children with SED, who meet additional eligibility criteria, there will be 1) programs to prevent individuals from inappropriately entering the justice and forensic mental health systems, 2) mechanisms to quickly identify individuals with mental illnesses who do become inappropriately involved in the justice system, and 3) programs to stabilize these individuals and link them to recovery-oriented services in the community that are responsive to their unique needs.

To achieve its purposes, this plan will require innovative financing strategies that will provide more equitable, risk-adjusted compensation for providers who deliver high quality services to individuals at highest risk for institutional involvement. Establishment of targeted, integrated specialty care networks serving the highest utilizers of deep-end services, accompanied by changes to Florida's Medicaid state plan, will be required to provide incentives for qualified providers to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice systems through assertive in-reach into the justice setting and diversion, as appropriate, to community-based stabilization and recovery services. These new financing and service delivery strategies will be designed around principles of managed care to control costs and guide implementation.

In an effort to identify individuals at highest risk for juvenile and criminal justice and other institutional involvement, and to achieve service delivery that is effective, efficient, and least wasteful, the state is encouraged to adopt a multi-tiered level of care classification system.

Under this system, service delivery will be targeted toward the ongoing needs of the individual and their relative risk of requiring institutional levels of care.

Under the proposed classification system individuals with the highest levels of need, those with SMI/SED and histories of institutional involvement coming out of criminal justice and state hospital settings, will receive access to intensive levels of care, including services specifically designed to facilitate community re-entry following periods of institutional involvement. Individuals at the next level of need, those who are not currently institutionally involved, however are at significant risk of becoming involved in the criminal justice system or other institutional setting as a result of SMI/SED, will receive services at the same intensity as those provided to individuals coming out of institutional settings, without the added benefit to address community re-entry needs. At the lowest level of need will be individuals accessing routine care in the community and not at substantial risk of involvement in the justice system or other institutional levels of care. In this proposal, individuals at the two highest levels of need will be targeted for services under the new Medicaid program. Those at the lowest level of need, who also make up the largest number of individuals accessing care through the public mental health system, will continue to access services under current Medicaid and DCF programs. Under this proposal, processes will be created to facilitate movement across levels of care, thereby ensuring adequate services in times of acute need when individuals are at risk of penetrating into institutional levels of care. This process maximizes limited state resources during periods of relatively stable recovery.

Florida's mental health system requires a great deal of work related to both financing and the improvement of the quality and effectiveness of care. For both financial and logistic reasons this work cannot be done quickly. Improvements in treatment capacity and the application of evidence-based practices must be approached from a systematic and practical perspective. Therefore, it is recommended that the program be incrementally implemented in three phases over a six year period. During initial implementation, the number of individuals covered under the Integrated Specialty Care Network (ISCN) will be purposefully limited to a very small number of individuals (roughly 900-1,000 participants) who are among the highest utilizers of the most expensive state-funded institutional services, in three strategically targeted areas around the state. This will serve to control costs, produce meaningful and significant reduction in admissions to state forensic facilities early on, and allow time to develop a controlled and strategic plan for expansion. Over time, the program will grow to cover about 25,000 individuals annually.

To allow the necessary flexibility to maximize resources and serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not currently covered, it is recommended that a funding and management partnership between DCF and AHCA be established. In this way, both Medicaid and general revenue funding can be blended to achieve optimal efficiency in the system. A Statewide Leadership Group, composed of representatives from the key departments of state government and other community stakeholders from across the state will also be in place to help drive these efforts, and to provide additional oversight and fiscal review.

A primary short-term goal will be to eliminate, as soon as possible, the 300 beds DCF has

recently contracted for forensic competency restoration services, thereby freeing up the $48 million to be reinvested both in less expensive, front-end community programs that reduce forensic hospital commitments and into the Reinvestment Grant Program to continue to build an integrated statewide community system of care to serve individuals with chronic mental illnesses and/or substance use disorders who are currently recycling through the justice and acute care mental health systems. By reinvesting service dollars in this way, the state will achieve the added benefit of being able to leverage additional federal resources through Medicaid and Medicare. By contrast, current investment in back-end services in prisons, jails, forensic and civil mental health facilities, and juvenile justice facilities is 100 percent dependent on state general revenue dollars to operate services.

Successful implementation of this plan and transformation of the existing public mental health system will require dedication and commitment from many stakeholders. To the extent that the state works to make these changes and strategically reinvests resources from costly and inefficient back-end services into the community, the resources to fund the full implementation of this proposal will be realized largely within current state funding levels, thereby minimizing the need to invest large amounts of additional revenues. It is critical, however, that savings achieved from reductions in forensic services be reinvested into the community-based care and not returned to general revenue.

While there is, and always will be, a need to invest in acute care services, 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. It makes no sense to continue investing in costly back-end services in the justice systems and forensic mental health system, at the expense of sacrificing resources that could be better used to support community-based prevention and treatment services that are likely to promote recovery and reduce the likelihood of forensic involvement.

The sections that follow describe in more detail the short- and long-term processes recommended to move the mental health system in Florida toward improved delivery of services and supports that will prevent inappropriate penetration of people with mental illness into the juvenile and criminal justice systems, and promote recovery, resiliency, and adaptive life in the community.

Target Population and Level of Care Classification:

The target population served under the proposed program will include individuals with SMI/SED involved in or at risk of becoming involved in the justice system or other institutional settings as a direct result of severe behavioral or psychiatric disorders. Within each network, enrollees will consist of individuals re-entering the community from jail, prisons, juvenile justice, and state psychiatric hospital settings, as well as individuals in the community who are at significant risk of becoming involved in juvenile or criminal justice or other institutional settings as a result of mental illnesses.

Under the current system of health care delivery, the level and intensity of care available to individuals who experience chronic mental illnesses and co-occurring substance use disorders is inadequate to meet the complex clinical and social needs encountered by this population. In

order to more competently and efficiently address the needs of individuals who experience psychiatric and behavioral disorders, particularly those with SMI/SED, it is recommended that the State of Florida implement strategies that are more effectively tailored to the needs of specific populations at increased risk of institutional involvement in the justice systems and/or state mental health system. Unfortunately, the vastly disparate and intermittent needs of individuals accessing care through the community mental health system means that it is virtually impossible to design a single, universal benefit that will balance the need to provide effective levels of care, while minimizing the delivery of unnecessary and often costly services.

For this reason, it is suggested that the State of Florida may benefit from the adoption of a service delivery system that takes into account severity, chronicity, and disability in determining appropriate levels of care. To some extent, the state has already initiated such strategies with the implementation of specialized community-based services such as FACT Teams. Access to such services remains limited, however, leaving many individuals who experience persistent psychiatric disabilities with few options for receiving needed levels of care. The following is a recommendation for a multi-tiered classification system for targeting appropriate levels of care within the community mental health system:

Tier I: Individuals without SMI/SED accessing routine, episodic, or crisis care, as well as individuals with SMI/SED, currently stabilized and not at risk of CJ involvement/institutional placement as a result of mental illness.

Tier II: Individuals with SMI/SED at risk of CJ involvement/institutional placement as a result of mental illness.

Tier III: Individuals with SMI/SED with current CJ involvement/institutional placement as a result of mental illness.

Effective implementation of such a system of classification is contingent upon:

- Early and comprehensive assessment of acuity, chronicity, risk, addiction, specialized needs, available supports, and consumer/family preference.
- Development of an individually-tailored plan of care incorporating evidence-based practices and specialized services targeting the unique experiences of people with histories of criminal justice system involvement.
- Timely access to problem-focused, goal-oriented treatment.
- Ongoing review and assessment to ensure that the services provided are appropriate and consistent with the identified level of care.
- Ongoing utilization review which targets service delivery and resource allocation among individuals with the most acute care needs, while minimizing unnecessary and costly administrative oversight of services among individuals accessing more routine levels of care.

For individuals accessing care at Tier I, which is the vast majority of mental health consumers, the goal of service delivery should be to foster ongoing recovery and to ensure access to supports and resources that will prevent further impairment or disability. Provided reasonable and efficient access to services, most of these individuals will function adaptively in the community

with modest supports, although they may encounter periods of acute crisis requiring more intensive intervention. In addition, while some individuals at this level of care may experience or have histories of involvement in the justice system, this should not be related to their current mental or behavioral health needs. Most individuals accessing care at Tier I are anticipated to experience relatively stable recovery and routine care, however, some may require a more acute level of care from time to time.

Individuals accessing care at Tier II will be experiencing ongoing moderate to severe functional impairment in the community as a result of mental illnesses. While these impairments will not have resulted in current institutional involvement, they will place the individual at substantial risk for becoming involved in the justice system or accessing care, either voluntarily or involuntarily, in other institutional settings. The goal of services provided at this level will be to achieve psychiatric stabilization and to prevent penetration into more acute levels of care. Such services will require expanded interventions to engage individuals who otherwise may be resistant or apprehensive about accepting treatment. Some individuals may require this level of care on an ongoing basis, whereas others may transition through this level of care during periods of acute illness exacerbation and recovery. In general, it is anticipated that most individuals accessing this level of care will do so for a period of several months, but possibly as long as a year or more.

Individuals coming out of institutional settings such as jails, prisons, juvenile justice facilities, and state psychiatric hospitals who are at increased risk of recidivism in the absence of immediate access to comprehensive community-based services, will receive services at the Tier III level of care. Similar to individuals receiving services at the Tier II level of care, individuals at Tier III will require access to expanded interventions that will promote adaptive community living and progress in recovery. In addition, because of the unique needs of individuals re-entering the community following periods of institutional confinement marked by severe psychiatric or behavioral disturbances, individuals receiving services at the Tier III level of care may require additional enhanced interventions to facilitate adaptive readjustment to life in the community. Such services may entail enhanced in-reach to the individual prior to release or discharge to the community, as well as additional assistance provided to ensure timely and successful access to critical services and supports upon community re-entry. Most individuals receiving services at the Tier III level of care will require such assistance only temporarily during the first few months following community re-entry.

Because enrollment in ISCNs will be limited, it will be necessary to develop additional eligibility criteria targeting the population to be served. It is recommended that enhanced eligibility criteria be tailored to community needs, developed in coordination with local planning councils, and incorporated into local plans. Examples of possible enhanced screening criteria may include:

- Homelessness/unstable housing
- Co-occurring disorders
- Specified number of prior admissions to juvenile or criminal justice or other institutional settings within specified period of time
- History of repeated use of crisis/emergency services

- History of medication/treatment noncompliance
- History of dangerousness to self or others
- Poor insight/cognitive impairment
- Poor social/self-care skills

Individuals accessing care under the proposed ISCNs correspond with those classified to be eligible for services at the Tier II & III levels of care. Individuals at the Tier I level of care will continue to access care as administered under the standard benefits and programs administered by Medicaid and DCF.

Implementation Strategy:

The redesign and transformation of Florida's mental health system and Medicaid program will not occur overnight. Both will be phased-in over time, and will require deliberate and systematic implementation on a community by community basis. In order to control costs and to ensure effective administration, initial implementation will be phased-in over a period of time, and initial enrollment will be capped and limited to areas of the state that are likely to produce the most benefit from enhanced community-based care. In addition, initial implementation will be limited to areas of the state that have demonstrated community readiness to undertake such system transformation. As such, it is recommended that the establishment of ISCNs be implemented in three phases that will move systematically toward statewide administration.

In order to initially target individuals and communities that are the highest contributors to institutional service utilization, Phase 1 implementation should target communities that: 1) send the largest numbers of individuals to state forensic hospitals and 2) demonstrate the willingness, commitment, and ability to implement the necessary changes (e.g., develop effective diversion programs and adopt best practices to prevent individuals from entering the justice and forensic mental health systems) to successfully undertake this effort. In addition, enrollment in the network should be capped and limited to individuals with SMI/SED coming out of jails, prisons, juvenile justice facilities, and state mental health facilities only (i.e., Tier III level of care). Because these individuals tend to be the highest utilizers of acute care services and at highest risk for recidivism and subsequent institutional involvement, providing more effective services at the time of community re-entry is anticipated to produce the most immediate and measurable impact on the system.

Over time, as savings are realized, resources currently allocated to the forensic mental health system should be reinvested into more cost-effective community-based programs serving individuals accessing routine care (i.e., Tier I), and enrollment in the ISCNs will be expanded to serve individuals in the community who are not currently institutionally involved, however are at significant risk of institutional placement in the justice system or state mental health system in the absence of access to more comprehensive care services (i.e., Tier II level of care).

Producing early impact will depend not only on the identification of fertile ground for improvement, but also on the local interest and political will of the judicial, criminal justice, juvenile justice, governmental, provider, advocacy, and consumer stakeholders. For this reason

areas that have submitted qualified applications for funding to improve the CJ/MH system under the HB 1477 grant program should be given priority consideration for Phase 1 implementation. These areas will have already demonstrated some initiative and will have an infrastructure in place that will facilitate local plans and legislative budget request (LBR) development.

Implementation in Phase 1 will take two years to complete. The experience garnered during this period of time will facilitate subsequent efforts in additional areas. For this reason Phases 2 and 3 will include four areas each so that at the end of Phase 3 all AHCA area mental health systems will have been affected. Early in the second year of Phase 1, four additional areas will be selected for Phase 2 using processes similar to those described in the initial phase. Efforts will begin in the final four AHCA areas during the second year of Phase 2.

It should be noted that although the current proposal recommends implementation areas corresponding to AHCA service areas, consideration should be given to whether this is the most efficient targeting for implementation or whether some other geographic breakdown (e.g., DCF Districts) may be preferable.

Local plan and legislative budget request development:

When the areas are selected for Phase 1 implementation, two-year local plans and budgets will be developed. The planning process must be community-based and directed by local planning councils as defined in HB 1477 and involving the courts, law enforcement agencies, State Attorney's Office, Public Defender's Office, correctional agencies, local government, community mental health and substance abuse treatment providers, social services providers, advocates, consumers, and family members. DCF district staff will play a vital role in identifying the appropriate players and driving the process. The Criminal Justice Mental Health Technical Assistance Center (TA Center) at FMHI will provide support for the plan and budget development work.

The plans should include the following:

- A description of locally established planning mechanisms and processes that will drive and oversee change in the CJ/MH system.
- Proposed changes in the deployment of existing resources to improve the effectiveness and efficiency of the system.
- Proposed expansions in service capacity and/or type that incorporate, among other things, the use of evidence-based and promising practices.
- Involvement of local government, the judiciary, and law enforcement agencies in support of implementation of enhanced service delivery.
- An articulation of local consensus concerning priorities and reasonable schedules for implementation.
- Plan for reducing admissions to state forensic facilities.

LBR's should be developed based on the plans and reflect the costs of phasing in the new and improved services and the annualization costs the following year. DCF and AHCA as well as the TA Center will help the local areas identify appropriate state revenue sources (e.g. Medicaid, general revenue etc.) for funding the different plan activities.

Plans and budgets for Phases 2 and 3 will be developed using the same processes described for Phase 1. A Statewide Leadership Group, composed of representatives from the key departments of state government as well as other community stakeholders from across the state, will be in place to help drive these efforts. Phase 1 areas will be allowed two fiscal years to fully implement their plans. The planning process for Phase 2 will begin during the second year of Phase 1 implementation and for Phase 3 in the second year of Phase 2. A summary of the schedule for plan and budget develop is presented in Table 2 below:

Table 2. Schedule of Plan and Implementation Dates

Phase:	Plan/LBR Development:	Implementation:
1	Fall 2007	FY 08-09 and 09-10
2	Fall 2009	FY 10-11 and 11-12
3	Fall 2011	FY 12-13 and 13-14

The redesign and enhancement process will take six years to complete.

Development of Statewide Leadership Group:

Because the criminal justice, mental health, and substance abuse initiatives being recommended will operate across jurisdictions, it is recommended that the Legislature authorize an independent, Statewide Leadership Group to direct and manage the implementation process over the six-year phase in period. To ensure a high level of cross-systems involvement and collaboration, it is recommended that the Statewide Leadership Group be co-chaired by the Secretaries of DCF and AHCA, and be comprised of the executive leadership of key departments of state government, quasi-state government, and community stakeholders including:

- Secretary of Department of Children and Families (DCF)
- Secretary of Agency for Health Care Administration (AHCA)
- Secretary of Department of Corrections (DOC)
- Secretary of Department of Juvenile Justice (DJJ)
- Secretary of Department of Elder Affairs (DOEA)
- Secretary of Department of Health (DOH)
- Secretary of Department of Education (DOE)
- Chief Justice of the Supreme Court of Florida/State Courts Administrator
- Commissioner of Florida Department of Law Enforcement (FDLE)

- Board Chair of the Florida Substance Abuse and Mental Health Corporation (SAMH Corp)
- Dean of the Louis de la Parte Florida Mental Health Institute (FMHI)
- Executive Director of the Florida Association of Counties (FAC)
- Executive Director of the Florida Sheriff's Association (FSA)
- Executive Director of the Florida Public Defender Association (FPDA)
- Executive Director of the Florida Prosecuting Attorneys Association (FPAA)
- Executive Director of the Florida Council for Community Mental Health (FCCMH)
- Executive Director of the Florida Alcohol and Drug Abuse Association (FADAA)
- Executive Director of the Florida Housing Finance Corporation (FHFC)
- Executive leadership from statewide advocacy associations (e.g., FPIC, NAMI, MHA)
- Consumers and family representatives

The specific functions of the Statewide Leadership Group include at a minimum the following:

- Communicating and advocating for the needs of projects with statewide, regional, and federal government authorities (e.g., recommended changes in process, rules, other regulatory requirements, resource utilization).
- Acting as the convener of criminal justice/mental health project leadership for the purpose of identifying problems, developing collaborative solutions when possible, sharing performance success and strategies that contributed to them.
- Developing best practice guideline for criminal justice/mental health project operations including system organization, communication channels, program operations that reflect current best practices.
- Developing standards based on the best practice guidelines.
- Developing policies and procedures designed to assure projects meet standards in areas where consistency across projects is important.
- Promulgating rules based on the policies and procedures.
- Developing a collaborative monitoring model that reviews programs against standards, policies and procedures and best practice guidelines using teams composed of the best qualified staff (and other state experts) that are external to the program being monitored.
- Implement the collaborative monitoring model and address corrective actions.
- Developing performance standards for programs and negotiating them with state level constituencies.
- Developing minimum common data reporting requirements that provide regular information on program operations and performance and summarize reports for external consumption.

- Providing technical assistance to projects by using internal staff as well as individual experts working in the projects and other university or field based experts.
- Representing the projects with the different departments and branches of government that have a stake in project performance.
- Disseminating on an ongoing basis best practice information and change technology and communicating it to the projects and interested constituencies.
- Vetting best practices through the leadership group to identify practice change warranting statewide implementation. Disseminating on an ongoing basis best practice information and change technology and communicating it to the projects and interested constituencies.
- Providing accountability for the investments made in CJ/MH programs and services.
- Providing ongoing program and system evaluation targeting quality assurance and performance improvement.

Staff from DCF and AHCA will work together to provide support to the Statewide Leadership Group and with local communities. In addition, the functions of the Leadership Group will incorporate many of the responsibilities of the Criminal Justice Technical Assistance Center (TA Center) housed at FMHI, as well as the Criminal Justice, Mental Health, and Substance Abuse Policy Council created within the SAMH Corporation under HB 1477. To facilitate implementation, it is recommended that for the phase-in periods the operational functions of the Statewide Leadership Group be contractually assigned to FMHI and the SAMH Corporation so that technical assistance, standard setting, network certification, monitoring functions, grant administration, and logistic coordination are located under the respective, existing organizational umbrellas. This is consistent with the unique statutory purposes of FMHI and the SAMH Corporation as defined by the Legislature:

> The purpose of the institute is to strengthen mental health services throughout the state by providing technical assistance and support services to mental health agencies and mental health professionals. Ch. 1004.44(1), F.S.
>
> The Florida Substance Abuse and Mental Health Corporation shall direct efforts designed to improve interagency coordination of substance abuse and mental health services in order to ensure that these services promote recovery and resiliency-based systems of care. The corporation shall provide oversight of the publicly funded substance abuse and mental health systems and make policy and resource recommendations that will promote system transformation by providing mechanisms for input from stakeholders, including primary consumers, family members, providers, and advocates, concerning the management of the overall system, and that will improve the coordination, quality, and efficiency of the system. Ch. 394.655(3)(a), F.S.

FMHI and the SAMH Corporation's will coordinate with local state agency representatives, provider networks, and local constituencies to facilitate the development and implementation of local plans. In addition, these entities will develop proposed budgets to cover the costs associated with the functions of the Statewide Leadership Group that exceed the SAMH Corporation's functions associated with HB 1477 and the TA Center functions already funded by

the 2007 Legislature. The proposed contracting scheme as well as the funding and management of the systems described in the next section are summarized in Figure 7.

Financing and Contracting Strategies for Enhanced Community-Based Services:

The provision of services under the current proposal will require providers to implement high-quality, evidence-based practices that are more targeted, frequent, and intensive than those typically provided in the current system. Such evidence-based practices (e.g., assertive community treatment, cognitive behavioral therapy, integrated dual diagnosis treatment, supported employment) are often inherently more expensive than traditional service offerings; and even when they are not, initial and ongoing training and monitoring to assure program fidelity requires additional financing considerations. Because the mental health system lacks sufficient capacity and resources within current funding levels to meet the demand for mental health and substance abuse services in the community, it is unrealistic to suggest that the system will be able to adequately meet the demand for additional services provided to those diverted from the justice system without the development of sound and reasoned financial investment strategies.

Because of a persistent lack of access to health care services across the board, many individuals targeted under this proposal are likely to present with multiple, co-morbid physical and psychiatric conditions. Furthermore, because symptoms and illnesses tend to co-vary across multiple diagnoses, poor functioning in one area tends to undermine wellness and recovery in another. As such, establishment of a comprehensive and responsive continuum of care serving individuals with SMI/SED involved in or at risk of becoming involved in the justice system requires careful consideration of the unique needs of the target population. These needs range from prevention and routine care services addressing primary and behavioral health to more complex needs including acute psychiatric crisis services, chronic physical illness (non-psychiatric), and catastrophic illness or injury. It is critical that a comprehensive continuum of care be established to support long-term wellness and recovery. To this end, it is recommended that the state create Integrated Specialty Care Networks (ISCNs) which blend funding from existing and newly-created programs to most efficiently serve both the physical and behavioral health care needs of the target population.

The primary sources of funding for initial service expansion and improvement will come from two appropriation categories, Medicaid and DCF general revenue SAMH funding. To offset state liability for these costs, every effort will be made to maximize enrollment in federally supported entitlement benefits such as Medicaid and SSI/SSDI. Use of promising practices for accessing these benefits, such as Stepping Stones to Recovery and the SSI/SSDI Outcome Access and Recovery (SOAR) model developed by the National GAINS Center with support from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), will play a key role in achieving this goal. Such practices have been demonstrated to increase initial approval rates for applications from 37 percent to 60-95 percent. For individuals coming out of prisons and other long-term institutional settings, additional pre-release/discharge planning to secure entitlement benefits and necessary supports will be initiated in accordance with practices

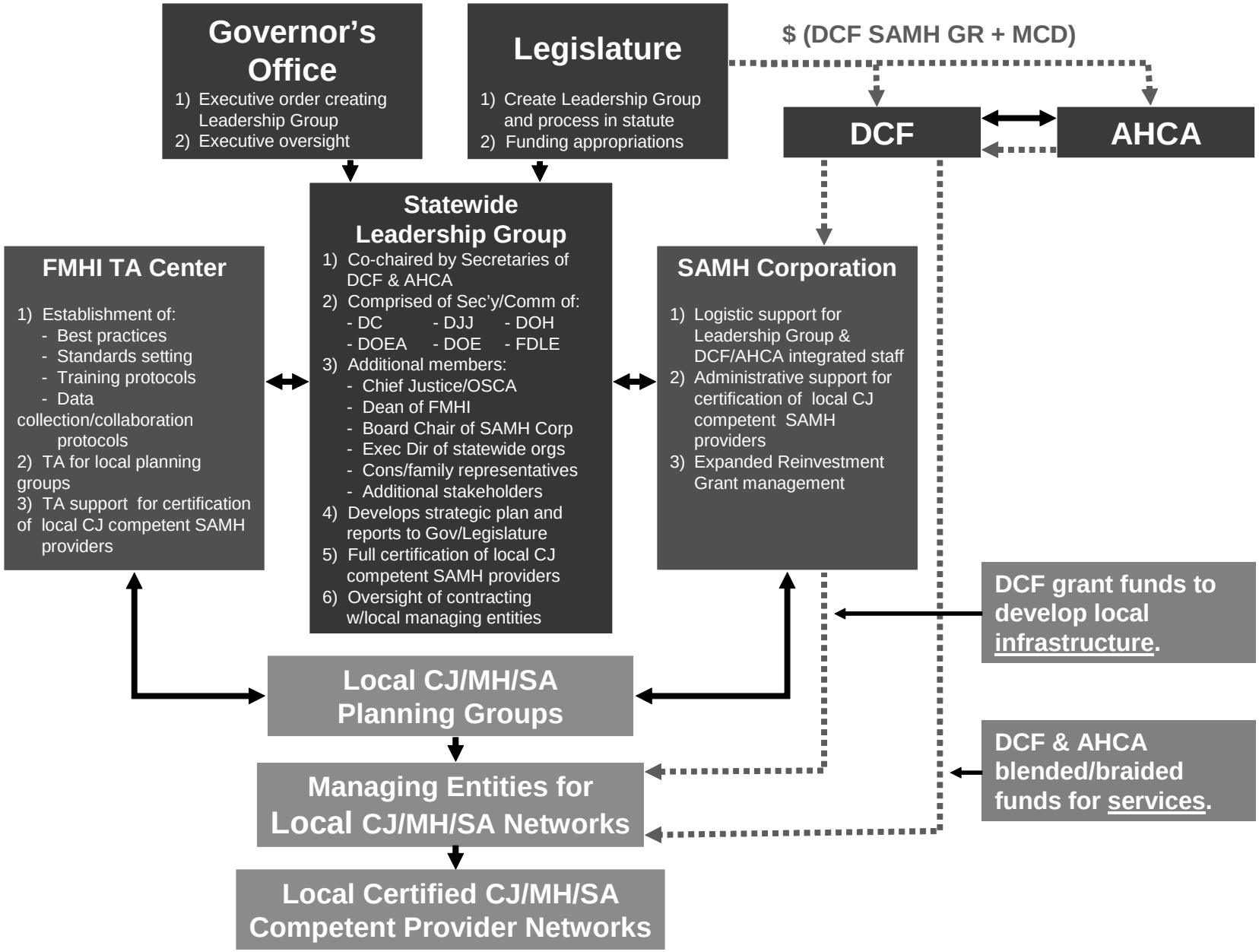


Figure 7. Proposed funding, management, and contracting plan

outlined in *Building Bridges: An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration*, published by the Bazelon Center for Mental Health Law (2002). In addition, specific enhancements in screening, assessment, and case-management services will be employed.

Medicaid:

A key component of the strategy to create a comprehensive continuum of care will be to expand access to cost-effective community-based services. Since 1981, federal Medicaid has allowed states to apply for optional Home and Community-Based Services (HCBS) waivers under section 1915(c) of the Social Security Act to cover a broad range of long-term community-based services for individuals who would otherwise require institutional levels of care. Under this program, the usual requirement to provide services that are comparable in amount, scope, and duration to all individuals in particular eligibility categories is removed enabling targeted populations to be served. Similarly, the HCBS waiver program does not have to be offered statewide and enrollment can be limited. As such, the HCBS waivers allow states to target specific populations of individuals, in specific geographic areas, to receive HCBS services.

While this program has been useful in establishing community-based services for many individuals who would otherwise require institutional levels of care, its applicability to individuals with mental illnesses has been relatively limited. In order to be approved for the HBCS waiver, states are required to meet a federal budget neutrality test which demonstrates that average costs for individuals accessing community-based services under the waiver do not exceed the average costs of institutional care. While there is little doubt that community-based mental health services are far more cost effective than institutional psychiatric care, demonstrating this in accordance with the federal definition of budget neutrality is often difficult, if not impossible. Because of the federal Institutions for Mental Diseases (IMD) rule which prohibits Medicaid reimbursement for care provided in Institutions for Mental Diseases, historically defined as inpatient facilities with more than 16 beds, there are no large federal expenditures on institutional settings (e.g., state/local psychiatric hospitals) to transfer to the community.

However, as of January 1, 2007, states have had the option to amend their Medicaid State Plan to cover many HCBS without the need for a waiver. Under the HCBS State Plan Amendment (SPA) option for HCBS, states do not have to demonstrate budget neutrality, however the ability to limit enrollment geographically, to cap enrollment, and to target specific populations remains in effect. Eligibility criteria are more flexible beyond the "otherwise need for institutional care" standard and states have the ability to establish waiting lists.

To be eligible for services under the HCBS SPA option, income cannot exceed 150% of federal poverty level (FPL), which is more restrictive than the waiver program, however states can design plans to cover some children in families with income above 150% of the FPL. States are encouraged to support self-directed care under the SPA option. Compared to the waiver program, which allows states to request approval of services beyond those provided in the basic

waiver, the SPA option authorizes a more limited services package. There are eight different services that can be covered as part of a HCBS SPA option:

- Case management
- Homemaker services
- Home health aide services
- Personal care services
- Adult day health services
- Habilitation services
- Respite care
- Day treatment and other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illnesses

For the most part, these services are considered to be sufficient to provide for the community-based needs of individuals with mental illnesses. Furthermore, it may be possible for states to include a broader array of services under "psychosocial rehabilitation" than has been permitted under more traditional state plan options.

To date, Iowa is the only state that has submitted and been approved to add HCBS to the services covered under their state plan, although many states are considering similar amendments to their Medicaid programs. The nature of the services covered under the HCBS SPA option, along with the mechanisms in place to manage implementation and subsequent service delivery, make it a favorable option for Florida in the effort to move toward improved delivery of services and supports that will prevent inappropriate penetration into the justice system and institutional levels of care.

Additional changes to the existing Medicaid contract and payment systems to create and implement comprehensive services under the proposed ISCNs are as follows:

- Individuals residing in the areas targeted for Phase 1 implementation, who are involved in or at risk of becoming involved in the justice system, must be identified and the numbers forecasted into the future. Estimating the "at risk" population will be difficult and there will be a danger of drift of individuals into this category in the out years.
- If enrolled in managed care, these individuals and their associated capitation, including that associated with psychiatric inpatient care, will be removed from the HMO's or pre-paid behavioral health plans and, depending on what areas are chosen for Phase 1, from plans operating in Medicaid reform areas.
- Recovery oriented services procedure codes and payment rates will have to be established for implementation of ISCNs in Phase 1 areas. These services will reflect evidence-based criminal justice mental health practices, including enhancements in specialized case-management services and provisions for in-reach into the juvenile and criminal justice setting and diversion services. Payment rates should be established based on those used for similar services in other states and/or reasonable costs. Reasonable and equitable

payment rates will help assure service offerings are driven by consumer need rather than financial expediency. Specific codes that need to be added or enhanced include:

- Intensive criminal justice case management: this would include the ability for the service provider to perform linkage, assessment, monitoring, advocacy, planning for counseling, arrangement of competency restoration if necessary, and liaison with court personnel and attorneys.
- Criminal justice advanced therapy: this code could be retained as at present with the addition of competency restoration as an eligible service under the provisions of this code.
- Criminal justice specialized transportation: additional code for transportation of individuals from jail/court to appointments or the residential facility.

Additional Medicaid Considerations and Recommendations:

- During Phase 1 of the ISCN roll-out, the question of how to best finance services to ensure successful implementation will arise. Under the state's current Medicaid reform initiative, this would entail establishing risk-adjusted capitation rates to reflect the increased demand and intensity in service delivery at enhanced levels of care. Depending on the availability of accurate and reliable historical data on which to base actuarial estimates, there is a risk of setting the capitation rate too high or too low to achieve optimal client and systems outcomes. As an alternative, it is recommended that the state consider funding services under a fee-for-service structure for the first few years of implementation, or longer if deemed appropriate, to establish capitation rates that are more reliable. Should the state opt to base capitation rates on an initial period of fee-for-service reimbursement, it is not recommended that this period be less than two years as this may be more reflective of factors associated with initial implementation as opposed to more stable patterns of service delivery.
- It is recommended that state develop policies and procedures to suspend, rather than terminate, Medicaid benefits upon incarceration. Although no benefit coverage would be provided during the period of incarceration, suspension would allow continued tracking, facilitate continuity of care, and permit prompt reinstatement of benefits.[9]
- There is little doubt that an enhanced benefit and improved payment rates will increase total Medicaid mental health expenditures for the targeted individuals in the Phase 1 areas, and therefore state general revenue commitments. The additional general revenue cannot come from existing DCF mental health funding since these resources will be needed to pay for services required by Medicaid enrolled individuals that are not paid for by Medicaid (e.g., residential support) and for non-Medicaid enrolled individuals. However, if the state needs to invest in improvements in community-based services to reduce juvenile and criminal justice and forensic facility involvement of individuals with serious mental illness, optimizing the use of Medicaid will reduce general revenue requirements. For this reason, the state should also consider in its discussions with the

[9] It should be noted that Medicaid coverage for many adults with mental illnesses is contingent on active receipt of Social Security benefits. As such, it is equally important that efforts be undertaken to ensure that Social Security benefits be suspended rather terminated upon incarceration.

federal Centers for Medicare and Medicaid Services (CMS), the strategy of increasing income eligibility for targeted individuals to 100% or 150% of the federal poverty level.

- It is recommended that Medicaid immediately implement a focused study to determine the extent to which current behavioral health contractual requirements for Health Maintenance Organizations and Prepaid Mental Health Plans for services to people in the justice system are being implemented. These requirements include linkages to pre-booking sites, access to psychiatric services within 24 hours of release from a jail, and outreach to enrollees who are homeless or at risk of criminal justice system involvement.

Department of Children and Families:

The contracting and funding mechanisms used for DCF mental health funding would remain intact during the first two years of implementation in each of the areas. The number and distribution of services among the cost centers will reflect the local plans with flexibility provided to shift resources so that consumer service plans can be appropriately funded. However, the nature of the entities with which DCF contracts will change. Contracts will be developed between DCF and integrated service provider networks in each of the areas. This mechanism will facilitate coordinated management and service provision.

Integration of Medicaid and DCF Mental Health and Substance Abuse Programs:[10]

To allow the necessary flexibility to maximize resources and serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not currently covered, it is recommended that a funding and management partnership between DCF and AHCA be established. In this way, both Medicaid and general revenue funding can be blended to achieve optimal efficiency in the system.

Under this recommendation, Medicaid purchasing and policy-setting responsibilities for Medicaid adult beneficiaries with SMI and children with SED, including populations involved with or at risk of involvement in the criminal or juvenile justice systems, would be co-managed by the DCF and AHCA. This would provide for the evolution of a well-integrated system of care for those with serious mental illness and involved in multiple systems of care.

The rationale for this recommendation reflects that while DCF is statutorily responsible for serving as the state's public mental health authority, Medicaid has become the principal payer for publicly-financed care. To ensure an effective blending of funding sources, provide cost effective care, and prevent cost shifts, it is essential that the state use a single purchaser and policy-setting authority for those with serious mental illness and high users of multiple systems of care and to ensure an alignment of Medicaid reform and mental health transformation strategies. This recommendation is consistent with Ch. 409.912 (4)(b)(2), F.S. relating to cost-effective purchasing of health care services which mandated that:

> By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy,

[10] Please see Appendix A for additional details relating to this proposal.

budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

It is recommended that this agreement be reviewed and amended as necessary.

Integrated Specialty Care Networks:

Each AHCA area will develop an Integrated Specialty Care Network (ISCN) having the capacity to provide comprehensive services and supports needed by the target population, including primary medical and acute care services. These services will be developed or revised so that they reflect consumer needs and service plans and the evidence-based practices for criminal justice/mental health consumers. Provider's offerings will be organized and coordinated so that service capacity is fully utilized and redundancy is minimized. Local communication and information systems will assure consumer care is coordinated when more than one provider is involved.

In order to participate in ISCN(s), providers must demonstrate that they are capable of providing high quality services that employ evidence-based practices in a way in that is efficient, effective, and accountable. Providers will be required to demonstrate established relationships with local juvenile and criminal justice systems and stakeholders in the community to facilitate a seamless continuum of care across systems. Providers will also be required to offer a comprehensive array of services and supports including interventions that focus on co-occurring disorders, trauma, and histories of justice system and institutional involvement, as well as assistance in accessing housing, employment, entitlement benefits, transportation and other necessary services.

Provider contracts under ISCNs will also incorporate measurable outcomes and include specifications for enhanced integration and responsiveness of services delivery, including:[11]

- For individuals re-entering the community from jails, prisons, or state hospitals:
    - Provider to make contact with consumer well in advance of release/discharge to the community and to be actively involved in discharge and transition planning processes. Ideally, initial contact should be made as early as possible within 90 days of release/discharge.
    - Provider to arrange face-to-face visit with consumer within 24-72 hours of release/discharge to the community. At a minimum, this contact should entail review of the individuals discharge plan with particular attention paid to current living arrangements, community supports, and access to medications.
    - Provider to complete face-to-face, comprehensive intake evaluation within 7 days of release/discharge to the community.
- For individuals living in the community who experience acute exacerbation of symptoms requiring admission to inpatient crisis services:

[11] Provider will obtain necessary consent and release of information forms where appropriate.

- Provider to make contact with staff (and consumer if possible) at crisis unit within 24 hours of notification of admission to discuss current medications, treatment history, current symptoms, and discharge planning needs.
- Provider to maintain daily contact with staff at inpatient facility throughout the duration of consumer's inpatient stay.
- To the extent practical, provider perform face to face visit with consumer at inpatient facility within 72 hours of notification of admission and at least semiweekly thereafter throughout the duration of consumer's inpatient stay. In the event that consumer is admitted to a facility outside of the provider's immediate geographic area, contact will be made by telephone.
- As appropriate, provider to contact consumer's primary family/social support to engage in discharge planning.
- As appropriate, provider to participate in case staffing at the inpatient facility.
- Provider to be actively involved in discharge and transition planning processes.
- Provider to arrange face-to-face visit with consumer within 24-72 hours of discharge to the community. At a minimum, this contact should entail review of the individuals discharge plan with particular attention paid to current living arrangements, community supports, and access to medications.
- Provider to complete face-to-face, evaluation within 7 days of release/discharge to the community.
- Provider to complete audit of consumer's compliance/engagement in treatment and functioning in the community prior to hospitalization. Based on results of audit, work with treatment/support-services providers, consumer, and family to identify triggers and early warning signs related to acute-care episode, and revise crisis treatment plan as necessary.

The Statewide Leadership Group with the participation of DCF and AHCA will review provider networks and service offerings of individual providers to ensure the use of evidence-based practices. These reviews will be done prior to the systems becoming live and annually thereafter. The Statewide Leadership Group will certify local communities, the networks and their individual providers indicating they are criminal justice/mental health competent. Providers will not be eligible to bill for services under the revised Medicaid HCBS fee-for-service system or for enhanced DCF funded services until they achieve this certification.

Each provider network will be managed by an existing or newly-created area administrative services organization (ASO). The ASO's primary functions will include the following:

- Service management (utilization management-making sure that people get the right service in the right amount at the right time) and coordination between MH/CJ systems;
- Service improvement (quality improvement) and development of best and promising practices.
- Contracting and contract management.

- Administrative services (data collection and outcome measurement).

The ASO will contract DCF mental health funds to network providers for the delivery of services to non-Medicaid enrolled consumers and for services not paid for by Medicaid for Medicaid enrolled clients. In addition network providers will report Medicaid billings to the ASO so that there is a complete accounting of service delivery for each consumer in the target population. The ASO will facilitate the coordination and integration of services and produce utilization, performance, quality and other reports for the Leadership group.

The Leadership Group will establish standards and monitor the ASO's and their provider networks by virtue of its relationship with the SAMH Corporation. Standards will include governance (including role of primary consumers of services), financial management, service access and coordination, information reporting and performance standard requirements.

Conversion to Capitation Contracts and Organizational Considerations:

Assuming the state opts to fund services under a fee-for-service mechanism initially with later conversion to capitation contracts: Funds will flow through fee-for-service mechanisms to each area as described above for at least two full fiscal years of operation. During this time new and improved DCF funded services will have been fully implemented and costs annualized. Medicaid revenue will have increased as a result of the enhanced fee-for-service benefits and cost-based payment rates. Although system improvements will require increased funding in the early years it is assumed that the Legislature will want to stabilize its liability in the out years. Therefore, beginning in year three in each area, combined DCF and Medicaid risk-based capitation or case rate contracts will be implemented. Subsequent changes in funding in these areas will only reflect changes in the number of individuals served and/or approved adjustments for inflation. A schedule of the incremental change in contracting process is presented in Table 3, which should be viewed in tandem with the implementation schedule described in Table 1

Table 3. Schedule of Conversion to Risk Base Contracts

Phase	Conversion to Risk-Based Contracts
1	July 1, 2010
2	July 1, 2012
3	July 1, 2014

The phase-in approach to service development and enhancement obviously makes areas ready for capitation contracts at different points in time. When these points arrive in each area there will have been an integrated provider network in place providing and managing care in the fee-for-service environment for two full years. Assuming performance has been adequate, this would logically lead to the development of capitation agreements with these organizations as they enter their third year of operations. In the long term, this would create 11 separate publicly funded (through AHCA and DCF) entities managing the care of adults involved in or at risk of becoming involved in the justice system. Although it could be argued that is not the most efficient organizational outcome, it is consistent with Florida's long history emphasizing local

control and management of health and human services. A summary of the short- and long-term contracting process are described in Figure 8.

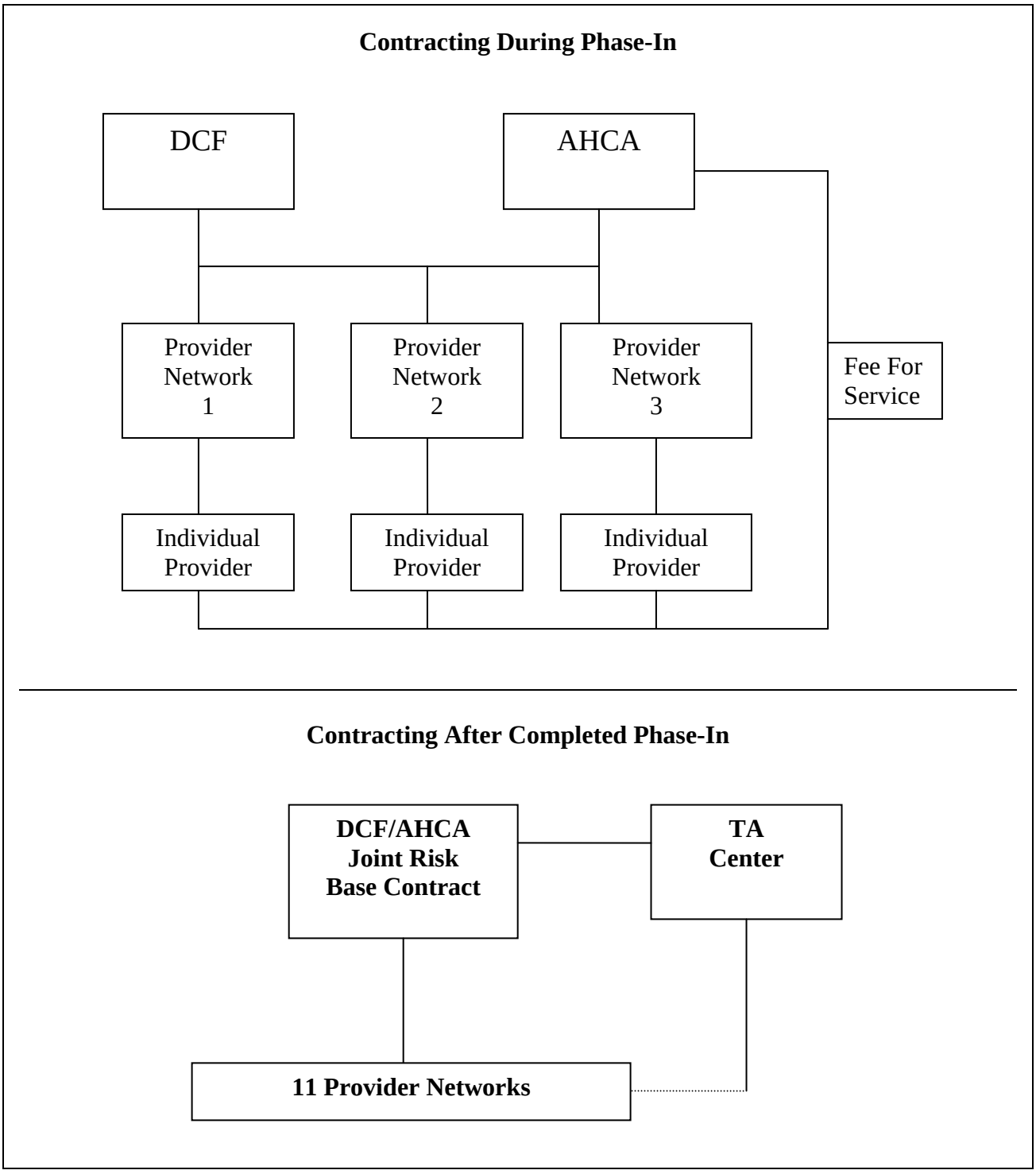


Figure 8. Contracting during and after phase-in process

Phase out of the Leadership Group:

Leadership and management functions are added to the responsibilities of the SAMH Corporation and the TA Center at FMHI to facilitate the phase in process of area programs and services previously described. As DCF and the AHCA finalize capitation contracts with area networks these functions will gradually diminish leaving the Criminal Justice/Mental Health Technical Assistance Center and the SAMH Corporation Policy Council to operate as described in HB 1477 by July 2014.

Reinvestment and Financial Incentives:

Some of the services and supports initially funded by DCF and Medicaid may, over the long-term, be supportable by other federal, state or local sources (e.g. HUD for housing) reducing the need for state resources for routine program operations. In addition, as efficiency of service provision improves over time, the ASO's may begin to produce operating surpluses. These surpluses should be maintained by the ASO's to assure organizational and financial stability. Funds in excess of the amounts required for these purposes should be reinvested in prevention and/or early intervention programs that improve the lives of all Floridians.

Data Recommendations:

The strategies that we propose require collaboration between many local agencies, between localities and the state, and between state agencies. Implementing and assessing the impact of these collaborative strategies requires the availability of good data. Data are essential for at least three reasons:

- First, data must be shared between agencies to assure adequate care to individuals who often cross agency lines.
- Second, data must be collected to enable localities to target populations for interventions funded by these initiatives.
- Third, local and state data must be available to analyze the impact of these initiatives.

Given the central role of data, we recommend the following:

1. Data templates should be developed to guide localities in collecting uniform data relevant to clinical care, planning, and program evaluation.
2. Model data-sharing agreements should be developed to enable localities to share data across systems and to assure that mistaken notions about confidentiality laws do not create barriers to appropriate data sharing.
3. Appropriate funding should be available to assure that local and state data can be integrated and analyzed to determine the effectiveness of local interventions.
4. The current role of the Florida Mental Health Institute makes it the appropriate entity to be charged with overall responsibility for carrying out these recommendations.

Part 3: A Guide for Local Planning and the Development of Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Systems

Background:

By making comprehensive, individualized mental health and substance abuse services available, appropriate, and readily accessible, the likelihood of individuals with SMI/SED becoming involved with the justice system will be substantially reduced. Untreated mental illnesses contribute to poor self-care, disorganized behaviors, and occasionally to violence and public safety concerns. Untreated mental illnesses are also associated with a significant increase in the risk of homelessness and high rates of substance abuse. All these factors lead to an increased likelihood of engagement with law enforcement and the initiation of involvement with the justice system. The current fragmented and under-resourced community mental health system in Florida is unable to provide even reasonably adequate mental health services to many citizens. As such, programs designed to divert individuals with SMI/SED from the justice system into community-based care will be of little consequence if adequate and appropriate services are not available.

For this reason, during each of the phase-in period of the proposed initiative, plans for service retooling and expansion must be developed. Although these plans must be the product of local community needs, they must also be guided by a common vision of the types of services and supports that are demonstrated to be effective and efficient. The process for creating service plans must include providers, law enforcement, local government, the judiciary, consumers, and family members. The Criminal Justice Mental Health and Substance Abuse Technical Assistance Center at the Florida Mental Health Institute (FMHI) will provide the data analysis, consultation, and hands-on assistance needed for the development of these plans.

While the needs of each community will be different, potentially producing significantly different priorities and objectives, the efforts of each community must be guided by a common vision and current knowledge regarding evidence-based and promising practices. The purpose of this section is to suggest the outlines of this vision and to describe some of the principles and practices that should be considered in the area planning and budgeting process.

Guiding Vision:

It has been four years since the publication of Achieving the Promise, the report from the President's New Freedom Commission on Mental Health recommending the transformation of the nation's public mental health system. It is the most important mental health policy document of the last 25 years and has been the catalyst for systems improvement activities throughout the country. The Commission assessed the current mental health system as "fragmented and in disarray leading to unnecessary and costly disability, homelessness, school failures and incarceration" and recommended fundamentally transforming service delivery based on a vision of recovery (New Freedom Commission on Mental health, 2003). The Commission's Report and the documents of its subcommittees provide valuable guidance for translating the vision of recovery into policies and practices.

Moving from more traditional and limiting views of mental illness to the recovery vision described by the New Freedom Commission requires clear articulation of the vision and supportive policies and practices (New Freedom Commission on Mental Health, 2003; TAPA Center for Jail Diversion, 2003). The Council of State Governments' Criminal Justice/Mental Health Consensus Project Report (2002) provides useful guidance. It is designed to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses that come into contact with the criminal justice system. The Consensus Project Report was written by Justice Center staff and representatives of leading criminal justice and mental health organizations and emphasizes that a comprehensive and efficient mental health system will result in fewer individuals inappropriately and avoidably coming into contact with the justice system.

Statement on Co-Occurring Mental Health and Substance Use Disorders:

Development of a comprehensive and competent system of care serving individuals with SMI/SED, particularly those involved in the criminal or juvenile justice systems, requires that equally prominent attention be given to the integrated treatment of co-occurring substance use disorders. Among individuals with SMI in the community, the prevalence of such co-occurring disorders (COD) is between 25 and 50 percent (Regier, Farmer, Rae, Locke, Keith, Judd, & Goodwin, 1990). Among individuals in the justice system, the prevalence of COD increases to roughly 72 percent among adults with SMI (Abram & Teplin, 1991) and 60 percent among youth with SED (Skowyra & Cocozza, 2007).

In traditional service systems, individuals with COD are often referred to parallel, but disconnected, sources of care. This results in increased barriers to accessing both mental health and substance abuse treatment services. In some cases, symptoms of mental illness may be discounted or regarded as secondary to the effects of substance use disorders. In other cases, individuals may be deemed too psychiatrically impaired to participate in traditional substance abuse treatment or too disruptive to the treatment setting. The burden of navigating such fragmented and discontinuous systems, which are frequently based on differing philosophies regarding treatment and recovery, is often counterproductive and results in poorer rates of follow through and lack of compliance with needed services. Consequently, many individuals with co-occurring disorders are labeled as *treatment resistant* when in reality it is the disconnectedness of the systems of care that are resistant to unique needs of the client (Steadman, 2007). This observation becomes even more significant in the context of people with histories of justice system involvement, as these individuals often experience additional difficulties in accessing and engaging services.

A comprehensive and competent system of care requires that treatment be provided across an integrated, coordinated, and client-centered continuum of care. As such, it is imperative that communities implement service planning and delivery strategies that are informed about and responsive to the unique clinical and social needs of individuals who experience COD, particularly for those involved in or at risk of becoming involved in the justice system.

Listed in Table 4 below are nine system characteristics identified in the Consensus Project Report that should be incorporated into the development of local plans and LBR's.

Table 4.

Characteristic:	Description:	Florida Examples:
Use of Evidenced-Based Practices	Promote the use of evidenced-based practices and promising approaches in mental health treatment, services, administration and funding.	• ACT Model of case management
Integration of Services	Initiate and maintain partnerships between mental health and other relevant systems to promote access to the full range of services and supports, to ensure continuity of care, and to reduce duplication of services.	• Transformation Working Group led by the SAMH Corporation includes a broad range of state agencies and focuses on issues specific to the mental health system
Co-Occurring Disorders Treatment	Promote system and services integration for co-occurring mental health and substance use disorders.	• Comprehensive, Continuous, Integrated System of Care (CCISC) model activities in District 11, 14, and the Suncoast Region
Housing Initiatives	Develop and enhance housing resources that are linked to appropriate levels of mental health supports and services.	• Florida Supportive Housing Resource Map to Services (including strategic plan) • Florida's Supportive Housing Coalition
Consumer and Family Member Involvement	Involve consumers and families in mental health planning and service delivery.	• Florida NAMI • Florida Peer Network
Cultural Competency	Ensure that racial, cultural, and ethnic minorities receive mental health services that are appropriate for their needs.	
Workforce Initiatives	Determine the adequacy of the current mental health workforce to meet the needs of system's consumers.	• Florida Council for Community Mental Health and the Substance Abuse Mental Health Corporation has conducted meetings on this critical issue

Characteristic:	Description:	Florida Examples:
System Accountability	Establish and utilize performance measures to promote accountability among systems administrators, funders, and providers.	• DCF Dashboard • Recovery Oriented Systems Indictors (ROSI)
Advocacy	Build awareness of the need for high quality comprehensive services and of the impact of stigma and discriminatory policies on access to them.	• Florida Partners in Crisis • Florida NAMI • Florida's chapter of Mental Health America

Acute care – The pivotal system issue:

Florida's law enforcement officers and courts are increasingly knowledgeable of and sensitive to issues surrounding mental illnesses and are likewise increasingly inclined to divert people with mental illnesses from the justice system to the mental health system. However, the capacity of facility-based mental health resources to accept people in crisis for appropriate treatment in lieu of incarceration is steadily diminishing. What's more, the capacity of Florida's mental health system to provide less restrictive and less costly non facility-based crisis services to people who do not strictly meet the legal criteria of danger to self or others because of mental illness is grossly inadequate.

Increase in Baker Act Involuntary Examinations:

When a mental health professional or law enforcement officer believes a person may be an imminent danger to self or others because of mental illness the person may be taken to a receiving facility (designated community hospital or crisis stabilization unit) for an emergency examination and subsequent treatment if authorized.

- There were at least 82,759 people with Baker Act involuntary examinations initiated in 2005.
- Twenty percent of these people had more than one involuntary exam initiated in 2005 (range 2 to 32).
- Between 2001 and 2005, the increase in involuntary examinations substantially exceeded population growth. Total involuntary examinations increased 35.2% while total population increased 9.4%. The number of involuntary examinations for children 4 through 17 increased 32.5% during this time period in contrast to 7.8% population growth for this group (Christy & McCranie, 2006).

Reduced Capacity of Facility-Based Care:

The number of licensed hospital psychiatric beds in Florida has decreased from 6,467 in 1994 to 4,014 in 2006. This is a drop from 45.8 beds per 100,000 total population in 1994 to 21.8 beds per total 100,000 population in 2006. Managed care, greater private insurance limitations on mental health benefits, reductions in Medicare payments for psychiatry, and higher profitability for other services, such as cardiac care, are driving the reduction in community hospital psychiatric bed capacity. With one in four of Floridians without any form of insurance coverage, these hospitals carry a substantial load of uncompensated care, including care for psychiatric services. As the number of facilities and beds decline, there are increasingly fewer potential resources for people in crisis as well as fewer portals available to law enforcement officers and people seeking care.

Crisis stabilization units (CSU) and Short Term Residential Treatment (SRT) units are acute care facilities operated by non-profit community mental health centers contracted to the Department of Children and Families. Florida pioneered the crisis stabilization model in the 1970's as a public cost containment and least restrictive treatment model. They are licensed under Chapter 394, F.S. and operate for about $282 per bed per day. DCF funded crisis stabilization and short-term residential treatment facility bed capacity increased from 1,102 in 1999 to 1,314 in 2006, just 62 more beds than needed to keep pace with population growth alone. Crisis stabilization units routinely run at or near capacity.

State Psychiatric Hospital bed capacity available for civil patients has decreased from 1,926 in 1997 to 921 in 2007, placing greater pressure on community-based facilities.

Florida Must Ensure that Maximum Value is Received for Facility-Based Acute Purchased by the State:

Increased use of managed care by Medicaid and commercial insurers has steadily reduced stays in these facilities to a point that many observers believe there is a minimal amount of time to achieve therapeutic gains necessary to release individuals back to the community. Although inpatient care is provided in licensed and accredited hospitals as well as in crisis stabilization units that are licensed and operated by accredited mental health organizations, there is no assurance that these entities use clinical pathways that maximize therapeutic gains in the time that is available. Since these services represent the most expensive unit of care purchased by the state, it is important to ensure that as much value is received as possible.

Inflation is Outpacing the Department's Buying Power:

The Department of Children and Families primarily purchases acute care from crisis stabilization units and short-term residential treatment facilities. The Department's payments for this service largely come from the Adult Baker Act funding category, which in fiscal year 2007-08 was $62 million, up from $49 million in 2000-01. Services at crisis units must be provided to anyone who presents regardless of their ability to pay. Crisis units are required to attempt to collect fees and third-party payments. Medicare does not pay for crisis stabilization unit services.

> $49M in Adult Baker Act funds in 2000 inflated forward for medical increases of approximately 4% is $63M in 2006. At the same time Florida's population increased by 13% during this same period. Given the increase in CSU bed capacity over this period, it is clear that funding for other community mental health services, such as case management, are being redirected to shore up crisis stabilization capacity.

In 2004, the Medicaid fee-for-service program purchased 105,366 inpatient psychiatric days in general hospitals at an average daily rate of $1,390 per day plus physician charges. The number and dollar value of days purchased by Medicaid HMOs and Prepaid Mental Health plans was in addition to this amount.

In many Florida communities, the acute care system is a patchwork of unrelated and often competing hospitals and crisis stabilization units. From the consumer and family's standpoint it can be a bewildering and hostile environment. Florida's Baker Act requires an officer who observes a person who appears to meet the legal criteria for an emergency evaluation (danger to self or others) to take the person to the nearest hospital or crisis unit authorized to accept people involuntarily.

This means law enforcement may take someone to a facility without vacancies, resulting in "wave offs" for officers, waits in emergency rooms and trauma for consumers. It may mean an individual ends up in a facility that doesn't have a contract with his payer or is not the facility preferred by the consumer.

What's more, a fragmented system does not ensure that an individual who does not strictly meet Baker Act criteria and is determined to not require inpatient level of care has immediate access to other available less intensive levels of crisis care appropriate to his needs. In such instances, individuals may be released to the street or placed on a long wait list for outpatient intervention when urgent but not emergency care is needed. A precipitous release back to the streets with no immediate and concrete assistance in stabilizing the situation can result in frustration by officers with a revolving door situation and inappropriate admissions to jails. It can result in an exacerbation of an individual's condition so that he soon does meet Baker Act criteria.

THE SOLUTIONS: BUILDING ON WHAT WE KNOW WORKS

Centralized Acute Care Referral Systems:

The centralized acute care system was originally developed in Hillsborough County Florida and now operates in several other communities including Orange and Pinellas Counties. In Hillsborough, leadership from the Department of Children and Families brought together a public/private partnership composed of county behavioral health systems, mental health and substance abuse providers, insurers, law enforcement, courts, state attorneys and public defenders, public and private hospitals, and Medicaid. These stakeholders through a series of scheduled meetings, data sharing and mutual agreements established an organized system of acute care in which the crisis stabilization unit operated by Mental Health Care, a Tampa based community mental health center, served as the central receiving facility where people are

brought for emergency evaluation. Under a centralized arrangement there is increased capacity for:

- Law enforcement officers to know where to take someone for evaluation.
- Efficient and prompt mental health evaluations without the wait time for officers frequently associated with busy emergency rooms.
- Linkages to a variety of programs and community resources that can lessen need for costly facility-based care. These linkages would be difficult to replicate at every hospital and receiving facility in the community but can be effectively coordinated centrally.
- Assistance for consumers in accessing the hospital or crisis unit that accepts payment from their insurance carrier and which has immediate vacancies.
- Provision of explicit medical clearance standards that are agreed to by all participating entities. This prevents the need for unnecessary transfers among facilities due to medical conditions.
- Facilitation of equitable and transparent distribution of consumers with third-party coverage among local facilities as well as equitable distributions of consumers without coverage when crisis stabilization units are at full capacity.
- Provision of a focus for Pre and Post booking treatment services with jails, public defenders, and State Attorneys
- Creation of synergies between programs working in concert to achieve positive outcomes for consumers.

Similarly, in Orange County, the Central Receiving Center (CRC) was established as the single point of entry by law enforcement officers for those experiencing mental health and/or substance abuse crises who require emergency evaluation. The CRC has achieved many of the same outcomes as the Hillsborough model and has helped to improve the utilization of limited crisis beds and increase service capacity. The CRC also has a formalized cross-systems governing board for oversight and planning and an operational group among the providers that manages the day to day functions.

In rural areas where there is a less complex delivery system a formal central receiving facility may be impractical. However, there are alternatives that build on the strengths of the centralized system concept. For example, in Pasco County the local CSU operates a Baker Act coordination center that operates on a 24-hour/7 day per week basis. When a person is brought in under the Baker Act law enforcement or hospital emergency rooms contact the center. The center keeps track of facilities' censuses, insurance payers, licensed/clinical capacities, and can direct the officer to the appropriate facility, reducing unnecessary waiting and delays in care.

Use of Defined Clinical Pathways to Optimize Value of Services Received in Facility-Based Acute Care Settings Purchased by the State:

The Department and the Agency for Health Care Administration should work with Medicaid plans and contracting facilities to establish clinical pathways that reflect efficient and effective practice. The state should work in concert with these entities by establishing a practice improvement initiative that will achieve this goal. Non-contracting facilities in Florida should be invited to participate in the initiative. (For example see attached algorithm in Appendix B from Glick and Tandon, The Acute Crisis Stabilization Unit for Adults, 2007).

Expanded acute care capacity:

There is not a credible needs formula that can determine the correct mix of acute/crisis care mental health services needed in a given community. However, it is clear from the figures cited above that a very large proportion of public acute care resources go into facility-based care and that considerably more could be justified. However, because of the high cost of hospitals, crisis stabilization units and short-term residential treatment facilities, the use of medical facility-based crisis care should be considered a last resort. Likewise, from a clinical perspective, a wider range of crisis services appropriate to individuals who do not immediately meet Baker Act criteria could prevent exacerbation of crises that often involve law enforcement.

There are a number of less restrictive and less expensive programmatic alternatives to facility-based acute care that have been used successfully in other states, countries and in some communities in Florida. Wider access to these types of care is desirable for the following reasons:

- Research has shown that they can be more cost effective than facility-based care for some people.
- Access to less restrictive but appropriate crisis care results in less trauma to consumers and therefore to more rapid stabilization.
- Alternative models can more easily be employed in rural underserved areas or areas that cannot support costly facility-based care.
- Such models do not require the fixed capital outlay of facility-based services.

There is a very wide range of alternatives to facility-based care that could prove useful in a given community. Within each of these alternatives there is wide variation in how programs with the same label are staffed and operated. Table 5 identifies community-based treatment models which have been shown to be effective and efficient and should be considered as communities develop plans for improving their acute care systems.

Table 5.

Intervention Model:	Description:
Mobile Crisis Teams	These are teams of medical and mental health professionals that can effectively include peer counselors as team members. A team provides rapid response, generally within several hours. A team may operate 24/7 or only during periods of peak demand. Teams can respond to calls for assistance from law enforcement, emergency rooms, shelters or individuals in crisis who need immediate assistance in their homes or at other places in the community. Teams may provide a one-time response with referral or more sustained services and supports over a period of weeks. By providing an immediate assessment a more accurate picture of a person's situation may be obtained and in 30% to 50% of the time, more intensive care can be averted.
Residential Crisis Respite Services	Services are provided to people in crisis in a small, homelike setting open 24/7 generally with 5 to 8 beds. Individuals who are not considered to be a danger to themselves or others generally access these services on a voluntary basis. The home provides housing, meals and short-term acute treatment and support services intended to resolve an immediate crisis and prevent hospitalizations or CSU admissions. Residents leave the home during the day for treatment and socialization and return in the evening. Stays are generally brief, 5 to 7 days, and followed by more sustained ambulatory care. Staffing may consist of one worker on day shift and two workers on the other two shifts. Programs in Nassau and Clay counties, Florida, are currently testing the model. Preliminary data from Nassau County indicates that this program has significantly reduced CSU admissions and reduced the necessity for law enforcement to transport people to Jacksonville. The cost of the program is about two thirds that of a crisis stabilization unit but could be reduced if the facility was not free standing. Crisis services can also be provided to individuals in the homes of families that are specially trained in crisis support services. District 8 Mental Health Program Office has been supporting this model of care for a number of years and currently has 50 individuals in care, about 10 of whom are in forensic status. The individuals receive services through mental health providers. The cost for the home setting is less than $50 per day.

Intervention Model:	Description:
Family Emergency Treatment Centers	These programs are urgent mental health care walk-in facilities that serve people who are in crisis but do not appear to immediately meet Baker Act criteria. They provide crisis intervention services that include medication, counseling and access to supports as well as a bridge to people awaiting treatment at local mental health facilities. For example, In Pinellas County this program is operated by Personal Enrichment Through Mental Health Services (PEMHS), which also operates the local CSU. The program receives referrals from a forensic outreach program serving some jail releases, a mobile crisis team and other programs.
Living Room	A living room is a quiet and pleasant room that may be co located with a CSU. It is a setting where people who present at a CSU for screening and who are not actively violent or suicidal or experiencing acute psychosis can get needed crisis intervention from professionals and trained peer counselors as well as medications and medical interventions. The living room service can deescalate crises and prevent deeper penetration into the acute care system. Such a program is currently operating in Pasco County and has been used in Arizona by Value Options, which operates Medicaid Prepaid Mental Health plans in Florida.
Psychiatric Advance Directives	A psychiatric advance directive is a document that is developed by an individual, with assistance from a mental health worker, if needed, that permits the person to decide in advance how they would like to be treated should a crisis occur. It may include preferences about medications, restraint and seclusion, the locus of treatment, and who to contact about care of their household. Research suggests that this device can reduce involuntary admission into acute care and may be a useful method for improving the course of treatment. It can also have the effect of making the treatment process more friendly and responsive for the consumer.
Telemedicine	Lack of timely access to physician/psychiatrist services is especially problematic in providing acute/crisis care in underserved areas. Telemedicine is currently billable under Medicaid in at least half the states. Florida Medicaid should permit codes for medication management and psychiatric evaluation by a physician to be provided through telemedicine where justifiable due to staffing shortages. Likewise, the Department should amend its cost center structure to explicitly support telemedicine within the limits noted.

The variety of acute care options described above should be incorporated into the Home and Community Based Services recommended for the target population should be compensated by the DCF contracting and payment system.

Evidence-Based Psychotherapeutic Medication Practices:

A range of psychotherapeutic medications (antipsychotics, antidepressants, mood stabilizers, etc.) are currently available for the effective treatment of major psychiatric disorders. In conjunction with psychotherapeutic and social support services, appropriate utilization of psychotherapeutic medications can significantly enhance individual recovery from mental illness and reduce the likelihood of justice system involvement or recidivism. Despite evidence-based standards of medication use, however, there is wide variation in patterns of psychotherapeutic medication use and frequent deviation from recommended best practice. The Medicaid Drug Therapy Management Program (MDTMP) currently funded by AHCA is designed to address these issues. The program periodically reviews and updates evidence based guidelines for the psychotherapeutic treatment of major mental illnesses. Pharmacy utilization indicators are derived from these guidelines and applied to pharmacy claims and service events in order to identify patients whose prescriptions appear to be inconsistent with evidence based medicine and their associated physicians. A hierarchy of interventions to address discrepancies between actual practices and best practices are applied to physicians whose prescriptions frequently deviate from evidence-based guidelines. These interventions include a variety of educational activities, mailings suggesting that prescription be re-evaluated, peer-to-peer telephone consultation, academic detailing and medical records reviews.

The MDTMP will increase the scope and intensity of its activities in AHCA areas as the phase in of CJ/MH programs proceeds. Analysis of physician prescribing behavior will be organized by provider network and interventions will be mounted in collaboration with the administrative service organizations in these areas. Every effort will be made to assure that individuals in the target population are receiving the right medication in the right dose and at the appropriate time. Deviations from evidence-based practices will be carefully scrutinized to assure they are in the best interests of the consumer. In addition, the program will monitor adherence with medication regimens and potential interactions between mental health and general medical medications and ensure treating physicians are appropriately advised.

In the development of local plans and budgets two issues related to psychotherapeutic medications are critical. First, the criminal justice and mental health organizations servicing the areas must ensure continuity of medications as individuals move from one component of the community to another. Developing a common formulary, using common medication treatment guidelines and communicating information across jurisdictions can accomplish this (For example from jail to community providers). The Leadership Group will assure that the institutional system is involved in this development so there is continuity in medications from forensic hospitals and the correctional systems to the community.

Second, Medicaid enrollees have reasonable access to a range of psychotherapeutic medications. However, the DCF appropriation category funding medications for individuals in the target population that are not Medicaid enrolled is woefully inadequate at $6.7M. Additional funding will be required to assure access to the appropriate medications for these individuals. Local planning and budgeting must address both of these issues, ensuring that medications do not have to be prescribed or switched based on availability rather than need.

Evidence-Based Supported Housing Practices:

People with disabilities, particularly individuals with mental illnesses, have high risk factors for homelessness. The FY 2002 Annual Report on Homeless Coalitions in Florida identified that 25.5 percent of individuals who are homeless had a mental health disorder.

Supportive housing has been documented as a critical intervention for persons with mental illnesses who are homeless or at risk of becoming homeless. Studies have demonstrated that people with disabilities who moved to permanent housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated (Florida Supportive Housing Coalition, 2004).

Most permanent supportive housing programs provide some type of case management and housing support, but also a broad array of services that can best match the needs of the individual, including mental health and substance abuse services, vocational/employment services, and life skills training/support (e.g., budgeting). All of the services can be delivered on-site and are designed with the goal of ensuring successful community functioning. These services can play a vital role in diverting people from emergency rooms, crisis care settings, long-term psychiatric care, nursing facilities, and the justice system.

In June 2003, the Department of Children and Families published Florida's Strategic Plan for Supportive Housing for Persons with Mental Illnesses. The plan was developed by a partnership of key stakeholders from throughout the state. It provides descriptions of strategies and implementation tasks in relationship to six key goals. However, to date, it has only been partially implemented. The plan provides a useful guide for implementing supportive housing, specific to the needs of mental health consumers in Florida and should be revisited by policy makers. If fully implemented, it can serve as the cornerstone for implementing effective supportive housing policies and practices.

In an effort to further develop housing resources for the target population, the Statewide Leadership Group recommended under this CJ/MH initiative should work with the Florida Housing Finance Corporation communicate the housing needs of individuals with SMI/SED and explore options for creating: 1) a Rental Assistance Program and 2) an Economic Development Housing Initiative that produces affordable housing for persons who are disabled or on SSI.

Case Management: The Glue Binding the Elements of Consumer Service Plans:

Individuals with SMI/SED often lack the wherewithal to access needed services and supports even when they are available in their communities. As a result they often languish in isolation only to emerge when symptoms and behaviors bring them to the attention of law enforcement. Case management is the key to reducing this isolation and assuring appropriate access to services. Key case management activities include planning, linking, monitoring, and advocacy. In more intensive models, direct services are provided. A variety of case management models are currently implemented throughout Florida, including brokered approaches that refer consumers to needed services, intensive case management that provides a range of direct services, and Assertive Community Treatment (ACT) that provides a comprehensive array of

services to the person in the community on a 24 hour basis. Case managers in each of these models provide an important interface between the mental health and justice system.

Rapp and Goscha (2004), in an important synthesis of case management research, identified ten principles or active ingredients of case management that are common to interventions that produced statistically positive outcomes for people with serious psychiatric disabilities. These ingredients are based on a comprehensive review of the research that focused on common denominators of case management interventions that produced statistically significant positive outcomes. This report examined 21 key studies and focused only on research that implemented a random assignment or a quasi-experimental research design. Brokered model studies were excluded because only two of the nine studies found any positive findings.

It is highly likely that all individuals with a SMI will require case management services. Local area plans must address this need focusing on the active ingredients described below. For individuals already involved in the justice system there are specialized case management services that are described in the last section of the report.

Active ingredients of effective case management include:[12]

1. Case managers should deliver as much of the "help" or services as possible rather than making referrals to multiple formal services. Direct-services provided as part of an on-going relationship produce the most positive outcomes.
2. Natural community resources are primary partners. Case managers need to establish networks with landlords, employers, ministers, neighbors, teachers, and peers on behalf of the people they serve.
3. Work is in the community rather than an office setting. In-vivo service delivery "removes problems of generalization, minimizes drop-out, enhances engagement and allows for more complete and accurate assessments."
4. Both individual and team case management works. While both approaches are successful, there is general consensus that treatment planning should be conducted by a team and that this type of planning is one of the most critical components of effective case management. The benefits of a team approach include reduced staff burnout, enhanced continuity of care, and more creative service planning.

   Person Centered Planning is critical to ensuring that evidenced based practices are appropriately and effectively implemented (Adams & Grieder, 2005).
5. Case managers have primary responsibility for a person's services. Fragmented responsibility is not consistent with the integrated goals and objectives of case management.
6. Case managers can be paraprofessionals. Supervisors should be experienced and fully credentialed. "The evidence is that case managers can be selected from a wide pool of people but need high quality supervision from seasoned professionals and easy access to medical personnel and other experts"

[12] Adapted from Rapp & Goscha (2004).

7. Caseload size should be small enough to allow for a relatively high frequency of contact. Caseload size needs to be tailored to the needs of consumers and the outcomes or benefits sought by the intervention. Frequency and quality of contact rather than hours of contact are critical.
8. Case management services should be available on an ongoing basis, based on the needs of the individual. Most research strongly suggests that immediate gains can be made with short-term services; many of these gains can be lost without long-term support. However, intensity of services over time should vary based on need.
9. People need access to familiar persons 24 hours a day, 7 days a week. Twenty-four hour case management is not required, but such access to crisis and emergency services is a necessity. The effectiveness of crisis services is enhanced by access to staff who have familiarity with the consumer, such as the case manager.
10. Case manager should foster choice. There is growing body of research suggesting that choice is associated with improved outcomes.

Case management services have generally been available to individuals with a severe mental illness that are enrolled in the Medicaid program although caseloads and payment rates have been inadequate. Continued access to adequate case management services under capitated arrangements should be reviewed. However, a major gap in access to case management services exists for individuals in the target population that have not yet established disability through the Social Security Administration. These are often younger individuals that have not had a sufficient history of disability. Local plans and LBR's must address this gap in order to assure continuity of care for these individuals.

Consumer and Family Education:

If the comprehensive and competent mental health system is recovery oriented and one of its goals is to empower those with an SMI and their families, educational and self-help programs are critical to its success. The Leadership Group will work with the NAMI and in-state peer networks to develop and underwrite the costs of implementing the most effective of these programs so that consumers and family members are able to fully participate in the recovery process.

Assuring Long-Term Assistance to CJ/MH/SA Consumers:

Access to shelter, income and medical and ongoing mental health care can reduce the need for emergency/crisis care. It has been suggested that as many as 25% of people eligible for Medicaid in Florida are not enrolled. Most people with serious mental illnesses become eligible for care by establishing through medical records that they have a serious and long-term disability that prevents them from engaging in substantial gainful employment. The bureaucratic and paper intensive process of establishing medical disability requires considerable persistence and cognitive capacity which represent formidable barriers for many people with a mental illness. Maximizing access to income and medical benefits leverages federal funds. To the extent that someone who is eligible is unable to negotiate this process a person either does without or relies on meager state resources. Florida should invest in a cadre of trained benefits specialists to help

people with mental illness in jails and in acute care initially obtain benefits or get their benefits reinstated promptly on release from a jail. Gap funding should be made available to help support people with serious mental illness while applications are pending. Since income benefits can be retroactive, bridge funds advanced by the state can often be recovered.

Workforce Development:

The development of a comprehensive and competent system of mental health care, built on a foundation of effective evidence-based practices, is contingent on the availability and maintenance of a highly qualified and skilled workforce. A recent report released by the Annapolis Coalition on the Behavioral Health Workforce (2007), identifies workforce issues including difficulties in recruiting and retaining staff, absence of clear career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with scarcely limited resources as raising serious concerns nationwide as to the ability of the public mental health system to deliver quality care.

In their report, *An Action Plan for Behavioral Health Workforce Development* (Annapolis Coalition, 2007), the Coalition suggests:

> The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as these are affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce.
>
> There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. While the incidence of co-occurring mental and addictive disorders among individuals has increased dramatically, most of the workforce lacks the array of skills needed to assess and treat persons with these co-occurring conditions. Training and education programs largely have ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are under-prepared from the moment they complete their training. (p. 1)

As such, the following recommendations are intended to address issues that will promote and sustain a more effective and competent mental health workforce:

- Promote workforce training programs and core curricula standards in the State University System of Florida, the community college system, private colleges and private universities, public schools, and the vocational education system to ensure that individuals pursuing careers in the mental health, substance abuse, behavioral health systems (particularly in the public health system), criminal justice, juvenile justice, and

legal professions possess the knowledge and skills that are necessary to work effectively in various traditional and nontraditional behavioral health settings. Particular emphasis should be placed on the use of evidence-based and promising practices.

- Promote continuing education, such that treatment teams and providers develop and maintain core competencies and skills in current evidence-based practices to effectively serve individuals involved in the CJ system, or at risk of involvement in the CJ system, especially those with histories of trauma/abuse, incarceration, and co-occurring mental health and substance use disorders.
- Identify effective leadership curricula and programs, and develop new training resources to address gaps in prevention and treatment for individuals involved in or at risk of involvement in the justice system.
- Develop workforce resources to serve racial and ethnic communities and individuals in a culturally competent fashion.
- Promote racial, ethnic, and cultural diversity among the workforce, and ensure adequate numbers of well-trained bilingual and bicultural staff.
- Address staffing shortages in rural communities.
- Expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.
- Develop certification for peer specialists.
- Promote the involvement of individuals in recovery in judicial education, law enforcement training (e.g., CIT), and continuing legal education (e.g., training provided by FL Bar Association) around mental illness and substance use disorders.
- Ensure licensure and certification standards for mental health, substance abuse treatment, criminal justice, and juvenile justice professionals address relevant criminal justice/mental health/substance abuse issues.
- Ensure non-licensed, frontline workers receive training adequate training in criminal justice/mental health/substance abuse issues.
- Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.
- Promote the increased availability and use of information technology to support the workforce training and service delivery.
- Ensure that fair, living wage jobs are available for both providers and consumers.
- Provide living wages and benefits to employees, as many mental health and substance abuse treatment professionals are not well compensated, resulting in high turnover, difficulty in recruiting, and sometimes quality and safety problems.

Part 4: A Guide for Developing Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Systems

Background:

All best practices demonstrating positive outcomes for reductions in recidivism and effective diversion from the juvenile and criminal justice systems among individuals involved with or at risk becoming involved with the juvenile or criminal justice system incorporate initiatives that involve multiple stakeholders working together. These stakeholder systems include mental health and substance abuse providers, law enforcement, jails, courts, defense attorneys, prosecutors, prisons, state funding agencies, local funding agencies, hospitals, provider networks, HMO's, social security, social services, families, consumers, housing services, vocational services, educational services and others.

Whereas a comprehensive and effective community mental health system best promotes prevention, ongoing recovery, and community integration, specialized mental health best practices have also been developed to address diversion from the justice system, mental health needs in jails and prisons, community re-entry, and the needs of individuals in the community at high risk of criminal justice involvement.

Community mental health service providers, law enforcement, and jails share the legal responsibility for effective implementation of these specialized services. Their respective and relative roles should be clear with mechanisms in place to effectively coordinate their functions. Also necessary are:

- Joint training on pre- and post-diversion programming.
- Effective screening and assessment for mental health needs of individuals at their first contact with the juvenile or criminal justice systems.
- Delineation of specific responsibilities for the provision of mental health diversion services.
- Improvements in the diagnostic and treatment services provided to individuals remaining in the juvenile or criminal justice system.
- Better coordination of services across agencies.
- Strengthening of pre-release planning to address mental health needs.
- Training and securing the effective involvement of families and consumers.

The Sequential Intercept Model:

Review of the literature has identified several known national best practices for use at various intersect points with the juvenile and criminal justice systems. The Sequential Intercept Model (Munetz & Griffin, 2006) is a suggested framework to consider when addressing what type of programs to initiate and when to use them at the various intercept points.

The sequential intercept model was initially developed to provide a conceptual framework for communities in Ohio to consider the interface between the criminal justice system and mental health systems as they grappled with the problem of the increasing criminalization of mental illness. The model organizes the interface with the justice system at five key points in which there are opportunities to divert individuals from further penetrating into the system or assisting individuals already engaged in the criminal process with improved community linkages that will sustain community living and recovery and reduce recidivism. The objective is to divert completely and early, with the hope that most people could be intercepted early and engaged in appropriate treatment and supports thereby decreasing the numbers at each subsequent point.

In this section we briefly discuss best mental health practices (both evidence-based and promising practices) at each point of intersection between the criminal justice and mental health systems that provides an opportunity for interception and effective diversion. The proximate objective of applying these approaches is appropriate redirection of individuals with mental illnesses from the juvenile or criminal justice system to the mental health system and provision of individually optimized mental health services; the ultimate objective is to optimize individual outcomes while promoting societal safety and the efficient and effective utilization of societal resources.

There are several points at which services can be provided to individuals with SMI/SED to prevent them from entering the justice system or appropriately redirecting them from the different steps in the justice system to the mental health system. If adequate mental health services are available and readily accessible in the community, individuals with SMI/SED are much less likely to engage in behaviors or get into situations that initiate an engagement with law enforcement. If prevention from criminal justice engagement is unsuccessful, there are several opportunities for diversion at several stages of the law enforcement-judicial hearing process. If individuals with a SMI are in jails or prisons because of the severity of their crime, provision of constitutionally adequate institutional mental health services in these correctional settings provides opportunities for reduced future criminal justice involvement. When individuals with SMI/SED are in the process of being released from institutional settings back into the community, provision of various reentry transition programs can substantially improve the process of successful community reintegration and reduce recidivism back to the juvenile or criminal justice system. Finally, once individuals with SMI/SED with a history of prior justice system involvement are back in the community, provision of certain individually optimized evidence-based services can reduce the probability of criminal justice recidivism. *Please see Appendix C for examples of CJ/MH/SA initiatives currently operating in Florida.*

Prevention:

Prevention refers to the process of providing appropriate mental health services to individuals to reduce the likelihood of initial engagement with the juvenile or criminal justice system.

Diversion:

Diversion refers to the process of diverting individuals with severe mental illness and/or co-occurring substance use disorders away from the justice system and into the community mental health system, where they are more appropriately served. Diversion thus entails:

1. Interception: Identification of mental health needs of individuals involved with the justice system as early as possible.
2. Defining alternatives: Negotiating individualized community-based treatment alternatives to incarceration.
3. Linkage to care: Implementing linkages to comprehensive systems of mental and behavioral health care and community supervision consistent with the disposition of the criminal justice contact.

While diversion involves the transfer of an individual from the criminal justice to the mental health pathway which often involves either not filing or dismissing charges in exchange for voluntary agreement to participate in some type of community-based mental health treatment program, the two systems tend to focus on different aspects of the process. Whereas criminal justice professionals emphasize aspects of criminal responsibility and jurisdiction, mental health professionals stress aspects of treatment which is the alternative to incarceration. Both elements are critical and a tight linkage between them is essential to successful diversion. Factors crucial to effective linkage between the two systems include:

- Interagency collaboration at the community level involving traditional and non-traditional stakeholders (with a defined memorandum of understanding regarding inter-agency collaboration and sharing of information).
- Active ongoing engagement.
- Boundary-spanners or staff who bridge the two systems.
- Effective and defined leadership.
- Use of coordinated judicial and behavioral health best practices.
- Cross-trained case managers.

There are two principal categories of diversion defined by the point in criminal justice processing at which diversion occurs. *Pre-booking* diversion refers to the identification of individuals with mental illness and/or co-occurring substance use disorders by police before formal charges are brought and their redirection to the mental health pathway. *Post-booking* diversion refers to the process of identifying and redirecting individuals to the mental health pathway after they have been arrested. Different mental health best practices are critical to the success of diversion efforts at these stages.

Pre-booking diversion:

Pre-booking diversion occurs at the point of contact between individuals with SMI/SED and law enforcement officers in the community and relies heavily on effective interactions between

police and the individual, and between police and community mental health services. Several best practices have been developed to facilitate successful pre-booking diversion. These include:

- *Crisis Intervention Team (CIT) Training*. This is a well-established program that provides specialized training to police officers about identification of and working with individuals with probable mental illness. Although other models of police-based diversion have also been developed, the CIT program is found to result in the lowest arrest rates, high utilization by law enforcement officers, rapid response time, fewer injuries to officers and citizens, and the most frequent diversion to treatment.
- *Centralized Mental Health Screening and Assessment Facility*. This is a model that emphasizes a defined point of crossover and potential hand-off from the law enforcement to the mental health system and has been found to result in enhanced effectiveness and efficiency of diversion from the criminal justice to the mental health system.
- Other *First Responder Training*. Specific programs have been developed to provide police dispatchers and other first responders with tools to evaluate the possibility of mental illness and how to effectively communicate with and respond to individuals with possible mental illnesses.
- Specified operational procedures relating to on-scene assessment, on-scene response, and incident documentation by police officers to incidents with possible mental illness have been found to promote appropriate diversion.
- The availability of an inventory of community mental health service resources that is available to law enforcement officers and a specified diversion algorithm that facilitates appropriate triage and linkage.

Post-booking diversion:

Post-booking diversion occurs after individuals have been arrested and the likelihood of mental illness has been identified. Currently, post-booking diversion is the most prevalent form of diversion of individuals with mental illnesses from the justice system to the mental health pathway. There are several points at which post-booking diversion can occur and these include:

- At or immediately after booking into jail, before the formal filing of charges.
- Pre-trial release from detention, with the condition of participation in treatment.
- Prior to disposition, for example, upon the prosecutor's offer of deferred prosecution.
- At disposition or sentencing and this may include either deferred sentencing or release on probation with conditions which include participation in treatment.
- When at risk of, or following, a violation of probation related to a prior conviction.

As with pre-booking diversion, successful post booking diversion from the criminal justice to the mental health pathway is contingent upon effective interception, linkage to appropriate mental health services, and ongoing close coordination between the two systems. Several evidence-based approaches have been developed to facilitate successful post-booking diversion. These include:

- *Use of Jail Mental Health Screening Tools:* Several screening tools have been developed to assist jails in the identification of individuals with SMI. These include the *Brief Jail Mental Health Screen* (BJMHS; Osher, Scott, Steadman and Robbins, 2004) and the *Correctional Mental Health Screen* (Ford and Trestmen, 2005). These tools have both been endorsed by the National Institute of Justice and been found to be effective in the identification of possible mental illness and the need for further mental health evaluation and services. Appropriate jail personnel must be available and trained to administer screening tools and interpret results.
- *Provision of Adequate Jail Mental Health Services:* Once the need for mental health services among persons in jail are identified a professional assessment must be done to determine what in jail services should be provided if immediate transfer to a primary mental health setting is not appropriate or possible. Coordination between local mental health agencies and the jail are necessary to ensure appropriate care. Ease of information sharing between the two systems is critical to facilitating continuity of care, as is elimination of other barriers.
- *Problem-Solving Courts and Specialized Court Dockets:* Several approaches have been developed to help individuals with mental illnesses to negotiate pretrial issues, adjudication, and the sentencing phases of the justice process and to enable their receipt of necessary mental health and substance abuse treatment services. These include educating prosecutors and defense attorneys about aspects of mental illness and community mental health resources, educating defendants with regard to rights and due process, development of mental health diversion alternatives to prosecution, provision of support and tools to assist defendants with mental illnesses and/or co-occurring substance use disorders with participating in their criminal proceeding (e.g., competency restoration), assisting individuals in complying with terms of pre-trial or post-trial release or probation, and provision of a range of dispositional alternatives and sentencing options for appropriate diversion.

  The *Mental Health Court* approach is the best developed such approach for individuals with SMI/SED and it integrates a number of these elements into a single comprehensive mechanism. There are several kinds of Mental Health Courts and key factors that facilitate their effective and efficient application have been defined. *Drug Courts* have a longer history than mental health courts and have also been found to be effective. Although a combined mental health and drug court approach is uncommon, it has been found to be the most effective approach to successful diversion in view of the common co-occurrence of mental illness and substance use disorders. *See Appendix D for resources on different types of judicial problem-solving interventions.*

Institutional Mental Health Services:

Several evidence-based and promising approaches have been developed to ensure the detection of mental illness and provision of appropriate mental health services to individuals incarcerated in prisons or jails. Some of these approaches include:

- Use of a consistent procedure to screen inmates for mental illness upon admission to state prison or jail facilities and use of standardized referral mechanisms, as appropriate, for follow-up mental health assessment and/or evaluation.
- Use of a defined procedure to develop a comprehensive and individualized mental health service plan based on the results of the assessment and to ensure the timely provision of recommended mental health services.
- Providing specialized training about mental illnesses and co-occurring substance use disorders to correctional staff regarding signs and symptoms of mental illness to facilitate earlier and more efficient identification of inmates with mental illnesses and behavioral management techniques to minimize disruptive behaviors and facilitate crisis intervention.
- Ensuring the provision of appropriate mental health services consistent with community and institutional standards and best practice.
- Revising standards and procedures in state forensic mental health systems to ensure the efficient and appropriate use of this expensive resource:
    - Developing standardized forensic evaluation procedures.
    - Developing community alternatives for competency restoration and placement of individuals adjudicated incompetent to proceed to trial or not guilty by reason of insanity (NGI).

Community Re-entry:

Several promising state and local approaches have been developed that facilitate the successful re-integration of individuals with SMI/SED back into the community upon release from jails or prisons. These include:

- Screening for active mental health benefits at the time of incarceration to ensure that benefits are reinstated upon release.
- Suspending rather than terminating entitlement benefits such as Social Security or Medicaid.
- Utilizing a systematic approach to pre-release planning that includes construction of and linkage to a comprehensive individualized service plan, and establishment of transition teams and community collaborations towards this end.
- Providing assistance to inmates in complete applications necessary to access benefits and services, and arrange expedited review and processing of these applications. In this regard, the use of the web-based application process has proven to be efficient and effective.
- Providing inmates with access to consumer information and mental health education so that they can better understand and manage their illnesses.

- Providing coverage for services and medication after release, while applications for benefits are pending. Several "bridge" plans have been developed around the country and can serve as models for this approach.
- Providing specialized parole supervision.
- Appointing a single agency to coordinate release planning.
- Sharing information across agencies and ensuring inter-agency coordination and collaboration through inter-agency agreements and collaborations.
- Ensuring that inmates have access to necessary medical and social benefits immediately upon release.
- Ensuring availability of housing and linkage to the community mental health system prior to release.

Several comprehensive programs to ensure continuous service delivery to individuals as they transition from jails/prisons to the community have been developed that combine a number of the above approaches. Since a break in one or more essential mental health or other services is a frequent cause of relapse and recidivism back into the criminal justice system, these programs are critical to effective and successful re-entry initiatives. Several such approaches include:

- *The APIC Model:* Developed by the National GAINS Center, this is a best practice approach to community re-entry from jails for individuals who experience co-occurring mental health and substance use disorders.
- *Building Bridges:* Developed by the Bazelon Center for Mental Health Law (2002), this model legislation has been developed to ensure the provision of necessary services for persons with SMI to enable their successful transition from incarceration in jails/prisons back into the community.
- *Gap Funding:* Gap funding is a concept in which a special pot of funding is available in each circuit to use to pay for community-based services and supports until the person becomes eligible for SSI/SSDI and Medicaid. The back pay the person would receive once their application is approved would go back into the funding pot as a reimbursement.

Other prison and jail re-entry initiatives have been adapted in some states for individuals with mental health needs include prison transition accountability plans (TAP) and jail community reintegration planning (CRP).

Specialized Community Mental Health Services for Individuals with Mental Illnesses with Prior Criminal Justice Involvement:

Several evidence-based mental health practices have been customized for individuals with histories of prior juvenile or criminal justice system involvement or a high risk of such involvement. The objective of these adaptations is to meet the specific needs of this population while promoting public safety and reducing the likelihood of recidivism back to the justice system. A key component of services is the role of specialized case management.

Forensic assertive case management (Forensic-ACT) has not been found to be superior to *forensic intensive case management (F-ICM)*, whereas forensic intensive case management has been found to be more effective than traditional intensive case management with regard to outcomes for this population. Although additional research is necessary, the National GAINS Center recommends caution against the overuse of Forensic-ACT for this population because of the greater expense and absence of evidence of greater effectiveness. Specialized *Criminal Justice Intervention and Transition Teams* are one variant of F-ICM that has been found to be effective in serving the needs of persons with severe and persistent mental illness who are at risk for incarceration. These teams coordinate community-based mental health treatment alternatives to incarceration, provide mental health linkage and transition planning for inmates released from jail or prison, and monitor mental health compliance and participation to minimize re-arrest, re-incarcerations, and improve public safety.

Specific co-occurring disorders treatment programs for individuals with prior forensic involvement are another successful adaptation of evidence-based mental health treatment that has been found to be effective in meeting the service needs of this group. Given the high prevalence of co-occurring mental illness and substance abuse in this population, such programs are of particular importance.

Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM; Rotter, McQuistion, Broner, & Steinbacher, 2005) is an approach that educates providers about the impact of incarceration on people with mental illnesses and subsequent treatment engagement, and is considered to be important in appropriateness of service delivery and outcomes for this population.

Adaptations of the evidence-based *supportive housing programs* for individuals with mental illnesses have also been developed for this group of individuals with a history of incarceration in prison or jails. A range of community housing options for this population must be available. This includes the development of residential treatment facilities with capacity designated specifically for individuals involved with the criminal justice system. Such capacity is of significance in providing the courts with community-based treatment alternatives to incarceration and providing a transitional community placement for inmates returning to the community in need of this level of supervised treatment and monitoring.

Because of the disproportionate number of individuals with SMI/SED with trauma histories, it is of critical importance that services provided are trauma-sensitive. This requires developing and implementing services that informed and aware of the impact of trauma and abuse on individuals with mental illnesses, as well as best practices for providing comprehensive and competent care for trauma victims.

Adaptations of the evidence-based *Illness Management and Recovery (IMR)* and *supported employment* for individuals with mental illnesses with a history of prior forensic involvement are in their early stages of development.

Community-Specific Criminal Justice Competent Mental Health Systems:

A variety of evidence-based strategies are available to successfully and efficiently divert individuals with SMI/SED, as appropriate, from the justice system to the mental health pathway, while enhancing both public safety and individual recovery. Since it is highly unlikely that any community will utilize each and every one of these approaches, the "best" strategies to be utilized in different communities will vary as a function of the specific strengths and unique needs of that community. Coordination and synchronization between the criminal justice and mental health systems at the community level is crucial to the success of any approach. Collaboration between these systems at the local/regional level is enhanced by the formalization and institutionalization of the relationship through the use of memoranda of understanding and specified procedures, development of protocols of information sharing across systems without violating individual civil liberties, and explicit statement how the partners will make resources available to address this shared problem. Workforce development and training in both systems are pivotal in promoting effective collaboration.

Recommendations:

The State of Florida is encouraged to consider adopting the following recommendations, which correspond to the five key points of intervention within the *Sequential Intercept Model*:

Intercept 1 – Pre-Booking:

1. All law enforcement agencies in Florida develop Crisis Intervention Team (CIT) programs. That the CIT training program be conducted a minimum of semiannually and that this training occurs in each county or set up regionally to serve multiple communities, as appropriate.
2. Funds be allocated from the legislature through FDLE to support the CIT training programs.
3. Each county have at a minimum one full time CIT coordinator who oversees the CIT training and ensures CIT is being utilized within each law enforcement agency.
4. The Florida CIT Coalition provide technical assistance to communities developing CIT.
5. FDLE certify CIT curricula and establish continuing education credit for CIT certification.

Intercept 2 – Post-arrest, booking, and initial court hearing:

1. All local jail booking units (adult and juvenile detention facilities) conduct a mental health and substance abuse screening using evidence-based tools. Recommended tools include the Brief Jail Mental Health Screen (Osher, Scott, Steadman and Robbins, 2004) and the Correctional Mental Health Screen (Ford and Trestmen, 2005).
2. All jails should be required to provide the names of individuals admitted to the jail to local community mental health providers or a local clearinghouse agency upon booking so that mental health consumers may be identified early and efficiently.

3. Each judicial circuit should develop a mental health post-booking diversion program that focuses on all misdemeanor as well as low-level, third degree felony charges for defendants with SMI or co-occurring SMI and substance use disorders.
4. Each Juvenile Assessment Center (JAC) should develop pre-trial release/diversion programs for youths with SED.
5. Judicial circuits consider the implementation of Public Defender model programs similar to those developed in Pinellas County and Orange County.

Intercept 3 – Courts:

1. All judicial circuits are encouraged to examine the feasibility of implementing mental health problem-solving strategies within both adult and juvenile courts.
2. Each judicial circuit should have specially trained probation officers to manage and monitor this population upon release from jail or prison.
3. Each judicial circuit should establish a community-based competency restoration program to divert from the forensic state hospital those individuals found incompetent to proceed to trial (ITP), not a danger to self or others, and not meeting other criteria for hospitalization.
4. Each judicial circuit should have an in-jail competency restoration program to begin restoration training while an individual awaits transfer to the state forensic hospital and continued restoration training when they return and are awaiting court hearings.
5. Designate a staff position to coordinate the commitment process both to and from the state forensic hospital to reduce length of stay in jail.
6. To reduce the de-compensation experienced by forensic mental health defendants when the court system is not timely in resolving cases after competency has been restored and to free up needed bed space and reduce waiting lists for individuals awaiting placement for competency restoration, recommended statutory change to decrease the time frame to return forensic patients to their respective jurisdictions once competency is restored and to ensure prompt judicial hearings upon return.
7. Specialized criminal justice/mental health case managers and entitlement benefits specialists should be located within jails to facilitate discharge planning, restoration of terminated or suspended benefits, and initial applications for individuals who are eligible, but not currently covered by benefits.

Intercept 4 – Re-entry from jail or prison:

1. Each judicial circuit should develop strategies that focus on inmates with SMI or co-occurring SMI and substance use disorders that will be transitioning back into the community from the jail. Strategies need to include the use of boundary spanners with both clinical and forensic knowledge and understanding to coordinate re-entry activities among the court, jail and community where this does not already exist. This function could be housed within the Public Defender's office, jail, community service provider or court.

2. Recommend continued use of the Department of Corrections and Department of Children and Families Interagency Agreement and established procedures for discharge planning from prison to the community. In coordination and collaboration with the DCF District Forensic Coordinators and the Department of Corrections mental health staff, the community service providers should have a dedicated staff person be part of this transition team for doing in-reach into the prison, coordinate appointments, assist with linkages and follow up with needed clinical and support services, housing, transportation and social security benefits.
3. Recommend use of the APIC model (GAINS Center), which focuses on assessing, planning, identifying and coordinating transitional care from jails back to the community.
4. Recommend adaptation/adoption of Building Bridges model legislation (Bazelon Center for Mental Health Law, 2002) to facilitate access to entitlement benefits for individuals coming out of jails and prisons.

Intercept 5 – Community corrections and supports:

1. Consider split sentences. Currently under the Interagency agreement between DCF and DOC a letter is sent to the court system encouraging the consideration for split sentences for inmates with serious mental illnesses. This process needs to receive more attention for potential use and outcomes which may reduce costs for state institutions.
2. Establish programs to provide *gap funding* for individuals awaiting approval of SSI/SSDI benefits, pre-screened to meet eligibility criteria.
3. Include select state and county probation officers to participate in the local CIT program for intensive training and integration within the local system of care.
4. Implement specialized case loads for state and county probation officers to work with individuals with serious mental illnesses and/or co-occurring substance use disorders that have been released from prison or jail.

Part 5: A Guide for Developing Comprehensive and Competent Juvenile Justice, Foster Care, and Child Protective Services Mental Health Systems

On any given day, there are roughly 130,000 juveniles residing in youth detention facilities across the country (Sickmund, 2004). Studies have consistently shown that anywhere from 65 to 70 percent of these youth have a diagnosable mental health disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002; Wasserman, Ko & McReynolds, 2004). Roughly 25 percent of these individuals experience conditions resulting in severe functional impairment (Shufelt & Cocozza, 2006).

Although the recommendations in this report are, for the most part, intended to address the needs of both adults with SMI involved in or at risk of involvement in the criminal justice system and youth with SED involved in or at risk of involvement in the juvenile justice system, it is necessary to devote specific attention to infants, children, and adolescents as these populations have unique developmental needs that are too often overlooked or responded to with inappropriate versions of interventions and treatment philosophies that are designed around adult mental health needs.

Youth involvement in the courts extends beyond the *juvenile justice/delinquency system*. Many infants, children, and adolescents involved in the *dependency/foster care system* or *child protective services* experience significant behavioral and emotional disturbances which contribute to and/or result from significant disruptions in family, social, and interpersonal functioning. Because children are often unable to articulate these difficulties and/or advocate for their own needs in these forums, it is imperative that a comprehensive and competent system of care incorporate interventions and safeguards to ensure that the needs of this most vulnerable population are recognized and addressed.

For years, little was known about the importance of attending to the emotional and behavioral needs of children involved in various legal proceedings, and the role the court system and judges may play in either contributing to or protecting children from more severe behavioral and emotional impairment. In fact, many experts mistakenly assumed that children involved in legal proceedings and the justice system were relatively unaffected by the process in long-term emotional ways and that behavioral or emotional difficulties that did arise were more likely pre-existent or coincident to legal matters. Recent research demonstrates that this is far from the case. Such experiences can result in profound disruptions in social and developmental functioning, particularly during infancy and early childhood development. Furthermore, these early experiences have been demonstrated to contribute to more severe forms of mental illness and functional impairment later in life. As such, early intervention is viewed as one of the most effective and efficient means by which to identify and respond to individuals at risk of long-term impairment and psychiatric disability.

The following recommendations addressing youth mental health needs in the juvenile justice and foster care systems were developed by reviewing the literature on best practices and by consulting stakeholders from across the state. Significant input was provided by the Florida Bar

Association's Mental Health Subcommittee of the Standing Committee on the Legal Needs of Children.

Early Childhood Development and Attachment:

Among the more compelling recent research on underlying causes of behavioral and emotional difficulties is the contribution of prenatal, neonatal, and early childhood development on later expression of mental illnesses and behavioral disorders. Research has demonstrated that poor maternal nutrition, health, and prenatal care, along with exposure to illicit drugs and other toxic substances in utero, have strong relationships with later development of behavioral and emotional difficulties (IOM, 2003).

Similarly, research now shows definitively that insecure and inconsistent patterns of attachment to key caregivers during the first years of life are associated with development of psychiatric difficulties, and can have profound effects on an individual's ability to develop and maintain meaningful relationships later in life. While risk factors associated with disorganized infant-caregiver attachment include parental trauma, maternal depression, maternal alcoholism, and other substance-use problems and illnesses, they are also associated with infants who are placed in environments that do not provide adequate opportunities to develop stable, secure relationships with one or more key caregivers (Lederman, Osofsky, & Katz, 2001). Such impermanence in relationships may occur, for example, when infants enter into the foster care system and move from one placement to another without having the opportunity to develop meaningful attachments. Often the result of such impoverished relationships early in life is development of a condition known as *reactive attachment disorder*.

Promising practices are being developed to improve screening and assessment of infants and young children's mental health. In particular, the *Miami-Dade County Juvenile Court* in partnership with community stakeholders has developed several very encouraging models of prevention and early intervention including the *Prevention and Evaluation of Early Neglect and Trauma (PREVENT) Initiative*, the *Infant and Young Children's Mental Health Pilot Project (IMHPP)*, and the *Miami Safe Start Initiative*.

Psychotherapeutic Medication Prescribing Practices:

Another trend which has raised concerns involves the off-label prescribing of psychotherapeutic medications to preschoolers and older children (Rawal, Lyons, MacIntyre, & Hunter, 2004; Zito, Safer, dos Reis, Gardner, Boles, & Lynch, 2000). In the absence of formal standards and clinical guidelines, the off-label use of these medications, usually in response to behavioral problems, has been questioned for both its safety and efficacy. To complicate matters, judges in dependency courts in Florida, and many other states, are now required to authorize the administration of psychotherapeutic medications to children in foster care, which presents further legal and ethical concerns that are worthy of review.

Chapter 39.407 of the *Florida Statutes* and Rule 8.355 of the *Florida Rules of Juvenile Procedure, 2007 Edition*, define the requirements for obtaining court authorization to administer psychotherapeutic medication to children in shelter care or foster care when parental consent has

not or cannot been obtained. In addition, DCF has developed procedures for pre-consent review of psychotherapeutic medication treatment plans for children under the age of 18 who are in the custody of DCF in out of home care. These procedures involve the mandatory review of medication treatment plans by a consulting child psychiatrist, under contract to DCF, prior to the administering of psychotherapeutic medications. As an example, for children between the ages of birth and five years in out of home placement the *Psychotherapeutic Medication Treatment Plan Review* (DCF form CF-FSP 5279; see Appendix E) is completed by the child's case manager and prescribing physician. The completed form is then sent to the University of Florida, School of Medicine via the MedConsult line for review by a consulting child psychiatrist. The final recommendation of the consulting child psychiatrist is intended to be used by the person who has legal authority to consent for extraordinary medical treatment or the judge who is providing the court order for treatment with a psychotherapeutic medication. Similar procedures are established and required for all children in the custody of DCF.

Because of concerns inherent in requiring judges to authorize medication administration for children in the dependency system, it is recommended that state rules, statutes, and procedures around the authorization and administration of psychotherapeutic medications to children in foster care and child protective services be reviewed. As appropriate, it is recommended that existing practices and procedures be expanded and/or revised to provide additional oversight and review of medication administration for all children and adolescents in the dependency system. Furthermore, it is recommended that specific training for juvenile judges around psychotherapeutic medication prescribing practices in foster care, along with bench materials for use by juvenile court judges, be developed. Alternatively, the state court system may explore strategies adopted by other states around the country in which psychotherapeutic medication being prescribed for children who are in the custody of the state must be reviewed and approved by a consulting child psychiatrist working for the courts. California has developed one of the more comprehensive such programs requiring the completion of a detailed application justifying the use of any psychotherapeutic medications.

Delinquency System: Florida's Sequential Redirection Strategy for Youth with Mental Illness Involved with or at High Risk for Involvement with the Juvenile Justice System:

Roughly 150,000 children and adolescents, under the age of 18, are referred to Florida's Department of Juvenile Justice (DJJ) every year. Many of these youth have been impacted by poverty, violence, substance abuse, and academic disadvantage. Over 70 percent have at least one mental health disorder, with females experiencing higher rates of disorders (81 percent) than males (67 percent). Of youth diagnosed with a mental health disorder, 79 percent meet criteria for at least one other co-morbid psychiatric diagnosis, the majority of whom (approximately 60 percent) are diagnosed with a co-occurring substance use disorder (Skowyra & Cocozza, 2007). At least 20 percent of these youth experience disorders that are so severe that their ability to function is significantly impaired. Representative diagnoses include:

- Major depressive disorder.
- Bipolar disorder.
- Conduct disorder.

- Attention deficit/hyperactivity disorder.
- Anxiety disorder.

Frequently, disruptive or delinquent behaviors in youths are the result or symptoms of undiagnosed and/or untreated mental health disorders. For some youth, contact with the juvenile justice system is often the first and only chance to receive help. All too frequently, however, the opportunity for effective early intervention is overlooked or neglected, and youth end up entering into a system that is ill-equipped to adequately respond to their treatment needs. Even after entering the juvenile justice system, roughly 50 percent of youth with SED remain undiagnosed. Those who are identified are often not adequately treated, contributing to deeper penetration into the juvenile justice system.

In July, 2007, the Florida Department of Juvenile Justice announced the formation of a 25-member *Blueprint Commission* to evaluate the state's juvenile justice system and to develop a comprehensive set of recommendations to effectively and efficiently maximize public safety and the rehabilitation of youth involved in, or at high risk of becoming involved in, Florida's juvenile justice system. We defer specific and comprehensive recommendations addressing the juvenile justice/mental health interface to the Blueprint Commission (whose final report is scheduled to be released in December, 2007); however, the following is a suggested framework for designing mental health interventions in the juvenile justice system.

Recently, the *National Center for Mental Health and Juvenile Justice (NCMHJJ)* released a report outlining a comprehensive model for addressing the needs of youth with mental illnesses involved in the juvenile justice system (see Skowyra & Cocozza, 2007). The model outlines a set of nine *core principles* which in turn relate to four *cornerstones* for system improvement. Finally, six *critical points of intervention* (corresponding more or less to those outlined in the Sequential Intercept Model) are identified. The components of the comprehensive model are as follows:

Core principles:

1. Youth should not have to enter the juvenile justice system solely in order to access mental health services or because of their mental illness.
2. Whenever possible and when matters of public safety allow, youth with mental health needs should be diverted into evidence-based treatment in a community setting.
3. If diversion out of the juvenile justice system is not possible, youth should be placed in the least restrictive setting possible, with access to evidence-based treatment.
4. Information collected as part of a pre-adjudicatory mental health screen should not be used in any way that might jeopardize the legal interests of youth as defendants.
5. All mental health services provided to youth in contact with the juvenile justice system should respond to issues of gender, ethnicity, race, age, sexual orientation, socio-economic status, and faith.
6. Mental health services should meet the developmental realities of youth. Children and adolescents are not simply little adults.

7. Whenever possible, families and caregivers should be partners in the development of treatment decisions and plans made for their children.
8. Multiple systems bear responsibility for these youth. While at different times a single agency may have primary responsibility, these youth are the community's responsibility and all responses developed for these youth should be collaborative in nature, reflecting the input and involvement of the mental health, juvenile justice, and other systems.
9. Services and strategies aimed at improving the identification and treatment of youth with mental health needs in the juvenile justice system should be routinely evaluated to determine their effectiveness in meeting desired goals and outcomes.

Four cornerstones:

1. Collaboration: The need for improved collaboration between the juvenile justice and mental health systems.
2. Identification: The need for improved and systematic strategies for identifying mental health needs among youth in contact with the juvenile justice system.
3. Diversion: The need for more opportunities for youth to be appropriately diverted into effective community-based mental health treatment.
4. Treatment: The need for youth in contact with the juvenile justice system to have access to effective treatment to meet their needs.

Critical intervention points:

There are several points at which services can be provided to youth with SED to prevent them from unnecessarily entering the juvenile justice system or appropriately redirecting them from the different steps in the juvenile justice system to the mental health system. These include:

1. Initial contact with law enforcement: This includes the initial contact a youth has with the police at the time they are suspected of committing a crime. *(Such intervention should include ensuring that school police are trained in CIT.)*
2. Intake (probation or juvenile court): This includes the point at which a youth is referred by law enforcement to juvenile court.
3. Detention*:* This includes the point at which a youth is placed in a secure detention setting.
4. Judicial processing: This includes the point at which a petition is filed in juvenile court, an adjudication hearing is held, and the judge orders a disposition in the case.
5. Dispositional alternatives (juvenile correctional placement or probation): This includes a discussion of two dispositional alternatives – placement in a juvenile correctional facility or placement on probation supervision.
6. Re-entry: This includes the point at which a youth is released from a juvenile correctional placement and returns home.

7. Prevention:* If adequate mental health services are available and readily accessible in the community, youth are much less likely to engage in behaviors or get into situations that initiate an engagement with law enforcement.
8. Children and families in need of services (CINS/FINS) matters:* This point of intercept is intended to make explicit the opportunity for intervention among children and families of children who persistently run away from home, who persistently disobey reasonable and lawful demands of their parents or legal guardians, who are habitually truant from school, or engage in other behaviors that place the child at risk of future abuse, neglect, or abandonment or at risk of entering the juvenile justice system as defined under Chapter 984, F.S.

** These points of intercept are not included in the original model contained in the NCMHJJ report, however have been added for the purposes of this report.*

Assessment in Juvenile Justice System:

The *Center for the Promotion of Mental Health in Juvenile Justice (CPMHJJ)* has developed six recommendations for best practices in mental health screening and assessment in the juvenile justice system and are recommended to guide assessment and evaluation in the juvenile justice system (Wasserman, Jensen, Ko, Cocozza, Trupin, Angold, Cauffman, & Grisso, 2003).[13] The recommendations have been adapted as follows:

Table 6. Mental health screening and assessment in the juvenile justice system

Recommendation:	Overview:	Description:
1) Emergent Risk	Provide an evidence-based, scientifically sound mental health screen within the first 24 hours of a youth's arrival at a facility.	An evidence-based, scientifically sound mental health screening should be included in the general health screen. While addressing legal protections for the youth, screening should attend to current use of any medications, service/treatment history, current substance use, and risk of suicidal, self-injurious, and assault behavior.
2) Mental Health Service Needs	Provide an evidence-based, scientifically sound mental health screening and/or assessment for all youth as early as possible in order to determine need for mental health services.	This comprehensive mental health assessment should occur prior to disposition to inform judicial and probation planning. Because mental health conditions may contribute to misbehavior, treatment may help prevent re-contact with the justice system. Because of the potential overlap between mental health conditions and criminal activity, screening and assessment must incorporate legal protections for youth. Among these protections is the guarantee that no information elicited through the screening process may be used in any way to jeopardize the child's legal interests in any law enforcement matter. Youths screening positive should receive comprehensive mental health assessments.

[13] These recommendations can also be found on the CPMHJJ website: http://www.promotementalhealth.org/practices.htm

Recommendation:	Overview:	Description:
3) Mental Health Assessment Components	A comprehensive mental health assessment must be based upon careful review of information from multiple sources and must measure a range of mental health concerns.	Most Axis I disorders and suicidality are important to measure, as well as youth's functioning and impairment in such contexts as home and school. Assessment should consist of direct observation and face-to-face interview with youth; mental status examination; chart review; school records review; interview with parents/other adults, if available; and family history.
4) Community Re-entry	Provide an evidence-based and scientifically-sound screening or assessment for all youth preparing to leave a post-adjudicatory secure facility and return to their communities.	In order to facilitate linkage to community mental health services, high risk youths should receive a comprehensive assessment, and low risk youths should receive a screen to identify any mental health concerns before release. Youths who screen positive should receive a full mental health assessment.
5) Re-Assessment	Provide evidence-based, scientifically sound screening/assessment on a regular basis for all youth.	Certain components of mental health status are likely to change over time in response to internal and external events. While the exact timing and interval for mental health screening and assessment may vary, at a minimum it should be a part of any routine medical screening and/or assessment. Youth who screen positive should receive a full mental health assessment.
6) Staff Training	Ensure that mental health staff are professionally credentialed, or directly supervised by credentialed staff. Provide training for staff (appropriate to their role) for assessment in evidence-based, scientifically sound mental health screening/assessm-ent/procedures.	Staff at a variety of levels need to be able to assist with assessing youth's risk to self and others, so that they will be able to inform treatment and service planning/disposition for the youth.

Key Recommendations for Screening and Assessment in the Juvenile Justice System:

1. **Every youth who comes into contact with the juvenile justice system should be systematically screened for mental health needs, on an ongoing basis, to identify acute crisis needs (e.g., suicide risk) and to identify youth who require further mental health assessment or evaluation:** Mental health screening is conducted to determine short-term needs. Screening results alone should not be used to make long-term treatment planning decisions, but to make informed decisions about the need for immediate service or follow-up evaluation.

2. **Mental health screening and assessment should be performed routinely as youth move from one point in the juvenile justice system to another:** While screening is considered most critical at a youth's earliest point of contact with the juvenile justice system, it should also be employed periodically to monitor mental health status at all stages of justice system involvement. Since screening provides a view of a youth's short-term and immediate needs, it is recommended that it be performed repeatedly, as youth transition within or out of the juvenile justice system (say from pre-trial detention to post-adjudication detention or from a secure detention facility to the community), as well as periodically during longer stays in detention to monitor any changes that may occur in a youth's mental status.

3. **The mental health screening process should include two steps:**

    a. **The administration of an *emergency mental health screen* –** The first step in the process involves an initial emergency screen to identify any immediate mental health needs, the potential risk of suicide or harm to self or others, and to determine whether the youth is currently taking any psychotherapeutic medication.

    b. **The administration of a *general mental health screen*** – The second step of the screening process involves the administration of a general mental health screen to identify mental health concerns that require further evaluation or assessment. This screen should be brief in nature and easily administered by non-clinical staff within a variety of juvenile justice settings.

4. **Youth identified as "in crisis" must be provided immediate access to psychiatric and other medical services:** Access to immediate mental health services should be available for all youth who, based on the results of the emergency screen or general mental health screen and staff observations, indicate a need for emergency services. Crisis conditions typically involve youth who are believed to be at risk of harm to self or others, youth who are at immediate risk of substance use consequences (e.g., withdrawal), youth in acute mental or emotional distress, and youth who are at risk of discontinued medication.

5. **Mental health assessment should be administered to any youth whose mental health screen indicates the need for further assessment:** This assessment should be based on direct observation and face-to-face interview with the youth, as well as review of information from multiple sources (e.g., mental status examination, case records, family interviews, school records), and must measure a range of mental health concerns. A mental health assessment will yield more detailed, and sometimes diagnostic, information about a youth's mental health status and can be used to form the basis of treatment recommendations.

6. **Instruments selected for identifying mental health needs among the juvenile justice population should be standardized, scientifically sound, have strong psychometric properties, and demonstrate reliability and validity for use with youth in the juvenile justice system.**
7. **It is important to recognize that the developmental needs of younger children and adolescents are different from those of older children and adolescents, and care should be taken to select instruments that are developmentally appropriate for the target group of youth who will be screened and assessed.**
8. **Mental health screening and assessment should be performed in conjunction with risk assessments to inform referral recommendations that balance public safety concerns with a youth's need for mental health treatment:** Assessing a youth's risk for future violence or re-offending is a critical function of the juvenile justice system and is necessary in order for the system to satisfy its obligations to ensure public safety. Mental health screening and assessment must be linked to the administration of risk assessments, to fully inform decision-makers about the risks and needs that each youth presents. The combined results of these screens and assessments should be used to guide decisions that not only ensure the appropriate level of security or supervision, but that also ensure that youth have access to the services and treatment that they need.
9. **All mental health screens and assessments should be administered by appropriately trained staff:** Most instrument developers provide guidelines for the level of training and/or education needed in order to appropriately administer the instrument. Often, screening instruments are designed to be administered by non-clinical staff that are trained on how to administer, score, and interpret the instrument. Assessments, on the other hand, typically require more extensive and individualized data collection and most often require the expertise of a mental health professional.
10. **Policies controlling the use of screening information are necessary to ensure that information collected as part of pre-adjudicatory mental health screen is not used inappropriately or in a way that jeopardizes the legal interests of youth as defendants.**
11. **Given the high rates of co-occurring mental health and substance use disorders among youth involved in the juvenile justice system, all screening and assessment instruments and procedures should target both mental health and substance use needs, preferably in an integrated manner using instruments specifically developed to identify the presence of mental health and co-occurring substance use disorders among youth.**
12. **Existing screening and assessment instruments and procedures should be reviewed and adapted, as necessary, to ensure that they are appropriate for use with various cultural, racial, and gender subpopulations within the juvenile justice system.**

Mental Health and Substance Use Disorders as Factors in Detention Hearings:

An area of concern in the juvenile justice system that should be further explored is the role of mental health and/or substance use disorders as factors considered by the court in determination hearings regarding detention care placement. Under current state statutes, mental health and substance use issues are not specifically addressed as part of the detention intake or determination processes. While statute 985.24(1)(b) does identify, "substantial risk of inflicting bodily harm on others as evidenced by recent behavior" as a finding in detention determination, it does not make reference to the possibility that such risk of harm may be related to underlying mental health and/or substance use disorders.

The Department of Juvenile Justice, in cooperation with representatives from the Conference of Circuit Judges of Florida, the Prosecuting Attorneys Association, the Public Defenders Association, the Florida Sheriffs Association, and the Florida Association of Chiefs of Police, is currently developing a new risk assessment instrument for use in detention determinations as defined under statute 985.245, F.S. Accordingly, this statute states:

> The risk assessment instrument shall take into consideration, *but need not be limited to*, prior history of failure to appear, prior offenses, offenses committed pending adjudication, any unlawful possession of a firearm, theft of a motor vehicle or possession of a stolen motor vehicle, and probation status at the time the child is taken into custody. The risk assessment instrument *shall also take into consideration appropriate aggravating and mitigating circumstances*, and shall be designed to target a narrower population of children than s. 985.255. *The risk assessment instrument shall also include any information concerning the child's history of abuse and neglect.* Ch. 985.245(2)(b), F.S. [Italics added]

Mental health and/or substance use disorders, particularly in the context of histories of abuse and neglect, are arguably among the strongest aggravating and mitigating circumstances precipitating juvenile justice system involvement. As such, incorporating mental health and substance abuse issues into the risk assessment and taking these issues into consideration in recommending various levels of secure, non-secure, or home detention, as well as eligibility for diversion programs, merits further examination.

In some circumstances, such consideration may support placement in more restrictive and secure hospital or detention facility settings because of a history of dangerousness and/or a current risk of harm to self or others. In other circumstances, youth with histories of mental illnesses and/or substance use disorders, particularly those experiencing acute exacerbation of symptoms immediately prior to justice system involvement and who do not present as a danger to the safety of the community or themselves, may be more appropriately diverted to non-secure placements at home or in other community-based settings, with linkage to new or existing treatment resources.

Because the short time period to detention determination often precludes the completion of comprehensive assessment, it is recommended that consideration be given to statements from parents or guardians regarding past or current mental health and/or substance abuse treatment. In any scenario, placement of youth with mental illnesses and/or substance use disorders in the least

restrictive setting with diversion to the community as appropriate, balanced against public safety concerns, should be a primary goal of the detention determination process.

Use of Evidence Based Practices:

The following policy statement regarding the use of evidence-based practices was developed by the *American Academy of Child and Adolescent Psychiatry* and is recommended to guide and inform the adoption of evidence-based practices for youth interventions in Florida:

> Evidence-Based Practice (EBP) comprises empirically-validated processes that facilitate the conscientious, explicit and judicious integration of individual clinical expertise with the best available external clinical evidence from systematic research in making decisions about the care of individual patients. The ultimate goal of EBP is to base clinical decision making in the areas of causation, diagnosis, prognosis, treatment and guidelines on empirical evidence. However, evidence is a continuum and the best available evidence may not (and often does not) include the kind of empirical validation that would support an unequivocal standard of care. For example, many interventions currently used in the psychiatric treatment of children and adolescents need more rigorous controlled studies. Furthermore, it is common for children to present with multiple diagnoses that affect their psychological, social and academic functioning, and current available evidence rarely encompasses all the factors relevant to a particular patient care decision in a single study. Thus, it is a central principle of EBP that a treating clinician must use all available information in developing an appropriate treatment plan for an individual child or adolescent.

Whereas a comprehensive and competent community mental health system best promotes prevention and adaptive functioning in the community, specialized mental health best practices have been developed to facilitate diversion and community reintegration among youth with SED involved in or at risk of becoming involved in the juvenile justice system. Stronger partnerships and coordination of activities and resources across the juvenile justice and mental health systems has the potential to result in better screening, assessment, and treatment at key points of juvenile justice involvement, enhanced opportunities for diversion away from the justices system, and increased access to ongoing, effective mental health services in the community.

Additional and Supporting Recommendations:

In May 2007, a public hearing organized by the *Mental Health Subcommittee of the Florida Bar's Standing Committee on the Legal Needs of Children* and *Florida's Children First*, was held in Broward County to address the mental health needs of children in the legal system.[14] The following recommendations were developed with significant input from this event:

[14] A full report from this event can be accessed at: http://floridaschildrenfirst.org/04_reports/CMHRecsFinal.pdf

I. Children/Youth in the Dependency System

A. Screening/Referral for Assessment:

1. Requirement to implement and expand assessment of children under the age of five, targeting prevention and early intervention.
2. Require screening for infant and early childhood neglect, trauma, and abuse with particular attention to possible presence of attachment disorders and other possible developmental delays. Recommend assessment and interventions be modeled after successful existing programs such as those in Miami-Dade County Juvenile Court.
3. Children who enter the dependency system but are not into placed into the state's "care and custody" should routinely be provided comprehensive behavioral assessments.
4. If those children are not provided complete assessments, they should be screened for mental health and substance abuse needs and referred for services.
5. Provide regular, ongoing screening and re-assessment of youth in foster care. Do not rely solely on initial assessment.

B. Health Insurance/Medicaid Enrollment:

1. Community-based care providers (CBCs) should apply for Medicaid for undocumented immigrant children who have been awarded Special Immigrant Juvenile status in the state's care and custody.
2. The state requires that CBCs enroll all children who are not eligible for Medicaid or receiving private insurance in the low-income health insurance program.
3. AHCA and DCF must work together to streamline the Medicaid approval so that children entering state care are enrolled in Medicaid within a week of entering care.
4. All CBCs should ensure that all caregivers apply for Medicaid or other appropriate low-income health insurance program for children in the dependency system not in the state's care and custody, unless the child is otherwise insured. The CBCs should be further required to assist caregivers with completing the initial application, and follow up to correct problems if Medicaid is denied.
5. The state should provide for seamless medical and behavioral health care coverage, with consideration of a managed care concept including full risk assumption, that allows foster children to maintain the same coverage and plan throughout their stay in foster care as well as after they are either re-united or placed in a permanent home, when eligible. Children must receive needed services regardless of changes in locale - the availability of medically necessary services should not depend on where a child lives.
6. The state should create a Medicaid *presumptive eligibility* status for children entering the system providing full coverage immediately.
7. The state should establish specific transfer criteria to ensure continuity of medical and behavioral health coverage for children leaving foster care.

C. Comprehensive Behavioral Health Assessments (CBHAs):

1. Establish standardized protocol for Comprehensive Behavioral Assessments (CBHAs) to ensure timely and consistent evaluations.
2. DCF should implement a quality assurance process to ensure the timely completion of CBHAs for all children in dependency.
3. DCF should implement a quality improvement processes to improve quality of CBHAs.
4. CBCs should educate case managers about how to use CBHAs in case planning.
5. DCF should implement a quality assurance process to ensure that CBHAs are incorporated into case plans.
6. OSCA and DCF should educate dependency judges about the importance of the required CBHAs and how they should be used in case planning.
7. DCF should require that CBCs conduct an annual training for all child welfare staff, from program managers down on the utilization of CBHAs and other behavioral health services.

D. Treatment:

1. Implementation of specialized interventions to target:
    a. Development of healthy patterns of reciprocal bonding and attachment.
    b. Abuse.
    c. Neglect.
    d. Provide gender-specific trauma services.
2. Provide children counseling to challenge the denial or reduction of mental health and substance abuse services
3. Train case managers and CBC staff receive training on services covered by Medicaid and how to advocate for children to receive those services.
4. DCF, CBCs and the Managed Care providers should work together to ensure available, accessible services across the entire continuum of mental health and substance abuse care.
5. CBCs should develop programs that enable children to remain in therapeutic foster homes after the need for therapeutic services has ended.
6. CBCs should develop adequate capacity in their inventory of foster homes to avoid placement in a therapeutic home when placement in a foster home with out patient services would be more appropriate.
7. Encourage the Community Based Care Partnership to increase utilization of Behavioral Health Overlay Services to maintain children in foster care placements.

E. Residential Treatment Centers

1. Appoint a guardian or attorney ad litem to all children facing commitment to locked residential facilities;
2. All facilities using residential treatment nomenclature should be reviewed to make sure they are appropriately licensed;
3. DCF should conduct an annual evaluation of existing residential programs for quality and begin to examine outcomes (success data); and
4. DCF should assess what types of programs are needed and plan accordingly.

F. Psychotherapeutic Medications:

1. Establish standards for reviewing and approving administration of psychotherapeutic medication to children, for use by the courts.
    a. Board-certified child psychiatrists, working for the courts, to review and sign off on all psychotherapeutic medications prescribed for children in foster care system and child protective services.
    b. Explore options such as telepsychiatry or other electronic means of consultation to serve areas where there are few child psychiatrists.
2. Judges, case managers and guardian ad litems should be trained on the evidence required to ensure appropriate use of psychotherapeutic medications, and what side effects to watch out for.
3. Train judges regarding state medication treatment plan review protocols.
4. Standards for reviewing and approving administration of psychotherapeutic medications should be developed for the courts.
5. Judges and representatives of the child should review the records provided for each judicial review for completeness and accuracy. If the records were not provided or are incomplete, appropriate actions and follow up should be included in court order.
6. Prescribing doctors should provide information directly to parents in order to obtain informed consent.
7. AHCA/DCF/CBC should be required to provide specific and comprehensive report of the provision of psychotherapeutic drugs to children and youth by age, gender, race, and location, each quarter.
8. Require AHCA/DCF/CBC to provide specific reports on children who have been on medications for extended periods or are taking multiple drugs.
9. AHCA should conduct an annual evaluation of the utilization of approved psychotherapeutic medication for children under the managed care services.
10. ACHA/DCF and its subcontractors should report physicians with unusual prescribing practices to appropriate authorities.

11. AHCA/DCF should ensure physicians report adverse incidents to the FDA and not only to the pharmaceutical companies.

II. Youth in the Delinquency System

A. Screening:

1. DJJ should implement measures to ensure that mental health and substance abuse information obtained in JAC assessments are conveyed to detention centers in which youth are placed.
2. DJJ should develop a standard informed consent form and protocols that meets recognized standards on testing of young incarcerated or detained human subjects.
3. DJJ should implement measures to ensure that information obtained through mental health and substance abuse screening processes not be made available to law enforcement for any purpose that may jeopardize the child's legal interests.

B. Health Insurance:

1. Provide families with the resources to obtain health insurance for youth within the families' financial means.
2. The state should create a Medicaid *presumptive eligibility* status for youth re-entering the community.
3. Develop state policies and procedures to suspend, rather than terminate, Medicaid benefits upon placement in juvenile detention.

C. Comprehensive Assessments:

1. Comprehensive assessments should be incorporated into a treatment plan for each youth, if the parent and child have given informed consent, or with the child's attorney's consent, or judicial order after a hearing where the child is represented by counsel.

D. Pre-Dispositional Behavioral Assessments:

1. Behavior assessments conducted on children prior to disposition should be provided to defense counsel for review and the opportunity to obtain revisions prior to submission to the court.
2. Public defenders should increase their use of independent experts to examine youth and make dispositional recommendations.

E. Treatment:

1. Implementation of specialized interventions to target:
    a. Development of healthy patterns of reciprocal bonding and attachment.
    b. Abuse.
    c. Neglect.

d. Provide gender-specific trauma services.

2. Increase behavioral health overlay services (BHOS) or other mental health care services to cover all children in the JJ system and residential treatment programs.
3. DJJ should work with community providers to provide youth with access to the mental health and substance abuse services they received in the community.
4. DJJ should initiate provision of mental health and substance abuse services to youth in detention centers.
5. Begin working with families, utilizing funding for aftercare services, prior to release from juvenile detention facilities.
6. Develop mechanisms to link educational records between schools in the community.

F. Youth Incompetent to Proceed:

1. DCF, DJJ, and the Courts should collaborate to reorganize current juvenile competency restoration program to:
    a. Establish more appropriate treatment goals and long-term case plans for children with developmental disabilities, such as mental retardation.
    b. Emphasize the use of crisis stabilization and community-based diversion in place of competency restoration where appropriate.
    c. Create community-based competency restoration programs where appropriate.
    d. Ensure adequate resources and infrastructure in the community to serve juveniles with severe behavioral disturbances.
    e. Review appropriate treatment and placement options for juveniles at substantial risk of harm to self or others.
2. DJJ should investigate best practices in other states to create appropriate systems for dealing with developmentally disabled youth in the criminal justice system.
3. Explore options for expansion of minimum risk commitment to include placement in mental health and substance abuse treatment programs.

G. Psychotherapeutic Medications:

1. All youth who are being involuntarily treated with psychotherapeutic medications should be appointed competent counsel to represent them.

H. Court Proceedings:

1. Guidelines and procedures should be developed for the handling of youth appearing in court under DJJ supervision.
2. Encourage courts to ensure meaningful opportunity for youth to confer with an attorney prior to pleading guilty or no contest in delinquency matters.

3. Ensure that the quality of legal representation within juvenile proceedings reflects the highest standards of practice.
4. Train public defenders on mental health and substance abuse issues for children and implement procedures to enhance the quality of advocacy at the dispositional phase.
5. Bar associations should provide educational programs with CLEs for private attorneys on mental health and substance abuse issues for children and implement procedures to enhance the quality of advocacy at the dispositional phase.

I. Probation and Conditional Release (Aftercare):

1. The courts routinely require that the JPOs identify treatment providers and ensure that services are in place.
2. DJJ and DCF should work with communities to enhance availability of mental health and substance abuse services for youth released from DJJ custody.
3. Develop specialized re-entry strategies for youth coming out of the juvenile detention settings.

III. Children/Youth With Developmental Disabilities

A. Provide children with developmental disabilities counsel to challenge the denial or reduction of services.

B. APD should implement Ch. 393.065(5)'s priority for enrolling children in the child welfare system in the Medicaid Waiver program for developmental services.

C. Implement or amend the "crisis tool" to expedite services for families when services would prevent the need for removing the child from the parental home.

IV. Additional Recommendations

A. Establish specific transfer criteria to ensure continuity of medical and behavioral health coverage for children leaving foster care, child protective services, and juvenile justice settings.

B. Encourage voluntary screening and/or evaluation of children of adult clients receiving services in the community mental health and substance abuse systems to promote early intervention and identification of treatment needs.

C. Encourage screening and/or evaluation of children of incarcerated adults with mental illnesses, along with the provision of prevention, early intervention, and primary care services as necessary.

D. Provide screening and assessment for individuals with traumatic brain injuries or other organic disorders.

Part 6: Judicial Education, Administration, and Community Collaborations

Judicial Education:

In recent years, there has been an increasing awareness and appreciation among the courts and members or the judiciary of the import of substance abuse, mental illnesses, and co-occurring disorders on a variety of areas of law and the justice system. While these issues may be most apparent in criminal forensic mental health and civil commitment arenas, they play a role in a variety of other judicial contexts, including juvenile justice, domestic violence, drug courts, family courts, and minor criminal matters. Substance abuse, mental health, and co-occurring disorders underlie 70-80% of the cases handled in the criminal division, 70% of the cases handled in the dependency division, 70-80% of the cases handled in the juvenile delinquency division of the courts, and no doubt contribute heavily to issues arising in dissolution cases. Yet, only a small percentage of the judiciary has received any education or training on these subjects.

At the very least, it is critical that judges are provided with basic knowledge regarding mental illnesses, the mental health system, and available resources in the community so that they are prepared to make informed decisions when mental health concerns or issues arise. Failure to do so may mean that decisions are based on mistaken stereotypes or assumptions about mental illnesses, which can have a variety of negative impacts on individuals, families, the community, and the justice system (Reed, 2002).

In addition, it is desirable for members of the judiciary to be knowledgeable about issues relating to mental illnesses because judges are uniquely positioned to play important roles in designing, implementing, and administering a variety of problem solving approaches to address complex social issues. For example, through court-based interventions such as drug courts and mental health courts, judges play a significant role in determining how individual cases involving defendants with mental illnesses should proceed and whether alternatives to prosecution or incarceration should be considered.

Judicial pioneers recognized that to turn a blind eye to the underlying factors that lead to crime, delinquency, and dependency; i.e., substance abuse, mental health, and co-occurring disorders, is to court failure. Furthermore, simply ordering people to get treatment without insuring access and follow through wastes valuable judicial resources and time, and produces a revolving door of human suffering. But, ensuring a judiciary that is knowledgeable, prepared, and competent in these substantive areas is a challenge. Although courses relating to substance abuse, mental health, and co-occurring disorders have been increasingly offered at judicial conferences in recent years, they tend to be attended by judges who already appreciate the prevalence of these issues in their work. It seems that until this year, these courses have been preaching to the choir.

The Mental Health Subcommittee of the Steering Committee on Families and Children in the Court worked with pertinent members of the court education community to incorporate education around issues of substance abuse, mental illnesses, and co-occurring disorders into the curriculums at Florida Judicial College/New Judges' College, Circuit and County Court Judicial Conferences, Florida College of Advanced Judicial Studies, and other subject-related seminars and conferences. The National Judicial College, the National Council of Juvenile and Family

Court Judges and the National Drug Court Institute also provide courses to educate the judiciary on these important subjects. In short, we need to take all of the opportunities for judicial education and saturate them with a variety of levels of knowledge and training on substance abuse, mental health, and co-occurring disorders. Indeed, work has already begun to accomplish this goal. Table 7 provides an overview of recent and upcoming judicial education

Table 7. Recent and upcoming judicial education opportunities

Date:	Venue:	Description:
June 2007	Circuit Court Judge's Conference	Three-hour plenary session addressing substance abuse, mental health, and problem-solving techniques. Judges experienced in drug courts, mental health courts, and problem-solving techniques discussed their awakening to the need for education on these subjects and the vast improvement in case outcomes when these issues are addressed appropriately.
July 2007	County Court Judge's Conference	Three-hour plenary session addressing substance abuse and problem-solving techniques with an emphasis on DUI cases. In addition a plenary session was dedicated to mental health issues.
2008	New Judge's College	NEW COURSE: 90-minute segment on co-occurring disorders will be presented by Judge Steve Leifman. The course will acquaint new judges with the pervasiveness of substance abuse, mental health, and co-occurring disorders, how to recognize them, and provide them with a decision tree to aid in fashioning more effective and meaningful dispositions. New judges will be given a list of resources that can be used when they encounter these issues.
June 2008	Advance Judicial Studies	This will be a three day intensive course covering a wide variety of substantive and procedural issues involved in handling cases involving substance abuse, mental health, and co-occurring disorders. *See Appendix F for full schedule.*
Summer 2008	Circuit Court Judge's Conference	Both the county and circuit conferences have once again dedicated *plenary* time to address mental health, substance abuse, and co-occurring disorders in the summer of 2008. Both sessions will be identical.
Summer 2008	County Court Judge's Conference	

Recommendations:

While it is critical that members of the judiciary become versed and competent in issues around substance abuse, mental illnesses, and co-occurring disorders as they relate to the justice system, being able to communicate effectively in judicial and administrative matters means that it is equally important that other stakeholders within the court system receive adequate training as well. As such, the following recommendations are intended to complement judicial education and to support expanded educational and training opportunities for stakeholders throughout the justice system:

- Trial court administrators should receive a course on the use of case management in the handling of cases involving substance abuse, mental health, and co-occurring disorders.
- Develop justice system competent certification standards for judges, lawyers, and other court personnel in mental health, substance abuse, and co-occurring disorders.
- Develop additional specialized and continuing educational opportunities for judges, lawyers, and other court personnel.
- Law schools should develop and promote curricula specifically on problem-solving approaches to issues relating to substance abuse, mental health, and co-occurring disorders. Those trained in this area should volunteer to guest lecture at law schools. The Florida Bar Association is encouraged to join in this effort by providing education and training for its membership.
- Create self-instruction manuals and links on the court system webpage to other sites for information on these issues.
- Compile a bench book on substance abuse, mental health, and co-occurring disorders containing resources that can be updated and that can be made available to judges around the state.
- Acquire and distribute the publication *Judge's Guide to Mental Health Jargon* to all members of the judiciary.

In short, work is underway to educate and train Florida's judiciary, but much more needs to be done. Most importantly, this can not be an endeavor to "quick fix" the court system. It must be a coordinated and long-term strategy to ingrain these subjects into judicial training.

Judicial Administration and Community Collaborations:

The Judiciary in Florida plays a unique and critical role in the juvenile/criminal justice, mental health, and substance abuse systems of care. Because of the prevalence of people with SMI/SED in our state who have difficulty accessing appropriate services and receiving the types of supports they need for stabilization and recovery within community living environments, the justice system often becomes by default the de facto mental health system.

Of all stakeholders, Judges have an influential role due to their positions of authority, respect, impartiality, and responsibility for administering justice. Therefore they should take a leadership role in their communities for convening, organizing and supporting existing inter- and cross-

systems collaborations that focus on planning and developing diversion and intervention programs; building system capacity for services and supports; and creating problem-solving cross system partnerships for cases involving mental health and/or substance abuse considerations. Cannon 4 of the Code of Judicial Conduct for the State of Florida specifically encourages judges to …*engage in activities that improve the administration of Justice*. This underlying effort certainly is contemplated by Cannon 4. As such, criminal justice, mental health, and substance abuse collaborations need to be formally organized with missions, goals and objectives. In addition, they need to be dynamic in their membership and have mechanisms to document their achievements and communicate their efforts.

In order to accomplish this, it is recommended that each Judicial Circuit develop both a formal mechanism to direct its leadership role through Administrative Orders as well as the establishment of Memoranda of Understanding (MOU) among community stakeholders. Suggested templates for developing such documents are included in *Appendix G*. In addition, examples of existing MOUs for jail diversion programs and community collaborations around the state are included in *Appendix H*.

At a minimum, it is recommended that each circuit through an Administrative Order consider:

- Strategies which will promote and sustain significant involvement of the courts and members of the judiciary in local criminal justice/mental health stakeholder collaborations.
- Ways in which the courts and members of the judiciary may serve in leadership roles in addressing the effect of mental illnesses on the judicial system and supporting the application of problem solving techniques in cases involving individuals with mental illnesses.
- Methods for the courts and members of the judiciary to stimulate, support, and sustain joint problem-solving initiatives among stakeholders in the juvenile justice, criminal justice and community mental health systems around issues relating to lack of community resources, access to community-based services, system duplication, lack of coordinated care, information sharing and programmatic and system outcomes.
- Processes to ensure information-sharing among relevant stakeholders within the courts, criminal justice system, juvenile justice system, and community mental health and substance abuse systems regarding people with mental illnesses who are involved with or at risk of becoming involved with the justice system, in order to improve early identification and treatment of these individuals. A multi-agency informed consent form should be created and considered for use.
- Roles, responsibilities, resources and commitment among stakeholders to the group and to the process for system improvement and system change.

With the input and guidance of judicial leadership, local cross-systems collaborations should focus system improvement efforts around two key areas: developing and implementing known best practices for juvenile and criminal justice system diversion, intervention and re-entry; and the educational needs of the various providers within the system for increasing awareness and

competency. It is recommended that local cross-systems collaborations consider the following structure:

- High level oversight body.
- Subcommittees addressing operational issues should include at a minimum:
    - Justice system efficiencies and system mapping.
    - Building community capacity.
    - Funding, financing, and legislative committee.
    - Complex Case Staffing committee.
- Mechanisms for evaluating program processes and outcomes, system processes and outcomes and expectations for reporting this information to the oversight body.
- Media outreach and liaison.

Community and Stakeholder Education:

The other key area each cross system coalition, consortium or task force should focus on through its judicial leadership is the educational needs of the various providers of the system. Each provider within the justice, mental health and substance abuse systems comes from different training backgrounds and sets of agenda and focus that effect outcomes. To be effective it is critical to consider improved training and educational efforts to build awareness, competencies and help create a common set of language and knowledge around this population.

In order to accomplish this it is recommended:

1. Each circuit work with FDLE as it continues to revise its law enforcement, corrections and probation academy training related to understanding and responding to people with mental illness, substance use disorders and those in crisis. Ensure the curriculum provides useful information for all new law enforcement, corrections, juvenile justice and probation officers.
2. All law enforcement agencies provide 8 hours of updated mental health and Baker Act/Marchman Act training annually to all officers through their block training schedules.
3. Eight to 16 hours of mental health and substance abuse training should be required annually for all judges, prosecutors, defense attorneys, correctional officers and state and county probation officers.
4. Require that those who conduct forensic evaluations attend the Forensic Evaluators training put on by FMHI.
5. Require eight hours of updated annual training for psychologists and psychiatrists conducting forensic evaluations.
6. Judicial circuits should promote the use of NAMI's Family to Family training program for parents and loved ones.

7. Each circuit should develop a training/information program directed at the judiciary and law enforcement that identifies community resources and how to access services.
8. Develop a glossary that standardizes mental health and substance abuse related terminology across all systems that address the needs of those with serious mental illness, substance use disorders as well as those with co-occurring mental illness and substance use disorders.

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Appendix A - A Proposal to Integrate Medicaid and DCF Mental Health and Substance Abuse Programs for the SPMI and SED Populations

Summary of Proposal

Medicaid purchasing and policy-setting responsibilities for Medicaid adult beneficiaries with severe and persistent mental illness and children with severe emotional disturbance, including populations involved with or at risk of involvement in the criminal or juvenile justice systems, would be reorganized in partnership between the Department of Children and Families and AHCA. This would provide for the evolution of a well-integrated system of care for those with serious mental illness and involved in multiple systems of care.

Rationale

The Department of Children and Families is statutorily responsible for serving as the state's public mental health authority, but Medicaid has become the principal payer for publicly-financed care. To ensure an effective blending of funding sources, provide cost effective care, and prevent cost shifts, it is essential that the state use a single purchaser and policy-setting authority for those with serious mental illness and high users of multiple systems of care and to ensure an alignment of Medicaid reform and mental health transformation strategies.

Populations Affected

The target population to be served by the DCF administered plans would include adults with severe and persistent mental illness; children with emotional disturbance; children and adults with substance abuse problems; children transitioning to independent living; individuals with criminal justice involvement; and other individuals and families that are at-risk because of mental and substance use disorders

The populations that would be affected by the realignment of administrative responsibilities would be the SPMI/SED populations enrolled in the Medicaid fee-for-service system and Medicaid managed care plans. Qualifying criteria would include diagnoses, historical service use, prescriptions, as well as certain risk criteria (e.g., inpatient/crisis service use, employment status, criminal justice system involvement, homelessness/unstable housing, lack of family/social supports, and assistance needs with activities of daily living). Initially, enrollment in the DCF program may be limited, with full phase in to occur over a two- to three-year period.

Program Coverages

Mental Health Benefits

In consultation with AHCA, DCF would define the community mental health and targeted case management benefits for the affected populations. Medicaid and DCF benefits would have a recovery orientation and emphasize intensive case management; disease/health management; community living and inclusion services and supports; supported employment, education and

housing services; habilitation and rehabilitation services; social and leisure skill development; personal care; protective oversight and supervision; and other services based on best practices.

Substance Abuse Benefits

DCF will work with AHCA to expand Medicaid substance abuse coverages in order to enhance federal funding support for behavioral health services and assure the availability of comprehensive mental health and substance abuse benefits for Medicaid beneficiaries.

Physical Health Care

For Medicaid beneficiaries served under the DCF/AHCA partnership, Medicaid physical health care benefits would be provided through the Medicaid fee-for-service system. Eligibles enrolled in Medicaid managed care plans would be reassigned to the FFS system at the time of their next open enrollment. The DCF managing entities responsible for SPMI/SED Medicaid beneficiaries will provide intensive case management, disease management, and health management services to Medicaid eligibles enrolled in the DCF managing entities. They will also be responsible for utilization management of physical health benefits and providing authorizations for care.

Eligibility Expansion

DCF and AHCA will explore the possibility of expanding Medicaid eligibility, though federal waiver, to SPMI/SED eligibles that are not currently eligible for Medicaid but served by DCF. This group would include populations with incomes immediately above Medicaid eligibility limits and those that do not meet disability level criteria. This would enhance the state's mental health system and access to care using expanded federal funding.

Managed Care

On a phase in schedule, DCF will establish managing entities to oversee the local/regional administration of services provided to both Medicaid and DCF populations. The managing entities would be responsible for creating and maintaining organized systems of care; purchasing care; coordinating, managing and integrating all contracted community mental health and substance abuse services in the designated district(s); establishing, credentialing and monitoring provider networks that include an appropriate mix of providers for the full range of mental health and substance abuse services provided, including acute and emergency care, medical services, residential treatment, recovery supports and preventive services; meeting medical loss ratio requirements; ensuring continuity of care when payer source and needs change; ensuring convenient, timely and accessible care; managing service utilization; designing and maintaining information systems; administering data collection, analysis and reporting activities; accepting responsibility for meeting performance and outcome measures; collaborating with related systems of care (e.g., education, criminal justice, juvenile justice, housing, employment, health care); complying with Medicaid state and federal fiscal and program requirements; developing local strategic plans; establishing consumer and family advisory groups; offering self-directed and consumer- and family-oriented care; and establishing quality assurance and improvement programs.

The DCF managing entities would lead system transformation at the local level, have established relationships with their communities and agreements with related health and social service agencies and programs, and provide a model design for the effective coordination, integration, and management of publicly-financed mental health and substance abuse services that are accessible, consumer-and family-oriented, and achieve desired performance and outcome measures. The managing entities would:

- Promote the recovery and resiliency of individuals served by the public mental health and substance abuse systems.
- Improve state and local accountability for access to and the quality, appropriateness and cost effectiveness of mental health and substance abuse care.
- Assure the continuity of care for all children, adolescents, and adults who receive services from the publicly funded mental health and substance abuse service systems.
- Provide early diagnosis and treatment to enhance recovery, prevent hospitalizations, and avoid crises.
- Identify and treat people with psychiatric disabilities and substance use disorders who are at high risk of poor outcomes and involvement in other systems of care.
- Improve the overall quality of mental health and substance abuse services through the use of evidence-based and promising practice models.
- Improve the coordination and integration of the mental health and substance abuse systems and other systems, such as the physical health, housing, employment, education, child welfare, emergency services, law enforcement, and criminal justice systems.
- Improve public safety through the use of prevention, early diagnosis and treatment, diversionary programs, and enhanced system coordination.
- Improve the assessment of local needs for mental health and substance abuse services.

Program Administration

DCF

Pursuant to a memorandum of agreement and other contractual arrangements, the Department of Children and Families would assume responsibility from the Agency for Health Care Administration for administration and the delivery of Medicaid mental health and substance abuse services for adults with severe and persistent mental illness and children with serious emotional disturbance. In consultation with the Agency for Health Care Administration, DCF would be responsible for establishing the Medicaid benefit package and designing service delivery and financing methods. DCF would enter into multi-year contracts with managing entities, ensuring fiscal accountability; promoting program achievement using model programs and best practices; assuring timely follow up on any corrective actions required; complying with applicable federal and state statutes and regulations; eliminating ethnic, gender, and age disparities in access to care; improving the public understanding of the causes, effects and treatment of mental illness and substance abuse; and promoting preventive programs and services.

AHCA

The Agency for Health Care Administration would continue to be the Single State Agency for the affected Medicaid population, through its contractor serve as the fiscal agent for the DCF-administered Medicaid program, and be responsible for federal and state reporting and maintenance of the Medicaid State Plan and required waivers.

Transition

Eligible beneficiaries enrolled in managed care plans would be reassigned to DCF managing entities upon termination of the Prepaid Mental Health Plans pursuant to contract or implementation of Medicaid reform in PMHP's geographic coverage area or at the time of open enrollment for those enrolled in HMOs or PSNs.

Budget Neutrality

DCF would assume responsibility for the operation of affected populations and benefits within existing appropriations levels. DCF and AHCA would jointly develop any future budget requests to reflect price or workload increases or program enhancements

Federal Authority

The federal authorities for the proposed realignment of certain Medicaid administrative roles and responsibilities are Title XIX of the Social Security Act, Title 42 of the Code of Federal Regulations, Part 431 and other relevant parts, and Section 6086 of the Deficit Reduction Act of 2005.

Appendix B - Adult Psychiatric Inpatient Unit Crisis Stabilization Pathway Based on a 5-Day Length of Stay

DAY 1: ASSESSMENT AND CRISIS MANAGEMENT

ASSESSMENT

Assessment and Need Evaluation

Physician:

- History, Examination, Formulation
- Order laboratory tests, consults

Nursing:

- Safety and other Needs Assessment

Social Work:

- Contact Outpatient team/Collateral
- Informants, Legal status, Resources

BEGIN TO DEFINE FOCAL PROBLEM

Why Admission Here Now??

TREATMENT

Establish safety and Plan Focused Intervention

- Continue outpatient medications as appropriate
- Safety precautions/monitoring as indicated
- Plan family/network interventions as appropriate
- Orient patient to the unit
- Plan individual therapy as feasible and indicated

DISCHARGE PLANNING

Assessment of after-care needs and resources

- Follow-up and living arrangements
- Financial stability and need for assistance
- Employment or educational issues
- Safety evaluation in likely post-discharge setting
- Other specific needs and issues

DAY 2: COMPLETE ASSESSMENT AND INITIATION OF "FOCUSED TREATMENT"

ASSESSMENT

- Finalize presumptive Diagnosis, evaluate laboratory results
- Define mental and physical health needs, Re-evaluate safety
- Monitor safety, vital signs, sleep, nutrition, self-care,
- Complete assessment of legal issues, living and financial needs.

CLEARLY DEFINE THE FOCAL PROBLEM

TREATMENT

Finalize and Begin definitive intervention

- Initiate new medication treatment and taper of prior medication as appropriate
- Utilize "prn" medications for specific target symptoms as appropriate
- Individual and group therapeutic interventions as appropriate
- Family and other network interventions
- Implement individualized safety and behavioral/cognitive plan

DISCHARGE PLANNING

Define after-care needs and Develop Plan to Address Them

- Address specific post-discharge needs-legal, living, care, fiscal,
- Coordinate with outpatient therapists or find new treators as needed
- Define approximate length of stay on inpatient unit

DAY 3: CONTINUE FOCUSED TREATMENT

ASSESSMENT
- Assess physical health and psychopathology
- Monitor safety, vital signs, self-care, sleep
- Review progress towards defined target outcomes

TREATMENT
- Continue to implement medication plan
- Continue individual and group therapy as indicated
- Evaluate effectiveness and response to interventions
- Family and other network interventions as required
- Medication and other patient education

DISCHARGE PLANNING

Concretize Post-discharge Plan
- Begin to arrange outpatient appointments
- Identify likely discharge date
- Coordinate other post-discharge arrangements as necessary

DAY 4: SAFETY ASSESSMENT AND DISCHARGE READINESS

ASSESSMENT
- Assess patient safety and physical/mental health
- Assess adequacy of self-care and support needs
- Evaluate response of target symptoms/needs
- Assess extent to which focal problem has been addressed

TREATMENT
- Complete implementation of medication plan
- Prepare discharge prescriptions
- Continue to assess response to various interventions
- Evaluate learned coping strategies
- Assess patient and family understanding

DISCHARGE PLANNING
- Identify tentative return to work/school and complete necessary paperwork
- Complete discharge paper-work
- Confirm appropriate post-discharge living and care arrangements

DAY 5: DISCHARGE WITH SMOOTH HAND-OFF

ASSESSMENT
- Carefully assess patient safety
- Repeat physical and mental examination
- Repeat structured assessments, including rating scales

TREATMENT
- Review safety plan
- Review post-discharge plan with patient and family
- Continue various interventions as appropriate
- Dispense post-discharge medications with education

DISCHARGE PLANNING
- Reconfirm and document post-discharge follow-up arrangements
- Complete all aftercare arrangements
- Review follow-up plan and confirm patient and family understanding

DISCHARGE PATIENT

Appendix C – Examples of CJ/MH/SA Initiatives in Florida

PROGRAM DESCRIPTION

Name of Program: Central Florida Crisis Intervention Team

Is this program: __X__ pre-booking ____ post booking (to include pretrial release, mental health courts, competency restoration ____ re-entry

County or counties this program serves: Orange County

Target population program serves: Adults and children with mental illnesses or serious emotional disturbances that are in crisis and come in contact with law enforcement officers

Brief description of how the program operates: The Central Florida CIT is a community partnership between law enforcement agencies, the local mental health and substance abuse treatment systems, mental health advocacy groups, and consumers of mental health services and their families. CIT is more than just training. It establishes Teams of trained officers within each law enforcement agency to respond effectively to people with mental illnesses, including those with co-occurring substance use disorders that are in crisis.

The Central Florida CIT strives to achieve the following goals:

- Better prepare police officers to handle crises involving people with mental illnesses, including those with co-occurring substance use disorders.
- Increase law enforcement officer safety, consumer safety and overall community safety
- Collaboratively, make the mental health system more understandable, responsive and accessible to law enforcement officers to the greatest extent possible with community resources:
    - Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health/substance abuse treatment system.
    - Improve access to mental health/substance abuse treatment in general and crisis care in specific for people who are encountered by law enforcement.
- Divert people with a mental illness who are in crisis from the criminal justice system whenever possible which is consistent with the Baker Act or Marchman Act.

Officers/deputies attend a 40 hour intensive training course put on primarily by the community mental health and substance abuse providers, families and consumers. Most of the instructors volunteer their time for training. Several previously trained CIT officers also assist with the training. The various law enforcement agencies involved have developed policies and procedures that recognize the role of the CIT officer within their agency and the receiving facility has developed user friendly policies for law enforcement. Once an officer becomes a CIT officer for their agency, they are the primary responder to calls that involve a person with a mental illness. The officer uses their knowledge and skills to de-escalate the situation in a peaceful manner, avoiding use of force whenever possible. These skills the officer utilizes are designed to increase officer and consumer safety. The CIT officer then is able to use their knowledge and discretion and take a person in crisis to the mental health receiving facility vs.

jail when appropriate. CIT trained officers wear a CIT pin on their uniform so they are recognizable in the community.

Bi-monthly, the CIT coordinators from each agency, the mental health and substance abuse providers and families and consumers meet to discuss system issues and to ensure the CIT program continues and thrives. The Central Florida CIT program holds an annual appreciation breakfast to honor the men and women who are CIT as well as an annual in-service training.

Who are the community partners involved with this program? Orange County Sheriff's office and all 12 local police municipalities as well as Orange County Corrections, Lakeside Behavioral Healthcare, Orange County Government, Human Services Associates, Center for Drug Free Living, Pathways Drop in Center, Orlando Regional Healthcare, and Florida Hospital

How long has the program been in operation? Seven years

Contact person:
Michele Saunders, LCSW
Florida Partners in Crisis
4836 Lonsdale Circle
Orlando, FL 32817
407 574 7182
Michele.fpic@comcast.net

PROGRAM DESCRIPTION

Name of Program: Northwest Florida CIT Group

Is this program: __X__pre-booking ____ post booking (to include pretrial release, mental health courts, competency restoration ____ re-entry

County or counties this program serves: Escambia and Santa Rosa Counties

Target population program serves: Persons with mental illness and/or substance use disorders.

Brief description of how the program operates: Multi-agency quarterly 40hr trainings from patrol units and corrections staff in Pensacola Police Dept., Escambia Sheriffs Office, Santa Rosa Sheriffs Office, UWF Police Dept, PJC Police Dept, Milton Police Dept. Headed by Mental Health and Law Enforcement Coordinators and Agency Coordinators. Five additional training slots at each class to include community first responders, EMS, probation officers, pre-trial release officers and adult protective services staff. Monthly group meetings held for program development and expansion.

Who are the community partners involved with this program?: Lakeview Center, DCF, NAMI, Mental Health Association with above law enforcement agencies.

How long has the program been in operation?: CIT Group partnership established in 2006, first training class October 2006.

Contact Person:
Peggie Iacuzio
Program Director
Lakeview Center Forensic
850 595 0041

Captain Fred Alford
Escambia County Sheriffs Office
850 436 9822

PROGRAM DESCRIPTION

Name of Program: Eleventh Judicial Criminal Mental Health Project, Miami, Florida

Is this program: __X__ pre booking __X__ post booking

County or counties this program serves: Miami-Dade County

Target population program serves: Individuals that are arrested for misdemeanors and have been identified with Severe Mental Illness.

Brief description of how the program operates: The Eleventh Judicial Criminal Mental Health Project (CMHP) was developed to redirect individuals with mental illnesses away from the criminal justice system and into community-based mental health treatment and services. The target populations are individuals with severe mental illnesses and possible co-occurring substance use disorders that are at risk of or have been arrested for misdemeanor offenses. The purpose of the Project has been to provide countywide Crisis Intervention Team (CIT) training for all police agencies, and to provide better access and linkage to mental health treatment and support services available in the community. The goal of the Project has been to assist individuals served to become diverted from the criminal justice system, and engaged in treatment, rehabilitation and support services that are essential to their long-term, successful adaptation to community living.

The program operates both a pre-booking (Crisis Intervention Team Training, CIT) and post-booking jail diversion program, and brings together the resources and services of healthcare providers, social-service agencies, law enforcement personnel, and the courts. Since the implementation of this program, individuals in acute psychiatric distress are more likely to be assisted by law enforcement in accessing crisis stabilization services in the community without being arrested. Individuals in acute psychiatric distress arrested for misdemeanors, who are booked into the jail are evaluated and, if appropriate, transferred to a crisis stabilization unit within 24-48 hours. Upon stabilization, legal charges are typically dismissed, and individuals are assisted at discharge with accessing treatment services, housing, and other entitlements in the community.

Who are the community partners involved with this program?: The success of the program can be attributed to the collaborative partnerships established among the judiciary, defense and prosecuting attorneys, local law enforcement agencies, community service providers, and other community representatives. The Florida Department of Children and Families has been instrumental in providing financial support and promoting common goals. The Miami-Dade Department of Corrections, Jackson Memorial Hospital, Public Health Trust- Corrections Health Services and the Mental Health Hospital play an essential role in providing assessments and treatment to the individuals served. Miami-Dade County has a comprehensive continuum of public and private behavioral health and substance abuse treatment and services. Department of Children and Families provides funding and support for indigent people through the Community Mental Health Centers (CMHC) and other private providers. There are a wide array of best

practice and evidenced based treatment programs within the community that are utilized by the CMHP.

How long has the program been in operation?: In mid-2000, the Eleventh Judicial Circuit of Florida, with funding and technical assistance from the National GAINS Center, convened a two-day summit meeting of traditional and non-traditional stakeholders to review how the Miami-Dade community dealt with individuals entangled in the criminal justice system due to untreated mental illnesses and co-occurring substance use disorders. The participants assessed the available behavioral health services, tailored the technical experts' suggestions with local input, and created the Eleventh Judicial Circuit's Criminal Mental Health Project (CMHP).

Contact Person:
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Project Director
Eleventh Judicial Circuit Criminal Mental Health Project
Jail Diversion Program
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Miami, Florida 33125
305 548-5319
305 416-0920 Fax
cischwartz@jud11.flcourts.org

PROGRAM DESCRIPTION

Name of Program: Public Defender's Office Jail Diversion Program

Is this program: ____ pre-booking __X__ post booking (to include pretrial release, mental health courts, competency restoration ____ re-entry

County or counties this program serves: Sixth Judicial Circuit (Pinellas County)

Target population program serves: Adults with serious mental illnesses (Axis 1) who are indigent

Brief description of how the program operates: The program used in the Sixth Circuit has evolved over the four years. Other areas interested in this model need to adapt to their needs.

We asked for and received a change in the probable cause affidavit for first appearance hearings that had a box the officer could check stating "Mental Health Issues". This helped the court recognize the issue as well as our interview staff. The interview staff then obtains information regarding previous mental health treatment and obtains appropriate releases. These releases are then given to the Medical Records Specialists, who obtains those records for the attorney.

Another source of identification is the court's psychologist who attends all weekday Misdemeanor First Appearance Hearings. The court psychologist knows many of the clients from previous contacts and can immediately refer to our Mental Health Department. The court psychologist can also immediately visit individuals exhibiting unusual behavior to determine if the person is competent or should be Baker Acted. If the court psychologist opines the person is incompetent, the State normally stipulates to that and the person is referred to our Misdemeanor Incompetent to Proceed (ITP) Program and the full range of services that are available there.

The jail's nursing staff is a constant referral source. The staff not only calls if the person has mental health issues, they also help prepare the person for release to us, ensuring the person is not released until we are there to provide transportation. The jail also will provide a prescription for 30 days of medication.

This program provides screening evaluations and therapy by five Masters Level Therapists. If the facility does not provide therapy, we can immediately go there to provide it. This is incredibly important as evidenced by our recidivism rates. The recidivism rate was 15%. I attribute this very low rate to the immediate providing of services. The impact of timing of delivery of services is directly reflected in our drug court; there is a two to four month wait for outpatient services and a 49% recidivism rate.

The program also provides for housing, medications and transportation. Transportation can involve picking up at the jail and delivery to a housing provider as well as transportation to the doctor or if necessary the probation officer.

The goal has been to have the Criminal Justice System delivery of mental health services self contained within the system. There are numerous advantages to this, including rapid delivery of appropriate services, increased accountability of services by judicial involvement and review, and a recognition that our needs and clients are often different than those of the community mental health providers.

In closing, it should be stressed the need for rapid delivery of services. In writing this I called our primary community mental health provider and inquired as of the second week of September what the first available appointment date would be, and was told it would be January. While this is not beneficial in any circumstance, it clearly is not practical in the Criminal Justice System.

Who are the community partners involved with this program?: Includes several community providers, judiciary, state attorney, Sheriff and other stakeholders when necessary

How long has the program been in operation?: Four years

Contact Person:
Bob Dillinger
14250 49th St. N
Clearwater, Fl 33762
727 464 6866 phone
727 464 6900 fax
Pd6@wearethehope.org

PROGRAM DESCRIPTION

Name of Program: Special Needs Diversion (SND) Court Program

Is this program: ____ pre-booking __X__ post booking (to include pretrial release, mental health courts, and competency restoration _ re-entry

County or counties this program serves: Orange County, Florida

Target population program serves: Misdemeanor and non-violent 2nd or 3rd degree felonies offenders suffering from serious and persistent mental illness who may have co-occurring substance abuse disorder, or are developmentally delayed, experiencing dementia or head injury.

Brief description of how the program operates: In Orange County, those charged with lesser crimes who exhibit mental illness are now being diverted toward appropriate care and away from formal prosecution. Cases are identified as part of the booking and medical/mental health screening process and referred to the Special Needs Diversion (SND) Court Program. The court will order the referred case to SND and the inmate will be released to case management with a discharge/treatment plan. The case will be followed by a case manager, community corrections and the court in compliance with the treatment plan which can last up to 12 months. Once the treatment plan is successfully completed the inmate graduates from the Program and the charges are dropped. If for some reason the treatment plan is not followed the case is revoked and the offender is returned to jail.

Who are the community partners involved with this program?: Lakeside Behavioral Healthcare, Inc. and community services for the homeless including entitlement services, public defender, state attorney, correction, community corrections and judiciary.

How long has the program been in operation?: December 2006

Contact Person:
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Lamerial.Daniels@ocfl.net

PROGRAM DESCRIPTION

Name of Program: Mental Health Screening of Inmates at Booking

Is this program: ____ pre-booking __X__post booking (to include pretrial release, mental health courts, competency restoration ____ re-entry

County or counties this program serves: Orange County

Target population program serves: Adults who enter the booking facility at Orange County jail who have been referred for a mental health screening

Brief description of how the program operates: Referred inmates are seen for an initial mental health assessment shortly after being booked into the facility, at which point a decision about mental health housing is made, as well as referrals to mental health sick call and psychiatric sick call. Each inmate is also given a mental health acuity score indicating the degree of mental illness.

The mental health unit utilizes an acuity level grading scale of mental health. All mental health inmates are assessed during screening for treatment intervention and accurate housing

How long has the program been in operation?: Approximately 4 years

Standard Operational Procedure:

AUTHORITY: Florida Model Jail Standard – 7.02

REFERENCE:

- ACA Standard: 3-ALDF-4E-12
- FCAC Standard: 19.04
- NCCHC Standard: J-G-04

PURPOSE: The MH Grading system was designed to provide information on three variables related to an inmate's mental health status: acuity of illness, chronicity of illness, and presence/absence of substance abuse factors. Each inmate will be rated on each of the above factors, providing a three-digit code (e.g., 3-2-1)

SCALES:

<u>Acuity of illness Scale</u>

This provides for assessment of current level of functioning using a condensed rating system patterned after the Global Assessment of Functioning (GAF).

5 = Includes individuals **with no discernable mental illness to those exhibiting some mild symptoms**. Mild symptoms include depressed mood, mild insomnia, and difficulties in social, occupational, or academic areas. Such individuals are generally functioning relatively well and have meaningful interpersonal relationships. This category includes anyone rated 61 or higher on the GAF Scale.

4 = Includes individuals displaying **moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or academic functioning (e.g., few friends, conflicts with peers and co-workers). This category includes anyone rated from 51-60 on the GAF Scale.

3 = Includes individuals displaying serious symptoms (e.g., suicidal ideation, severe obsession rituals, i.e., frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). This category includes anyone rated from 41-50 on the GAF Scale.

2 = Includes individuals who display any of the following:

- Impairment in reality testing (speech is at times illogical, obscure, or irrelevant)
- Major impairment in several areas, such as work or school, family relations, judgment, thinking, mood, (e.g., depressed person avoids friends, neglects family, and is unable to work; arguments/physical altercations with family members).

This category includes anyone rated from 31-40 on the GAF Scale.

1 = This category describes an individual whose behavior is considerably influenced by delusions or hallucinations; is unable to function in almost all areas; is suicidal; is unable to take care of self; whose communication is grossly impaired. This category is used to describe the mostly acute ill individuals who would normally be rated 30 or below on the GAF Scale.

Chronicity of Illness Scale

This segment of the rating scale was designed to identify those individuals who carry a diagnosis considered to include the severe and persistently mentally ill.

5 = Includes individuals who do not meet any of the categories described below, and who do not present as in need of mental health services at this time.

4 = Includes any individual who has received outpatient mental health services and counseling within the past two years, but has never been treated on an inpatient basis or been prescribed psychotropic medication.

3 = Includes any individual who has ever experienced a major psychiatric crisis that

- Resulted in a psychiatric hospitalization or
- Involved a suicide attempt, and
- The situation occurred over one year ago.

2 = Includes any individual who has experienced any of the following over the past year, and who does not fall into the category of severely and chronically mentally ill, as defined in #5.:
   A. A psychiatric hospitalization
   B. Been prescribed psychotropic medication
   C. Engaged in any self-destructive behavior, or any suicide attempts

1 = This category is used to identify the seriously and chronically mentally ill, and there is evidence that the inmate meets the criteria for one of the following diagnostic groups:
   A. Schizophrenic or Schizoaffective Disorder
   B. Bipolar Disorder
   C. Brain damage associated with aggression towards others
   D. Major Depression
   E. Any individual who has been force medicated within the past year
   F. Any individual who has been Baker Acted within the past year

Level of Addiction Scale

This segment of the Rating System was designed to identify individuals with substance abuse and chemical dependency issues.

5 = Available evidence does not support the existence of any substance abuse or chemical abuse problem,

4 = There is insufficient evidence to determine whether or not substance abuse is an issue, but the Mental Health Specialist does not feel it can be ruled out at this time.

3 = Identifies those individuals whom the Mental Health Specialist determines may have problems related to the use of alcohol and/or drugs, but there is insufficient evidence to categorize the individual as meeting the DSM !V R criteria for either substance abuse (see #2 below) or substance dependence (see #1 below)

2 = Identifies individuals meeting the criteria for **substance abuse.** Substance abuse is a maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by the presence of one (or more) of the following over the past year:
   A. Failure to fulfill major role obligations at work, school, or home
   B. Recurrent use of substance which contributes to physical hazards (i.e., DUI arrests)
   C. Recurrent substance-related legal problems (arrests for substance-related disorderly conduct)

D. Continued substance use despite having persistent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

1 = Identifies individuals meeting the criteria for

Substance dependence. Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following over the past year:

A. **Tolerance:** as manifested by either a need for markedly increased amounts of the substance to achieve intoxication or the desired effect **OR** markedly diminished effect with continued use of the same amount of the substance.
B. **Withdrawal:** as manifested by either the characteristic withdrawal syndrome for the particular substance **OR** the same substance is taken to avoid or relieve withdrawal symptoms.
C. The substance is often taken in larger amounts or over a longer period than was intended.
D. There is a persistent desire or unsuccessful efforts to cut down or control substance use
E. A great deal of time is spent in activities necessary to obtain the substance, use of substance, or recovery from its effects.
F. Important social, occupational, or recreational activities are given up or reduced because of substance abuse.
G. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Contact Person:

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Appendix D – Criminal Justice/Mental Health/Substance Abuse Web Resources

LAW ENFORCEMENT

Without adequate training and access to community-based mental health resources, law enforcement officers face tremendous obstacles in responding to people with mental illness. This section identifies resources for local law enforcement agencies looking to address mental health issues.

- **A GAINS Center Guide for Implementing Police-Based Diversion Programs for People with Mental Illness:** Summarizes what law enforcement agencies are doing across the country to improve their responses to people with mental illness and explores how these agencies have overcome barriers to create and maintain effective programs by collaborating with the mental health community.
  www.gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf

- **Law Enforcement/Mental Health Partnership Program:** Describes a Consensus Project national initiative to provide resources for law enforcement leaders and their community partners to develop and enhance law enforcement/mental health programs. (Products are currently in development).
  http://consensusproject.org/downloads/Lawenforcementonepager.pdf

- **Consensus Project Report Recommendations:** Offers detailed recommendations, endorsed by leaders representing law enforcement and mental health systems across the country, to help policymakers and practitioners improve outcomes of law enforcement encounters with people with mental illness.
  http://consensusproject.org/topics/toc/ch-II

- **Navigating the Mental Health Maze: A Guide for Criminal Justice Personnel:** Provides a crash course for criminal justice professionals whose understanding of mental illness and the mental health system may be limited.
  http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf

- **Online Program Profiles of Specialized Law Enforcement-Based Responses:** Allows users to search law enforcement-based response programs in other communities across the country, and post questions directly to representatives of these programs.
  http://consensusproject.org/programs

COURTS

People with mental illness appear repeatedly before judges and cycle in and out of jail for low-level crimes which are often the result of untreated mental illness. This section identifies resources for mental health courts or other court-based initiative targeting defendants with a mental illness.

- **Essential Elements of a Mental Health Court:** Outlines 10 elements essential to mental health court design and implementation and provides background on why each element is important and how courts can adhere to it. (Product currently in draft form).
  http://consensusproject.org/mhcp/essential.elements

- **A Guide to Mental Health Court Design and Implementation:** Explains critical issues such as determining whether to establish a mental health court, defining the target population, ensuring confidentiality, sustaining the court, and other key considerations. http://consensusproject.org/mhcp/Guide-MHC-Design.pdf

- **A Guide to Collecting Mental Health Court Outcome Data:** Describes practical strategies for collecting data and evaluating the effectiveness of mental health courts. Written for mental health court practitioners and policymakers who want to measure the impact of court-based programs.
  http://consensusproject.org/mhcp/MHC-Outcome-Data.pdf

- **Navigating the Mental Health Maze: A Guide for Criminal Justice Personnel:** Provides a crash course for criminal justice professionals whose understanding of mental illness and the mental health system may be limited.
  http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf

- **A Judges' Primer on Mental Illness, Addictive Disorders, Co-occurring Disorders, and Integrated Treatment:** A one-page reference, written for judges, on mental illness, addictive disorders, co-occurring disorders, and integrated treatment.
  http://consensusproject.org/downloads/judges-primer.pdf

- **Online Program Profiles of Mental Health Courts and Other Court-Based Programs:** Allows users to search through court-based programs and post questions directly to representatives of these programs. The database contains program profiles in the following issue areas: Pre-trial, Adjudication and Sentencing, Training.
  http://consensusproject.org/programs

- **An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court:** Special courts that sentence people with mental illnesses who are convicted of misdemeanors and low-level felonies to treatment instead of jail have the potential to save taxpayers money, according to a RAND Corporation study conducted for the Council of State Governments Justice Center.
  www.rand.org/pubs/technical_reports/TR439

- **Problem Solving Justice Toolkit:** Interactive, online toolkit for implementing problems solving approaches in the justice system. Developed by the National Center for State Courts.
  http://www.ncsconline.org/d_research/Documents/ProbSolvJustTool-v16.pdf

- **Effective Judging for Busy Judges:** Publication put out by Nation Judicial College and Bureau of Justice Assistance which outlines critical elements of problem-solving approaches and provides links to many resources.
  http://www.judges.org/pdf/effectivejudging_book.pdf

CORRECTIONS

The number of people with mental illness who are in prison or jail, or under probation or parole supervision, has increased dramatically in recent years. This section identifies resources for initiatives targeting people with mental illness upon their admission to jail or prison, while they are incarcerated, and after they are released to the community to the supervision of probation and/or parole.

- **Corrections/Mental Health Case Studies:** Offers detailed and frank discussion of the successes and setbacks that corrections and mental health leaders in Kansas and Orange County, Florida faced as they worked together to improve the response to people with mental illnesses transitioning from jail or prison to the community.
  http://consensusproject.org/updates/features/nic-case-study

- **Collaboration Assessment Tool:** Enables leaders in corrections or mental health organizations to assess their current level of collaboration and chart a course for improving collaboration in four categories: knowledge base, systems, services, and resources.
  http://consensusproject.org/assessment

- **Consensus Project Report Recommendations:** Offers detailed recommendations, endorsed by leaders representing jail, prison, community correction, and mental health systems across the country, to help policymakers and practitioners improve corrections-based responses to people with mental illness.
  http://consensusproject.org/the_report/toc/ch-IV

- **Re-Entry Policy Council Report Recommendations:** Offers detailed recommendations for improving the likelihood of successful re-entry among adults with mental illness released from prison and jail.
  www.reentrypolicy.org/reentry/Ch_B_Prison_and_Jail.aspx

- **Navigating the Mental Health Maze: A Guide for Criminal Justice Personnel:** Provides a crash course for criminal justice professionals whose understanding of mental illness and the mental health system may be limited.
  http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf

- **SSI/SSA and Medicaid:** Provides background, relevant research, and case studies on promptly connecting people released from prison and jail, including those with mental illness, with Medicaid and other federal benefits.
  www.reentrypolicy.org/reentry/Access_to_Federal_Benefits.aspx

MENTAL HEALTH ADVOCACY

In communities across the country, mental health advocates have been a driving force for change in improving responses to people with mental illness involved in the criminal justice system. But while advocates in these communities may be familiar with how the lives of individuals with mental illness in the criminal justice systems can be impacted, they may be less familiar with how to engage potential partners in these systems. The resource in this section provides

strategies for advocates to reach out to representatives from criminal justice / mental health systems looking to address these issues.

- **The Advocacy Handbook:** Recommends strategies to mental health advocates who want to improve outcomes for people with mental illness involved in the criminal justice system and are seeking to engage and focus policymakers and leaders in the criminal justice system.
  http://consensusproject.org/advocacy

ADDITIONAL RESOURCES:

Council of State Governments – Online Program Profiles of Corrections/Mental Health Programs: Allows users to search through corrections/mental health programs in the following areas and post questions directly to representatives of these programs. The database contains program profiles in the following issue areas: http://consensusproject.org/programs/

Council of State Governments – Criminal Justice/Mental Health Consensus Project:
http://consensusproject.org

Council of State Governments – Criminal Justice/Mental Health Information Network:
www.cjmh-infonet.org

Council of State Governments – Re-Entry Policy Council:
www.reentrypolicy.org/reentry/default.aspx

Council of State Governments/GAINS Center – Judges Leadership Initiative:
http://consensusproject.org/JLI

Florida Department of Children and Families (DCF): www.myflorida.com/cf_web

Florida Partners in Crisis (PIC): http://floridapartnersincrisis.org

Florida Substance Abuse and Mental Health Corporation: http://samhcorp.org

Florida's Children First (FCF): http://floridaschildrenfirst.org

Miami-Dade County Grand Jury Report – Mental Illness and the Criminal Justice System: A Recipe for Disaster/A Prescription for Improvement:
www.miamisao.com/publications/grand_jury/2000s/index.html

Miami-Dade County Mayor's Mental Health Task Force – Final Report:
www.miamidade.gov/mayor/library/03.29.07-Miami-Dade-County-MMHTF-Final-Report.pdf

National Alliance on Mental Illness: www.nami.org

National GAINS Center /TAPA Center for Jail Diversion: http://gainscenter.samhsa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

- **Center for Mental Health Services (CMHS):** http://mentalhealth.samhsa.gov/cmhs
- **Center for Substance Abuse Treatment (CSAT):** http://csat.samhsa.gov
- **Center for Substance Abuse Prevention (CSAP):** http://prevention.samhsa.gov

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): http://nrepp.samhsa.gov/

Appendix E – Psychotherapeutic Medication Treatment Plan Review

PSYCHOTHERAPEUTIC MEDICATION TREATMENT PLAN REVIEW
Pre-Psychotherapeutic Medication Consent Review for Children Birth through 5 Years Old

Prescribing Practitioner's Name:_____
Address:
Phone Number:_____
Fax Number:_____

SECTION 1: DEMOGRAPHIC INFORMATION (to be completed by the Child Case Manager / Child Welfare Worker)

Child's Name:_____ Date of Office Visit:_____
Address:_____
Child's Date of Birth:_____ Age:_____ DCF District/Region:_____
Case Manager/Child Welfare Staff:_____ Phone Number:_____
Case Manager Supervisor:_____ Phone Number:_____
DCF Contracted Agency:_____ Fax Number:_____
Obtaining Informed Consent was attempted from the parent/guardian: ☐ YES ☐ NO Date:_____
Person Consulted:_____ Relationship to Child:_____
Please Explain:_____

Sections 2 through 5 are to be completed by the Prescribing Practitioner

SECTION 2: DIAGNOSIS / DISORDER / BEHAVIORAL HYPOTHESIS

☐ Depression	☐ Oppositional Defiant Disorder	☐ ADHD	☐ Anxiety Disorder
☐ Conduct Disorder	☐ Post Traumatic Stress Disorder	☐ Substance Abuse	☐ Mental Retardation
☐ Substance Abuse	☐ Reactive Attachment Disorder	☐ Bipolar Disorder	☐ Autism/Asperger's
☐ Psychosis	☐ Learning Communication/Speech	☐ Other (specify)_____	
☐ Rule Out:_____			

SECTION 3: PSYCHOTHERAPEUTIC MEDICATION PLANNED

Medication:_____ Dose:_____ Dosage Range:_____
Titration Plan:_____
_____
Start Date:_____ to address the following target symptoms:_____
_____
Define treatment success/failure:_____
Define monitoring plan (include frequency of planned monitoring):_____
If the above medication fails to meet the identified goal, the following medication in the same drug class will be tried:
Medication:_____ Dose:_____ Dosage Range:_____
Titration Plan:_____
_____

(continue Section 3 on next page)

PSYCHOTHERAPEUTIC MEDICATION TREATMENT PLAN REVIEW

Pre-Psychotherapeutic Medication Consent Review for Children Birth through 5 Years Old

Prescribing Practitioner's Name:_____

Child's Name:_____

Date/Time of Office Visit:_____

Date/Time Faxed to UF:_____

SECTION 3: PSYCHOTHERAPEUTIC MEDICATION PLANNED (continued from page 1)

Additional Supporting Information:_____

_____

SECTION 4: OTHER PLANNED TREATMENTS / THERAPIES / EVALUATIONS / TESTS (Please list provider(s))

_____

_____

_____

SECTION 5: MEDICAL PROBLEMS AND OTHER MEDICATIONS (including over-the-counter medications)

_____

_____

_____

Signature of Prescribing Practitioner / Date

Section 6 is to be completed by the UF Consultant Child Psychiatrist

SECTION 6: PSYCHOTHERAPEUTIC MEDICATION TREATMENT PLAN REVIEW

Phone consultation between:_____ (Prescribing Practitioner/Title) and _____ (UF Child Psychiatrist)

Date/Time:_____

UF Child Psychiatrist Review (check one):

☐ I concur with the treatment plan listed by the attending prescribing practitioner on page 1.

☐ I concur with the treatment plan on page 1 with the following modifications that I have discussed with the prescribing practitioner:_____

_____

☐ I need the following information to provide an opinion about this child's psychotherapeutic medication treatment plan:

_____

_____

☐ I do not concur with the identified treatment plan and recommend an alternative plan:

_____

_____

University of Florida, School of Medicine, Department of Psychiatry

MedConsult: Phone number: 866-453-2266

MediConsult: Fax number: 352-392-9887

_____
UF Child Psychiatrist's Signature / Date

Date and time faxed to the child's case manager:_____

CF-FSP 5279, PDF 02/2006

Page 2 of 2

Appendix F –2008 Advanced Judicial Studies Program
Substance Abuse and Mental Health in the Justice System

DRAFT SCHEDULE

MONDAY, JUNE 2, 2008		TUESDAY, JUNE 3, 2008		WEDNESDAY, JUNE 4, 2008	
8:00 - 9:45	• Pre-Test & Small Group Breakout - Common myths surrounding SA & MH – Judge Steve Leifman, Judge Martha Lott, & Judge Mark Speiser • History and Future of Mental Health Issues and Substance Abuse in the Criminal Justice System - Judge Steve Leifman	8:00 - 9:30	• Expert Evaluations and Competency Restoration- Dr. Randy Otto	8:00 - 9:30	• Community Treatment • Baker Act – Judge Lott • Marchman Act Proceedings - Judge Lott • Juvenile Medication Orders– Judge Lott
9:45 - 10:00	**Break**	9:30 - 9:45	**Break**	9:30 - 9:45	**Break**
10:00- 11:00	• Prevalence of Substance Abuse and Mental Health, Course of Illness and how this leads to court interface - Dr. Fred Osher – Center for Behavioral Health, Justice, and Public Policy, Judge Steve Leifman	9:45 - 11:00	• Best Practices in Substance Abuse and Mental Health Treatment – Dr. Randy Otto (FMHI)	9:45 - 11:00	• Felony Forensic Courts • Misdemeanor MH Courts • Drug Courts – Judges Speiser
11:00- 11:05	**Stretch Break**	11:00- 11:05	**Stretch Break**	11:00- 11:05	**Stretch Break**
11:05- 12:00	• Screening and Assessment including co-occurring defined and explained as it appears in the judicial system – Dr. Fred Osher	11:05- 12:00	• Best Practices In Substance Abuse and Mental Health Treatment and *(Continued)*	11:05- 12:00	• Statutory & case law update – John Patrila
12:00- 1:00	**Lunch**	12:00- 1:00	**Lunch**	12:00- 1:00	**Lunch**
1:00 - 2:15	• Identifying with Substance Abuse and Mental Health Issues (Virtual Experience and use of Video) – Judge Leifman and Dr. Fred Osher	1:00 - 2:15	• Fashioning Appropriate Dispositions–, Judges Lott & Speiser;	1:00 - 2:15	• Ethical, privacy, & confidentiality issues – John Patrillo
2:15 - 2:30	**Break**	2:15 – 2:30	**Break**	2:15 – 2:30	**Break**
2:30 - 3:15	• Screening, Assessment and In Court Proceedings - Dr Fred Osher	2:30 - 3:30	• Role Playing Scenarios By Division in Break out groups – Judges Lott and Speiser	2:30 – 3:30	• Consumer Panel Judge Leifman
3:15 – 3:20	**Stretch Break**	3:30 – 3:35	**Stretch Break**	3:30 - 3:35	**Stretch Break**
3:20 – 4:05	Understanding Terminology (Family Feud Game) – Judges Leifman, Lott, & Speiser	3:35 – 4:35	• Questions – Dr. Randy Otto	3:35 – 4:35	• Post test – Judges Lott & Speiser

Appendix G – Sample templates for Administrative Order and Memorandum of Understanding

MODEL ADMINISTRATIVE ORDER:

Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee

The attached Model Administrative Order is intended to assist circuits in developing available resources for and responses to people in the court system who experience mental health and/or substance abuse disorders.

The concepts presented here are derived from the work of the Special Advisor on Criminal Justice and Mental Health, and the Mental Health Subcommittee of the Steering Committee on Families and Children in the Court.

The format of the model administrative order is intended to be a guideline from which each circuit can develop its own administrative order to address this area of critical importance.

IN THE _____ JUDICIAL CIRCUIT
_____ COUNTY, FLORIDA

WHEREAS, the _____ Judicial Circuit recognizes the myriad difficult issues that arise when persons with mental illness and/or substance use disorders become involved in the juvenile or criminal justice systems;

WHEREAS, the Supreme Court of Florida, Steering Committee on Families and Children in the Court was charged with addressing these issues and its subcommittee on Mental Health has made the following recommendations for systemic improvements:

Each judicial circuit is encouraged to consider developing a Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee to define strategies, criteria, and community alternatives within statutory authority and existing resources for diverting individuals involved in or at risk of becoming involved in the criminal justice system to the community mental health system for appropriate levels of treatment and support services;

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee should develop local strategies which will promote and sustain significant involvement of the courts and members of the judiciary in collaborative association with local criminal justice and mental health system stakeholders;

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee should assume a leadership role to address the impact of mental illnesses on the judicial system and collaborate with stakeholders to effectively address these impacts at every level of contact with the justice system;

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee should stimulate, support, and sustain joint problem-solving initiatives among stakeholders in the criminal justice and community mental health/substance abuse treatment systems to address issues relating to untreated mental illnesses and/or substance use disorders, and access to community-based services;

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee should work collaboratively with all stakeholders to consider pre-booking and post-booking interventions (e.g., mental health courts, pre-trial diversion programs, jail re-entry programs, specialized crisis response programs for law enforcement officers) involving evidence-based approaches to alleviating problems associated with and contributing to untreated mental illnesses and substance use disorders in the criminal justice and juvenile justice systems and in the community;

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee should work to improve information-sharing among relevant stakeholders within the courts, criminal justice system, juvenile justice system, and community mental health system regarding people with mental illnesses who are involved with or at risk of becoming involved with the justice system, in order to improve early identification and treatment of these individuals;

NOW, THEREFORE, pursuant to the authority vested in me as the Chief Judge of the _____ Judicial Circuit, in order to effectuate the aforementioned improvements, and to better serve the needs of the citizens of the state of Florida, it is hereby ORDERED as follows:

Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee

The Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee of the _____ Judicial Circuit is hereby established. The Chief Judge or designee shall be the Chair of the Criminal Justice Mental Health/Substance Abuse Advisory Committee of the _____ Judicial Circuit. Membership should include representatives from the following:

Judiciary	Trial Court Administrator
Magistrates	Clerk of Court and Staff
Psychiatrists	Case Managers
Psychologists	Department of Children and Families
Substance Abuse Service Providers	Department of Juvenile Justice
Guardian ad Litem	Department of Corrections
Private Attorneys	Consumers
State Attorneys	School Board/Dept. of Education
Public Defenders	Local Government Officials
Legal Services/Legal Aid	Community Organizers
Law Enforcement	Local Colleges, University Professionals
Crisis Intervention Teams	Probation Officers

Criminal Justice/Juvenile Justice/Mental Health/Substance Abuse Advisory Committee shall meet quarterly or upon call of the Chair.

This Administrative Order shall become effective upon signing.

DONE AND ORDERED in Chambers in _____ County, Florida, this ___ day of _____, 2007.

_____
CHIEF JUDGE

SUGGESTED TEMPLATE FOR THE DEVELOPMENT OF A MEMORANDUM OF UNDERSTANDING (MOU) FOR CROSS SYSTEM COLLABORATION

A Memorandum of Understanding (MOU) is a document describing relationships among parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

For purposes of developing cross system collaboration among justice, mental health and substance abuse systems as well as with other parties and organization that provide resources, services and supports to individuals with mental illnesses, substance use disorders and/or co-occurring disorders this sample MOU template is designed to establish a framework and articulate responsibilities for its stakeholders.

Title of MOU: The title should reflect the purpose of the group's work

Intent: This section should articulate the desire to formalize relationships across systems to address the needs of their target population. It should identify the stakeholder groups to be involved at a minimum and indicate their desire to work together.

Example:

The intent of this MOU is to establish and maintain a partnership with the judicial system, juvenile and criminal justice system, local mental health and substance abuse providers, hospitals, families, consumers, provider networks, HMO's, social services, educational system, social security, housing, vocational services and other organizations that share and will promote the common goals and objectives to address the needs of individuals with serious mental illnesses and/or substance use disorders that come in contact with the juvenile or criminal justice system

Another example:

The intent of this MOU is to formalize the establishment of the (name of group) and to develop goals, objectives and guiding principles that address the needs of individuals with serious mental illnesses and/or substance use disorders that come in contact with the juvenile or criminal justice system; as well as establish membership and responsibilities of its members.

Purpose: This section should state the purpose of this document in guiding the group's work

Example:

This agreement is intended to guide the (name of group) in identifying the needs of individuals with serious mental illnesses and/or substance use disorders that come in contact with the juvenile or criminal justice system and developing shared strategies and best practices that will address the needs and create system improvements, increase public safety, use limited resources effectively and efficiently and promote advocacy for increased resources

Goals: This section should outline the goals the group identifies that relate to the overarching reason they have come together., i.e. what do they hope to accomplish, what changes do they want to make, what are their primary outcomes, etc.

Example:

The goals of (name of group) are to:

1. *Reduce recidivism of individuals with mental illnesses and/or co-occurring substance use disorders from having contact with the juvenile or criminal justice system*
2. *Increase public safety*
3. *Increase access to services*
4. *Increase capacity of community-based services*
5. *Improve information sharing and data collection for continuity of care and outcome reporting*
6. *Improve coordination of care among systems*

Example:

Improve access to and quality of mental health and substance abuse services and supports through a systematic approach to developing and supporting strategies to introduce, adapt and apply evidence-based and best practices that reduce contact with the juvenile or criminal justice system for individuals with serious mental illnesses and/or substance use disorders

Guiding Principles: This section addresses the shared principles, values and ideals the group will adhere to in its work together. This section can also outline the overall responsibilities of its members. Guiding principles may be written as "Where As"

Examples

The members of (name of group) agree to adhere to the following guiding principles:

1. *Be respectful of the ideas and opinions of all members*
2. *Be responsive to assigned responsibilities*
3. *Promote open communication*
4. *Work for the common good of the community and the people it serves*
5. *Adopt a shared vision and mission, goals and objectives*

Example:

Whereas, *the participating members agree to support this MOU*
And whereas, *this agreement is intended to promote system change and improvements to reduce contact with the juvenile or criminal justice systems for individuals with serious mental illnesses, emotional disorders and/or substance use disorders; and to promote recovery and resiliency*
And whereas, *the participants of this agreement will work in collaboration to support and strengthen this agreement*

Objectives: This section outlines the strategies or processes of how the group will achieve its goals. Also this section may also articulate the various roles and responsibilities of the members.

Example:

The objectives of this (name of group) to achieve its goals are:
1. *To complete a system mapping how a person moves through the system that will identify strengths and weaknesses of the system, its resource needs, duplication, etc.*
2. *To identify and recommend evidence based and best practice approaches that will help support a process of change within the community*
3. *To build on existing management and leadership skills at all levels to enable the application of innovative and creative approaches for change and improvements*
4. *For members of this MOU to share resources to change and improve the system*

Responsibilities of the Members: This section can be broad or specific for each member.

Example:

All members of the (name of group) will designate staff members to participate in meetings and serve on committees
All members are expected to support the specific activities of this group (name of group)
All members must be willing to share necessary information for system change and improvements
One member may be identified as providing meeting space
One member may offer staff to take minutes of group

Closing sentence before the signature lines: This is intended to imply that by signing this MOU the person signing agrees with its intent, purpose, content and duties.

Example:

This agreement will be signed by the appropriate agency representatives. By signing, the parties agree to support and uphold this agreement. The parties agree to renegotiate this Agreement if revisions of any applicable laws or regulation make changes in this Agreement necessary, or at least annually.

Signature Page: There should be a separate signature page that lists the Name and Title of each participant and the date.

Example:

Signed by: _____
Name: John or Jane Doe
Title: Judge or Sheriff or CEO, etc
Date:_____

Appendix H – Sample MOUs

District 7

Alcohol, Drug Abuse and Mental Health Program Office

Florida House Bill 2003

Section 18

Cooperative Agreement

Diversion of Misdemeanant Offenders From the Criminal Justice System to the Civil Baker Act System

---

Intent: The intent of this cooperative agreement is to establish and maintain a partnership with the judicial system, the criminal justice system, and local community mental health and substance abuse providers to divert individuals with mental health disabilities and misdemeanor charges from the judicial system to the local Baker Act delivery system.

Purpose: This agreement is intended to promote the early identification and diversion of misdemeanant offenders who are experiencing an emotional crisis pursuant to section 394.463, F.S. and section 394.462 (1) (f), F.S.

Goal: The goal of this agreement is to:

1) Encourage pre-booking diversionary strategies that reduces the likelihood of a misdemeanant mentally ill offender being unnecessarily incarcerated in the Orange County Jail.

2) Promote the diversion of individuals with misdemeanor offenses and mental health disabilities from the jail to the local civil Baker Act delivery system.

3) Define and establish linkage and referral responsibilities to facilitate such diversionary practices.

4) Enhance procedures for the assignment of Traditional and/or Intensive Case Management services for this population.

5) Initiate a system to enable law enforcement to have access to mental health professionals on difficult cases.

6) Establish a system which reviews individuals with mental health disabilities and misdemeanor offenses who have been incarcerated in the Orange County

7) jail versus the Civil Baker Act delivery system. This process will be used for the purposes of improving the process of diversion of misdemeanant offenders.

Whereas, the participating members of the judicial system, the criminal justice, law enforcement and mental health and substance abuse providers agree to support this Cooperative Agreement,

And whereas, this agreement is intended to promote pre-booking and post-booking intervention strategies for the diversion of individuals with mental health disabilities and misdemeanor charges from the judicial system to the civil Baker Act mental health delivery system,

And whereas, the participants of this agreement will work in collaboration to support and strengthen this agreement.

Now therefore, together as a community, the below mentioned continuity of care practices will occur to promote this cause:

1. Each organization will agree to identify a point of contact to actively assist in the resolution of roadblocks that are incurred within the civil and forensic mental health delivery system of Orange County.

2. The Department of Children & Families (DCF) will maintain a list of the assigned liaisons that will be distributed to community stakeholders in this agreement. This working document will be entitled the "Community Points of Contact: Systems Resolution Agreement" (See attached document).

3. The law enforcement agencies serving Orange County will make reasonable efforts within the scope of their departmental policies to divert individuals with non-criminal or minor criminal behaviors to the nearest civil Baker Act receiving facility when it is apparent that an individual is in need of involuntary Baker Act examination pursuant to section 394.463, F.S., and transported thereto, pursuant to section 394.462 (1) (f), F.S.

4. The DCF and local community mental health and substance abuse providers will work in partnership with law enforcement to promote educational services and training that encourages patrol officer's developing working knowledge of the local civil Baker Act delivery system. These educational services will be designed to promote the diversion of individuals with mental health disabilities to the less restrictive civil Baker Act system.

5. With the initiation of the Voluntary Medical Security Program, which provide an identification bracelet and/or ID card identifying individuals with mental illness or special needs, the Orange County Sheriffs Office and the Orange County Corrections Department in cooperation with Lakeside Alternatives, Inc. will identify possible diversion options and/or appropriate treatment resources.

6. Lakeside Alternatives, Inc. agrees to coordinate with the Department of Corrections to facilitate post booking assessment that identify misdemeanant offenders who are

experiencing mental health related difficulties for the purposes of appropriate treatment interventions in the community.

7. Orange County Department of Corrections, and Lakeside Alternatives, Inc., in conjunction with the Public Defender's Office, and the State Attorney's Office, will assist the judicial system in the early identification of individuals with apparent mental health disabilities and to initiate jail diversion practices when appropriate.

8. Orange County Department of Corrections, and Lakeside Alternatives, Inc., agree to work cooperatively to identify less restrictive community placement options that may be offered to the defendant and for the Court's consideration, after review by the State Attorney's Office. These placement options are not limited to inpatient Baker Act evaluation, but should strive for the less restrictive form of community placement.

9. Lakeside Alternatives, Inc., will maintain written protocols with Orange County Corrections for the transfer of misdemeanant offenders from the jail when involuntary Baker Act examination criteria is met and the Court allows for such a diversion pursuant to section 394.463, F.S.

10. In cases when the court has released individuals from the Department of Corrections, while inpatient at Lakeside Alternatives, Inc., Lakeside Alternatives, Inc. will coordinate community discharge and referral services that appropriately link the individual to community mental health and/or substance abuse providers upon discharge. These services will include referrals for any ongoing medication need and/or referral for case management services, as appropriate. If the individual is returned to the jail and then released, Lakeside Alternatives, Inc. agrees to provide the Department of Corrections with a discharge plan to ensure continuity of treatment while incarcerated.

11. An individual can be referred for consideration of acceptance into Traditional or Intensive Case Management services pursuant to DCF District 7 – Alcohol, Drug Abuse and Mental Health Program Office policy by any party involved in the intervention and diversionary practices referenced in this agreement.

12. Orange County Department of Corrections and Lakeside Alternatives, Inc. agree to work cooperatively to develop mechanisms for community referral information. This information will be made available to selected individuals who have been identified with mental illness and are release into the community.

13. In the event an individual affected by this agreement has existing Traditional or Intensive Case Management services, the assigned Case Manager will be responsible for assisting in the facilitation of diversion practices pursuant to forensic case management policies and procedures of the DCF District 7 – Alcohol, Drug Abuse and Mental Program Office.

Furthermore, this Agreement shall be reduced to writing and signed by appropriate agency representatives. The parties agree to renegotiate this Agreement if revision of any applicable laws or regulations make changes in their Agreement necessary, or at least annually.

In The County Court of The Eleventh Judicial Circuit In And For Miami-Dade County

County Court Jail Division - Mental Health Agreement November 27, 2000

Current law requires law enforcement officers serving Miami-Dade County, having custody of individuals based on non-criminal or minor criminal behavior that meets the statutory guidelines for involuntary examination, to transport such persons to the nearest Baker Act receiving facility for examination, in accordance with the requirements of Florida Statutes 394.462(1)(f). In the event an individual with mental illness is arrested for a misdemeanor, pursuant to Florida Law 99-396, the following procedures shall be implemented by the signatories hereto:

Mental Health Procedures

(1) When an, individual is arrested for a misdemeanor (other than Domestic Violence*), a Corrections Health Services qualified mental health professional (i.e. a physician, clinical psychologist, psychiatric nurse or clinical social worker) will examine the individual in need of mental health services. Based upon the examination, the professional may execute a Professional Certificate to initiate an involuntary examination pursuant to F.S.394.463(2)(a)(3). When possible, the Professional Certificate should be issued within 24 hours of the arrest.

*Domestic Violence Division will be responsible for creating an agreement consistent with their needs.

(2) Upon execution of a Professional Certificate, Corrections Mental Health will immediately notify the Public Defender's Office (or other defense counsel), the State Attorney's Office and the Mental Health Administrator's Office and provide them with a copy of the Professional Certificate and the name and address of the receiving facility that has agreed to provide an involuntary examination.

(3) Upon receipt of the Professional Certificate from Corrections Mental Health, the Mental Health Administrator's Office will calendar the case before the county court jail division judge the next day of court for an Order of Transport to that receiving facility. The Mental Health Administrator's Office will also provide telephonic notice to the State and Defense of the calendared case. The signed Order to Transport will be delivered by the Mental health Administrator's Office to the Corrections Transportation Unit. In the event that the State or Defense has an objection to the transportation order, it is to be raised at the scheduled court hearing.

(4) Transportation to and from the receiving facilities and court hearings (in lieu of re-booking) will remain the responsibility of Miami-Dade County Corrections & Rehabilitation Department, upon receipt of court order. The court will issue a bench warrant hold upon release to a receiving facility. The bench warrant hold shall be designated in the computer as BWTH (bench warrant treatment hold). Corrections Mental

Health shall also provide the receiving facility with a copy of the Professional Certificate, any other evaluations and a copy of the arrest affidavit. Corrections Mental Health shall work with the Public Defender's Office (when the Public Defender client agrees to treatment) and the Mental Health Administrator's Office to identify an appropriate receiving facility.

(5) The Baker Act receiving facility will be responsible for performing an evaluation to determine whether or not the individual meets criteria for involuntary placement pursuant to Chapter 394, Part I of the Florida Statutes.

(5a) If it is determined that the individual meets criteria for involuntary placement pursuant to the Baker Act, the receiving facility shall provide the Baker Act Assistant State Attorney with a copy of the arrest affidavit or charging document, a copy of the individuals' psycho-social history and the names, addresses and telephone numbers of any person expected to testify in support of the patient's continued detention and the substance of their anticipated testimony.

(5b) Once it is determined that the individual does not meet criteria for involuntary placement pursuant to the Baker Act, but the individual wishes to receive aftercare treatment, the receiving facility shall complete an aftercare report prior to the discharge of the individual charged with a misdemeanor(s) and will make all appropriate referrals. The report will include recommendations for aftercare services, including but not limited to, documentation of medication distribution in sufficient quantity pending follow-up appointment, a follow-up appointment for continuing mental health care, and an appropriate residential placement, if available. The report will be faxed by the facility 24 hours prior to the discharge to the Mental Health Administrator's Office and to the Public Defender's Office (or other defense counsel) and the State Attorney’s Office. The Mental Health Administrator's Office will notify the Offices of the Public Defender and the State Attorney of the impending discharge and shall place the matter back on calendar before the county court jail division judge within 24 hours of the notice and shall provide telephonic notice to the state and defense of the calendared case. The report shall be presented to the court at the hearing. When the individual is ready for discharge, the Mental Health Administrator's Office will make arrangements with Corrections Transportation Unit to transport the individual back to court. Unless otherwise required, Corrections shall return the individual directly to Courtroom 6-7 (Jail Division), without first re-booking the individual.

(5c) Once it is determined that the individual does not meet criteria for involuntary placement pursuant to the Baker Act, and the individual does not wish to receive aftercare treatment, the receiving facility shall denote and sign the aftercare report that aftercare services were offered, explained and refused.

(6) Upon returning the individual to the Jail Division, the County Court Judge shall consider the disposition of the pending criminal charges and, when possible, appropriately resolve them.

(7) The Florida Department of Children and Families will provide information regarding available resources for medication payment.

(8) The Florida Department of Children and Families will provide a continuum of appropriate mental health services, including case management services for the following individuals:

- Those individuals charged with a misdemeanor offense who upon transfer to a Baker Act receiving facility are determined to meet Baker Act eligibility requirements by a Baker Act receiving facility physician.

- Those individuals charged with a misdemeanor offense who are diagnosed as chronically and persistently mentally ill and who have an Axis I diagnosis of a major mental illness pursuant to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

- Those individuals charged with a misdemeanor offense who are determined to meet all necessary Medicaid eligibility requirements shall be provided intensive case management services.

The provision of mental health services by the Department of Children & Families is subject to the limitations as referenced in Attachment I of the Agreement. The provision of mental health services by the Department is further limited to and contingent upon availability of funding by the Legislature and allocation of necessary resources by the State Alcohol, Drug Abuse, and Mental Health (ADM) program office.

(9) The City of Miami Police Department and the City of Miami Beach Police Department agree to implement a "Memphis style" Crisis Intervention Team (CIT) program within their respective departments. The parties hereto will assist those police departments in the planning, training and implementation of this program.

(10) A multi-agency Task Force consisting of representatives of the agencies participating in this Agreement will meet on a monthly basis to discuss and resolve issues pertinent to individuals charged with misdemeanors who are in need of mental health services. This Task Force will work with all of the Police Departments in Miami-Dade County regarding the response of police to persons with mental illness who may be in crisis.

(11) Upon signature of the Florida Department of Children and Families, this amended Agreement shall supersede the previously agreed and signed November 22, 1999 County Court Jail Division-Interim Mental Health Agreement.

The undersigned this 27th day of November, 2000 agree to follow the above procedures.

_____	_____
District Administrator Florida Department of Children and Families, District 11	11th Judicial Circuit Court
_____	_____
Department of Corrections	Public Defender's Office
_____	_____
State Attorney's Office	City of Miami Police Department
_____	_____
City of Miami Beach Police Department	JMH – Public Health Trust

In The County Court of The Eleventh Judicial Circuit In And For Miami-Dade County

ATTACHMENT I
COMMUNITY MENTAL HEALTH CENTER (CMHC) PROVIDER AGREEMENT

If after professional screening and evaluation a misdemeanor defendant seems to be in need of acute care, the individual shall be referred to a Crisis Stabilization Unit (CSU) or a Jackson Memorial Hospital crisis unit. If the defendant appears to be mentally ill, but does not need acute services, the individual shall be referred to Community Mental Health Centers that have agreed to provide the following services:

1. Follow-up appointment with the psychiatrist within 7 days of jail release.
2. Sufficient medication to last through next follow-up appointment.
3. Housing, as available, since temporary & emergency housing is always needed.
4. Tracking and linkage to continued care by a case manager.

Or if the individual is an alleged felon, they will be referred to UM/JMH treatment services.

The CMHCs who will render the services outlined in this agreement are:

_____
Bayview Center for Mental Health

_____
Citrus Health Network

_____
Community Health of South Dade, Inc.

_____
Douglas Gardens Community Mental Health Center

_____
Lock Towns Community Mental Health Center

_____
Miami Behavioral Health Center

_____
New Horizons Community Mental Health Center

Hillsborough County Jail Diversion
Memorandum of Understanding (MOU)
October 16, 2006

I. Background:

For several years Hillsborough County Criminal Justice Office in collaboration with a host of community partners has been developing an array of jail diversion interventions for persons with mental illness and/or substance use disorders. In 2006, Hillsborough County was awarded a federal Substance Abuse and Mental Health Services Administration (SAMHSA); Center for Mental Health Service (CMHS) Targeted Capacity Expansion (TCE) grant for jail diversion services. The timing of this grant is congruent with several jail diversion activities in Hillsborough County and the Florida Department of Children and Families Substance Abuse and Mental Health (SAMH) Program Office in the Suncoast Region. The grant will serve as a catalyst for further jail diversion system and service delivery development.

II. Vision:

It is the vision of the Hillsborough County Jail Diversion partners that persons arrested for misdemeanors who are in need of mental health and/or substance abuse services should be offered treatment as an alternative to incarceration. The Jail Diversion partners recognize that recovery-oriented services that are evidence-based will yield positive outcomes for persons and enhance their opportunities to be productive citizens. It is also envisioned that a comprehensive, continuous and integrated system of care be established in Hillsborough County for persons who will benefit from a wide array of community-based jail diversion services.

III. Goals:

The following goals are agreed upon by the Hillsborough County Jail Diversion partners:

<u>System Level</u>:

- To establish a Strategic Plan to implement the SAMHSA Jail Diversion Grant over the next three years (2006-2009).
- To agree on a set of Recovery-oriented principles that will drive the system.
- To establish a longer range Jail Diversion Plan for Hillsborough County.
- To establish a community-wide MOU that is mutually beneficial to Jail Diversion partners and the community at large.

<u>Program Level:</u>

- To develop and implement a Forensic Intensive Case Management Program (F-ICM) based on evidenced-based mental health (Assertive Community Treatment – ACT *modified),* substance abuse and co-occurring (SAMH) models and best practices.

- To utilize all other community-based mental health, substance abuse, health and social service programs in Hillsborough County that will support the Jail Diversion system and individuals served by it.
- To implement a Jail Diversion program that ensures voluntary treatment and public safety.

Clinical/Practice Level:

- To identify individuals entering or within the Hillsborough County Jail with mental illness and/or substance use disorders that would benefit from community-based mental health and/or substance abuse diversion services.
- To provide evidence-based treatment services to persons served by the SAMHSA Jail Diversion grant and other sources of mental health or substance abuse funded services in the County.
- To develop a comprehensive, continuous and integrated array of services for persons in need of mental health and/or substance abuse services and may also need health or social services.

Principles and Values: Consumer and Family Driven

The Hillsborough County Jail Diversion Partners agree to adopt SAMHSA's National Consensus Statement on Mental Health Recovery (available upon request) in guiding the Jail Diversion Grant and strategic plan. The fundamental components of recovery include the following:

1. Responsibility
2. Self-direction
3. Individualized and person-centered
4. Empowerment
5. Holistic
6. Non-linear
7. Strengths-based
8. Peer Support
9. Respect
10. Hope

IV. Purpose:

This MOU between Hillsborough County Government and an inclusive group of community partners will establish a comprehensive jail diversion system for persons in need of mental health and/or substance abuse treatment and recovery. The MOU is a cooperative agreement that is mutually beneficial to the parties named below and will outline the expectations, roles, responsibilities and goals of all partners.

V. Community Partners:

Lead Agency – Hillsborough County Government, Criminal Justice Office – SAMHSA Jail Diversion Grantee.

Partners:

- Hillsborough County Sheriff's Office (Jail).
- Hillsborough County Health and Social Services.
- Citizens, consumers and family members receiving and recovering from mental health and substance use disorders in Hillsborough County.
- Agency for Community Treatment Services, Inc. (ACTS).
- Mental Health Care, Inc. (MHC).
- University of South Florida; Florida Mental Health Institute (FMHI); Department of Mental Health Law and Policy (MHLP).
- Florida Department of Children and Families, Suncoast Region Substance Abuse and Mental Health Program Office (DCF-SAMH).
- Central Florida Behavioral Health Network, Inc. (CFBHN).
- Drug Abuse Comprehensive Coordinating Office, Inc. (DACCO).
- Gulf Coast Community Care.
- Homeless Coalition of Hillsborough County, Inc.
- National Alliance on Mentally Illness: NAMI Hillsborough.
- Public Defender's Office of Hillsborough County.
- State Attorney's Office for the Thirteenth Judicial Circuit.
- 13th Judicial Circuit Court.
- Hillsborough County Public Safety Coordinating Council.
- Other community partners are welcome to join as a part of building a comprehensive system of care.

VI. Duration of the MOU:

This agreement will be in effect on the date signed by all partners and shall be in effect until the MOU is cancelled by the partners in accordance with the terms set forth herein. The MOU will be an integral part of the Strategic Plan and serve as a guide for achieving many of the goals of the SAMHSA Jail Diversion grant and larger system development in Hillsborough County.

VII. General Provisions:

This MOU does not create additional jurisdiction or limit or modify existing jurisdiction vested in the parties. It is understood by all parties that each should fulfill its responsibilities under this MOU in accordance with the provisions of law and regulations that govern their activities. Nothing in this MOU is intended to negate or otherwise render ineffective any such provisions or operating procedures. If at any time a party is unable to perform its functions under this MOU consistent with such party's statutory and regulatory mandates, the affected party shall

immediately provide written notice to the others to establish a date for mutual resolution of the conflict.

VIII. Responsibilities:

In consideration of the mutual aims and desires of the parties of this MOU and in recognition of the public benefit derived from effective implementation of the programs involved, the primary parties of the Jail Diversion grant agree that their responsibilities under this MOU shall be as follows:

Hillsborough County Government: Criminal Justice Office – Jail Diversion Grant Management and system coordination and long range strategic planning.

ACTS – Service provider contracts, substance abuse and co-occurring services coordination, development of client confidentiality "business associate" or "covered entity" agreements.

MHC – Primary F-ICM program development and implementation, practice guidelines, best practices, providing client demographics to USF-FMHI for evaluation purposes and obtaining "release of information" for collaborating treatment providers.

FMHI – SAMHSA Jail Diversion strategic planning, data collection and evaluation. FMHI will be responsible for getting approval from the USF Institutional Review Board (IRB) to conduct the Jail Diversion evaluation. FMHI will also offer a series of best practices application to the community through faculty consultation and training.

All other partners - Active participation in the strategic planning process and involvement on agency appropriate committees, such as the Service Delivery Committee, Evaluation Committee or Project Implementation Committee.

IX. Confidentiality and Procedures for Sharing of Information:

Treatment Partners (MHC, ACTS, HCSO, etc.) – Will agree to participate as a "business associate" or "covered entity" of MHC or ACTS in sharing confidential information with other providers for continuity of care. The treatment partners further agree that they will communicate and/or disclose to one another, client information pertaining to mental health, alcohol and substance abuse treatment only with the client's written consent or as otherwise authorized by applicable law (HIPAA, 42 CFR II).

Non-treatment partners – Responsible for sharing aggregate, non-identifying clinical information for grant and evaluation purposes.

X. Effective Administration and Execution of this MOU:

A. This MOU shall be reviewed annually and remain in full force and effect until specifically abrogated by one of the parties to this MOU with thirty (30) days written notice to the other party.

B. Effective execution of the MOU can only be achieved through communication and dialogue. It is recognized that each partner in this MOU works in a complex legal, social and political environment. It is the intent of this MOU to foster a means of communication and resolve questions, misunderstandings or complaints that are not specifically addressed in the MOU.
C. After the execution of this MOU, Criminal Justice Office will provide copies to all parties and submit the MOU to SAMHSA for approval and release of Jail Diversion grant funding to proceed with F-ICM services.

MIAMI/DADE COUNTY (DCF DISTRICT 11A)

MEMORANDUM OF AGREEMENT AND CONSENSUS DOCUMENT

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

June 4, 2004

Overview

Individuals with co-occurring psychiatric and substance disorders in District 11 are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. They are commonly "system misfits", incompletely served in both mental health and substance abuse treatment settings, with resulting overutilization of resources in the criminal justice system, the primary health care system, the homeless shelter system, and the child welfare system. In addition to having poor outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all behavioral health settings that they can be considered an expectation, rather than an exception.

In order to provide more welcoming, accessible, integrated, continuous, and comprehensive services to these individuals (adults, children, families), the following entities in District 11 have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change to improve outcomes within the context of existing resources: These entities include funders (both direct funders such as DCF District 11 and Miami Dade County as well as funding entities that are contracted to manage or oversee various funding streams within the District system: Jackson Memorial Hospital Managed Medicaid organization, South Florida Provider Coalition, Miami-Dade County Homeless Trust, etc.), Advocacy organizations (e.g., NAMI, SAMH Planning Council, consumer orgs); Mental Health, Substance Abuse, and Children's Mental Health Providers; Juvenile Justice; Mental Health Court Jail Diversion (Dade); Public Health Trust – Jackson Memorial Hospital (Dade); Community Based Care (CMH).

This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000) which espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system:

1. Dual diagnosis is an expectation, not an exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
2. The core of treatment success is any setting is the availability of empathic, hopeful treatment relationships that provide integrated treatment and coordination of care during each episode of care, and, for the most complex patients, provide continuity of care across multiple treatment episodes.

3. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.

4. Within the context of any treatment relationship, case management and care, based on the client's impairment or disability, must be balanced with empathic detachment, confrontation, contracting, and opportunity for contingent learning, based on the client's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.

5. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is required.

6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change. Appropriately matched interventions may occur at almost any level of care.

7. Consequently, there is no one correct dual diagnosis program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are dual diagnosis programs that at least meet minimum criteria of dual diagnosis capability, but each program has a different "job", that is matched, using the above model, to a specific cohort of patients.

8. Similarly, outcomes must be also individualized, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

Using these principles, we have agreed to implement a CCISC as a comprehensive quality improvement project in District 11, incorporating quality improvement activities at the funder level, advocacy level, and provider level, to achieve a system change process with the following four core characteristics:

1. The CCISC requires participation from all components of the behavioral health system, with expectation of achieving, at minimum, Dual Diagnosis Capability standards (and in some instances Dual Diagnosis Enhanced capacity), and planning services to respond to the needs of an appropriately matched cohort of dual diagnosis patients.

2. The CCISC will be implemented initially within the context of existing treatment resources, by maximizing the capacity to provide integrated treatment proactively within each single funding stream, contract, and service code.

3. The CCISC will incorporate utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with psychiatric and substance disorders, and promote integration of appropriately matched best practice treatments for individuals with co-occurring disorders.

4. The CCISC will incorporate an integrated treatment philosophy and common language using the eight principles listed above, and develop specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.

Action Plan for the District:

1. The DCF District Leadership, in partnership with representatives of managed care funders, providers and stakeholders, will assist in sustaining the Project Leadership Team, which is empowered to make key decisions regarding implementation activities that will take place under the authority of DCF, and will affect performance and participation of providers and stakeholders. The Project Leadership Team is the collaborative process for overseeing a transformation of the District 11 behavioral health service delivery system, with the first step being a focus on developing a systemic CQI process regarding co-occurring disorders. Over time, other initiatives may come under the auspice and design of this Team. Membership in the Project Leadership Team will be open to all funders, providers and stakeholder agencies that commit to contributing empowered consistent membership to the team, to be bound by its decisions, and to commit to the initial activities defined in this memorandum of agreement document.

2. DCF will work collaboratively with all funders in the system to assure that performance objectives and quality improvement plans developed by those funders (in the funder's own performance contract with the state or county) incorporate indicators that are consistent with and supportive of the provider activities and system development activities that are included in this Charter Document, and that these indicators are translated by the funders into provider contracting and oversight mechanisms in a manner that is developmentally consistent with the timing of the objectives agreed to in this charter.

3. The Project Leadership Team will be convened by DCF with a letter to CEOs of involved entities. The Team will create a committee to define its mission and scope, and disseminate that mission and scope, along with this memorandum of agreement document, to all providers and stakeholders.

4. The Project Leadership Team will be designed in such a way that there is clear representation of the Children's System on the Leadership Team, and with the intent that the elements of this memorandum of agreement will be integrated so that dual diagnosis capability will be built as an expectation of the Children's System.

5. The Project Leadership Team will design a plan for educating collaborative systems to this initiative and bringing them into the Leadership Team process: Education, Juvenile Justice, Adult Criminal Justice systems, Child Welfare, and helping them to

begin to initiate project expectations into their own contracts and program design activities.

6. The Project Leadership Team will create a subcommittee to develop a systemic policy welcoming individuals and families with co-occurring disorders into the system of care, and creating a definition of co-occurring disorders that recognizes that family members of children are included in the definition (e.g. Substance abusing parents of emotionally disturbed children; mentally ill parents with substance abusing children).
7. This initiative will be organized as a comprehensive CQI project under the auspices of the District, all funders, Planning Council representatives, and the Leadership Team. They will formally charter the initiative within that framework.
8. The Leadership Team will score the CO-FIT within the next six months to establish a baseline measure for CQI improvement, and to define a methodology for project outcome evaluation.
9. The Leadership Team will identify an individual to be Project Director and develop resources for project management, such as defining responsibility will be to develop mechanisms for collecting data to monitor project performance by participants at all levels.
10. The Leadership Team will develop a process to identify simple methodology for district level data capture for the prevalence of individuals and families with cod in the service population, and align this with quality improvement efforts to improve data collection for each of the funders. Efforts will be made to create a consistent reporting mechanism for this information across the multiple funders, to the extent possible.
11. The leadership Team will develop and recommend mechanisms to establish incentives for participation by agencies and providers, and align these incentives with any quality improvement incentive mechanisms developed by the funders.
12. The Leadership Team will assist in the development by each funder of clear instructions or interpretive guidelines for providers on how to provide, document, and bill for appropriate integrated treatment within the context of any funding stream or contract. This will include the development of an integrated scope of practice for singly defined clinical staff, which will define the range of appropriate activities.
13. The Leadership Team will work to integrate dual diagnosis capability, cultural competency, and Children's system of care values into all other initiatives, so that all key initiatives are properly aligned.
14. Invite Drug Court to the table.
15. Invite the Marchman and Baker Act offices to the table.
16. The District will work in partnership with providers, trainers, stakeholders to effect administrative, policy, and procedure changes to remove barriers to implementation, and to facilitate utilization of existing resources to promote implementation.

Action Plan for Managed Care Funders and other intermediaries:

1. To participate with DCF in aligning performance objectives, quality improvement efforts, provider incentives, data collection, etc, with the elements of CCISC implementation incorporated in this charter.
2. To participate actively in the Leadership Team and in appropriate committees to work in partnership with providers and stakeholders in designing the quality improvement process for movement toward DDC implementation.
3. To support the use of the CCISC toolkit by providers, and to participate in using the CO-FIT as part of system level assessment of progress in CCISC implementation.
4. To align policy development regarding welcoming, screening, billing for integrated services with the overall objectives of DCF and with the development of CCISC implementation
5. To support the provision of technical assistance, training, and consultation as appropriate to supporting the internal quality improvement objectives for their funded providers within the context of this initiative.

Action Plan for Providers and Stakeholders:

In the first year of implementation, all participating agencies or programs will agree to the following action steps:

1. Adopt this memorandum of agreement as an official policy statement of the agency or program, with approval of the Board of Directors. Circulate the approved document to all staff, and provide training to staff and board members regarding the principles and the CCISC model.
2. Assign appropriately empowered staff to participate in District 11 integrated system planning and program development activities: in particular the Project Leadership Team, and any relevant subcommittees.
3. Formally adopt the goal of achieving dual diagnosis capability as part of the agency's or program's short and long range strategic planning and quality improvement processes.
4. Participate in agency or program self-survey using the COMPASS to evaluate the current status of dual diagnosis capability.
5. Develop an agency or program specific action plan outlining measurable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward dual diagnosis capability. Monitor the progress of the action plan at six-month intervals. Participate in system wide training and technical assistance with regard to implementation of the action plan.
6. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating agency specific improvements in integrated screening and data capture in the action planning process. Incorporate efforts to identify comorbidity in populations that are also identified by cultural background.

7. Participate in system wide efforts to improve welcoming access for individuals with co-occurring disorders (of all cultural backgrounds) by adopting agency or program specific welcoming policies, materials, and expected staff competencies.

8. Participate in system wide efforts to demonstrate increased efficiency of resource utilization by developing agency specific policies, procedures, and training for staff to define an appropriate integrated scope of practice for each category of staff and to provide, document, and bill for appropriate integrated treatment within any service contract or funding stream.

9. Assign staff to participate in system wide efforts to develop dual diagnosis capability standards, and dual diagnosis practice guidelines. One first step will involve defining the content of an integrated assessment, for the purpose of measurable clinical process outcome monitoring, as well as clinical training.

10. Develop policies and procedures to support welcoming and eliminate any arbitrary barriers to access based on comorbidity (e.g., no crisis evaluation until alcohol level is below a certain amount; no admission of intoxicated individuals to CSU, no admission to addiction treatment of individuals on psych meds) in both emergency and routine situations.

11. For all agencies participating in any children's system of care initiative, incorporate dual diagnosis capability into activities related to those initiatives: interagency care coordination meetings, prevention activities, wraparound services.

12. For prevention services, there will be an emphasis on identification of opportunities to develop specific prevention approaches to substance abuse in individuals (children and young adults) with emotional problems and serious emotional disturbance, and to engage in early intervention with substance abusing young people to prevent the emergence of mental illness.

13. Participate in system wide efforts to identify required attitudes, values, knowledge, and skills for all clinicians regarding co-occurring disorders, and adopt the goal of dual diagnosis competency for all clinicians as part of the agency's long range plan.

14. Participate in clinician competency self survey using the CODECAT and use the findings to develop an agency or program specific training plan.

15. Identify appropriate clinical and administrative staff to participate as identified "champions" and change agents for the initiative, and who may also become trainers in a system wide train-the-trainer initiative, if developed. These individuals will be designated to work with the Project Director, and to assume responsibility for implementation of the agency or program training plan in relation to its action plan.

LIST OF ACRONYMS

ACT	Assertive Community Treatment
AHCA	Florida Agency for Health Care Administration
APD	Agency for Persons with Disabilities
ASO	Administrative Services Organization
CBC	Community-Based Care
CBHA	Comprehensive Behavioral Health Assessment
CIT	Crisis Intervention Team
CJ/MH	Criminal Justice/Mental Health
CRC	Central Receiving Center
CSU	Crisis Stabilization Unit
DCF	Florida Department of Children and Families (formerly DHRS)
DHRS	Florida Department of Health and Rehabilitative Services (currently DCF)
DJJ	Florida Department of Juvenile Justice
DOC	Florida Department of Corrections
DOH	Florida Department of Health
F.S.	Florida Statute(s)
FADAA	Florida Alcohol and Drug Abuse Association
FCCMH	Florida Council for Community Mental Health
FDLE	Florida Department of Law Enforcement
F-ICM	Forensic Intensive Case Management
FMHI	University of South Florida, Louis de la Parte Florida Mental Health Institute

FPIC	Florida Partners in Crisis
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services (Medicaid)
IMR	Illness Management and Recovery
ISCN	Integrated Specialty Provider Network
ITP	Incompetent to Proceed to Trial
JAC	Juvenile Assessment Center
MHA	Mental Health America (formerly the National Mental Health Association)
MOU	Memorandum of Understanding
NAMI	National Alliance on Mental Illness
NGI	Not Guilty by Reason of Insanity
OSCA	Office of the State Courts Administrator
SAMH Corp	Florida Substance Abuse and Mental Health Corporation
SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SPMI	Severe and Persistent Mental Illness
SOAR	SSI/SSDI Outreach Access and Recovery
SPECTRM	Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

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