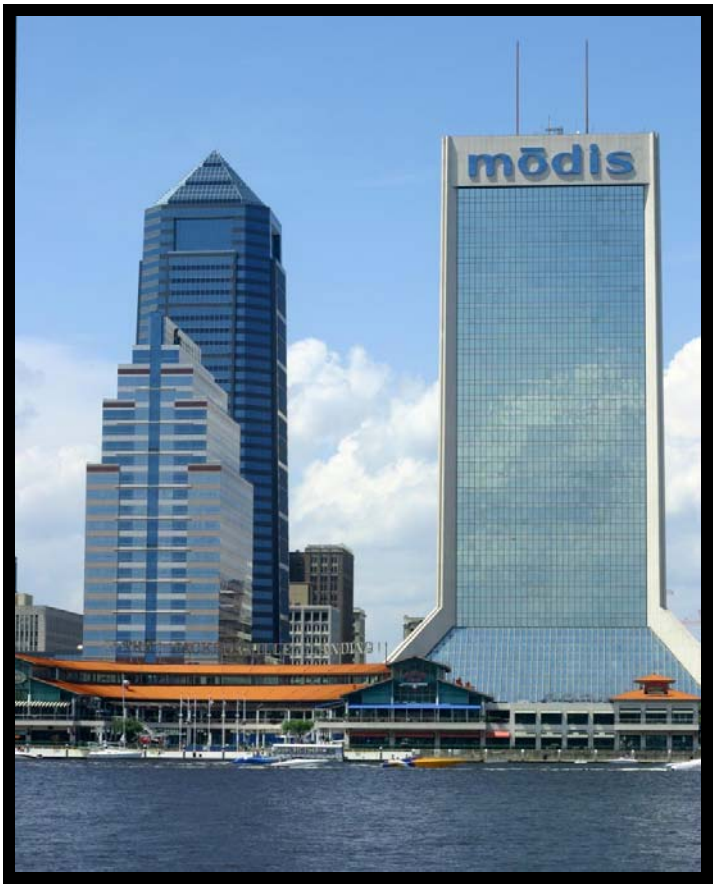
Adult Mental Health Strategic Plan

City of Jacksonville, Florida



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A STRATEGY FOR THE FUTURE

Adult Mental Health Strategic Plan

City of Jacksonville, Florida

Ms. Sherry Burns, Chair, Adult Mental Health Task Force

Report produced by:

Adult Mental Health Task Force

Technical assistance provided by:

City of Jacksonville
Community Services Department

Additional technical assistance provided by:

Human Services Research Institute
Cambridge, MA

January 2006

January 6, 2006

Honorable John Peyton, Mayor
City of Jacksonville, FL
City Hall at St. James
Jacksonville, FL 32202

Dear Mayor Peyton,

On behalf of the Adult Mental Health Task Force, it is my pleasure to submit to you the Adult Mental Health Strategic Plan: A Strategy for the Future.

This report provides a comprehensive assessment of the adult mental health system in Jacksonville, and it offers a number of recommendations to improve the system.

We found that Jacksonville's mental health system reflects many of the same problems found throughout the nation; it is fragmented, unresponsive to the needs of individuals and families, not recovery oriented, and it is significantly under-funded. Many of our recommendations however, are designed to affect process changes, with minimal initial costs. Longer-term capacity changes could be accomplished incrementally, after the system has maximized existing resources.

Our guiding vision throughout this project was to foster a community in which everyone in Jacksonville who requires mental health services will have access to effective treatment, leading to recovery. We believe that this report provides a useful guide to plan for the challenges of the future.

The strategic plan is the product of the hard work of a cross section of mental health professionals, advocates, and concerned citizens. The Task Force members have affixed their signatures to the report to underscore their commitment to its goals for improving the mental health system in Jacksonville.

We would like to express our appreciation for the technical assistance provided to the Task Force by the City of Jacksonville, and to Dr. Delphia S. Williams, Director of Community Services, and her staff.

Sincerely,

Sherry Burns,
Chair,
Adult Mental Health Task Force

Adult Mental Health Strategic Plan
A Strategy for the Future

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I. Executive Summary

Introduction

The Adult Mental Health Strategic Plan grew out of concerns over a crisis in the availability of Adult Living Facilities (ALFs) for persons with mental illnesses in Jacksonville, as well as concerns over a variety of reports that pointed to widespread problems with the mental health system throughout the country. The Adult Mental Health Strategic Plan is the product of the Adult Mental Health Task Force. The Task Force's mission was to maximize mental health services in Jacksonville. The first step in fulfilling its mission was to produce an adult mental health strategic plan, designed to maximize resources, improve services, and address gaps and other problems with the current system.

With the support of Mayor John Peyton, the City of Jacksonville's Community Service Department took the initiative and convened an Adult Mental Health Task Force. The primary goal of the Task Force was to produce an Adult Mental Health Strategic Plan. The Task Force organized itself as an independent body, and the City's Community Service Department, through its Mental Health and Welfare Division, provided ongoing technical support.

Additional technical support for the project was provided by the Human Services Resource Institute of Cambridge, Massachusetts (HSRI). HSRI is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Technical assistance from HSRI included an onsite mental health assessment workshop, ongoing technical support, a review of the strategic plan process and related documents, and a specialized computer-assisted assessment of data generated from the Task Force Workgroups.

The Adult Mental Health Strategic Plan follows a standard strategic plan format, and begins with a background summary of major mental health publications and documents. The review provides the basic rationale that justifies the need for a local mental health strategic plan.

The President's New Freedom Commission on Mental Health, and the Surgeon General's Report on Mental Health for example, both indicate that the nation's mental health system is fragmented, disorganized, ineffective, and in disarray. Moreover, the reports provide numerous statistics that detail the prevalence of mental illnesses, and the personal and financial costs associated with mental illnesses.

The unmistakable conclusion is that the entire system must be reorganized and made less fragmented, more client-centered, and recovery driven. One in five Americans experience a mental disorder in a one year period, and mental illnesses account for more than 15% of the overall health burden from all causes – even more than all cancers.

Highlights

The following are highlights from the remaining sections of the Executive Summary:

- Major reports indicate that the country's mental health system is dysfunctional, inefficient, and not client-driven or recovery-oriented.

- The City of Jacksonville facilitated an independent Adult Mental Health Task Force to assess the local adult mental health system and to recommend improvements.

- Analysis indicates local system is fragmented, unresponsive to client needs and serves less than 20% of those with even the most severe mental illnesses. Jacksonville has an estimated 62,000 persons with severe mental illnesses, and over 171,000 with a diagnosable mental illness, yet public funding supports services to only about 11,000 adults with severe mental illnesses.

- Mental illness results in staggering costs, amounting to over 15% of the global cost of all diseases. Jacksonville's publicly funded adult mental heath system accounts for over $56 million in direct costs alone. The $56 million is only about 20% of the cost of an adequate service system, which could run over $282 million if fully implemented. The local system is primarily limited to services for the most severe mental illnesses. Initial improvements would require minimal costs and focus on system-level and organizational changes. Long-range programmatic changes that lead to specific improvements in client-outcomes can be accomplished and budgeted for incrementally, and should be linked to research-based practices.

- Jacksonville's adult mental health system has no systematic, reliable management information system, has insufficient housing options for persons suffering with mental illnesses, and has no widespread use of research-based mental health strategies for mental health promotion, prevention of mental illnesses, or mental health treatment.

- Public access to services is significantly affected by funding limitations, complicated and fragmented program requirements, and the stigma associated with mental illness.

- Initial efforts to improve Jacksonville's adult mental health system should focus on broad, system-wide improvements and long-range planning for mental health system transformation that are consistent with efforts currently underway at the federal and State levels.

- Recent research suggests that local governing bodies, such as Mental Health Authorities, are the most effective tool to help communities transform their mental health systems.

- Recommendations for improving the system are reflected in the following goals of the Adult Mental Health Task Force:

1. Institute wide-spread use of evidence-based practices, with performance objectives and an oversight process that ties evidence-based performance to funding.

2. Establish a non-profit, local Mental Health Coalition of mental health agency professionals, advocates, and concerned citizens, to function as a focal point for adult mental health issues, to coordinate major grant applications, and to facilitate collaborative working relationships among the various mental health system stake-holders.

3. Establish permanent subcommittees of the Mental Health Coalition for Prevention, Treatment, Housing, Rehabilitation, and Public Input.

4. Advocate for an overall increase in mental health funding that will enable 20% of the new mental health funding to be directed towards mental health promotion and mental illness prevention activities.

5. Solicit SAMHSA and State technical assistance in the development of a comprehensive management information system, future outcome measures, and evidence-based practices, to be consistent with emerging federal mental health transformation process.

6. Task Mental Health Coalition to develop a comprehensive mental health promotion/ mental illness prevention plan.

7. Establish a local Mental Health Authority, empowered to affect the distribution of mental health funding, recommend statutory changes, hold public hearings, act as legislative liaison for mental health issues, and to provide standards and practices oversight.

8. Advocate for parity in State mental health funding.

9. Reorganize mental health system to be client-driven, recovery-based, with minimal system fragmentation, and an adequate level of services.

10. Reduce disparity between publicly funded mental health services and private services.

11. Support “Blueprint to End Homelessness” goals and objectives, of the Emergency Services and Homeless Coalition, especially as they relate to the Chronically Homeless population.

Gap Analysis

A variety of significant studies of the mental health system have concluded that the system is fragmented, unresponsive to the needs of consumers, is not recovery oriented, and serves only a fraction of those suffering from mental illness due to under-funding and the stigma associated with mental illness.

The challenge for the Adult Mental Health Task Force was to determine the extent to which the gaps or deficiencies identified in the mental health system in general, apply to the City of Jacksonville in particular.

Epidemiological data, costs and funding data, system access data, and specialized assessment information related to Prevention, Treatment, Housing, Rehabilitation, and Public Input, were analyzed by five Workgroups of the Task Force, and by the Task Force as a whole. Gaps and deficiencies in Jacksonville's mental health system were identified and summarized in the Findings subsection. The gaps provided the rationale for a number of recommendations to improve the system, as well as the basis for a general implementation strategy to carry out the recommendations.

Prevalence of mental illnesses in Jacksonville

The Analysis section provides a snapshot of Jacksonville's adult mental health system. An estimate of the number of persons with mental illness in Jacksonville was made by extrapolation, using federal epidemiological estimates of mental illness in the adult population and data from the U.S. Bureau of the Census. Jacksonville has an estimated 171,353 individuals with a diagnosable mental illness. There are an estimated 42,059 individuals with a Severe Mental Illness (SMI), and an additional 20,250 who suffer from Severe and Persistent Mental Illness (SPMI).

DCF District 4 statistics however, indicate that 10,298 adults were treated in the publicly funded mental health system in the most recent one year period, and an additional 843 were discharged from hospitals with psychiatric diagnoses according to the Agency for Health Care Administration (AHCA) for an overall total of 11,141. Statistically, we would expect 62,309 persons just with SMI/SPMI in Duval County – a subset of the estimated 171,353 diagnosable illnesses.

According to the Surgeon General's Report on Mental Health, "less than one-third of adults with a diagnosable mental disorder receives treatment in one year." The 11,141 adults treated in Jacksonville's mental health system represent only about 18% of those estimated to suffer with SMI or SPMI alone, which is substantially less than one third of the potential number of persons needing treatment, according to federal estimates - and that number does not include those with less severe disorders, for whom there are few publicly funded treatment services. There is a significant gap then, between the estimated number of persons with a diagnosable mental illness in Duval County, and the number who are receiving services, both with respect to those with SMI/SPMI, and those who suffer with less severe forms of mental illnesses.

Costs associated with mental illnesses

Costs associated with mental illnesses can be assessed in terms of both indirect and direct costs. The Surgeon General's Report cites the **indirect costs** (overall loss of productivity) of mental illness at nearly $79 billion in 1990. On a global level, the World Health Organization calculates the latest **indirect costs** associated with mental illnesses account for over 15% of the overall burden of diseases. In 1996, the **direct cost** to the nation for mental disorders was $69 billion.

The direct costs of publicly funded mental health services in Jacksonville have been calculated by combining the DCF District 4 funding for mental health and substance abuse services, City of Jacksonville funding used for a match for DCF dollars, (as well as additional mental health and substance abuse services) and Medicaid funding used to pay for psychiatric care at hospitals in Jacksonville. The combined DCF District 4 and City of Jacksonville mental health and substance abuse funding for the most recent one year period totaled $22,203,176. An additional $28,673,560 in Medicaid funding was used to cover outpatient costs, and $5,884,674 was charged to hospital psychiatric care in Jacksonville for 2004, for a grand total of $56,761,410 in public funds directed at the adult mental health system in Jacksonville.

An analysis of the Treatment, Housing, and Rehabilitation service components of Jacksonville's mental health system described in the Findings, Conclusions, and Recommendations sections, reveals that mental health clients are only receiving a fraction of the amount and variety of services that are needed in a system that provides sufficient quality care. Computer modeling of mental health costs suggests that the cost of an adequate service system could run over $282 million when, and if, fully implemented.

Funding Considerations

The goals and objectives for improving the adult mental health system in Jacksonville are primarily process oriented, and are aimed at system-wide improvements initially, as opposed to specific client-outcome goals, or increased service capacity. The Task Force recognizes that major organizational and quality issues must be addressed prior to expanding actual services with concomitantly increased costs. The proposed goals and objectives would require very little start-up funding. Initial funding could be addressed through federal system transformation grants, or through a combination of local funding options, such as City of Jacksonville Public Service Grants, general funds, or City Council discretionary funds, as well as local philanthropic support. The information that has been collected in the Adult Mental Health Strategic Plan will be an invaluable aid in securing grant funding

Community Profile

The City of Jacksonville is ranked as the 14th most populated city in the United States with over 800,000 residents, and has the largest land area of any City in the country. Jacksonville's two largest racial groups are white, with 65.8% of the population, and Black or African Americans comprising 27.8%. The median home value is $89,600, but 11.9% of the population lives below the poverty level.

System Overview

Florida's Department of Children and Families (DCF) is the official mental health authority of Florida, and Duval County is one of five counties in DCF District 4. DCF contracts with local provider agencies for mental health services and Jacksonville, through its Mental Health and Welfare Division, provides matching funds to support the service system. The mental health system in Jacksonville consists of community mental health with crisis stabilization units, substance abuse centers, and public and private mental health receiving hospitals. Within this network is a patchwork of mental health and substance abuse services that are driven by the individual program needs and priorities of the provider agencies, as well as the requirements of various funding sources.

System Access

Access to the array of mental health services in Jacksonville is greatly affected by a client's ability to pay for services. The publicly funded mental health system is primarily designed to serve the severely mentally ill (SMI) and the severe and persistently mentally ill (SPMI) populations.

Mental health services in Jacksonville are typically paid for by private insurance, out-of-pocket, and Medicaid or Medicare. A portion of Medicaid eligible persons are covered for mental health services under the current Medicaid HMO, and some are covered for mental health services on a fee for service basis at local provider agencies that bill Medicaid. At the time of this writing Duval County is also a demonstration site for a new Medicaid Managed Care Program.

In an effort to control costs, the State of Florida is currently revising the amount of services and the types of medications that will be covered under Medicaid. There is an ongoing debate at this time regarding how the new limits on amount of services and medication formulary will affect clinical outcomes.

Trapped between the managed care and public sectors however, is a group of uninsured individuals and families who do not qualify for the public sector programs, cannot afford to pay for services themselves, and have no access to private health insurance.

Funding sources

Public funding for Jacksonville's mental health system comes from DCF District 4, the City of Jacksonville, and Medicaid, through its coverage of psychiatric hospital costs and outpatient costs. Over the most recent one year period, DCF funding amounted to $15,655,303, and the City contributed $6,547,873. An additional $28,673,560 in Medicaid funding covered outpatient costs, and $5,884,674 was charged to Medicaid for hospital psychiatric care in Jacksonville for 2004. A grand total of $56,761,410 in public funds then was directed at the adult mental health system in Jacksonville in a one-year period. The majority of public funding is directed to assist the poor and indigent in Duval County, as well as the working poor.

At the time of this report, DCF District 4 funding for Severe and Persistently Mentally Ill (SPMI) clients is the lowest in the state, at $559.97. Florida's Substance Abuse and Mental Health Corporation has recommended to the Governor that the per-client average should be increased to $1,165 for all districts.

Methodology

The assessment of Jacksonville's adult mental health system was accomplished by collecting data from a variety of existing sources as detailed in the Gap Analysis subsections, and by developing specific assessment instruments that were used to gather additional data. The data were collected and distributed to the overall Task Force, and to the five Workgroups to assist them in preparation for their SWOT analysis.

The five Workgroups provided progress reports to the main Task Force for review and comments each month. Each Workgroup also reviewed a packet of information relevant to its area of concern. The packets of information were distilled from selected sections of the reports and documents described in the Background section of this report, as well as information collected from other sources, as referenced in the packets.

The SWOT analysis produced the final assessment of perceived gaps and deficiencies in the local system, as discussed in the Findings subsection of the Gap Analysis. The findings in turn provided the rationale for the recommendations to improve the system, as well as an overall strategy to implement the recommendations.

The Human Services Resource Institute (HSRI) conducted an on-site training workshop on conducting a needs assessment. Key informant surveys were developed specifically for the Public Input and the Prevention Workgroups. A series of Public Input focus groups were also held.

The Treatment, Housing, and Rehabilitation Workgroups assessed their respective areas by using the Service Prescription and Evaluation Survey (SPES) and its related Service Descriptions, or Taxonomy, as part of their assessment process. The SPES system was similar to the process that HSRI has implemented in over 20 States.

The SPES assessment began with the development of taxonomy of the existing major mental health service components. A list of additional services that would be required to achieve an adequate level of services (a description of services not currently available) was added to the service prescriptions. Each service component included a unit cost that was based on a combination or funding source reimbursement data, provider agency cost figures, and cost estimates provided by the Workgroup members.

The Workgroups then provided judgments about the percentage of clients currently in the system who would require each of the services in an improved, or more adequate system. The clients currently in the system were divided according to their functioning level (RAFLS) score. The Workgroups provided estimates of the percentage of clients who are actually receiving the array of services, according to their functioning level. Finally, the Workgroups provided judgments about the reasons for any discrepancies between adequate service levels and the level of service clients are actually receiving.

The Workgroups consisted of a cross section of mental health professionals, administrators, mental health advocates, and concerned citizens. The results of the SPES process were provided to HSRI and were used as the basis of a computer-assisted assessment to determine costs associated with an improved system, as well as expected client movements throughout the mental health system. The client patterns were based on expected changes in functioning levels, based on a pre-existing data base of client functioning patterns. The estimated costs associated with an improved services system have been described in the Analysis section of this report.

Findings

The following is an overview of the findings from each of the five Workgroups:

Prevention

The Workgroup found that there are only five agencies conducting prevention programs in Jacksonville. The five programs have very limited funding, have few measures of program effectiveness, are not based on best practices or evidence-based standards, and do not conduct longitudinal studies of program effectiveness. There are no publicly funded prevention activities in Jacksonville. The Workgroup concluded that the lack of public funding for prevention activities is inconsistent with the recommendations of major mental health reports, and represents a significant gap in the mental health system.

Treatment

A survey of the of the mental health system by the Treatment Workgroup revealed that there is a significant difference between the level of services currently received by clients, and the level of services they should be receiving in an adequate treatment system. The Treatment Workgroup determined that the discrepancy between actual services received and an adequate level of services were due to the following primary reasons: insufficient capacity of the service; an inability to pay for the service; the service was denied to clients due to behavioral issues; or the client refused the service. Some discrepancies resulted because an option was not even available.

The Treatment Workgroup also found that most of the problems with the mental health system in Jacksonville are similar to those described in the major reports previously outlined. The problems include a fragmented system with multiple funding sources and provider agencies, each with its own set of service priorities and client criteria. The fragmented system presents a difficult maze for many clients to deal with, and does not facilitate a client-driven array of services. The fragmented system has also been noted in the results of focus groups conducted by the Public Input Workgroup, as documented in the findings section of this report.

The Treatment Workgroup concluded that there is a significant gap between the estimated number of persons who require treatment, and the actual number being served, as well as a significant gap between the level of service clients receive and the level of services they should be receiving. They also concluded that the system is fragmented and not client driven, and is reflective of the dysfunctional service system nationwide. Moreover, recent research suggests that Mental Health Authorities are the most effective tool to help communities transform their mental health system.

Housing

The Housing Workgroup found similar discrepancies between services provided and services that should be available in an adequate housing service system for people with mental illnesses. The reasons for the discrepancies were consistent with those found in the Treatment system analysis: insufficient capacity of the service; an inability to pay for the service; service was denied to due client behavioral issues; or the client refused the service. Some service discrepancies were due to the fact that the service option was not available.

Research by the Emergency Services and Homeless Coalition (ESHC) indicates that of the estimated 2,580 persons who are homeless in Jacksonville on any given day, 50% have recently experienced mental health problems. Persons who are chronically homeless (repeatedly homeless over a period of years), disproportionately impact the cost of homelessness in Jacksonville, are more likely to have serious mental illnesses, often have co-occurring substance abuse problems and/or physical problems.

The Emergency Services and Homeless Coalition has recently completed a comprehensive ten-year plan to address homelessness in Jacksonville, titled “Ending Homelessness in Jacksonville: A Blueprint for the Future.” At the heart of the plan is the development of new permanent housing units for homeless individuals and families. The cost of homeless to the City of Jacksonville is a staggering $35 million annually, $27 million of which is the result of costs associated directly with emergency shelters, housing, and other services. Since the “Blueprint” contains specific goals and objectives to address the chronically homeless, and by definition the approximately 50% of the chronically homeless who suffer from mental illnesses, it should form the nucleus of a housing strategy.

Rehabilitation

As a result of the continuing efforts of Mental Health Consumer Advocacy Groups, the mental health system is moving towards a more consumer-driven process, as opposed to the complex web of services and their funding sources that currently drives the system. Instead of viewing mental illness as a lifelong deterioration, with a primary focus on symptom relief similar to a medical model, the focus should be on recovery, which implies restoration of self-esteem and identity, and obtaining a meaningful role in society

The Rehabilitation Workgroup concluded that the same gap in services exists for rehabilitation services as exists for treatment and housing services, with essentially the same reasons: insufficient capacity of the service; an inability to pay for the service; service was denied due to client behavioral issues; or the client refused the service. Some service discrepancies were due to the fact that the service option was not available.

Public Input

A number of primary themes were identified across three focus groups comprised of a cross section of Jacksonville residents:

- Fragmentation of services and funding
- Few housing options for people with mental illnesses
- Turnover among mental health staff contributes to poor services
- Stigma significantly inhibits people from seeking treatment
- Access to the system is limited by inability to pay and system complexity
- More money is needed across the services
- The system is not client driven
- Lack of client transportation options affects outcomes
- System does not encourage client and support system participation

A formal survey identified lack of housing options, lack of specialized services for seniors, system access, lack of funding for services, and the stigma that affects client access, as primary issues affecting the quality of mental health services in Jacksonville.

The results of the focus group and survey assessment processes are consistent with the major findings presented in a variety of reports, such as the President's New Freedom Report. Most of the major reports consistently indicate that stigma remains the major impediment to mental heath progress, that services and funding are fragmented, that the complex system restricts access because it is overwhelming to consumers, that there is shortage of affordable housing, that community-based care is needed, that more education programs are needed, and that consumers and families need to be involved in their own care

Data Limitations

The process of gathering the data used in this report was very tedious and time consuming. Most of the data either had never been collected, or had not been systematically collected and used collectively for strategic planning purposes. DCF data regarding service provider outcomes has only recently become available, and has not been fully analyzed at the time of this draft. It appears however, that the provider outcome data for Jacksonville may have to be extracted manually from District 4 reports. At the time of this draft, data on the number of jail inmates who have received psychiatric services has not been collected, primarily because the overall data collection process has taken so long. Much needs to be done to establish regular and useful data collection and management information systems. Most of the members of the Task Force that represent provider agencies maintain that there is very little management information data that is useful to them for planning purposes.

Recommendations and Implementation Plan

The individual recommendations of the five Workgroups have been combined and converted into the Long Range Goals and Objectives of the Strategic Plan, as provided in Phase II. The Phase I Implementation Plan goal and its objectives and action items, was derived from a recommendation that was generic to all the Workgroups and is therefore viewed as a fundamental objective needed to move the system significantly forward. The Phase I objective must be achieved before any meaningful progress can be made on the long range objectives. The second generic recommendation, to establish a local mental heath authority, was included in the long range objectives, because the process would require a considerable amount of time.

Phase I – Implementation Plan

Goal: Establish a local Mental Health Coalition

Objectives

1. Convene a committee to study the process of creating a Mental Health Coalition as a non-profit organization of mental health agency professionals, advocates, and concerned citizens, to function as a focal point for adult mental health issues, to coordinate major grant applications, and to facilitate collaborative working relationships among the various mental health system stake-holders.

Action Items

a. Draft Mental Health Coalition steering committee members from current Adult Mental Health Task Force.

b. Solicit start-up funds for Mental Health Coalition from City of Jacksonville's Public Service Grant process, or other City funding options.

Phase II – Long Range Goals and Objectives

Goal: Maximize mental health services in Jacksonville

Objectives

1. Institute wide-spread use of evidence-based practices, with performance objectives and an oversight process that ties evidence-based performance to funding.

2. Establish permanent subcommittees of the Mental Health Coalition for Prevention, Treatment, Housing, Rehabilitation, and Public Input.

3. Advocate for an overall increase in mental health funding that will enable 20% of the new mental health funding to be directed towards mental health promotion and mental illness prevention activities.

4. Solicit SAMHSA and State technical assistance in the development of a comprehensive management information system, future outcome measures, and evidence-based practices, to be consistent with emerging federal mental health transformation process.

5. Task Mental Health Coalition to develop a comprehensive mental health promotion/ mental illness prevention plan.

6. Establish a local Mental Health Authority, empowered to affect the distribution of mental health funding, recommend statutory changes, hold public hearings, act as legislative liaison for mental health issues, and to provide standards and practices oversight.

7. Advocate for parity in State mental health funding.

8. Reorganize mental health system to be client-driven, recovery-based, with minimal system fragmentation, and an adequate level of services.

9. Reduce disparity between publicly funded mental health services and private services.

10. Support “Blueprint to End Homelessness” goals and objectives, of the Emergency Services and Homeless Coalition, especially as they relate to the Chronically Homeless population.

II. Introduction

A. Rationale, Purpose, and Scope of Plan

The genesis of the Adult Mental Health Task Force and its product, the Adult Mental Health Strategic Plan, was a White Paper Report by the City's Mental Health and Welfare Division. The White Paper outlined a crisis in the availability of Adult Living Facility beds for persons with severe and persistent mental illnesses (SPMI). The use of ALFs as a housing option was in response to the deinstitutionalization of persons with SPMI, as well as the continued reduction of bed space at the Northeast Florida State Hospital (NEFSH).

Over the past several years, the state has continued to reduce treatment beds at NEFSH. About 500 persons with severe and persistent mental illness now live in ALFs in Jacksonville. Since November 2000, Operation Spot Check, a statewide initiative under the direction of the State Attorney's office, has inspected 18 local ALFs for health and safety violations. The result has been the relocation of 226 residents, the permanent closure of 111 ALF beds, and the temporary closure of 149 beds. The deinstitutionalization process and the systematic reduction in bed space at NEFSH, along with reduced availability of ALF bed space has greatly contributed to an overburdened local mental health system.

Disparity in the amount of State funding for Duval County has added to the strain on the mental health system in Jacksonville. Department of Children and Families (DCF), District 4 funding for adult mental health services has traditionally been lower than allocations to other areas of the state. Although the efforts of the City Council and the Duval Delegation brought additional "equity" funds to the area during the state's previous fiscal year, the District still ranks last in adult mental health funding. While ADM has $1.8 million invested in other housing options for adults with mental illness, community providers and the clients they serve are still dependent upon ALFs for housing.

To some extent, the move towards an Adult Mental Health Strategic Plan may be viewed as a local-level response to growing concerns over the quality of mental health and substance abuse services throughout the State of Florida. Those state-wide concerns resulted in the creation of the Florida Substance Abuse and Mental Health Corporation.

Other factors that indicated the need for an Adult Mental Health Strategic Plan were the proliferation of major federal reports that chronicled the staggering number of persons in need of mental health care and decried the current mental health system as dysfunctional. The accumulated anecdotal reports of dissatisfaction with Jacksonville's mental health service system from both consumers and providers of mental health services also contributed to the concerns.

The dwindling financial resources that have accompanied the uncertain times in which we now live also dictates a more systematic approach to addressing current and future mental health system needs. Moreover, as stewards of public funding for mental health services, the City of Jacksonville has taken a leadership role in advocating for a strategic plan to address the mental health service needs for Jacksonville.

The District 4 ADM office develops an annual mental health plan, but that plan is a district level state plan, and is in response to a state formulated planning approach. In addition, the District 4 plan has not traditionally engaged key representatives from local government, provider agencies, consumers of mental health services, and advocacy groups in a more traditional strategic planning process.

To address the growing concern over the quality of mental health services in Jacksonville and the need for long range planning specific to the needs of Jacksonville, the City of Jacksonville's Community Services Department, with the support of Mayor John Peyton, took the initiative by convening an Adult Mental Health Task Force. The mission of the Task Force was to begin an ongoing strategic planning and systems change process that would help provide the best mental health services to the citizens of Jacksonville with the available resources. The specific goal of the Task Force was to produce an Adult Mental Health Strategic Plan – the tool that would be used to help maximize the adult mental health system in Jacksonville.

The scope of the plan was limited to the adult mental health system because services, funding, and planning issues that impact children are vested in the Jacksonville Children's Commission. Alcohol and substance abuse were also not included due to the practical limitations of time, and the resources needed to fully assess both areas.

Although the City of Jacksonville initiated the Task Force with the support of the Mayor, and provided ongoing technical and clerical assistance, the Task Force organized itself as an independent body with broad representation from government, provider agencies, advocacy groups, mental health professionals, and concerned citizens. The Adult Mental Health Strategic Plan will be presented to the Mayor's Office for consideration and review. The City of Jacksonville will be a primary resource to facilitate the process of addressing the recommendations of the Task Force.

In summary then, the plan is an effort to assess Jacksonville's mental health system in response to a variety of reports that indicate significant problems with the mental health system. The plan was also conceived as a needed planning document to maximize resources, improve services, and to address perceived problems with the existing system; those efforts are reflected in the Adult Mental Health Task Force's Mission, which is to maximize mental health services in Jacksonville.

Additional technical assistance to the Task Force was provided by the Human Services Resource Institute (HSRI) of Cambridge, Massachusetts. The HSRI is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal government. The technical assistance was provided at no cost to the City of Jacksonville. The technical assistance included ongoing consultation and review of the strategic plan process and documents, workshop training on strategic planning issues, and specialized computerized assessment of data generated from the Treatment, Housing, and Rehabilitation Workgroups.

B. Organization of the Plan

The Adult Mental Health Strategic Plan follows a standard strategic plan format. Following the Executive Summary and Introduction, the first main section begins with a description of the Mission, Vision, Guiding Principles, and the Goal that guided the Task Force in the development of the strategic plan. The next section provides a review of the major issues affecting the mental health service system nationally, and locally.

The background section is followed by a gap analysis of the mental health service system in Jacksonville, including a review of the methodology used in collecting data about the mental health system and the results of the analysis. The Gap Analysis is followed by a discussion of the limitations of the current management information system and data issues.

The final section discusses the recommendations for improving the mental health system in Jacksonville. The recommendations are specific to each of the five Workgroups that assessed different components of the local mental health system; the five areas are Prevention, Treatment, Housing, Rehabilitation, and Public Input. A number of generic recommendations are also presented. The generic recommendations were those that all Workgroups agreed upon, or were recommendations that developed from the Task Force body as a whole.

The Adult Mental Health Strategic Plan is primarily designed to address improvements on a system-wide level and therefore primarily contain process-goals, as opposed to outcome-goals. Many of the recommendations in the plan are designed to affect system-wide changes that will eventually lead to improved programming and improved client outcomes.

Finally, although there is a discussion regarding overall gaps in services with respect to the estimated number of persons with mental illnesses in Jacksonville, the plan looks at the totality of needs, or gaps as assessed from each of the five Workgroups. A gap is defined as a perceived difference between the current level of services and a level and quality of service sufficient to meet the needs of mental health clients. Those gaps are summarized in the findings section for each of the Workgroup areas, and in the conclusion section. The recommendations, and the resultant goals for improving the system, are in response to the perceived gaps.

III. Mission, Vision, Guiding Principles, Goal Statement

Task Force Mission Statement

- To maximize mental health services in Jacksonville

Task Force Vision Statement

- To foster a community in which prevention of mental illness is fully promoted, and everyone who requires mental health and substance abuse services will have access to effective early detection and treatment, leading to recovery.

Task Force Guiding Principles

- Provide responsive, high quality, cost effective services
- Focus support on the most vulnerable citizens in Jacksonville
- Design programs using Best Practices
- Promote opportunities for participation
- Maximize choice of services
- Value public and multi-sector input
- Eliminate barriers to services
- Explore and apply new technologies
- Recognize and respect individual integrity
- Value philosophy of continual improvement
- Consistent with Mayor's Guiding Principles, including enhancing the quality of life for all citizens of Jacksonville

Task Force Goal Statement

- To develop a comprehensive adult mental health strategic plan for the City of Jacksonville

IV. Background

The Adult Mental Health Task Force reviewed a number of significant reports and documents prior to undertaking an analysis of the adult mental health system in Jacksonville, in order to gain a systematic perspective on the major issues affecting the adult mental health system. The review ranged from major federal reports to local studies, all of which have implications for Jacksonville's mental heath system. The perspective gained from these reports provided the motivation to assess and improve the local services system, as well as the framework on how to proceed. The Adult Mental Health Strategic Plan was designed to be consistent with the background references. Due to the number and length of the reports, only a very brief summary of some of the major findings from a representative sample are provided below:

President's New Freedom Commission Report

In 2003, the President's New Freedom Commission on Mental Health released *Achieving the Promise: Transforming Mental Health Care in America.* The report was in response to the President's charge to the Commission to study the problems in the mental health system, and to make specific recommendations to improve the system. The report indicated that the entire mental health system, from the federal level to the local level was in disarray, contained multiple gaps in services, and was not responsive to the needs of persons with mental illnesses and their families. Moreover, the report indicated that the latest state-of-the-art treatments were not reaching the public, and that services are fragmented by multiple funding sources and agencies, each with its own set of administrative and bureaucratic rules that created obstacles to mental health services.

The major obstacles that prevent persons with mental illness form obtaining the quality care they deserve are the stigma associated with mental illness, financial limitations, and the fragmented system itself. The major conclusion of the report was that the current system must be replaced with an efficient, effective, reliable, and integrated system of care – essentially a fundamental transformation is needed.

The report provided six overall goals designed to move towards system transformation, along with a series of recommendation to obtain the goals. The six overall goals are: Americans must know that mental health is essential to overall health; the mental health system must be consumer and family driven; disparities in service must be eliminated; early screenings and assessments must become common practice; best practices must be delivered and research accelerated; the system must maximize the use of technology.

The report also provided a number of sobering statistics regarding the prevalence of mental illnesses and their associated costs; those statistics will be cited in the analysis section of this strategic plan.

The Surgeon General's Report

Mental Health: A Report of the Surgeon General, stresses that mental health is a fundamental component of overall health, and notes that despite the many effective treatment options available today, nearly half of those suffering from mental illnesses do not seek help, due to the stigma associated with mental illnesses. According to the report, one in five Americans experiences a mental disorder in any one year period, and mental disorders account for more than 15% of the overall burden of diseases from all causes – even more than all cancers. The report stresses the need for more new approaches, more research, and better dissemination of information.

Healthy People 2010

The U.S. Department of Health and Human Services' report, Healthy People 2010, provides a long list of sobering statistics on mental illnesses:

- Mental disorders immense public health burden
- Mental illness is on par with heart disease and cancer as cause of disability
- 22% (40 million) of U.S. population 18-64 years have diagnosed mental disorder in a one year period
- 2.6% Serious and Persistent Mental Illness (SPMI)
- 5.4% Serious Mental Illness (SMI)
- 25% of older people experience specific mental disorders that are not a part of normal aging
- Modern treatment highly effective but only 25% of persons with mental disorders obtain help, while 60-80% of heart disease patients obtain help
- 40% of persons with severe mental disorders do not even seek help
- People with mental disorders are overrepresented in jail populations, and many do not receive treatment
- 29% of adults with lifetime mental health disorders have history of co-occurring addictive disorders, while 37% of those with alcohol disorder have had a mental disorder
- As the life expectancy of individuals increases, the sheer numbers of experiencing mental disorders late in life will expand.
- New treatments and research have tremendous potential to relieve burden of mental disorders, but stigma associated with mental disorders must be eliminated
- 2010 Mental Health and Mental Disorders section has numerous goals and objectives to improve the Mental Health and Substance Abuse services system

DCF District 4 Plan

Florida's Department of Children and Families, District 4 Mental Health and Substance Abuse Plan indicates an upward trend in crisis bed utilization, and a need for short term residential (SRT) beds, but indicates that no funding is available for SRT resources. The report also calls for more Florida Community Treatment (FACT) teams to manage state hospital discharges. FACT teams are specialized intensive case management teams that typically have smaller case loads. The District 4 Plan also notes the crisis in the availability of Adult Living Facility beds for persons with severe and persistent mental illnesses (SPMI). The use of ALFs as a housing option was in response to the deinstitutionalization of persons with SPMI, as well as the continued reduction of bed space at the Northeast Florida State Hospital (NEFSH).

Over the past several years, the state has continued to reduce treatment beds at NEFSH. About 500 persons with severe and persistent mental illness now live in Adult Living Facilities (ALFs) in Jacksonville. Since November 2000, Operation Spot Check, a statewide initiative under the direction of the State Attorney's office, has inspected 18 local ALFs for health and safety violations. The result has been the relocation of 226 residents, the permanent closure of 111 ALF beds, and the temporary closure of 149 beds. Bed availability is now fewer than 20 in facilities with a limited mental health license. The deinstitutionalization process and the systematic reduction in bed space at NEFSH, along with reduced availability of ALF bed space has greatly contributed to an overburdened local mental health system. The District 4 Plan reports that the greatest need is for additional housing options, additional crisis stabilization capacity, and increased coordination among funding sources and providers.

NAMI – Roadmap to Recovery and Cure

The National Alliance for the Mentally Ill (NAMI) also describes the mental health system as being in shambles, under funded, and failing to deliver advances in mental health treatment to the public. NAMI strongly recommends increased funding for mental health research and treatment, and improved dissemination of recent advances in treatment options and mental health information.

COJ 2010 Comprehensive Plan, Housing Element

The Special Needs Housing sub-section of the Housing Element of the City of Jacksonville's 2010 Comprehensive Plan, like the DCF Plan, indicates that there is an insufficient supply of housing opportunities in Jacksonville, especially for those suffering from mental illnesses. The Housing Element echoes the deteriorating conditions in the ALFs as well.

Florida Substance Abuse and Mental Health Corporation

The Florida Substance Abuse and Mental Health Corporation was created by the Florida Legislature to review the status of the State's substance abuse and mental health service delivery system and to make recommendations to improve the services. In its 2004 Annual Report, the Corporation listed as its number one recommendation the development of an integrated mental health and substance abuse management information system. They found that the existing state-wide management information system makes it impossible to determine cost effectiveness, evaluate outcomes, and study programs.

Campaign for Mental Health Reform

The Campaign for Mental Health Reform is a national partnership of diverse organizations concerned about the state of mental health services in the U.S. The Campaign maintains that few substantive steps have been taken to implement the fundamental transformation of the mental health system that was recommended by the President's New Freedom Commission Report on Mental Health. The Campaign, in its Emergency Response, A Roadmap for Federal Action on America's Mental Health Crisis, provides a detailed action plan for an emergency response addressing the inactivity in mental health system reform efforts. As a first step, they advocate for maximizing the effectiveness of scarce resources via a seamless system of consumer driven services. The first action item to achieve the first step is to create a federal interagency task force to review and realign the current mental health service structure.

V. Gap Analysis

A variety of significant studies of the mental health system have concluded that the system is fragmented, unresponsive to the needs of consumers, is not recovery oriented, and serves only a fraction of those suffering from mental illness due to under-funding and the stigma associated with mental illness. The challenge for the Adult Mental Health Task Force was to determine the extent to which the gaps or deficiencies identified in the mental health system in general, apply to the City of Jacksonville in particular.

The subsections below provide epidemiological data, cost data, funding information, system access profiles, and other information as a foundation for determining gaps in the local mental health system. The information was combined with specialized assessment results from each of five Workgroups, as the grist for the SWOT Analysis (Strengths, Weaknesses, Opportunities, and Threats) conducted by the Workgroups. The SWOT process in turn, produced a final determination of perceived gaps in the system as presented in the Findings subsection of the Gap Analysis. The findings subsequently led to the recommendations to improve the system, as well as a general implementation plan strategy.

The five Workgroups acted as prisms to focus the data from the Gap Analysis subsections, in concert with their own specialized assessment information. Each of the five Workgroups also reviewed packets of supplemental information relevant to their specific area of focus. The five Workgroups corresponded to the major components of the Continuum of Care in Jacksonville, and included an added dimension of Public Input. The five Workgroups that processed the Gap Analysis data and generated their own assessment information were as follows: Prevention; Treatment; Housing; Rehabilitation; and Public Input.

A. Prevalence of Mental Illness in Jacksonville and service gaps

An estimate of the number of persons with mental illness in Jacksonville was made by extrapolation, using federal epidemiological estimates of mental illness in the adult population and data from the U.S. Bureau of the Census. Extrapolations yielded the following summary estimates of mental illnesses and substance abuse:

- Estimates of Mental Illnesses
  - 2000 census population of Jacksonville was 778,879, a 16% increase over previous census.
    - Source: US Bureau of the Census 2000
  - 22% of population estimated to have a diagnosable Mental Disorder (MD) in a one year period, which translates to 171,353 for Jacksonville.
  - 5.4% of population estimated to have a Severe Mental Illness (SMI), which translates to 42,059 for Jacksonville.
  - 2.6% of population is estimated to have a Severe and Persistent Mental Illness (SPMI), which translates to 20,250 (State uses 1.5% = 11,683) for Jacksonville.
    - Source: Healthy People 2010, NIH
  - Studies show that people in lower socioeconomic strata are two to three times more likely to have a mental disorder, and are more likely to have higher levels of psychological stress. Poverty disproportionately affects racial and ethnic minorities. For example, while 8% of the white population is poor, 24% of African Americans are poor.
    - Source: Mental Health: Culture, Race, and Ethnicity, A Supplement To Mental Health: A Report of the Surgeon General
  - 11.9% of Duval County's population in 1999 was below the poverty level, and the African American population is 27.8%.
    - Source: US Bureau of the Census 2000
  - According to The Centers for Disease Control (CDC), the national average of deaths by suicide is 11 per 100,000

persons. Duval County's rate is 13.4, with 113 deaths attributed to suicide in 2004.

- Source: Florida Department of Health

- Substance Abuse Correlations

  - Adults who used illicit drugs within the past year are more than twice as likely to have SMI.

  - Among persons with SMI, 27.3% used an illicit drug in the past year, while the rate was 12.5 percent among those without SMI.

  - SMI is highly correlated with drug dependence or abuse. Among adults with SMI, 21.3% were dependent on, or abused alcohol or illicit drugs, while the rate among adults without SMI was only 7.9%. Adults with SMI are more likely than those without SMI to be dependent on, or abuse illicit drugs (8.6% vs. 2.0%) and alcohol (17.0% vs. 6.7%).

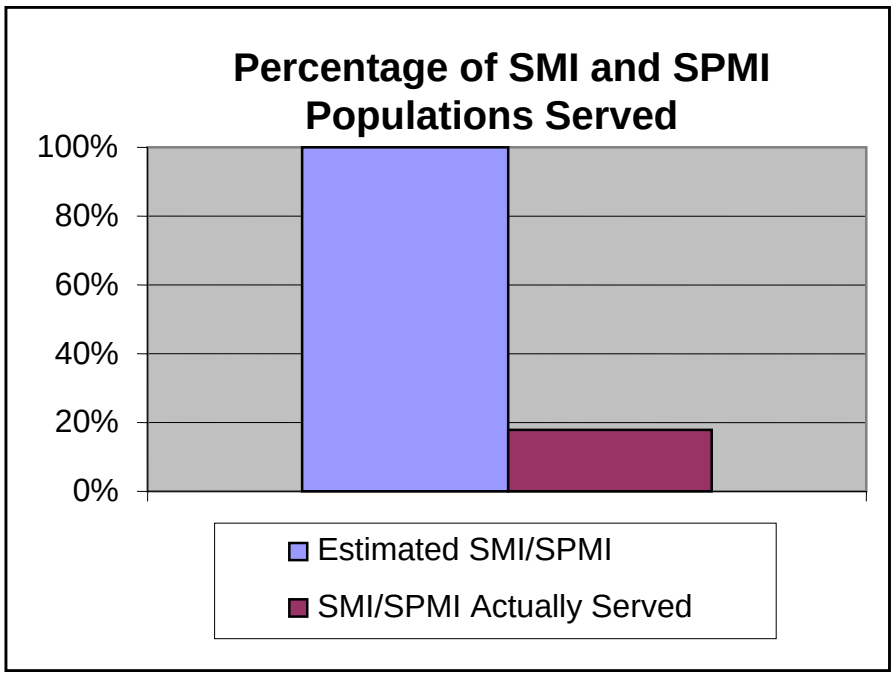
    - Source: National Survey on Drug Use & Health, SAMHSA

DCF District 4 statistics indicate that 10,298 adults were treated in the publicly funded mental health system in the most recent one year period, and an additional 843 were discharged from hospitals with psychiatric diagnoses according to the Agency for Health Care Administration (AHCA) for an overall total of 11,141. Statistically, we would expect 62,309 persons with SMI/SPMI alone in Duval County. Caveats regarding these statistics and other management information however, are discussed in Chapter VI, Data Limitations. It is significant however, that according to the Surgeon General's Report, "less than one-third of adults with a diagnosable mental disorder receives treatment in one year."

It is also important to note that the majority of mental health services funding for Duval County is for adults who suffer from severe mental illness (SMI), or severe and persistent mental illness (SPMI). The current funding priorities do not usually cover services for adults who have less severe diagnosable conditions. Based on statistical estimates, there could be over 171,000 persons in Jacksonville with a diagnosable mental condition.

The 11,141 adults treated in Jacksonville's mental health system represent only about 18% of those estimated to suffer with SMI or SMPI alone, as indicated in Figure 1, below. The 18% service rate is substantially less than one third of the potential number of persons needing treatment, according to federal estimates - and that number does not include those with less severe disorders, for whom there are few publicly funded treatment services.

Figure 1. Percentage of Severely Mentally Ill (SMI) and Severe and Persistently Mentally Ill (SMPI) Actually Served

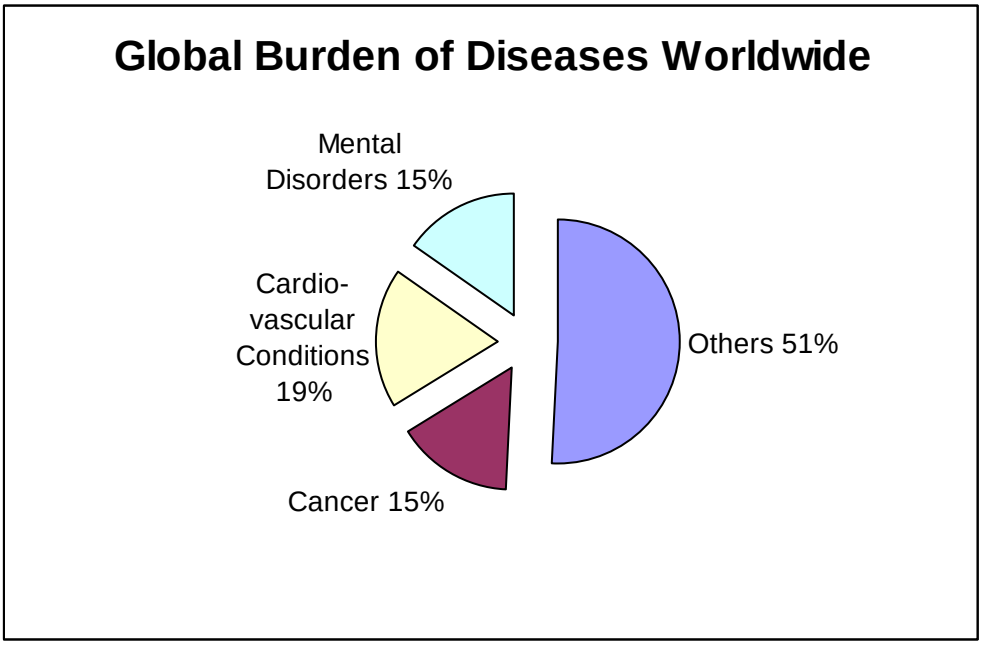


There is a significant gap then, between the estimated number of persons with a diagnosable mental illness in Duval County, and the number who are receiving services, both with respect to those with SMI/SPMI, and those who suffer with less severe forms of mental illnesses.

B. Costs associated with mental illnesses

Costs associated with mental illnesses can be assessed in terms of both indirect and direct costs. The Surgeon General's Report cites the **indirect costs** (overall loss of productivity) of mental illness at nearly $79 billion in 1990. On a **global level**, the World Health Organization calculates the **indirect costs** associated with mental illnesses account for over 15% of the overall burden of diseases.

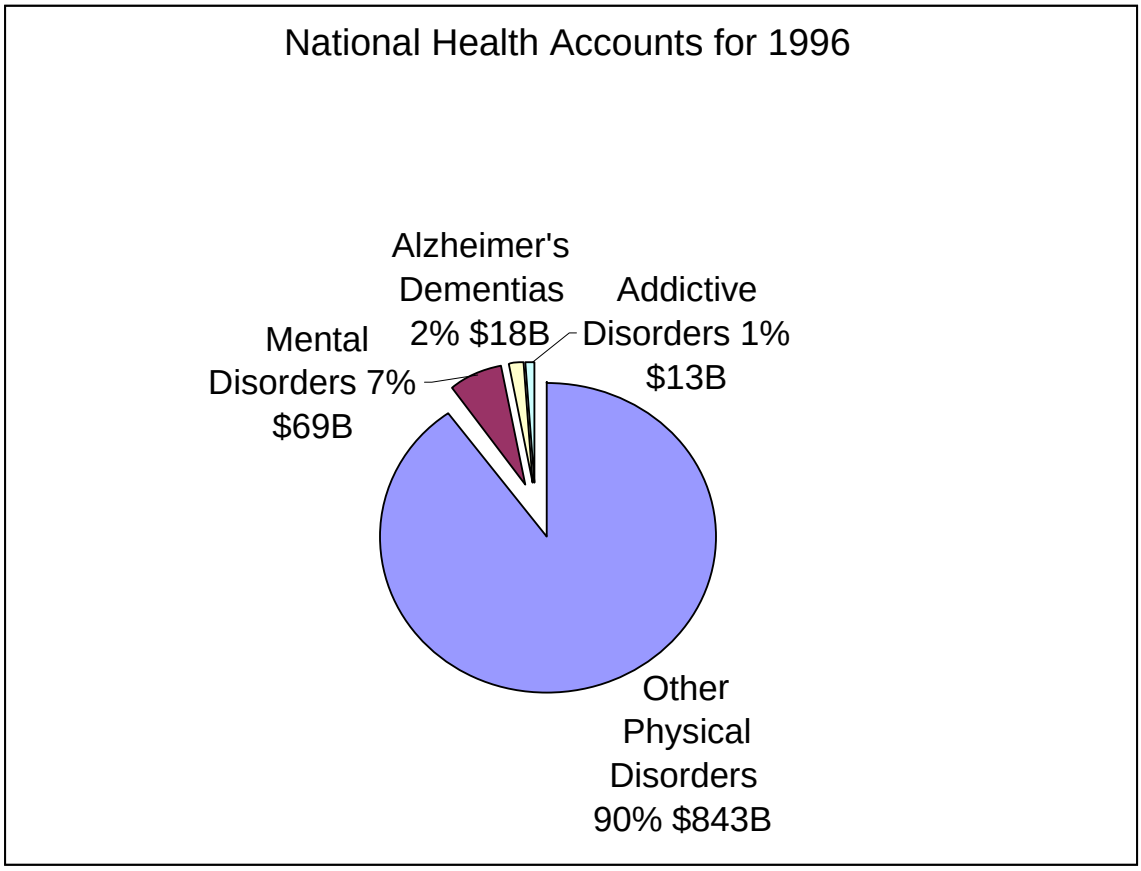
Figure 2. Global Burden of Diseases Worldwide



Source: Mental Health: A Report of the Surgeon General

The **direct costs** associated with the treatment of mental and addictive disorders are staggering. The Surgeon General's Report cites $99 billion in **direct costs** associated with the treatment of mental, addictive, and dementia disorders in 1996. As illustrated in Figure 3 below, more than two thirds of that figure, or $69 billion, was for mental health services alone.

Figure 3. National Health Accounts for 1996



Source: Mental Health: A Report of the Surgeon General

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The **direct costs** of publicly funded mental health services in **Jacksonville** have been calculated by combining the DCF District 4 funding for mental health and substance abuse services, City of Jacksonville funding used for a match for DCF dollars, (as well as additional mental health and substance abuse services) and Medicaid funding used to pay for psychiatric care at hospitals in Jacksonville.

The combined DCF District 4 and City of Jacksonville mental health and substance abuse funding for the most recent one year period totaled $22,203,176. An additional $28,673,560 in Medicaid funding was used to cover outpatient costs, and $5,884,674 was charged to hospital psychiatric care in Jacksonville for 2004. A grand total of **$56,761,410** in public funds was directed at the adult mental health system in Jacksonville in a one-year period.

Combined City of Jacksonville, DCF District 4, and Medicaid Hospital and Outpatient Psychiatric Funding

Total COJ MH, SA, and PSG	$6,547,873
Total DCF SA and MH for Jax	$15,655,303
Total Medicaid Hospital Psychiatric Costs for Jax	$5,884,674
Total Medicaid Outpatient costs for Jax	$28,673,560
Grand Total	**$56,761,410**

Sources: DCF District 4, City of Jacksonville's Mental Health and Welfare Division, and State of Florida Agency for Health Care Administration

The cost figures above reflect publicly funded Mental Health (MH), Substance Abuse (SA), and City of Jacksonville Public Service Grant (PSG) social service programs, as well as hospital and outpatient psychiatric services for which Medicaid was billed.

Costs associated with many of the recommendations contained in this strategic plan are difficult to project due to the focus of the recommendations. The Adult Mental Health Strategic Plan is primarily designed to address improvements on a system-wide level and are therefore process-goals, as opposed to outcome-goals.

Many of the recommendations contained in this report are designed to affect system-wide changes that will eventually lead to improved programming and improved client outcomes. The process goals recommended in the strategic plan are subject to an infinite amount of variables, depending on the administrative changes that may occur to implement the recommendations. Those issues are discussed more fully in the conclusions, recommendations, and implementation section of this plan.

Direct costs associated with suggested improvements to the treatment, housing and rehabilitation services as analyzed in this report may be estimated however, using a process, or system view, of current costs and then estimating future costs of a more optimal system. Cost estimates for current treatment, housing, and rehabilitation services were developed by the respective Workgroups, and those cost figures were used to estimate the costs of an adequate service system.

An adequate service system is by definition an array of services needed to provide quality mental health services, according to the analysis of the three Workgroups. An adequate system is in contrast to the current service system which, according to recent federal reports, is fragmented, not client driven, and essentially dysfunctional. An improved system would consist of an increase in the amount of services currently provided to clients, as well as additional services not currently provided.

The current publicly funded system for Jacksonville costs approximately $56 million. Those costs are based on the current level of services. The treatment, housing, and rehabilitation Workgroups developed a service delivery system taxonomy that would be consistent with an adequate system, along with associated cost figures. The Human Services Resource Institute (HSRI), provided a computer-assisted analysis of the proposed service system and estimated that the costs of providing an increased level of services to the number of clients currently served would be approximately $282,761,928. An improved service system would therefore cost approximately an additional $226,761,928.

Incremental increases may be calculated using a percentage of the estimated costs of implementing an optimal system. For example, a 25% increase in service effectiveness would cost an additional $56,690,482. A more complete discussion of the service system analysis is contained in the methodology section of this report.

The projected costs associated with the housing component of an adequate service system do not take into account the costs of developing some of the housing options that do not currently exist. The costs associated with developing supportive housing services that would serve homeless individuals with mental illnesses have been calculated by Jacksonville's Emergency Services and Homeless Coalition (ESHC).

The Emergency Services and Homeless Coalition has recently completed a comprehensive ten-year plan to address homeless in Jacksonville, known as “Ending Homelessness in Jacksonville: A Blueprint for the Future.” At the heart of the plan is the development of new permanent housing units for homeless individuals and families. The cost of homeless to the City of Jacksonville is a staggering $35 million annually, $27 million of which is the result of costs associated directly with emergency shelters, housing, and other services.

Research by the ESHC indicates that of the estimated 2,580 persons who are homeless in Jacksonville on any given day, 50% have recently experienced mental health problems. The Blueprint has a comprehensive strategy to address the problem of homeless in Jacksonville, including strategies that are directed at the long-term or chronic homeless population. The goal is to stabilize the chronically homeless through permanent supportive housing, income sources and employment opportunities. Among its specific actions, the plan calls for developing 145 supportive housing units in two years and 800 units in five years. The plan has a comprehensive approach to financing the various goals and actions items and has justified the costs against the current and spiraling costs of the traditional crisis approach to dealing with homelessness.

The ESHC estimates that the cost of developing 145 supportive housing units in two years would be over $14 million, and a total of 800 units over five years would be almost $90 million. Due to the fact that the supportive housing units would also serve homeless individuals who do not suffer from mental illnesses however, it is not practical to identify specific costs of developing housing for the homeless who have mental illnesses. The closest estimate would be that approximately half the projected housing costs would benefit homeless individuals who have mental illnesses.

Costs Summary

Cost of current public MH system	$56,761,410
Estimated cost of adequate MH system	$282,761,928
Estimated cost of Supportive Housing	$90,000,000
(800 unit, five year plan)	

C. Funding Considerations

The goals and objectives for improving the adult mental health system in Jacksonville are primarily process oriented, and are aimed at system-wide improvements initially, as opposed to specific client-outcome goals, or increased service capacity. The Task Force recognizes that major organizational and quality issues must be addressed prior to expanding actual services with concomitantly increased costs. The proposed goals and objectives would require very little start-up funding. Initial funding could be addressed through federal system transformation grants, or through a combination of local funding options, such as City of Jacksonville Public Service Grants, general funds, or City Council discretionary funds, as well as local philanthropic support. The information that has been collected in the Adult Mental Health Strategic Plan will be an invaluable aid in securing grant funding.

The goals and objectives provided in this Plan are presented as Phase I, short-term goals and Phase II, long-term goals. The Phase I, short-term goal is to create a local adult mental health coalition. A local mental health coalition would involve minimal costs, and could initially use existing community resources for meetings, as well as ongoing technical assistance resources of the City of Jacksonville – similar to the Task Force process itself. The current Adult Mental Health Task Force membership would form the nucleus of an emerging coalition. The coalition, in turn, would file for non-profit status and establish itself as the primary local entity empowered to pursue grant and other funding sources to support the current goals and objectives of the Strategic Plan, as well as goals that develop in the course of the coalition's work.

The goals and objectives outlined in Phase II of the Implementation Plan are also primarily process-oriented, and require relatively small funding investments, with the exception of the creation of a local Mental Health Authority. The Mental Health Authority would be responsible for facilitating long-term funding options, such as specific City budget allocations and revenue options, as well as prioritizing the multiple funding streams affecting mental health services for the Jacksonville community, including state and federal funding. Start-up funding for a Mental Health Authority will require the same kind of commitment from the City that initiated the current array of authorities and commissions.

Funding directed at expanding the actual level of services recommended in the Strategic Plan would be required only after the current system has completed the process of system improvement, and has maximized existing funding through improved agency collaboration, reduced service redundancies and minimized fragmentation. Requests for incremental funding increases therefore, would be made within the context of an optimally functioning system, and incremental increases in service would be correlated with cost savings to the City; such correlations are currently beyond the capacity of the current mental health management information system.

D. Community Profile

- The City of Jacksonville ranks as the 14th largest city in the United States, with more than 800,000 residents

- The six county Northeast Florida region has more than 1.1 million residents.

- Jacksonville is the largest city in the contiguous United Sates in area, covering 841 square miles, and containing three major beach communities.

- Jacksonville has an International Airport, four modern seaports, the largest urban park system in the county, and is the center of three major Interstate Highways, and four major U.S. Highways.

- Jacksonville is consistently ranked among the best cities in which to live.

Source: COJ Website

- Percentage of white persons is 65.8

- Percentage of Black or African American persons is 27.8

- Median value of owner-occupied housing units is $89,600

- Per capita money income, percent, 1999 was $20,753

- Persons below poverty, percent, 1999 was 11.9

- Persons 65 years old and over, percent 2000 was 10.5

Source: U.S. Census Bureau, City of Jacksonville Planning and Development

E. Environmental Analysis

1. System Overview

The Florida Mental Health Act or the "Baker Act", Chapter 394, Florida Statutes, designates the Department of Children and Family Services (DCF) as the "Mental Health Authority of Florida". The department is responsible for a complete and comprehensive statewide program of mental health services and may contract to provide, or be provided with, services and facilities to carry out its responsibilities.

The DCF District 4 Substance Abuse and Mental Health (SAMH) office contracts for services in Duval and the four surrounding counties. District 4 is one of the lowest funded areas in adult mental health in the state. Agencies that contract with DCF are required to provide matching funds on a 75-to-25, state-to-local ratio. The City of Jacksonville is directed by statute to participate in the funding of alcohol and mental health services under its jurisdiction.

In Duval County, Renaissance Behavioral Health Systems operates the City's two community mental health centers, Mental Health Center of Jacksonville, located on the northside, and Mental Health Resource Center, located on the southside. These facilities house the county's crisis stabilization units (CSU) or public receiving beds which serve children and adults. Currently there are 54 beds at the two facilities, but an expansion of at least 10 beds on the northside is anticipated before the end of the year. Law enforcement officers, family members, and mental health professionals may bring persons in crisis to the nearest public or private (Shands, Ten Broeck, Baptist) receiving facility for evaluation and brief stabilization.

Gateway Community Services and River Region Human Services are publicly funded providers of comprehensive services for persons with substance use disorders. Gateway operates the community's residential detoxification ("detox") program and River Region operates the public methadone program. Both agencies provide a variety of outpatient, residential, and aftercare services.

The Department of Children and Family Services is responsible for establishing and maintaining separate and secure facilities for the involuntary treatment of defendants who are charged with a felony and who have been found to be incompetent to proceed (ITP) due to their mental illness or have been found not guilty by reason of insanity (NGI). Defendants committed to the department by the Circuit Court in Jacksonville usually receive treatment either at North Florida Treatment and Evaluation Center in Gainesville or at Florida State Hospital in Chattahoochee.

Instead of ordering commitment of individuals who have been found either ITP or NGI, or upon return from hospitalization, the court may order the conditional release of a defendant in the community. Based on a recommendation that outpatient treatment is appropriate, a written plan is filed with the court, and the court specifies the approved plan through its conditional release order. In Duval County, the conditional release order directs the Mental Health Center of Jacksonville (MHCJ) to provide community control for the defendant and to submit periodic reports to the court. These reports ensure that the defendant is participating in treatment as directed and is following any other court ordered conditions including competency training.

Persons who are arrested and held in the Jacksonville Sheriff's Office Pretrial Detention Facility (PTDF) are screened for medical, including psychiatric, conditions by nurses with Correctional Medical Services (CMS), the contract provider of medical services for Duval County's correctional facilities. Inmates who request or are determined to need psychiatric evaluation or mental health services are referred to the CMS mental health team.

A staff person employed by the Mental Health Center of Jacksonville and housed at the PTDF works closely with CMS staff to promote continuity of care for persons receiving psychiatric services in the community. Upon release from jail, persons with mental illness are reconnected or referred to community providers for treatment services and housing.

The Mental Health Center of Jacksonville also employs a diversion specialist who is housed at the PTDF and works closely with judges and court staff to divert persons with mental illness from jail to the crisis units for stabilization and treatment. About 68 people are screened each month for diversion and approximately 30% are diverted.

The chart below summarizes the major inpatient service capacities, along with their current utilization rates as a function of their capacity.

Inpatient Capacities and Utilization Rates for Jacksonville

Name of Facility	Facility Type	Bed Capacity	Utilization Rate
Northeast Florida State Hospital	State Treatment	110	66% (72)
Mental Health Center of Jacksonville	Private – Nonprofit Baker Act Receiving - MH	 30 10	 92% 85%
Mental Health Resource Center	Private – Nonprofit Baker Act Receiving – MH Level 4 Adult Therapeutic Foster Care	24 (CSU) 24 (Level 4)	97% 100%
Baptist Hospital	Private Hospital	39	82%
Shands Hospital	Private Hospital	56	81%
Ten Broeck	Private Hospital	51	95%
CRC	Level 4 - Adult Therapeutic Foster Care	30	78%
Gateway Community Center	Private – Nonprofit Marchman Act Receiving - SA	Detox (20) Stabilization (10) Adult Res. Lev. 1&2 (14) WRP Lev. 1&2 (10) R&B Lev. 3 (32) Residential Lev. 4 (Help Ctr.) (6)	93% 38% 83% 109% 101% 52%
River Region HS	Private – Nonprofit SA	SA Residential Level 2 (51)/4 (10)	90%/80%

Note: There are no Level 1-3 public MH beds currently available for Jacksonville.

2. System Access

Access to the array of mental health services is greatly affected by a client's ability to pay for services.

Over the past decade, managed care has become a major payer for private health care. The purpose of managed care has been to control spiraling mental health service costs, mostly by limiting hospital stays and rigorously managing outpatient service usage (Stroul et al., 1998). For the most part, managed care furnishes the same traditional services available under fee-for-service insurance. Managed care has shortened hospital stays and increased the use of short-term therapy models (Eisen et al., 1995; Merrick, 1998). Managed care also has lowered reimbursements for services provided by both individual professionals and institutions. This has been accompanied by the construction of provider networks, under which professionals and institutions agree to accept lower than customary fees as a tradeoff for access to patients in the network.

Mental health services provided by the public sector however are more wide-ranging than those supported by the private sector, and the types of payers are more diverse. Some public agencies, such as Medicaid and state and local departments of mental health are mandated to support mental health services. Others provide mental health services to satisfy mandates in special education, juvenile justice, and child welfare, among others.

Medicaid is a major source of funding for mental health and related support services. For the most part, Medicaid has supported the traditional mix of outpatient and inpatient services.

Trapped between the managed care and public sectors is a group of uninsured individuals and families who do not qualify for the public sector programs, cannot afford to pay for services themselves, and have no access to private health insurance.

Mental health services in Jacksonville are typically paid for by private insurance, out-of-pocket, and Medicaid or Medicare. A portion of Medicaid eligible persons are covered for mental health services under the current Medicaid HMO, and some are covered for mental health services on a fee for service basis at local provider agencies that bill Medicaid. At the time of this writing the State is also considering Duval County as a demonstration site for a new Medicaid Managed Care Program.

In an effort to control costs, the State of Florida is currently revising the amount of services and the types of medications that will be covered under Medicaid. There is an ongoing debate at this time regarding how the new limits on amount of services and medication formulary will affect clinical outcomes.

Persons who are not Medicaid eligible, but do not have sufficient income to pay for health care insurance often fall between the cracks of the existing system. Only a limited amount of funding is available from DCF to cover indigent costs, and that is primarily used to cover Medication Management services. Due to the limited funds available for Medication Management, no new Medication Management clients are being accepted unless they enter the system via a referral from a CSU facility.

Those in need of mental health services typically are faced with a maze of separate funding sources and agencies, each with its own rules and regulations that are often in conflict with each other. Determining what services may or may not be covered is often a frustrating and time consuming process.

F. Funding Sources and Issues

The following chart displays the combined most recent one year funding for mental heath and substance abuse services from the City of Jacksonville, DCF District 4 (for Duval County), and from Medicaid to cover psychiatric hospital discharges and outpatient costs. DCF District 4 provides contracted mental health (MH) and substance abuse (SA) services funding to various provider agencies, and the City of Jacksonville provides additional MH and SA funding to area provider agencies as both a match to DCF funding, and as additional resources. The Public Service Grant (PSG) dollars are separate competitive grants awarded by the City to area provider agencies for specialized grass roots social services programs.

Combined City of Jacksonville, DCF District 4, and Medicaid Hospital and Outpatient Psychiatric Funding

Total COJ MH, SA, and PSG	$6,547,873
Total DCF SA and MH for Jax	$15,655,303
Total Medicaid Hospital Psychiatric Costs for Jax	$5,884,674
Total Medicaid Outpatient costs for Jax	$28,673,560
Grand Total	**$56,761,410**

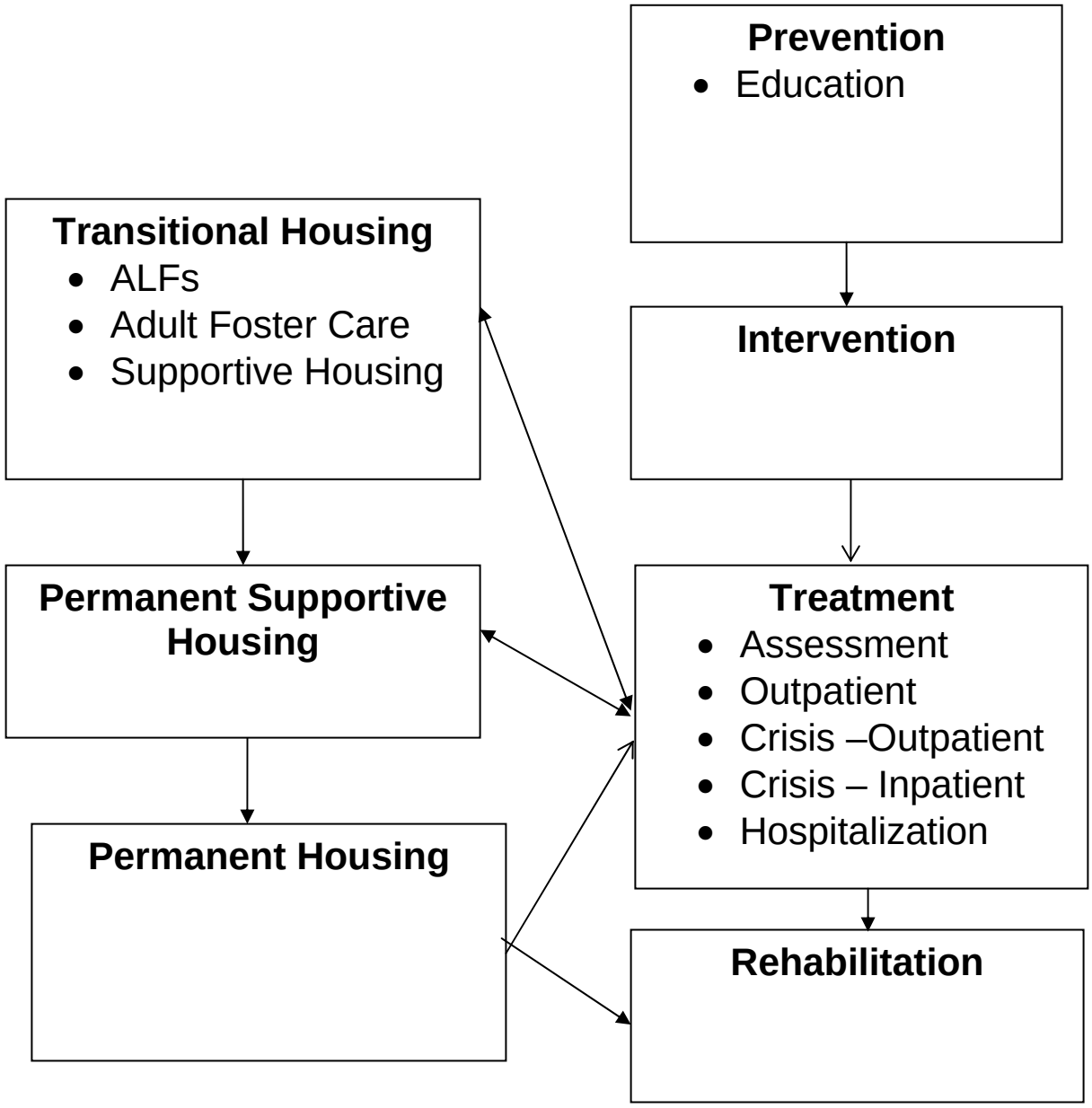
Note:

At the time of this report, funding for DCF District 4 per SPMI client is the lowest in the state, at $559.97. Florida's Substance Abuse and Mental Health Corporation has recommended to the Governor that the per client average should be increased to $1,165 for all districts.

G. Continuum of Care

The Treatment Workgroup of the Adult Mental Health Task Force has determined that the mental health continuum of care system in Jacksonville consists of the following major components: Prevention; Intervention; Treatment; Rehabilitation; Transitional Housing; Permanent Supportive Housing; and Permanent Housing. The interaction between the various elements of the continuum of care is represented by the figure 4, below.

Figure 4 Jacksonville's Adult Mental Health Continuum of Care



Supportive Services
Outreach
Case Management
Support and advocacy groups

H. Methodology

The methodology used to complete the assessment of Jacksonville's adult mental health system was a combination of collecting existing data from a variety of sources as detailed in the Gap Analysis subsections, and developing specific assessment instruments to gather additional data. The existing data was collected and then distributed to the Task Force and to the five Workgroups as part of the information they reviewed in preparation for their SWOT analysis. The five Workgroups provided progress reports to the main Task Force for review and comments each month. The five Workgroups corresponded to the major components of the Continuum of Care in Jacksonville, and included an added dimension of Public Input. The five Workgroups that processed the Gap Analysis data and generated their own assessment information were as follows: Prevention; Treatment; Housing; Rehabilitation; and Public Input.

The SWOT analysis produced the final assessment of perceived gaps and deficiencies in the local system, as discussed in the Findings subsection of the Gap Analysis. The findings in turn provided the rationale for the recommendations to improve the system, as well as an overall strategy to implement the recommendations.

The Human Services Resource Institute (HSRI) provided an on-site training workshop on conducting a needs assessment. Key informant surveys were developed specifically for the Public Input and the Prevention Workgroups. A series of Public Input focus groups were also held. The Treatment, Housing, and Rehabilitation Workgroups assessed their respective areas by using the Service Prescription and Evaluation Survey (SPES) and its related Service Description Descriptions, or Taxonomy, as part of their assessment process. The SPES system was similar to the process that HSRI has implemented in over 20 States.

Each Workgroup conducted a SWOT analysis using the data it collected and reviewed, their list of strengths, weaknesses, opportunities, and threats, as well as supplemental information provided to them by the internal consultant staff for the project. The packets of information were distilled from selected sections of the reports and documents described in the Background section of this report, as well as information collected from other sources, as referenced in the packets. A summary of the SWOT process for each Workgroup is provided in the Findings section of this report.

The final recommendations from each of the Workgroups and from the entire Adult Mental Health Task Force, is provided in the Conclusions, Recommendations, and Implementation section. Each of the five Workgroups developed a series of recommendations that were designed to address their findings.

The specifics regarding the assessment instruments used, the data collected, and the overall assessment process followed by each of the Workgroups is provided in the findings section of this report, and is broken down according to the five Workgroups. A copy of the assessment instruments used by the Workgroups is provided in the appendices. A copy of the information sources reviewed by each of the Workgroups, and the results is also provided in the appendices.

The entire process was directed at developing a snapshot of the existing adult mental health system in Jacksonville, including gaps in services, quality and accessibility issues. The snapshot was used to compare Jacksonville's mental health system with federal level assessments of the country's mental health system. The process was also used as a springboard to develop a systematic plan to improve the system.

I. Findings/Gap Summaries

The following sections contain details of the assessment process followed by the Prevention, Treatment, Housing, Rehabilitation, and Public Input Workgroups, as well as the overall findings of each Workgroup. The findings section includes discussions of gaps in services, and a discussion of major prevention issues.

1. Prevention Findings

In Mental Health: A Report of the Surgeon General, the need for greater emphasis on prevention activities is stated succinctly: "Preventing an illness from occurring is inherently better than having to treat the illness after its onset." There are however, a multitude of issues to consider when planning prevention activities. The information provided to the Prevention Workgroup contained a brief, but systematic overview of major issues affecting mental health prevention planning, including the following: extent of the problem; prevention benefits and issues, the stigma associated with mental illnesses and its affect on prevention efforts; public health model; promotion and prevention concepts; risk and resiliency factors; evidence-based programs; and process vs. outcome measures.

A survey of prevention programming activities in Jacksonville was conducted by the Prevention Workgroup of the Adult Mental Health Task Force. The Workgroup members surveyed all provider agencies known to conduct prevention activities. They also contacted any agency that may provide prevention services. The Workgroup contacted each agency by phone and asked a series of prepared questions from a specially developed prevention survey. A copy of the survey used to assess prevention programming is provided in appendix B.

The Prevention Workgroup reviewed the summary of prevention programs in Jacksonville, along with the prevention background information described above, prior to conducting a SWOT analysis. The results of the SWOT analysis provided the springboard that the Workgroup used to formulate its list of recommendations to address the findings discussed in this section. The background information that the Workgroup reviewed prior to the SWOT process is provided in appendix C**.** The results of the Prevention Workgroup's SWOT are provided in appendix D.

Prevention findings:

The Prevention Workgroup found that prevention activities in Jacksonville are currently limited to those conducted by five agencies: Jacksonville Chapter of National Alliance for the Mentally Ill (JAMI); Jacksonville Chapter of the Mental Health Association (JMHA); Gateway Community Services; SAGES; and Urban Jax.

The programs have very limited budgets, and consist primarily of education and support group programs. The program conducted by SAGES is primarily alcohol and substance abuse related. There are no longitudinal studies of program impact, and there is no specific coordination of prevention goals and objectives between providers. There are very limited measures of program effectiveness, which includes anecdotal client satisfaction reports. None of the programs are linked to specific evidenced-based programs. There are no publicly funded prevention activities in Jacksonville.

The Workgroup concluded that the lack of public funding for prevention activities is inconsistent with the recommendations of major mental health reports, and represents a significant gap in the mental health system. The chart below provides a summary of current prevention activities in Jacksonville:

Adult Mental Health and Substance Abuse Prevention Services

AGENCY	PROGRAM NAME	PROGRAM DESCRIPTION	BUDGET	# SERVED
NAMI	National Alliance for the Mentally Ill (NAMI) Brainmatter	Weekly support groups for families Library-based information programs on latest brain-science information (MH)	$800 per library class of 20	Not provided
MHA	Mental Health Association of NE Florida	Serves Seniors and their caregivers. Education on signs and symptoms of depression, strategies, and referral info. (MH)	$35,000 United Way Area Agency on Aging, NE FL.	Not provided
Gateway Community Services	Northeast FL. Prevention Center	Serves adults, adolescents, and children. Substance Abuse Education/Awareness (SA)	$109,000 (Adults) State of Florida	12,000 (total)
SAGES	SAGES Coalition	Serves Seniors 60+, their caregivers, and area professionals. Education on alcohol, substance abuse, and mental illness signs, symptoms, strategies, and referral info. (MH) (SA)	$10,845 FSU Grant	175 Seniors 111 Pros.
Urban Jax	Mobile Client Assessment Program	Serves Seniors 60+. Education on mental health illness signs, symptoms, strategies, and referral info. (MH)	$90,000 DCF, SAMH	50

Note: Mental Health prevention programs are designated as (MH), and Substance Abuse programs as (SA).

2. Treatment Findings

The President's New Freedom Report on the nation's mental health system concluded that the current mental health system is fragmented and in disarray. The system consists of multiple funding source agencies, each with its own set of complex regulations, goals, objectives, and management information systems (Achieving the Promise: Transforming Mental Health Care in America, DHHS, 2003).

The complexity and inefficiency of the system contributes to poor services and limits access to mental health services. Services are provided according to program objectives and funding rules, rather than the needs of customers. Moreover, some agencies that are part of this fragmented system are not even directly involved with mental health issues, such as Medicaid and Medicare programs. In fact, the largest Federal program that supports people with mental illness – the Social Security Administration, with its SSI and SSDI programs - is not even a health service organization. The fragmentation of the mental health system is found in virtually all local communities. A recent focus group public opinion analysis of a cross section of Jacksonville's community confirmed that system fragmentation is a major contributing factor to system access and quality of care in Jacksonville.

There are a multitude of issues to consider in preparation for assessing a mental health system, and for producing a plan to improve the system. To insure a common understanding of the major issues associated with the mental health treatment system, the Treatment Workgroup was provided with a background information packet. The packet consisted of a systematic overview of major issues associated with mental health treatment, presented in the form of a collection of separate, but related information and data sources. A copy of the Treatment Notes packet is provided in Appendix E of this report.

The Treatment Workgroup conducted a survey of the local mental health system that was based on a process developed by the Human Services Resource Institute (HSRI). The survey process, known as the Service Prescription and Evaluation Survey (SPES), has been used in over 20 states. HSRI and its associated consultant section, The Evaluation Center, are funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). HSRI provided an onsite workshop on conducting a behavioral system needs assessment for the Adult Mental Health Task Force. Subsequent to the workshop, HSRI has provided ongoing technical assistance to the Task Force.

The SPES process began with the development of a taxonomy, or description of the existing major mental health service components. A list of additional services that would be required to achieve an adequate level of services (a description of services not currently available) was added to the service prescriptions. Each service component included a unit cost that was based on a combination of funding source reimbursement data, provider agency cost figures, and cost estimates provided by the Treatment Workgroup members. The Treatment Workgroup then provided judgments about the percentage of clients currently in the system that would require each of the services in an improved system. The clients currently in the system were divided according to their functioning level (RAFLS) score. The Workgroup provided estimates of the percentage of clients who are actually receiving the array of services, according to their functioning level. Finally, the Workgroups provided judgments about the reasons for any discrepancies between adequate service levels and the level of service clients are actually receiving.

The Treatment Workgroup consisted of a cross section of mental health professionals, administrators, mental health advocates, and concerned citizens. The results of the SPES process were provided to HSRI and were used as the basis of a computer-assisted assessment to determine the estimated cost of an improved system, as well as estimated client treatment patterns throughout the mental health system. The client patterns were based on expected changes in functioning levels, based on a pre-existing data base of client functioning patterns. The estimated costs have been described in the Analysis section of this report.

The results of the SPES survey were charted and reviewed by the Treatment Workgroup. The chart used to display the survey results is provided in Appendix G. The associated service descriptions and unit costs are provided in Appendix H. The service description list found in Appendix H also contains the service descriptions for the Housing and Rehabilitation Workgroups, which used the same survey process.

The Treatment Workgroup reviewed the SPES results, along with the Treatment Notes background information described above, prior to conducting a SWOT analysis. The results of the SWOT analysis provided the springboard that the Workgroup used to formulate its list of recommendations to address the findings discussed in this section. The results of the Treatment Workgroup's SWOT are provided in Appendix F.

Summary of Treatment Findings:

DCF District 4 statistics indicate that 10,298 adults were treated in the publicly funded mental health system in the most recent one year period, and an additional 843 were discharged from hospitals with psychiatric diagnoses according to the Agency for Health Care Administration (AHCA) for an overall total of 11,141. Statistically, we would expect 62,309 persons with SMI/SPMI alone in Duval County. It is significant however, that according to the Surgeon General's Report, "less than one-third of adults with a diagnosable mental disorder receives treatment in one year."

It is also important to note that the majority of mental health services funding for Duval County is for adults who suffer from severe mental illness (SMI), or severe and persistent mental illness (SPMI). The current funding priorities do not usually cover services for adults who have less severe diagnosable conditions. Based on statistical estimates, there could be over 171,000 persons in Jacksonville with a diagnosable mental condition. The 11,141 adults treated in Jacksonville's mental health system represent only about 18% of those estimated to suffer with SMI or SMPI alone, which is substantially less than one third of the potential number of persons needing treatment, according to federal estimates - and that number does not include those with less severe disorders, for whom there are few publicly funded treatment services. There is a significant gap therefore, between the estimated number of persons with a diagnosable mental illness in Duval County, and the number who are receiving services, both with respect to those with SMI/SPMI, and those who suffer with less severe forms of mental illnesses.

With respect to the survey of the mental health system via the SPES process, the Treatment Workgroup found that there is a significant difference between the level of most services currently received by clients, and the level of services they should be receiving in an adequate treatment system. The Treatment Workgroup determined that the primary reasons for the discrepancy between actual services received and an adequate level of services were due to the following reasons: insufficient capacity of the service; an inability to pay for the service; the service was denied to due client behavioral issues; or the client refused the service. Some service discrepancies occurred because the service option was not available.

The SPES evaluation did show an interesting bell-shaped curve of service use, with the majority of services provided to clients with moderate to poor functioning levels, and fewer overall services provided to higher functioning clients and clients who have very low functioning levels. The bell-shaped curve of estimated service use is consistent with actual distribution of clients reported by DCF, and is consistent with the perceptions of the Treatment Workgroup members.

The Treatment Workgroup also found that most of the problems with the mental health system in Jacksonville are similar to those described in the major reports previously outlined. The problems include a fragmented system with multiple funding sources and provider agencies, each with its own set of service priorities and client criteria. The fragmented system presents a difficult maze for many clients to deal with, and does not facilitate a client-driven array of services. The fragmented system has also been noted in the results of focus groups conducted by the Public Input Workgroup, as documented in the findings section of this report.

The fragmented system in Jacksonville begins with a funding-driven separation between mental health and substance abuse services. The division of services is antithetical to co-occurring disorders that have a concomitant need for joint substance abuse and mental health services in a seamless system. Moreover, the array of services that clients receive is often dependent on their point of entry into the system, or the location of their residence, especially with respect to crisis stabilization services.

There is clearly no single and consistent point of entry into the publicly funded mental health system in Jacksonville, and clients must navigate a complex web of provider agencies and services limited by funding mandates and multiple authorization criteria. The complexity of the system is a barrier for clients seeking help, who, by the nature of their illnesses may have limited decision making skills, as well as other cognitive impairments.

Multiple agencies deliver substance abuse services in Jacksonville, each with their own intake, assessment, treatment, and case management systems. Clients who also require mental health treatment often must be referred to another agency, and the referral process may not necessarily be seamless or well integrated, with effective follow-ups and inter-agency collaboration. Even within the substance abuse system, some clients may have to go to one agency for detoxification services and another for a methadone program. State DCF District Four funding and federal Medicaid reimbursements primarily cover services for persons with severe and persistent mental illnesses; therefore clients often need to move between publicly funded agencies or between publicly funded and private services, depending on their clinical needs.

Adding to this patchwork of services is a complicated array of crisis units and public and private hospitals. Typically, clients who require crisis stabilization are taken to one of five facilities, from which they may need to be transferred to another facility, depending on their insurance status and client choice. Providers often complain about the limited availability of beds for transfer of patients to public facilities, especially for indigent care, and the public facilities spend several hundred thousand dollars each year transferring individuals to private hospitals (Shands, Baptist, and Ten Broeck).

Future system transformation strategies should focus on efforts to streamline barriers imposed by funding restrictions, interagency competition, overlapping and redundant services, and reducing the multiplicity of discreet services that are dispersed throughout the system. Services should be oriented around the needs of clients, as opposed to the convenience of administrative agencies, program managers, supervisors, and direct service providers, and should provide seamless transition through the system. System transformation must include significant changes in policies and procedures, flexible spending options, regulatory relief, leveraging of funding, and improved coordination among existing providers and funding sources.

The Workgroup concluded that there is a significant gap between the estimated number of persons who require treatment, and the actual number being served, as well as a significant gap between the level of service clients actually receive, and the level of services they should be receiving. They also concluded that the system is fragmented and not client driven, and is reflective of the dysfunctional service system nationwide.

3. Housing Findings

An estimated 842,000 adults and children are homeless in a given week, with that number swelling to as many as 3.5 million over the course of a year. People who are homeless are the poorest of the poor. While almost half (44%) of people who are homeless work at least part-time, their monthly income averages only $367 compared to the median monthly income for U.S. households of $2,840. Those who have disabilities and are unable to work can find it nearly impossible to secure affordable housing in virtually every major housing market in the country.

The Emergency Services and Homeless Coalition (ESHC) has recently completed a comprehensive ten-year plan to address homeless in Jacksonville, known as “Ending Homelessness in Jacksonville: A Blueprint for the Future.” At the heart of the plan is the development of new permanent housing units for homeless individuals and families. The cost of homeless to the City of Jacksonville is a staggering $35 million annually, $27 million of which is the result of costs associated directly with emergency shelters, housing, and other services.

Research by the ESHC indicates that of the estimated 2,580 persons who are homeless in Jacksonville on any given day, 50% have recently experienced mental health problems. Persons who are chronically homeless (repeatedly homeless over a period of years), disproportionately impact the cost of homelessness in Jacksonville, are more likely to have serious mental illnesses, often have co-occurring substance abuse problems and/or physical problems.

The Blueprint has a comprehensive strategy to address the problem of homeless in Jacksonville, including strategies that are directed at the long-term or chronic homeless population. The goal is to stabilize the chronically homeless through permanent supportive housing, income sources and employment opportunities. Among specific actions, the plan calls for 145 supportive housing units in two years, and 800 units in five years, with an estimated cost of $90 million. The plan has a comprehensive approach to financing the various goals and actions items and has justified the costs against the current and spiraling costs of the traditional crisis approach to dealing with homelessness.

Since homeless persons with accompanying mental illness form a significant portion of the homeless population, it follows that a comprehensive plan to address homelessness, including the chronically homeless, should be supported by the Homeless Workgroup and the Adult Mental Health Task Force. The range of housing and social proposed by the plan should assist persons with mental illness along the entire spectrum of illnesses. Additional work of course will have to be done to align the array of housing services in Jacksonville as delineated by the Housing Workgroup, with the large scale mental health system transformation that will be occurring at the federal and state levels.

As a compliment to the work already completed by the ESHC, the Housing Workgroup conducted an analysis of the housing service system in Jacksonville, based on a process developed by the Human Services Resource Institute (HSRI). The survey process, known as the Service Prescription and Evaluation Survey (SPES), has been used in over 20 states. HSRI and its associated consultant section, The Evaluation Center, are funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). HSRI provided an onsite workshop on conducting a behavioral system needs assessment for the Adult Mental Health Task Force. Subsequent to the workshop, HSRI has provided ongoing technical assistance to the Task Force.

The SPES process began with the development of a taxonomy, or description of the existing major mental health service components. A list of additional services that would be required to achieve an adequate level of services (a description of services not currently available) was added to the service prescriptions. Each service component included a unit cost that was based on a combination of funding source reimbursement data, provider agency cost figures, and cost estimates provided by the Treatment Workgroup members.

The Housing Workgroup then provided judgments about the percentage of clients currently in the system that would require each of the services in an improved system. The clients currently in the system were divided according to their functioning level (RAFLS) score. The Workgroup provided estimates of the percentage of clients who are actually receiving the array of services, according to their functioning level. Finally, the Workgroup provided judgments about the reasons for any discrepancies between adequate service levels and the level of service clients are actually receiving. The result of the SPES process for the Housing Workgroup is provided in Appendix I.

The Housing Workgroup also conducted a SWOT analysis of the housing service system. The process was similar to that of the Treatment Workgroup, described above. The background information provided to the Housing Workgroup is provided in Appendix J.

As was the case with the Treatment Workgroup analysis, the Housing SPES process indicated that there is usually a significant difference between the level of housing options and related services and those currently received by clients. The Housing Workgroup also determined that the primary reasons for the discrepancy between actual services received and an optimal level of services were due to the following: insufficient capacity of the service; an inability to pay for the service; service was denied to due client behavioral issues; or the client refused the service. Some service discrepancies were due to the fact that the service option was not available.

The Housing Workgroup reviewed the background information and the SPES process analysis prior to conducting their SWOT analysis. The SWOT analysis results are provided in Appendix K.

The Housing Workgroup concluded that there is a significant gap between the housing options that should be available for persons with mental illnesses, and the services that actually exist. As was the case for the Treatment Workgroup, the Housing Workgroup, also concluded that the system is fragmented and not client driven, and is reflective of the dysfunctional service system nationwide.

4. Rehabilitation Findings

As a result of the continuing efforts of Mental Health Consumer Advocacy Groups, the mental health system is moving towards a more consumer-driven process, as opposed to the complex web of services and their funding sources that currently drives the system. Instead of viewing mental illness as a lifelong deterioration, with a primary focus on symptom relief similar to a medical model, the focus should be on recovery, which implies restoration of self-esteem and identity, and obtaining a meaningful role in society (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999).

The fragmented mental health system that exists across the county and in Jacksonville is service driven and complex and needs to move towards a consumer-driven and recovery-based system that is consistent with the emerging system transformation efforts underway at the Federal and State levels. An array of services that include psychosocial rehabilitation and vocational rehabilitation services would contribute to the process of recovery for patients with mental illnesses.

The Rehabilitation Workgroup conducted an analysis of the rehabilitation service system in Jacksonville, using the same SPES analysis process used by the Treatment and Housing Workgroups. The results of the SPES process are found in Appendix L.

The Rehabilitation Workgroup found the same discrepancy between an optimal rehabilitation service system and the system that actually exists, with the same general reasons: insufficient capacity of the service; an inability to pay for the service; service was denied to due client behavioral issues; or the client refused the service. Some service discrepancies were due to the fact that the service option was not available.

The Rehabilitation Workgroup conducted a SWOT analysis using the results of the SPES and the background information found in Appendix M as a springboard. The results of the SWOT are provided in Appendix N.

The Rehabilitation Workgroup concluded that the same gap in services exists for rehabilitation services as exists for treatment and housing services, with the essentially the same reasons: insufficient capacity of the service; an inability to pay for the service; service was denied to due client behavioral issues; or the client refused the service. Some service discrepancies were due to the fact that the service option was not available.

5. Public Information Findings

In addition to the information collected from the Prevention, Treatment, Housing, and Rehabilitation Workgroups, the Task Force provided for direct public input in the Adult Strategic Plan process via a series of focus groups.

The following is a summary analysis of public opinion information obtained through three focus groups. The focus group participants were solicited by the Adult Mental Health Public Opinion Workgroup. The Workgroup endeavored to contact a broad cross-section of participants. The participants included mental health consumers, family members, mental health professionals and other professionals, mental health advocates, and concerned citizens. A total of 35 participated.

The focus groups were conducted on May 19, 24, and 25. The May 19 and 25 groups were held from 6:00 p.m. until 7:30 p.m., and the May 24 group was held from 12:00 p.m. until 1:30 p.m. All three focus groups were conducted in the large conference room of the Jacksonville Community Council, Inc.

The groups that met on May 24 and 25 were asked to complete a mental health survey in addition to participating in the focus group process. Three versions of the survey were developed for use with consumers of mental health services, family members of consumers, and for mental health system professionals. All three surveys were nearly identical. The wording of the questions was changed slightly to make it more appropriate to each group. The survey forms are reproduced in Appendix O. There were 18 statements on the survey, and 23 surveys were returned. The overall results obtained from the survey are discussed here within the context of the entire public opinion analysis.

The statements of each focus group process were verbally summarized and recorded. The statements were then typed as raw data and then summarized into relevant categories in separate reports. The summary information in this report is a synthesis of the most salient issues from each of the three summary reports, along with the survey results.

Populations in need of services

- Seniors – specialized services for current seniors are insufficient, and the system will not be able to handle Baby Boomer Seniors.
- Homeless persons with mental illnesses, especially housing services and housing options.
- The entire North Side of Jacksonville is underserved.
- Jail populations are underserved.
- Young adults are underserved. There are no programs for transitioning young adults.

Mental Health Service System Issues

- Service fragmentation and complexity, duplication of efforts, insufficient sharing of information, especially psychotropic medication with other medication providers.
- Funding sources tied to fragmented system often dictates treatment options
- Gatekeepers, public, consumers and their support system not knowledgeable about mental health system.
- Mental illness stigma inhibits people from seeking help and limits their support system.
- System does not encourage participation of family and other support members in treatment process
- Baker Act process is too short (72 hours) to allow for adequate assessment of patients and determination of appropriate treatment options and involvement of patient support system.
- Patients are allowed too much self-determination when they are not capable of making appropriate decisions, due to the nature of their illnesses.
- Limited Baker Act receiving options
- Duval County Baker Act resources are serving other counties as well, burdening the system.
- Insufficient transportation available, and too there are not enough treatment sites.
- Insufficient outcome tracking.

- Mental Illness is a systemic issue, and is tied to our culture.
- Specialized training, such as CIT, is a great help.
- There is no central point for people to register complaints about mental health services. In the past, the Mental Health Planning Council was an option.
- Mental Health funding for Florida and Jacksonville is very low.
- Due to funding and program cutbacks, faith-based programs are overburdened.

Mental Health Service System Needs/Recommendations

- Transportation for persons with mental illness and their support system
- More clubhouse programs and other high performing programs
- More FACT teams
- Intensive outpatient services to prevent progression of mental illnesses
- Additional Baker Act receiving facilities
- More education programs for the public in general, consumers, gatekeepers, support systems.
- Mental health professionals need to involve client's family and support system in treatment process
- Psychiatric medication professionals need to have better contact with other medical community to share medication information.
- Mental health services and funding should be seamless and based on client needs.
- Mental health laws affecting client self-determination need to be revised to prevent persons with mental illnesses from deteriorating due to poor decisions.
- Other counties should have their own Baker Act receiving facilities.
- Use Peer Specialist Model to help with continuity of care and stigma.
- Mental Health Services should come under Health Department.
- Need an organization like a Mental Health Planning Council, as well as a support organization for mental health professionals.
- Improve information sharing between provider agencies.
- Continue and expand programs like CIT training.

- Improve funding levels for mental health services.
- Improve information sharing between provider agencies.
- Establish a mental health information clearinghouse.
- Provide more programs to serve young adults
- Need mental health court option
- Need to insure changes in mental health system at the specific, programmatic level, with appropriate review of changes
- Provide more training and financial assistance to faith-based programs.
- Change mental health system to client-driven, not service-driven. Funding should follow clients, not provider agencies.
- Need cultural shift to deal with stigma issues and need for additional funding

Human Resource Issues

- Great variability in quality of mental health professionals
- Turnover among professionals too high, inhibits continuity of care and bonding
- Paperwork overloads professionals and contributes to turnover
- Low salaries for professionals contributes to turnover

Human Resource Needs/Recommendations

- Need to reduce paperwork and other administrative overload on mental health professionals
- Need to Increase pay for mental health professionals – current pay scales are not sufficient for the responsibility level, and are below that of positions that do not require a comparable level of education, training, and responsibility
- Need more consistent quality among mental health professionals
- Need to reduce turnover among mental health professionals

Summary of Mental Health Survey Results:

Most of the survey scores tended to average out towards the midpoint between strongly disagree and strongly agree. Most notable however, were the following:

1. Most respondents disagreed that there are enough housing options available for mental health clients. The average score was 1.7.
2. Most respondents disagreed that there are adequate mental health services for seniors. The average score was 2.2.
3. Most respondents disagreed that Jacksonville residents are able to access all the mental health services they need. The average score was 2.2.
4. Most respondents agreed with the statement that the mental health system in Jacksonville needs more money. The average score was 4.7.
5. Most respondents agreed with the statement that the stigma associated with mental health is a problem, with an average score of 4.6.

The strong opinions noted above were consistent with the raw statements from the focus groups sessions, and are also found in the summaries of the focus group process.

Conclusions:

The same primary themes were identified across the three focus groups:

- Fragmentation
- Housing
- Turnover
- Stigma
- Access
- Money
- System driven, not client driven
- Transportation
- Does not encourage client and support system participation

The results of the focus group process are consistent with the major findings presented in a variety reports, such as the President's New Freedom Report. Most of the major reports consistently report that stigma remains the major impediment to mental heath progress, services and funding are fragmented, the complex system restricts access because it is overwhelming to consumers, there is shortage of affordable housing, community based care is needed, more education programs are needed, and consumers and families need to be involved in their own care.

VI. Data Sources and Limitations

The data and other information sources used in the preparation of this report represents a combination of existing information and information specifically collected from the various Workgroups. Epidemiological information (the incidence, distribution, and control of disease) was obtained first by extrapolating estimates of the rates of mental illnesses from authoritative sources (see Analysis) using U.S. Census population statistics for Jacksonville.

The next levels of incidence data were obtained from the State of Florida, Department of Children and Families, District 4. The DCF data is limited to programs funded through DCF, and primarily reflects data on SMI/SPMI populations, since those are the populations for which DCF provides funding. Therefore, there are few statistics on the numbers of persons with other diagnosable disorders since most public funding is directed at the SMI/SPMI population. In addition, at the time of this report, it is unclear if the criteria used in classification of clients in various categories refer to their diagnosis at time of entering the system, or at some later point. It may be possible to clarify this question eventually, through additional meetings with DCF staff.

The number of persons who were hospitalized with a mental illness for which Medicaid was used as the primary funding source was eventually obtained from Florida's Agency for Health Care Administration (AHCA). The process of obtaining the hospital Medicaid information was very time consuming and tedious however, since the information had not previously been requested. Similarly, the process of obtaining the DCF data was time consuming and tedious because the information had not been requested previously, or used for comparative purposes in longitudinal studies.

DCF annually reports on the performance of its contracted service providers on a district-wide basis. There is no separate performance report for the City of Jacksonville at this time, although it appears that it may be possible to eventually collect the information by sifting through the many hundreds of pages of information contained in the District 4 summary.

Statistics on the suicide rate for Jacksonville was obtained from the Florida Department of Health, Office of Vital Statistics.

The Treatment, Housing, and Rehabilitation Workgroups used a specific mental health system analysis process that was based on training and ongoing technical assistance provided by the Human Resource Services Institute (HSRI), and its technical assistance branch, The Evaluation Center. HSRI is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). The Workgroups assessed their respective mental health service component using the Service Prescription and Evaluation Survey process (SPES), which has been used in over 20 states. Each of the Workgroups also was provided with a background information packet relative to their respective areas, to insure that each member of the Workgroups was familiar with the same basic information. The results of the SPES process have been include in the Appendices of this report and summarized in the respective Workgroup report sections.

The Prevention Workgroup obtained information on prevention programs in Jacksonville through the use of a specifically designed survey that was administered by phone. The Prevention Workgroup used its knowledge of the mental health system in Jacksonville to develop a list of agencies that were thought to provide some prevention programs and activities. Although it appears that the prevention information reflects an accurate assessment at this time, the survey still relied on the judgment of the Workgroup members regarding what agencies may provide prevention services.

The Public Information Workgroup also used a key informant survey method, coupled with a series of focus groups. The Public Information Workgroup used a wide variety of civic organizations and other network contacts to solicit members for the focus groups. It is unknown at this point to what extent the participants represent a true cross-section of public input, or were weighted towards participants who primarily had negative experiences or complaints.

Much needs to be done to establish regular and useful data collection and management information systems. Most of the members of the Task Force who represent provider agencies maintain that there is very little management information data that is useful to them for planning purposes.

VII. Recommendations and Implementation Plan

Each of the Workgroups developed a list of recommendations that were designed to address the issues or gaps that surfaced as a result of their individual assessment processes. The recommendations of each Workgroup are listed below. There were however, a number of recommendations that each of the Workgroups offered that were universally agreed upon, and those recommendations are listed below under the heading Generic Recommendations. The generic recommendations were viewed as essential to addressing the major issues affecting the adult mental health system in Jacksonville.

The specific recommendation regarding the establishment of a Mental Health Authority is based upon the recognition among the Task Force members that large-scale changes are necessary, and that only a powerful oversight organization could bring about those changes. The consensus of opinion regarding the need for a Mental Health Authority is supported by The Surgeon General's Report. The Report noted that the traditional mental health system is not capable of bringing about the large scale organizational changes necessary to integrate the various services currently provided by the patchwork of providers and funding sources. The Surgeon General's Report indicated that when Mental Health Authorities are established and sufficiently strengthened, they produce measurable increases in organizational centralization and reduced fragmentation of services.

A. Generic Recommendations

1. Establish a Mental Health Coalition and a Mental Health Authority

   a. MH Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant Applications, develop mental health planning documents, and provide standards and practices oversight.
   b. Mental Health Authority to be independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, to recommend statutory changes, and act as legislative liaison.
   c. Create permanent sub-committees of the Mental Health Coalition, for Prevention, Treatment, Housing, Rehabilitation, and Public Information.

B. Prevention Recommendations

1. Establish a Mental Health Coalition and a Mental Health Authority
    a. MH Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant Applications, develop mental health planning documents, and provide standards and practices oversight.
    b. Mental Health Authority to be independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, to recommend statutory changes, and act as legislative liaison.
2. Establish permanent Prevention Sub-committee of the Mental Health Coalition
3. Advocate for an overall increase in mental health funding that will enable 20% of new mental health funding to be directed towards mental health promotion and mental illness prevention activities
4. Solicit SAMHSA TA for consistency with emerging Federal and State transformation goals and objectives, especially as they relate to information systems, outcome measures, and evidence-based practices
5. Establish wide-spread use of evidence-based prevention programs, including on-going quality control measures
6. Task Mental Health Coalition to develop a comprehensive prevention plan

C. Treatment Recommendations

1. Establish a Mental Health Coalition and a Mental Health Authority

    a. Mental Health Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant RFPs, develop mental health planning documents, and provide standards and practices oversight of mental health provider agencies

    b. Mental Health Authority should be an independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, approve mental health planning documents, recommend statutory changes, and act as legislative liaison.

2. Establish a permanent Treatment Sub-committee of the Mental Health Coalition
3. Advocate for parity in mental health funding at state level
4. Solicit SAMHSA technical assistance for consistency with emerging Federal and State transformation goals and objectives, especially as they relate to information systems, outcome measures, recovery and customer-driven approaches, and evidence-based practices
5. Eliminate rules and regulations that exclude consumers from receiving services due to behaviors associated with mental illnesses
6. Value clinicians
7. Improve current management information system at both the planning and client information levels, and insure consistency with emerging system changes at the federal and local levels
8. Eliminate “two mental health systems” (public/private service quality discrepancies)

D. Housing Recommendations

1. Establish a Mental Health Coalition and a Mental Health Authority

    a. MH Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant RFPs, develop mental health planning documents, and provide standards and practices oversight of mental health provider agencies
    b. Mental Health Authority to be independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, approve mental health planning documents, recommend statutory changes, and act as legislative liaison.

2. Establish permanent Housing Sub-committee of the Mental Health Coalition
3. Support Blueprint to End Homelessness goals and objectives, particularly as they apply to Chronically Homeless persons
4. Continue to support DCF Supportive Housing initiatives
5. Establish a local Housing Resource Center for persons with mental illnesses
6. Solicit SAMHSA TA for consistency with emerging Federal and State transformation goals and objectives, especially as they relate to information systems, outcome measures, and evidence-based practices
7. Improve current management information system at both the planning and client information levels, and insure consistency with emerging system changes at the federal and local levels.

E. Rehabilitation Recommendations

1. Establish a Mental Health Coalition and a Mental Health Authority

    a. MH Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant RFPs, develop mental health planning documents, and provide standards and practices oversight of mental health provider agencies

    b. Mental Health Authority to be independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, approve mental health planning documents, recommend statutory changes, and act as legislative liaison.

2. Establish permanent Rehab Sub-committee of the Mental Health Coalition
3. Solicit SAMHSA TA for consistency with emerging Federal and State transformation goals and objectives, especially as they relate to information systems, outcome measures, and evidence-based practices
4. Support mental health parity in DCF funding
5. Insure on-going consumer participation in the mental health planning process

F. Public Information Recommendations

Many of the suggestions listed in this summary would eventually be addressed through the systems recommendations from the Prevention, Housing, Rehab, and Treatment Workgroups. The Public Information Workgroup therefore supports the recommendations put forth by each of the four other Workgroups, as detailed in their reports.

1. Establish a Mental Health Coalition and a Mental Health Authority

   c. MH Coalition should have non-profit status and be the authorized local entity to pursue major Mental Health Grant RFPs, develop mental health planning documents, and provide standards and practices oversight of mental health provider agencies
   d. Mental Health Authority to be independent government entity empowered to hold public hearings, approve distribution of federal, state, and local mental health funding, approve mental health planning documents, recommend statutory changes, and act as legislative liaison.

2. Establish permanent Public Information Sub-committee of the Mental Health Coalition

3. Support the specific recommendations proposed by the Prevention, Treatment, Housing, and Rehab Workgroups.

4. As the Mental Health Coalition is formed, identify those specific suggestions detailed in the Public Information Workgroup report that may be implemented immediately or in parallel, to the larger, system-wide recommendations provided by the Workgroups.

G. Implementation Plan

The Adult Mental Health Strategic Plan is designed to improve the overall mental health system, and as such its final recommendations may be viewed as process objectives that support the original mission of the Task Force which was to maximize mental health services in Jacksonville. The individual recommendations of the Workgroups therefore, may be conceptualized as the objectives necessary to achieve the goal of maximizing mental health services in Jacksonville. The overall goal and its supporting objectives may also be viewed as activities of phase two of a two phase process.

The Phase I Implementation Plan goal and its objectives and action items, was derived from a recommendation that was generic to all the Workgroups and is therefore viewed as a fundamental objective needed to move the system forward. The Phase I objective, to establish a local Mental Health Coalition, must be achieved before any meaningful progress can be made on the long range objectives. The second generic recommendation, to establish a local mental heath authority, was included in the long range objectives, because the process would require a considerable amount of time.

Phase I – Implementation Plan

Goal: Establish a local Mental Health Coalition

Objectives

1. Convene a committee to study the process of creating a Mental Health Coalition as a non-profit organization of mental health agency professionals, advocates, and concerned citizens, to function as a focal point for adult mental health issues, to coordinate major grant applications, and to facilitate collaborative working relationships among the various mental health system stake-holders.

   Action Items

   a. Draft Mental Health Coalition steering committee members from current Adult Mental Health Task Force.

   b. Solicit start-up funds for Mental Health Coalition from City of Jacksonville's Public Service Grant process, or other City funding options.

Phase II – Long Range Goals and Objectives

Goal: Maximize mental health services in Jacksonville

Objectives

1. Institute wide-spread use of evidence-based practices, with performance objectives and an oversight process that ties evidence-based performance to funding.

2. Establish permanent subcommittees of the Mental Health Coalition for Prevention, Treatment, Housing, Rehabilitation, and Public Input.

3. Advocate for an overall increase in mental health funding that will enable 20% of the new mental health funding to be directed towards mental health promotion and mental illness prevention activities.

4. Solicit SAMHSA and State technical assistance in the development of a comprehensive management information system, future outcome measures, and evidence-based practices, to be consistent with emerging federal mental health transformation process.

5. Task Mental Health Coalition to develop a comprehensive mental health promotion/ mental illness prevention plan.

6. Establish a local Mental Health Authority, empowered to affect the distribution of mental health funding, recommend statutory changes, hold public hearings, act as legislative liaison for mental health issues, and to provide standards and practices oversight.

7. Advocate for parity in State mental health funding.

8. Reorganize mental health system to be client-driven, recovery-based, with minimal system fragmentation, and an adequate level of services.

9. Reduce disparity between publicly funded mental health services and private services.

10. Support “Blueprint to End Homelessness” goals and objectives, of the Emergency Services and Homeless Coalition, especially as they relate to the Chronically Homeless population.

VIII. Appendices

Appendix A Adult Mental Health Task Force Members

The following pages contain the list of Task Force and Workgroup members, who contributed to the project, as well as a list of the technical staff :

Adult Mental Health Task Force
Membership and Endorsement

We, the undersigned, do hereby endorse the "Adult Mental Health Strategic Plan: A Strategy for the Future," and pledge our continued commitment to its goals for improving the adult mental health system in Jacksonville, Florida.

Name	***Affiliation***	***Signature***
Paul Andrews	Ten Broeck Hospital	_____
Sherry Burns	I.M. Sulzbacher Center for the Homeless	_____
Susan F. Byrne	Mental Health Association of Northeast Florida	_____
Gene Costlow	Department of Children and Families	_____
Nancy Dreicer	Department of Children and Families	_____
Dr. Frank Emanuel	Florida A&M University	_____
Reginald Gaffney	Community Rehabilitation Center, Inc.	_____
Tom Garwood	City of Jacksonville Mental Health and Welfare Division	_____

Name	***Affiliation***	***Signature***
Herb Helsel	City of Jacksonville Council on Elder Affairs	_____
Marie Hightower	Vocational Rehabilitation Center	_____
Pete Jackson	City of Jacksonville	_____
Tom Joyner	City of Jacksonville Mental Health and Welfare Division	_____
Dr. Laura Lane	Jacksonville Community Council, Inc.	_____
Michael Lanier	Baptist Medical Center	_____
Wanda Lanier	Emergency Services and Homeless Coalition	_____
Herbert Latney	Duval County Health Department	_____
Sheriff John Rutherford	Jacksonville Sheriff's Office	_____
Patricia Sampson	Northwest Behavioral Health Services, Inc.	_____

Name	***Affiliation***	***Signature***
Greg Sikora	Renaissance Behavioral Health Services, Inc.	_____
Heather Vaughn	Lutheran Social Services	_____
Angela Vickers	Mental Health Advocate	_____
Dick Warfel	Department of Children and Families	_____
Dr. Delphia S. Williams	City of Jacksonville Community Services Department	_____
Derya Williams	River Region Human Services, Inc.	_____
Iris Young	Jewish Family and Community Services	_____

Adult Mental Health Task Force
Prevention Workgroup Members

NAME	AFFILIATION
Susan F. Byrne	Mental Health Association of Northeast Florida
Fred Carey	Department of Children and Families
Dr. Frank S. Emanuel	Florida A&M University
Annette Kjeer	Gateway Community Services / SAGES
Peggy Kircher	National Alliance on Mental Illness
Susan Shulman	Gateway Community Services
Angela Vickers	Mental Health Advocate
Chief Tara Wildes	Jacksonville Sheriff's Office

Adult Mental Health Task Force
Treatment Workgroup Members

NAME	AFFILIATION
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Gene Costlow	Department of Children and Families
Dr. Frank Emanuel	Florida A&M University
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Emma Hayes	Ten Broeck Hospital
Herb Helsel	Council On Elder Affairs
Tom Joyner	City of Jacksonville Mental Health and Welfare Division
Herbert Latney	Duval County Health Department

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Robert Sommers, PhD	Renaissance Behavioral Health Services
Susan Shulman	Gateway Community Services
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Jessica Warthen	Florida A&M University
David Whittinghill	University of North Florida
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Adult Mental Health Task Force
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Sherry Burns	I.M. Sulzbacher Center For the Homeless
Mike Cochran	I.M. Sulzbacher Center For the Homeless
Gene Costlow	Department of Children and Families
Nancy Dreicer	Department of Children and Families
Carl Falconer	River Region Human Services
Tom Garwood	City of Jacksonville Mental Health and Welfare Division
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Margie Grove	Department of Children and Families
Emma Hayes	Ten Broeck Hospital

Randy Jennings	Gateway Community Services
Reesce Joyner	Community Rehabilitation Center
Wanda Lanier	Emergency Services and Homeless Coalition
Monica Mitchell-Reed	Sugar Hill
Shannon Nazworth	Grove House
Patricia Orlandi	Volunteers of America Florida
Linda Reuschle	City of Jacksonville, Mental Health and Welfare
Fred Sarkees	Mental Health Resource Center
Dave Shaver	Consumer Support Services
Megan Shaver	Mental Health Resource Center
Robin Spires	River Region Human Services

Adult Mental Health Task Force
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Janet M. Cunningham	RCI Employment Services
Tom Garwood	City of Jacksonville Mental Health and Welfare Division
Margaret Ghee	River Region Human Services
Marie O. Hightower	Vocational Rehabilitation Center
Helena Pizzarro	North West Behavioral Health Services
J. Russell Richardson	Community Rehabilitation Center
Dave Shaver	Consumer Support Services
Heather Vaughan	Lutheran Social Services
Karen Hicks	Mission House
Barbara Smith	National Alliance on Mental Illness

Adult Mental Health Task Force
Public Input Workgroup Members

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Tom Garwood	City of Jacksonville Mental Health and Welfare Division
Peggy Kircher	National Alliance on Mental Illness
Annette Kjeer	Gateway Community Services/SAGES
Barbara Smith	National Alliance on Mental Illness
Pat Vail	Mental Health Association of Northeast Florida
Angela Vickers	Mental Health Advocate

Technical Assistance Staff

- Dr. Delphia S. Williams, Director, Community Services Department, COJ

  Project approval, liaison with Mayor's Office, overall project guidance

- Tom Joyner, Chief, Mental Health and Welfare Division, COJ

  Project operational oversight, liaison with Director

- Linda Reuschle, Program Manager, MH&W Division, COJ

  Internal project consultant

- Tom Garwood, Human Services Planner, Senior, MH&W Division, COJ

  Project Coordinator, Primary Author

- Kathi Moore, Executive Secretary, MH&W Division, COJ

  Clerical support

- David Hughes, Project Manager, The Evaluation Center, HSRI, Cambridge, MA

  External project consultant

Appendix B Prevention Survey

Adult Mental Health and Substance Abuse Prevention Programs Survey

The purpose of this survey is to assess the type and amount of prevention programming conducted by an organization. The information will be used for the Adult Mental Health Strategic Plan being developed by the Adult Mental Health Task Force. The information collected from this survey will be will be part of a broad array of information related to the adult mental health system in Jacksonville.

The Prevention Programs survey is divided into to two categories: Mental Health; and Substance Abuse. If your organization does not provide programs under one of the categories, please indicate by NA for not applicable. **If there is more than one prevention program in a category, please separate the responses accordingly.** This survey pertains only to adult mental health and substance abuse programs. If you have any questions regarding this survey, please contact Tom Garwood, Human Services Planner, Senior, with the City of Jacksonville, at 766-1720, Extension 247. **Please print or type responses.**

Mental Health Prevention Programs

1. Please indicate the name(s) of the organization's mental health prevention program(s).

2. What population is served by the program(s)?

3. How long has/have the program(s) been in operation?

4. How many staff are assigned to the program(s)? Briefly list number and position titles.

5. What is the budget for the program(s)?

6. What is the funding source and amount for the program(s)?

7. Briefly describe the program, including where it is conducted, what physical resources are used, and what materials and/or supplies are used, and how the information disseminated.

8. Please summarize any program effectiveness and/or customer satisfaction results, either formal, or anecdotal. Please include any information on numbers served.

9. Briefly indicate any outstanding needs related to the program(s).

Please add any additional information you feel may be helpful.

Appendix C Prevention Notes

Prevention Notes

Extent of the problem

Psychiatric disorders account for five of the top ten causes of disability worldwide, according to the World Health Organization (WHO). In fact, five conditions (Unipolar Major Depressive, Alcohol Use, Bipolar Disorder, Schizophrenia, and Obsessive-Compulsive Disorders) account for 11 percent of the total worldwide disease burden. Moreover, the WHO estimates that the total disease burden from these conditions will increase to 15 percent by the year 2020. The WHO cautions that "the United States needs to move ahead aggressively with a promotion and prevention agenda. If it does not do so, the already strained mental health treatment system and other social services will be completely overwhelmed in less than 20 years." The following statistics underscore the severity of the problem:

- During a 1-year period, 22 to 23 percent of the U.S. adult population – or 44 million people – have diagnosable mental disorders. (U.S. Department of Health and Human Services, 1999).
- Only 10 to 30 percent of people in need of mental health services receive appropriate treatment. (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999).
- In 1996, the direct cost of mental health treatment and rehabilitation services in the United States totaled $69 billion. In 1990, indirect costs due to lost productivity were estimated at $78.6 Billion (Rice & Miller, 1996, cited in Mental Health: A Report of the U.S. Surgeon General, U.S. Department of Health and Human Services, 1999).
- In the U.S., 78% of people with major depression do not receive treatment. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

The following estimates related to mental illness take on a particular significance when they are extrapolated using census and demographic profiles for Jacksonville:

Mental Health Fast Facts

1. 2000 census population of Jacksonville was 778,879, a 16% increase over previous census.

   Source: US Bureau of the Census 2000

2. 22% of population estimated to have a diagnosable Mental Disorder (MD) in a one year period, which translates to 171,353 for Jacksonville. The most recent statistics for publicly funded mental health services in Jacksonville however, indicate that only 10,298 persons were served. (DCF, District 4 statistics for Jacksonville**)**

3. 5.4% of population estimated to have a Severe Mental Illness (SMI), which translates to 42,059 for Jacksonville.

4. 2.6% of population is estimated to have a Severe and Persistent Mental Illness (SPMI), which translates to 20,250 (State uses 1.5% = 11,683) for Jacksonville.

   Source: Healthy People 2010, NIH

5. Studies show that people in lower socioeconomic strata are two to three times more likely to have a mental disorder, and are more likely to have higher levels of psychological stress. Poverty disproportionately affects racial and ethnic minorities. For example, while 8% of the white population is poor, 24% of African American are poor. (Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General)

   a. 11.9% of Duval County's population in 1999 was below the poverty level, and the African American population is 27.8%.

   Source: US Bureau of the Census 2000

Substance Abuse and Mental Health Fast Facts

1. Adults who used illicit drugs within the past year are more than twice as likely to have SMI.

2. Among persons with SMI, 27.3% used an illicit drug in the past year, while the rate was 12.5 percent among those without SMI.

3. SMI is highly correlated with drug dependence or abuse. Among adults with SMI, 21.3% were dependent on, or abused alcohol or illicit drugs, while the rate among adults without SMI was only 7.9%. Adults with SMI are more likely than those without SMI to be dependent on, or abuse illicit drugs (8.6$ vs. 2.0%) and alcohol (17.0% vs. 6.7%)

   Source: National Survey on Drug Use & Health, SAMHSA

Prevention benefits and issues

The benefits of prevention programs and services are well documented in the field of medicine, and prevention strategies are now an integral part of the modern, holistic approach to health. Indeed, preventive health strategies have become part of our modern lifestyle.

In a recent report titled Special Report: Preventive Intervention Under Managed Care: Mental Health and Substance Abuse Services. National Mental Health Information Center, the National Mental Health Information Center provided the rational for prevention efforts aimed at reducing mental illness and substance abuse:

“The prevalence and consequences of substance abuse and mental health problems in the United States create an imperative not only to develop adequate, appropriate, and effective treatments, but also to maximize the potential of preventive approaches. The burden of these problems includes the suffering of the individual and of those in that person’s environment, the costs of medical treatment and other related services, and the loss of productivity at work and at home. The stigma that is often associated with mental health and substance abuse problems imposes an additional burden. Many of these problems are chronic or recurring; are difficult to treat; and require extensive, expensive services that may not be available or sufficient to meet community demands. For all of these reasons, prevention and early identification of mental disorders and substance abuse is vastly preferable to the human and material costs of related illness, treatment, and rehabilitation.”

The National Mental Health Information Center also suggests that “Programs and services that prevent substance abuse and mental health disorders have the potential to lessen an enormous burden of suffering and to reduce both the cost of future treatment and lost productivity at work and home.”

In the mental health and substance abuse fields however, the prevention situation is more complex than that of the medical domain. The National Mental Health Information Center has also concluded the following: “While the establishment and continuing expansion of this knowledge base is encouraging, the substance abuse and mental health arena is vast, the focus on prevention is relatively new, and funding for prevention intervention research is insufficient to produce the quality and quantity of data needed to make an irrefutable case for effectiveness and cost offset.”

Recently however, there has been a growing body of evidence that supports the rational for increased prevention activities and research:

> “The mental conditions for which the most evidence-based interventions are currently available are the most frequently occurring disorders – conduct and oppositional defiant disorders among children and adolescents, and dysthymia and major depressive disorders among adults. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

The National Institutes of Mental Health supports the growing optimism and utility of prevention efforts:

> Scientifically rigorous studies are now yielding promising evidence of the efficacy of preventive interventions….The field is ready to build on prior research accomplishments and integrate these with advances in the biomedical, behavioral, and cognitive sciences (Priorities for prevention research at NIMH: A report by the National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 1998)

In Mental Health: A Report of the Surgeon General, the need for greater emphasis on prevention activities is stated succinctly: “Preventing an illness from occurring is inherently better than having to treat the illness after its onset.”

Perhaps most important is the growing evidence that supports the cost-benefit of cutting-edge prevention programming:

> While documented state of the art is in an early stage of development, intervention research has produced solid evidence that selected preventive programs and services are associated with positive outcomes and that the cost of providing them may be offset by savings elsewhere in the health care system (Dorfman, 1999, p.3. Cited in The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

Stigma as a factor affecting the promotion of mental health and preventing mental illness

The stigma associated with mental illness is the number one factor that has contributed to the limited efforts directed at mental health promotion and to prevention programming (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services, Department of Health and Human Services, 1999).

Indeed, stigma, according to the Surgeon General's Report on Mental Health, "is the most formidable obstacle to future progress in the arena of mental illness and health" (U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999).

The integration of strategies directed at eliminating the stigma associated with mental illness is fundamental to mental health promotion, prevention, treatment, and recovery successes.

Public Health Model

The Surgeon General's report on Mental Health promotes a public health model approach to deal with mental illness. A public health model is broader in scope than the traditional medical model, and includes epidemiological surveillance, health promotion, disease prevention, and access to services. Core elements of a public health approach includes identifying sources of the problem via populations vs. individuals, identifying patterns of risk and protective factors, identifying trends in prevalence and incidence, using evidence-based interventions that reduce risk factors and enhance protective factors, evaluation of interventions, and public education regarding the effectiveness of interventions. No major epidemic has ever been eradicated by treating individual cases. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services, Department of Health and Human Services, 1999)

Promotion and Prevention

The continuum of mental health services now includes the concept of mental health promotion. Mental health promotion places an emphasis on enhancement of well-being, and is directed at individuals, groups, and large populations. The goal of mental health promotion activities is to enhance competence, self esteem, and a sense of well-being. Promotion therefore may be viewed as the first step along a continuum that ranges from promotion through prevention, intervention, treatment, and recovery (Dorfman, 1999, (p.3) Cited in The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services). Moreover, there is an interactive effect between prevention and treatment and recovery efforts, as the following illustrates:

> …in the course of conducting a preventive intervention such as screening children of parents with depression, a clinician or researcher is likely to identify one or more children who may already have the full blown illness and are in need of treatment. Similarly, in the course of treating a mother with depression, the clinician is likely to identify her children as in need of prevention services. (p.15)

Thus, clinicians in the course of treatment must also be thinking about preventing comorbidity, disability, and relapse. Promotion and prevention efforts should be occurring at any point along the spectrum of activities aimed at positively impacting mental health. To underscore this concept, in Surely The Time is Right, the author notes the similarity between mental health promotion programs and techniques used by consumers in the recovery movement, including wellness action plans, self-advocacy, psychoeducational classes and seminars, strengths model case management, and spiritual practices.

Risk/resiliency Factors

A key factor in the Public Health approach to mental health issues is the concept of risk reduction and enhancement of protective factors.

> Preventive interventions are best directed at risk and protective factors rather than at categorical problem behaviors. Greenberg, et al, 1999a

There is a growing body of risk and protective factors that are common to many mental disorders, as well as for specific disorders. The risk and protective factors may also be used at different points along the continuum of interventions, and may be identified for the general population or for high risk populations (U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999).

Evidence-based programs

The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) is currently in the process of transforming its entire approach to mental health care. One important component of SAMHSA's transformation process is the development and promotion of evidence-based mental health programs for treatment and for prevention. Specifically with regard to prevention issues, SAMSHA has developed a Strategic Prevention Framework that includes an action plan for promoting mental health and prevention mental illness. One of the action plan goals is to increase the number of states and communities that use evidence-based prevention policies and practices. One of the tools SAMHSA uses to promote the use of evidence-based practices is the National Registry of Evidence-based Programs and Practices (NREPP). The NREPP catalogs the most promising evidence-based programs, as well as the latest Model Programs, which are tested programs that include implementation resources and technical assistance. The use of evidence-based and model programs is fundamental to developing approach to promoting mental health and preventing mental illness.

The following information on system transformation was summarized the from SAMHSA website:

The mental health system transformation process includes an emerging new set of resources and data systems. An integrated system of National Outcome Measures is under development and will impact the transformation planning process. Therefore, it is essential that the first step in strategic prevention program planning should be obtaining the necessary technical assistance that will ensure that the future prevention programming efforts are integrated with the SAMHSA's emerging data measurement tools and systems. SAMHSA's information system is complex and in a state of transition. It is essential to have close coordination with SAMHSA's new technical assistance services prior to identifying and implementing specific evidence-based or model programs, as well as pursuing grant resources.

Process vs. outcome measures

The development and implementation of a scientifically grounded strategic prevention plan must begin with an emphasis on process, or system changes that need to be in place before specific prevention programs can be implemented and evaluated. Therefore, the suggested recommendations included below are designed to facilitate the development of a coordinated and strategically sound prevention system change as a prelude to adopting and tracking evidence-based and model prevention programs. In addition, the actual service providers that implement prevention activities will be responsible for developing and tracking outcome measures. Moreover, the acquisition of financial resources through grant acquisitions will have a significant impact on the actual programs implemented and evaluated. The overriding emphasis should be on implementing prevention programs that are consistent with SAMHSA's emerging prevention platform strategies, and are rooted in evidence-based and model program recommendations.

Adult Mental Health and Prevention

The Adult Mental Health Strategic Plan, by definition, focuses on the adult mental and substance abuse system – primarily the mental health system. It is for that reason that the focus of prevention efforts presented here is primarily on the adult population. With respect to prevention however, the distinction between adult and childhood prevention issues is particularly artificial, since any positive or negative behavioral impacts on children will ultimately affect the adult.

Summary of local Prevention Programs

A survey of prevention programming activities in Jacksonville was conducted by the Prevention Workgroup of the Adult Mental Health Task Force. The Workgroup members surveyed all provider agencies known to conduct prevention activities. They also contacted any agency that may provide prevention services. The Workgroup contacted each agency by phone and asked a series of prepared questions from a specially developed prevention survey.

Prevention activities in Jacksonville are currently limited to those conducted by five agencies: Jacksonville Chapter of National Alliance for the Mentally Ill (JAMI); Jacksonville Chapter of the Mental Health Association (JMHA); Gateway Community Services; SAGES; and Urban Jax. The programs have very limited budgets, and consist primarily of education and support group programs. The program conducted by SAGES is primarily alcohol and substance abuse related. There are no longitudinal studies of program impact, and there is no specific coordination of prevention goals and objectives between providers. There are very limited measures of program effectiveness, which includes anecdotal client satisfaction reports. None of the programs are linked to specific evidenced-based programs. There are no publicly funded prevention activities in Jacksonville. The chart below provides a summary of current prevention activities in Jacksonville:

Adult Mental Health and Substance Abuse Prevention Services

AGENCY	PROGRAM NAME	PROGRAM DESCRIPTION	BUDGET	# SERVED
NAMI	National Alliance for the Mentally Ill (NAMI) Brainmatter	Weekly support groups for families Library-based information programs on latest brain-science information (MH)	$800 per library class of 20	
MHA	Mental Health Association of NE Florida	Serves Seniors and their caregivers. Education on signs and symptoms of depression, strategies, and referral info. (MH)	$35,000 United Way Area Agency on Aging, NE FL.	
Gateway Community Services	Northeast FL. Prevention Center	Serves adults, adolescents, and children. Substance Abuse Education/Awareness (SA)	$109,000 (Adults) State of Florida	12,000 (total)
SAGES	SAGES Coalition	Serves Seniors 60+, their caregivers, and area professionals. Education on alcohol, substance abuse, and mental illness signs, symptoms, strategies, and referral info. (MH) (SA)	$10,845 FSU Grant	175 Seniors 111 Pros.
Urban Jax	Mobile Client Assessment Program	Serves Seniors 60+. Education on mental health illness signs, symptoms, strategies, and referral info. (MH)	$90,000 DCF, SAMH	50

Note: Mental Health prevention programs are designated as (MH), and Substance Abuse programs as (SA).

Appendix D Prevention Workgroup SWOT Results

Prevention Workgroup SWOT Results

Strengths

1. Zeitgeist of local mental health system is beginning to support need for increased prevention activities
2. MH professional community is knowledgeable of prevention issues
3. Local advocacy groups support the need for increased prevention activates

Weaknesses

1. Insufficient funding for prevention programs
2. Stigma associated with mental illness inhibits support for prevention
3. Local mental health culture still not supportive or knowledgeable enough of prevention issues
4. Professional community overloaded with other duties and priorities

Opportunities

1. Increasing grant and other financial supports
2. Increased support nation-wide and through federal system for increased prevention activities
3. Growing public awareness of mental illness issues and statistics and coverage in press
4. Federal and state mental health systems in transition towards transformation
5. Increasing numbers of persons with mental illness is overburdening treatment resources

Threats

1. Cutbacks in Medicaid and other funding, insufficient funds to meet demands
2. Stigma associated with mental illness still limits support and limits prevention efforts

Appendix E

Treatment Notes

Extent of the problem

Psychiatric disorders account for five of the top ten causes of disability worldwide, according to the World Health Organization (WHO). In fact, five conditions (Unipolar Major Depressive, Alcohol Use, Bipolar Disorder, Schizophrenia, and Obsessive-Compulsive Disorders) account for 11 percent of the total worldwide disease burden. Moreover, the WHO estimates that the total disease burden from these conditions will increase to 15 percent by the year 2020. The WHO cautions that "the United States needs to move ahead aggressively with a promotion and prevention agenda. If it does not do so, the already strained mental health treatment system and other social services will be completely overwhelmed in less than 20 years." The following statistics underscore the severity of the problem:

- During a 1-year period, 22 to 23 percent of the U.S. adult population – or 44 million people – have diagnosable mental disorders. (U.S. Department of Health and Human Services, 1999).
- Only 10 to 30 percent of people in need of mental health services receive appropriate treatment. (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999).
- In 1996, the direct cost of mental health treatment and rehabilitation services in the United States totaled $69 billion. In 1990, indirect costs due to lost productivity were estimated at $78.6 Billion (Rice & Miller, 1996, cited in Mental Health: A Report of the U.S. Surgeon General, U.S. Department of Health and Human Services, 1999).
- In the U.S., 78% of people with major depression do not receive treatment. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

The following estimates related to mental illness take on a particular significance when they are extrapolated using census and demographic profiles for Jacksonville:

Mental Health Fast Facts

1. 2000 census population of Jacksonville was 778,879, a 16% increase over previous census.

Source: US Bureau of the Census 2000

2. 22% of population estimated to have a diagnosable Mental Disorder (MD) in a one year period, which translates to 171,353 for Jacksonville. The most recent statistics for publicly funded mental health services in Jacksonville however, indicate that only 10,298 persons were served. (DCF, District 4 statistics for Jacksonville)

3. 5.4% of population estimated to have a Severe Mental Illness (SMI), which translates to 42,059 for Jacksonville.

4. 2.6% of population is estimated to have a Severe and Persistent Mental Illness (SPMI), which translates to 20,250 (State uses 1.5% = 11,683) for Jacksonville.

Source: Healthy People 2010, NIH

5. Studies show that people in lower socioeconomic strata are two to three times more likely to have a mental disorder, and are more likely to have higher levels of psychological stress. Poverty disproportionately affects racial and ethnic minorities. For example, while 8% of the white population is poor, 24% of African American are poor. (Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General)

    a. 11.9% of Duval County's population in 1999 was below the poverty level, and the African American population is 27.8%.

    Source: US Bureau of the Census 2000

Substance Abuse and Mental Health Fast Facts

1. Adults who used illicit drugs within the past year are more than twice as likely to have SMI.

2. Among persons with SMI, 27.3% used an illicit drug in the past year, while the rate was 12.5 percent among those without SMI.

3. SMI is highly correlated with drug dependence or abuse. Among adults with SMI, 21.3% were dependent on, or abused alcohol or illicit drugs, while the rate among adults without SMI was only 7.9%. Adults with SMI are more likely than those without SMI to be dependent on, or abuse illicit drugs (8.6$ vs. 2.0%) and alcohol (17.0% vs. 6.7%)

Source: National Survey on Drug Use & Health, SAMHSA

Summary of Treatment Services and Issues:

The President's New Freedom Report on the nation's mental health system indicates that the current mental health system is fragmented and in disarray. The current system consists of multiple funding source agencies, each with its own set of complex regulations, goals and objectives, and management information systems (Achieving the Promise: Transforming Mental Health Care in America, DHHS, 2003). The complexity and inefficiency of the system contributes to poor services and limits access to mental health services. Services are provided according to program objectives and funding rules, rather than the needs of customers. Moreover, some agencies that are part of this fragmented system are not even directly involved focused on mental health issues, such as Medicaid and Medicare. In fact, the largest Federal program that supports people with mental illness is not even a health service organization – the Social Security Administration, with its SSI and SSDI programs. The fragmentation of the mental health system filters down to virtually all local communities. A recent focus group public opinion analysis of a cross section of Jacksonville's community confirmed that system fragmentation is a major contributing factor to system access and quality of care in Jacksonville.

Recovery and Consumer-driven Issues

As a result of the continuing efforts of Mental Health Consumer Advocacy Groups the mental health system is moving towards developing a mental health system that is driven by the needs of its consumers, and not by the complex web of services and funding sources. Instead of viewing mental illness as a lifelong deterioration, or at best, symptom relief according to a medical model concept, recovery implies restoration of self-esteem and identity, and obtaining a meaningful role in society (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999). The fragmented mental health system that exists across the county and locally in Jacksonville is service driven and complex; it needs to move towards a Consumer-driven and Recovery-based system that is consistent with the emerging system transformation efforts underway under Federal and State guidance.

System analysis

Extrapolating from federal estimates of persons who have diagnosable mental disorders in the general population at any one time, Jacksonville has an estimated 171,353 persons who are in need of treatment. Although the management information data of the current mental health system in Jacksonville is not as comprehensive as it should be, the publicly funded system is currently serving only 10 to 13 thousand people in need on an annual basis. **The difference between the estimated need and those currently being served represents the service gap for Jacksonville.**

The Treatment Workgroup of the Adult Mental Health Task Force is conducting a system analysis of the mental health service delivery system in Jacksonville. Part of that analysis consists of identifying the current array of services, along with the percentage of clients from varying functioning levels who are using those services. In addition, the Workgroup developed a list of mental health services that would be necessary for an adequate level of care, and then estimated the percentage of clients who would require each of the services. Factoring in the costs for delivering the actual vs. adequate services will produce useful planning information in determining how much more an adequate system would cost, and how clients will move between services as a function of their illnesses. That analysis is currently underway. A preliminary analysis of the system however, indicates that clients are not receiving the amount of services they should, due to inability to pay, insufficient capacity of the service, service access problems, or that the service does not exist. Each member of the Treatment Workgroup has received a copy of the final Service Planning and Evaluation Survey (SPES) matrix, and the associated Service Descriptions; these data should also be reviewed prior to the SWOT analysis.

DCF Treatment Stats.

SAMH Data System Stats. (7/1 – 6/30)	FY 01 - 02	FY 02 - 03	FY 02 - 03
Unduplicated Adult CSU Admissions	2,129	2,528	2,584
Unduplicated Adult Admissions – Gateway Detox	1,247	1,483	1,514
Unduplicated Adults Receiving MH Treatment*	6,913	6,862	6,500
Unduplicated Adults Receiving SA Treatment*	6,485	5,783	6,332
• Treatment includes Residential Levels 1-4, Day/Night, In-home-On-Site Medical, Outpatient Counseling-Individuals or Groups, FACT, and SRT. • Does not include Case Management, Detox, Methadone, or Supported Housing/Employment.			

Inpatient Capacities and Utilization Rates for Jacksonville

Name of Facility	Facility Type	Bed Capacity	Utilization Rate
Northeast Florida State Hospital	State Treatment	110	66% (72)
Mental Health Center of Jacksonville	Private – Nonprofit Baker Act Receiving - MH	 30 10	 92% 85%
Mental Health Resource Center	Private – Nonprofit Baker Act Receiving – MH Level 4 Adult Therapeutic Foster Care	24 (CSU) 24 (Level 4)	97% 100%
Baptist Hospital	Private Hospital	39	82%
Shands Hospital	Private Hospital	56	81%
Ten Broeck	Private Hospital	51	95%
Community Rehabilitation Center	Level 4 - Adult Therapeutic Foster Care	30	78%
Gateway Community Services	Private – Nonprofit Marchman Act Receiving - SA	Detox (20) Stabilization (10) Adult Res. Lev. 1&2 (14) WRP Lev. 1&2 (10) R&B Lev. 3 (32) Residential Lev. 4 (Help Ctr.) (6)	93% 38% 83% 109% 101% 52%
River Region HS	Private – Nonprofit SA	SA Residential Level 2 (51)/4 (10)	90%/80%

Note: There are no Level 1-3 public MH beds currently available for Jacksonville.

Data Issues

The collection of data to be used for the Adult Mental Health Strategic Plan was extremely difficult, time consuming, and each data set has at least some caveats.

The first data set collected was the number of persons with mental illness served in the public system in the most recent one year period. The data was obtained from DCF District Four and the number of persons was categorized according to client functioning levels for purposes of the Service Planning and Evaluation Survey (SPES), which is used in conjunction with the Service Descriptions for Jacksonville. The evaluation system produces estimates about the services each functioning group is actually receiving, and those estimates can be compared with an analysis of the services clients should be receiving in an ideal system, along with a comparison of the costs of the current system with the costs projected for an optimal system. The SPES system approach to evaluating mental health systems was introduced at a training workshop conducted by David Hughes of the Evaluation Center, which is affiliated with The Human Services Resource Institute, a SAMHSA funded research and consulting agency. The SPES system has been used in over 20 States and is the recommended method for evaluating mental health systems. The data however was not readily available, and required several meetings with DSF to obtain. In addition, the data had to be converted from GAF scores to SPES Functioning Levels Scores, which in turn required a conversion process. The conversion tables required additional time to obtain and to apply to the data. It is unclear at this time whether the DCF data includes hospital admissions. The SPES system however is a system analysis and looks at services clients are actually receiving and compares that data against an optimal system. The comparison yields useful information regarding the discrepancies between actual services and optimal services. Any missing data with respect to numbers of clients will impact the accuracy of projected costs, as opposed to an understanding of the services clients are actually receiving vs. what they should receive in an optimal system.

Data on costs of the mental health system in Jacksonville was also difficult and time consuming to obtain. In fact, the data on Medicaid costs for Jacksonville is still considered “informal” at this time, and it is unclear whether or not that data includes the cost of hospital admission costs associated with Medicaid reimbursements.

Additional data associated with client satisfaction, outcomes, and other clinical data may be available via the Agency for Health Care Administration (AHCA), and through other State of Florida data sources, but those resources have yet to be tapped. Technical assistance from the State will be required to develop a methodical data collection system that is consistent with long range and ongoing evaluation of the mental health system.

Mental Health and Substance Abuse Funding Sources and Programs

City of Jacksonville Adult **Mental Health** Funding - FY 04-05

Mental Health Programs	2,415,091
Title I MH Ryan White	258,289
Public Service Grants - MH	209,000
Total MH	**$2,882,380**

City of Jacksonville Adult **Substance Abuse** Funding - FY 04-05

Substance Abuse Programs	3,233,668
Title I SA Ryan White	148,825
Public Service Grants - SA	283,000
Total SA	**$3,665,493**

City of Jacksonville combined MH and SA funding - **$6,547,873**

State of Florida, Department of Children and Families – District 4
Mental Health and Substance Abuse Funding for COJ - FY 04-05

Adult Mental Health Programs	$9,369,458
Adult Substance Abuse Programs	$6,285,845
Total District 4 Funding for COJ	**$15,655,303**

Note: DCF District Four, of which Jacksonville is a part, is the lowest funded district in the State for Adult Mental Health.

Combined City of Jacksonville and DCF District 4 Funding - Mental Health and Substance Abuse

Total COJ MH, SA, and PSG	$6,547,873
Total DCF	$15,655,303
Total MH and SA Funding for COJ	**$22,203,176**

Medicaid Funding for Duval County January 1, 2004 – December 31,

Mental Health	$27,881,204.97
Substance Abuse	$792,355.42
Total MH and SA Medicaid Funding	**$28,673,560.39**

Note: It is unknown at this time if the Mental Health Medicaid billing dollars includes Inpatient services.

- Overview of current system, and relevant history

  The Florida Mental Health Act or the “Baker Act”, Chapter 394, Florida Statutes, designates the Department of Children and Family Services (DCF) as the “Mental Health Authority of Florida”. The department is responsible for a complete and comprehensive statewide program of mental health services and may contract to provide, or be provided with, services and facilities to carry out its responsibilities.

  The DCF District 4 Substance Abuse and Mental Health (SAMH) office contracts for services in Duval and the four surrounding counties. District 4 is one of the lowest funded areas in adult mental health in the state. Agencies that contract with DCF are required to provide matching funds on a 75-to-25, state-to-local ratio. The City of Jacksonville is directed by statute to participate in the funding of alcohol and mental health services under its jurisdiction.

  In Duval County, Renaissance Behavioral Health Systems operates the City’s two community mental health centers, Mental Health Center of Jacksonville, located on the North- side, and Mental Health Resource Center, located on the Southside. These facilities house the county’s crisis stabilization units (CSU) or public receiving beds which serve children and adults. Currently there are 54 beds at the two facilities, but an expansion of at least 10 beds on the north side is anticipated before the end of the year. Law enforcement officers, family members, and mental health professionals may bring persons in crisis to the nearest public or private (Shands, Ten Broeck, Baptist) receiving facility for evaluation and brief stabilization.

  Gateway Community Services and River Region Human Services are publicly funded providers of comprehensive services for persons with substance use disorders. Gateway operates the community’s residential detoxification (“detox”) program and River Region operates the public methadone program. Both agencies provide a variety of outpatient, residential, and aftercare services.

Forensic (FS 916) Commitment/Treatment and Jail-based Services

The Department of Children and Family Services is responsible for establishing and maintaining separate and secure facilities for the involuntary treatment of defendants who are charged with a felony and who have been found to be incompetent to proceed (ITP) due to their mental illness or have been found not guilty by reason of insanity (NGI). Defendants committed to the department by the Circuit Court in Jacksonville usually receive treatment either at North Florida Treatment and Evaluation Center in Gainesville or at Florida State Hospital in Chattahoochee.

Instead of ordering commitment of individuals who have been found either ITP or NGI, or upon return from hospitalization, the court may order the conditional release of a defendant in the community. Based on a recommendation that outpatient treatment is appropriate, a written plan is filed with the court, and the court specifies the approved plan through its conditional release order. In Duval County, the conditional release order directs the Mental Health Center of Jacksonville (MHCJ) to provide community control for the defendant and to submit periodic reports to the court. These reports ensure that the defendant is participating in treatment as directed and is following any other court ordered conditions including competency training.

MHCJ has three forensic case managers with an active caseload of 75-85 clients in the community and one competency trainer who assists clients in restoring their competency while being case managed. Violations of the conditional release order or any deterioration in the defendant's condition are reported to the court as soon as known. The court may modify the release order or commit (recommit) the defendant to the department for inpatient care. When a defendant no longer requires court supervised follow-up care, the court terminates its jurisdiction and discharges the defendant.
MHCJ case managers also track the movement of approximately 65 institutionalized forensic defendants. Every quarter, case managers visit the institutions to meet with clients and hospital staff in anticipation of the clients' return to court and eventual release to the community.

Persons who are arrested and held in the Jacksonville Sheriff's Office Pretrial Detention Facility (PTDF) are screened for medical, including psychiatric, conditions by nurses with Correctional Medical Services (CMS), the contract provider of medical services for Duval County's correctional facilities. Inmates who request or are determined to need psychiatric evaluation or mental health services are referred to the CMS mental health team.

A staff person employed by the Mental Health Center of Jacksonville and housed at the PTDF works closely with CMS staff to promote continuity of care for persons receiving psychiatric services in the community. Upon release from jail, persons with mental illness are reconnected or referred to community providers for treatment services and housing.

The Mental Health Center of Jacksonville also employs a diversion specialist who is housed at the PTDF and works closely with judges and court staff to divert persons with mental illness from jail to the crisis units for stabilization and treatment. About 68 people are screened each month for diversion and approximately 30% are diverted.

- Current Service Array for Jacksonville

  Inpatient
  Forensic Hospital – State
  State Hospital
  Partial Hospitalization
  Assessment
  Crisis Stabilization
  Non-residential Crisis Support
  Outpatient – Individual
  Intensive Outpatient Services
  Outpatient Group
  Day/Night
  Case Management
  Intensive Case Management
  Forensic Case Management
  FACT Team
  Intervention
  Medical Services – Medication Management
  Outreach
  Information and Referral
  Outpatient Detoxification
  Residential Detoxification

System access/payment options/costs/Managed Care

Access to the array of mental health services is greatly affected by a client's ability to pay for services.

Over the past decade, managed care has become a major payer for private health care. The purpose of managed care has been to control spiraling mental health service costs, mostly by limiting hospital stays and rigorously managing outpatient service usage (Stroul et al., 1998, in Mental Health: A Report of the Surgeon General). For the most part managed care furnishes the same traditional services available under fee-for-service insurance. Managed care has shortened hospital stays and increased the use of short-term therapy models (Eisen et al., 1995; Merrick, 1998, in Mental Health: A Report of the Surgeion General). Managed care also has lowered reimbursements for services provided by both individual professionals and institutions. This has been accompanied by the construction of provider networks, under which professionals and institutions agree to accept lower than customary fees as a tradeoff for access to patients in the network.

Mental health services provided by the public sector however are more wide-ranging than those supported by the private sector, and the types of payers are more diverse. Some public agencies, such as Medicaid and state and local departments of mental health are mandated to support mental health services. Others provide mental health services to satisfy mandates in special education, juvenile justice, and child welfare, among others.

Medicaid is a major source of funding for mental health and related support services. For the most part, Medicaid has supported the traditional mix of outpatient and inpatient services.

Trapped between the managed care and public sectors is a group of uninsured individuals and families who do not qualify for the public sector programs, cannot afford to pay for services themselves, and have no access to private health insurance.

Mental health services in Jacksonville are typically paid for by private insurance, out-of-pocket fees, and Medicaid or Medicare**.** Approximately one third of Medicaid eligible persons will be covered for mental health services under the existing Medicaid HMO. Another one third of Medicaid eligible persons will be covered for mental health services under the newly emerging Pre-paid mental health managed care plan under bid in Northeast Florida**.** In addition, another one third of dually eligible persons (Medicaid/Medicare) will be covered for mental health services on a fee for service basis at local provider agencies.

In an effort to control costs, the State of Florida has revised the amount of services and the types of medications that will be covered under Medicaid. There is an ongoing debate at this time regarding how prior service authorization and changes to the medication formulary will affect clinical outcomes.

Persons who are not Medicaid eligible, but do not have sufficient income to pay for health care insurance often fall between the cracks of the existing system. Only a limited amount of funding is available from DCF to cover indigent treatment costs including medication management**.** Due to the limited funds available for Medication Management, no new Medication Management clients are being accepted from the Jacksonville community unless they are part of the forensic system (FS 916) or they have recently been discharged from a CSU.

Those in need of mental health services typically are faced with a maze of agencies and programs operating with various funding sources, rules and regulations**.** Determining what services they may be eligible to receive is often a frustrating and time consuming process.

Stigma

The following information on Stigma has been summarized from Mental Health: A Report of the Surgeon General:

The stigma associated with mental illness "is the most formidable obstacle to future progress in the arena of mental illness and health, according to the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999).

The integration of strategies directed at eliminating the stigma associated with mental illness is fundamental to mental health promotion, prevention, treatment, and recovery successes.

Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996, in Mental Health: A Report of the Surgeon General). Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment (Sussman et al., 1987; Cooper-Patrick et al., 1997, in Mental Health: A Report of the Surgeon General). Concern about stigma appears to be heightened in rural areas in relation to larger towns or cities (Hoyt et al., 1997, in Mental Health: A Report of the Surgeon General). Stigma also disproportionately affects certain age groups

Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others. For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma. The issuance of this Surgeon General's Report on Mental Health seeks to help reduce stigma by dispelling myths about mental illness, by providing accurate knowledge to ensure more informed consumers, and by encouraging help seeking by individuals experiencing mental health problems.

Another way to eliminate stigma is to find causes and effective treatments for mental disorders (Jones, 1998, in Mental Health: A Report of the Surgeon General).

The stigma surrounding *mental disorders* may be inadvertently reinforced by leaving to mental health care only those behavioral conditions without known causes or cures.

Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate.

As stigma abates, a transformation in public attitudes should occur. People should become eager to seek care. They should become more willing to absorb its cost. And, most importantly, they should become far more receptive to the messages that are the subtext of this report: mental health and mental illness are part of the mainstream of health, and they are a concern for all people.

There is likely no simple or single panacea to eliminate the stigma associated with mental illness. Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved. Knowledge of mental illness appears by itself insufficient to dispel stigma (Phelan et al., 1997). Broader knowledge may be warranted, especially to redress public fears (Penn & Martin, 1998). Research is beginning to demonstrate that negative perceptions about severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness (Penn & Martin, 1998). Overall approaches to stigma reduction involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions (Corrigan & Penn, 1999).

Evidence-based programs and System Transformation

The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) is currently in the process of transforming its entire approach to mental health care. One important component of SAMHSA's transformation process is the development and promotion of evidence-based mental health programs for treatment and for prevention. One of the tools SAMHSA uses to promote the use of evidence-based practices is the National Registry of Evidence-based Programs and Practices (NREPP). The NREPP catalogs the most promising evidence-based programs, as well as the latest Model Programs, which are tested programs that include implementation resources and technical assistance. The use of evidence-based and model programs is fundamental to developing approach to promoting mental health, preventing mental illness, and treating mental illnesses. The system transformation is designed to address the special needs of seniors and the homeless, and to include diverse adjunct services such as Faith-based programming.

The following information on system transformation has been summarized from SAMHSA website and related links:

The mental health system transformation process includes an emerging new set of resources and data systems. An integrated system of National Outcome Measures is under development and will impact the transformation planning process. Therefore, it is essential that the first step in strategic treatment program planning should be obtaining the necessary technical assistance that will ensure that the future prevention programming efforts are integrated with the SAMHSA's emerging data measurement tools and systems. SAMHSA's information system is complex and in a state of transition. It is essential to have close coordination with SAMHSA's new technical assistance services prior to identifying and implementing specific evidence-based or model programs, as well as pursuing grant resources.

Process vs. outcome measures

The development and implementation of a scientifically grounded strategic treatment services plan must begin with an emphasis on process, or system changes that need to be in place before specific programs can be implemented and evaluated. Therefore, the suggested recommendations included below are designed to facilitate the development of a coordinated and strategically sound service delivery system change as a prelude to adopting and tracking evidence-based and model programs. In addition, the actual service providers that implement system improvements will be responsible for developing and tracking outcome measures. Moreover, the acquisition of financial resources through grant acquisitions will have a significant impact on the actual programs implemented and evaluated. The overriding emphasis should be on implementing programs that are consistent with SAMHSA's emerging system transformation platform, and are rooted in evidence-based and model program recommendations.

Adult Mental Health Treatment

The Adult Mental Health Strategic Plan, by definition, focuses on the adult mental and substance abuse system – primarily the mental health system. It is for that reason that the focus of treatment issues presented here is primarily on the adult population.

Appendix F Treatment Workgroup SWOT Analysis

Treatment Workgroup SWOT Results

Strengths

1. Good use of existing models of effective treatment programs and practices
2. Knowledgeable, dedicated professionals
3. History of effective collaborations among professionals and agencies
4. Good reputation for innovative programs and effective outcomes

Weaknesses

1. Services and programs are funding-driven, not customer-driven
2. Lack of a “Champion,” or high-profile supporter of MH issues
3. High turnover rate among professional workforce
4. Funding Issues
    a. Insufficient funding for necessary treatment programs
    b. Constant change in funding support leads to here-to-day, gone-tomorrow programs and services
    c. Programs oriented to funding sources and not customer needs
5. Local government structure difficult to influence and inclined to business- as-usual thinking
6. Rapid growth is taxing limited resources and outpacing future resources
7. Current management information system does not provide accurate or comprehensive data, and is not developing to meet future needs, both on the planning level and on the client information sharing level
8. Lack of a state-wide influential mental health agency
9. Stigma and NIMBY limits public support for program options and funding

Opportunities

1. Medicaid reform and managed care changes may provide opportunity to impact emerging treatment strategic planning process and goals
2. President's New Freedom Report and other major reports support recovery, customer-driven, and other system transformation concepts
3. Success of system transformation and innovative programming in other states generates zeitgeist for change
4. Strategic Planning Process may generate opportunity to cultivate a local champion of mental health issues
5. National Medicaid reforms may contribute to healthful system changes
6. Need to address stigma associated with mental illness may provide useful prevention and other programs
7. System transformation process may provide opportunity to reduce public/private service quality discrepancies (i.e., two mental health systems)
8. New system transformation grants
9. Best Practices and Evidence-based Programs will lead to more effective treatment services and outcomes

Threats

1. Competition for dwindling funding resources
2. Medicaid reforms may lead to reduced services
3. Rapid growth is further taxing existing resources and outpacing future resources
4. Local government structure difficult to influence and inclined to business-as-usual thinking
5. Cutbacks in funding are leading to reduced services, which increases the likelihood that an underserved consumer will have a disproportionately negative effect on the public's perception of persons with mental illness

Appendix G

Service Planning and Evaluation Survey (SPES)

Service Prescription				Optimal Services Across Functioning Levels							Actual Services Across Functioning Levels						Reasons for Discrepancies
		Units	Unit Costs	1	2	3	4	5	6		1	2	3	4	5	6	
	Treatment																
1	Inpatient	Day Rate		100	100	20	0	0	0		60	60	30	10	05	05	6-11,13 5-11,13 4-11,13 3-11,13 2-2,4,7 1-2,4,7
2	Forensic Hospital (State)	Day Rate		05	0	0	0	0	0		10	10	05	0	0	0	2-11 3-11
3	State Hospital	Day Rate		25	5	0	0	0	0		1	1	0	0	0	0	1-2,5 2-2,5
4	Partial Hospitalization	Day Rate		0	20	40	20	0	0		0	1	1	1	0	0	2-,2,4,5 3-2,4,5 4-2,4,5
5	Consultation Services	Hr/Day		0	20	30	60	30	20		0	0	0	0	0	0	1 through 6 – 1,4
6	Assessment	Hours		0	0	100	100	100	100		0	0	100	100	100	100	
7	Crisis Stabilization	Day Rate		100	100	05	5	0	0		80	80	5	5	0	0	1-2,4,7,10 2-2,4,7,10
8	Short-term Residential Treatment (SRT)	Day Rate		0	20	40	20	0	0		0	0	0	0	0	0	2-1 3-1 4-1
9	Non-residential Crisis Support	Hours		100	100	10	10	5	5		80	80	5	5	1	1	1-7,2,10 2-7,2,10 3-7,2,10 4-3,7,2,10 5-7,2,10 6-7,2,10

Service Planning and Evaluation Survey (SPES)

Service Prescription				Optimal Services Across Functioning Levels							Actual Services Across Functioning Levels						Reasons for Discrepancies
		Units	Unit Costs	1	2	3	4	5	6		1	2	3	4	5	6	
	Treatment, Continued																
10	Day Care Services	4 hr. Day		0	0	0	0	50	65		0	0	0	0	0	0	1 through 6 -1
11	Outpatient - Individual	Hours		0	0	0	100	100	100		0	0	0	70	80	80	4-2,4,5 5-2,4,5 6-2,4,5
12	Intensive Outpatient Services	Hours		0	0	0	50	60	50		0	0	0	5	10	5	4-2,5,4 5-2,4,5 6-2,5,4
13	Outpatient Group	Hours		0	0	0	20	80	80		0	0	0	1	1	1	4-2,5,4 5-2,5,4 6-2,5,4
14	Day / Night	4 hr. Day		0	0	80	50	30	0		0	0	70	40	20	0	3 through 6 – 4,7,10
15	Case Management	Hours		0	0	100	100	10	5		0	0	60	60	1	0	3-4,7, 4-4,7 5-4,7 6-7
16	Intensive Case Management	Hours		0	10	30	10	0	0		0	5	25	5	0	0	2 through 6 - 7
17	Forensic Case Management	Hours		0	0	35	10	0	0		0	0	35	10	0	0	
18	FACT Team	Hours		0	0	70	30	0	0		10	50	40	15	0	0	4-2 3-2,5 2-11 1-11

Service Planning and Evaluation Survey (SPES)

Service Prescription				Optimal Services Across Functioning Levels							Actual Services Across Functioning Levels						Reasons for Discrepancies
		Units	Unit Costs	1	2	3	4	5	6		1	2	3	4	5	6	
	Treatment, Continued																
19	Intervention	Hours		0	0	50	60	40	0		0	0	25	30	20	0	3-2,3,4,5,7 4-2,3,4,5,7 5-2,3,4,5,7
20	Medical Services Medication Management	Hours		0	0	100	100	20	0		0	0	70	70	10	0	3-4 5-4 4-4
21	Respite Services	Hours		0	0	70	50	30	0		0	0	0	0	0	0	3-1 5-1 4-1
22	Outreach	Hours		0	0	50	50	30	20		0	0	5	5	5	0	3-2,4 5-2,4 4-2,4
23	Information and Referral	Hours		0	100	100	100	100	100		0	50	50	50	50	50	2 through 6 - 2,4,5,6,7
24	Outpatient Detoxification	Day Rate		0	0	5	5	20	60		0	0	7	5	15	10	3-11,12,14 5-4,7 6-4,5,7
25	Residential Detoxification	Day Rate		0	0	10	20	40	30		0	0	0	3	10	5	3-9 4-2,4 5-2,4,7 6-2,4,7

Reason Codes

If amount received was less than the ideal:	***If amount received was more than the ideal:***
1. Service does not exist 2. Service has insufficient capacity 3. Client was refused for behavioral reasons 4. Inability to pay 5. Accessibility problem 6. Language or cultural problem 7. Client refused service 8. Family/other request 9. Clinician decided service should not be provided 10. Other reason not listed above	11. Service substitute for ideal service 12. Clinician decided service should be provided 13. Client requested service be provided 14. Family requested service be provided 15. Other reason not listed above

Appendix H

Service Definitions

TREATMENT

Inpatient
Inpatient services are provided in hospitals licensed under Florida Statutes as general hospitals and psychiatric specialty hospitals. They are designed to provide intensive treatment to persons exhibiting violent behaviors, suicidal behaviors and other severe disturbances due to substance abuse or mental illness.

Unit: Day Rate - Unit Costs: $456

Forensic Hospital (State Hospital)
Separate and secure facilities and programs for the treatment or training of defendants who are charged with a felony and who have been found to be incompetent to proceed due to their mental illness, retardation, or autism, or who have been acquitted of felonies by reason of insanity. Such secure facilities shall be designed and administered so that ingress and egress, are strictly controlled by staff responsible for security in order to protect the defendant, facility personnel, other clients, and citizens in adjacent communities.

Unit: Day Rate - Unit Costs: $248

State Hospital
Any state-owned, state operated, or state-supported hospital, center, or clinic designated by the department for extended treatment and hospitalization, beyond that provided for by a receiving facility, for persons who have a mental illness.

Unit: Day Rate - Unit Costs: $270

Partial Hospitalization
Partial hospitalization programs are time-limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Services are available at least five days per week and may be free-standing or part of a broader system of care but are identifiable as a distinct and separately-organized service unit. A partial hospitalization program consists of a series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency based upon participant need. Partial hospitalization programs are typically designed for persons who are experiencing increased symptomatology, disturbances in behavior, or other conditions that negatively impact the mental or behavioral health of the person served. The setting is neither inpatient or residential and program participants do not pose an immediate risk to themselves or others. Services are provided for the purpose of diagnostic evaluation, active treatment of a participant's condition, or to prevent relapse, hospitalization, or incarceration. Partial

hospitalization programs function as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute level of care is tenuous.

Unit: Day Rate - Unit Costs: $350

Consultation Services

Services may involve brief social/mental health case review, technical information, guidance to law enforcement or mental health professionals, consultation with friends and family, and arranging for alternate living arrangements in order to reduce stressors.

Unit: Hour - Unit Costs: $35

Assessment

Assessment services assess, evaluate, and provide assistance to individuals and families to determine level of care, motivation, and the need for services and supports to assist individuals and families identify their strengths.

Unit: Hours - Unit Costs: $70

Crisis Stabilization

These residential acute care services provide, on a 24 hour 7 days per week basis, brief, intensive mental health residential treatment services to meet the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization.

Unit: Day Rate - Unit Costs: $289

Short-term Residential Treatment (SRT)

These individualized, stabilizing acute and immediately subacute care services provide short and intermediate duration (120 days) intensive mental health residential and habilitative services on a twenty-four (24) hour per day, seven days per week basis. These services must meet the needs of individuals who are experiencing an acute or immediately subacute crisis and who, in the absence of a suitable alternative, would require hospitalization.

Unit: Day Rate - Unit Costs: $291

Non-residential Crisis Support

These non-residential care services are generally available 24 hours, 7 days a week, or during some other specific time period, to intervene in a crisis or provide

emergency care. Examples include: mobile crisis, crisis support, crisis/emergency screening, crisis telephone, and emergency walk-in services.

Unit: Hour - Unit Costs: $43

Day Care Services

Day care services provide a structured schedule of activities for four or more consecutive hours per day for children of persons who are participating in a substance abuse or mental health day - night service or residential service. . The service event unit should be one day, regardless of the number of hours involved.

Unit: 4 Hour Day - Unit Costs: $30

Outpatient-Individual

Outpatient services provide a therapeutic environment that is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. They are usually provided on a regularly scheduled basis by appointment with arrangements made for non-scheduled visits during times of increased stress or crisis. Note: this cost center is limited only to face-to-face contact. Only the district office can approve an exception. This cost center is used when reporting an individual's services which are provide one-on-one.

Unit: Hour - Unit Costs: $71

Intensive Outpatient Services

Intensive outpatient treatment programs are clearly identified as a separate and distinct program. The intensive outpatient program consists of a scheduled series of sessions appropriate to the individual plans of the persons served. These may include services provided during evenings and on weekends or interventions delivered by a variety of services providers in the community. The program can function as a step-down program from other more intensive services and may be used to prevent or minimize the need for a more intensive and restrictive level of treatment; and is considered to be more intensive and integrated than traditional outpatient services.

Unit: Day - Unit Costs: $175

Outpatient-Group

Outpatient services provide a therapeutic environment that is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. They are usually provided on a regularly scheduled basis by appointment with arrangements made for non-scheduled visits during times of increased stress or crisis. Note: this cost center is limited only to face-to-face contact. Only the district office can approve an exception. This cost center is used when reporting an individual's services which are provided in a group environment. Each

individual within the group would have a separate service event record to record group participation.

Unit: Hour - Unit Costs: $17

Day / Night

Day-night services provide a structured schedule of non-residential services for four or more consecutive hours per day. Activities and adult mental health programs are designed to assist individuals to attain skills and behaviors needed to function successfully in living, learning, work, and social environments. Generally, a person receives three or more services a week. Activities for substance abuse programs emphasize rehabilitation, treatment, and education services, using multidisciplinary teams to provide integrated programs of academic, therapeutic, and family services.

Unit: 4 Hour Day - Unit Costs: $46

Case management

Case management services consist of activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery and evaluating the effect of the services received. Services delivered at a staff to client ratio of 1-40.

Intensive Case Management

Intensive Case management services consist of activities aimed at assessing recipient needs, planning services, linking the service system to a recipient, coordinating the various system components, monitoring service delivery and evaluating the effect of services received. These services are typically offered to persons who are being discharged from a hospital or crisis stabilization unit, who are in need of more professional care, and who will have contingency needs to remain in a less restrictive setting. Services delivered at a staff to client ratio of 1-10.

Unit: Hour - Unit Costs: $72

Forensic Case Management

Forensic Case Management services are Intensive Case Management Services provided to individuals involved with the justice system. Case loads are greatly reduced and services are greatly accelerated in an effort to prevent arrest and other system recidivism. Forensic Case Managers generally have specific training and experience in working with the unique needs of this population and within the justice system.

Unit: Hour - Unit Costs: $49

FACT Team

Non-residential case management services available twenty-four (24) hours per day, seven (7) days per week. Include community-based treatment, rehabilitation and support services provided by a multidisciplinary team to persons with severe and persistent mental illness. An agency must be contracted for this service to report under this cost center.

Unit: Hour - Unit Costs: $45

Intervention

Intervention services focus on reducing risk factors generally associated with the progression of substance abuse and mental health problems and promote and enhance engagement for additional services as appropriate. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services that emphasize short-term counseling and referral and treatment as needed. These services are targeted toward individuals and families and include jail diversion programs.

Unit: Hour - Unit Costs: $49

Medical Services

Medical services provide primary medical care, therapy and medication administration to improve the functioning or prevent further deterioration of persons with mental health or substance abuse problems. Included is psychiatric mental status assessment. For adults with mental illness, medical services are usually provided on a regular schedule with arrangements for non-scheduled visits during times of increased stress or crisis. This service includes medication administration of psychotropic drugs and psychiatric services.

Unit: Hour - Unit Costs $288

Respite Services

Respite service is an organized program that is designed to sustain the family or other primary care giver by providing time limited, temporary relief from the ongoing responsibility of care giving.

Unit: Hour - Unit Costs: $12

Outreach

Outreach services are provided through a formal outreach program to both the community at large and to individuals. This includes HIV outreach and outreach to women substance abusers. Services include education of the public and risk groups, identification and linkage with high risk groups, planning and linking with other service providers, risk reduction and intervention, case management for non clients, screening and referral to substance abuse and mental health treatment programs.

Unit: Hour - Unit Costs: $35

Information and Referral

A service that maintains information about resources in the community, links people who need assistance with appropriate service providers, and provides information about agencies and organizations that offer services. The information and referral process involves being readily available for contact by the individual, assisting the individual with determining which resources are needed, providing referral to appropriate resources, and following up to ensure the individual's needs have been met, if the individual agrees to such follow-up activities.

Unit: Hour - Unit Costs: $35

Outpatient Detoxification

Provides non-residential detoxification services using medication and/or a psychosocial counseling regimen to assist recipients in their efforts to withdraw from the physiological and psychological effects of the abuse of addictive substances. Services are designed to help persons maintain their current residential status, and/or improve their overall functioning and attempt to engage the service recipient in additional individualized treatment services during and following detoxification. Provides structured activities 4 or more hours a day, 7 days a week. Services are primarily directed at duel-diagnosed patients.

Unit: 4 Hour Day - Unit Costs: $78

Residential Detoxification

Residential Detoxification programs use medical and clinical procedures to assist recipients in their efforts to withdraw from the physiological and psychological effects of substance abuse. These programs serve adults with substance abuse problems. Residential detoxification and addiction receiving facilities are intended to provide emergency screening, evaluation, short-term stabilization, and treatment in a secure environment and attempt to engage the service recipient in additional individualized treatment services during and following detoxification. Services are primarily directed at duel-diagnosed patients.

Unit: Day Rate - Unit Costs: $190

HOUSING

Supported/Supportive Housing

Supported housing/living services assist persons with substance abuse and psychiatric disabilities in the selection of housing of their choice and provides the necessary services and supports to assure their continued successful living in the community and transitioning into the community. Services include training in independent living skills. For substance abuse, services provide for the placement and monitoring of recipients who are participating in non-residential services and persons who have completed or are completing substance abuse treatment and need assistance and support in independent or supervised living within a live-in environment.

Supported Housing refers to a service option in which housing and the programmatic services are two separate entities, while **Supportive Housing** is a service option in which housing and program services are combined as one entity. While participation in program services is technically optional in both **Supported** and **Supportive** housing services, **Supported Housing** services often are linked to provider-related goals and objectives that either require, or strongly encourage participation in program services by clients.

Services Unit: Hour - Unit Costs: $63

Operations Unit: Day - Unit Costs: $63

Note: Service cost rate is for program service costs, and operations costs are costs associated with operating and maintaining the physical facility. The operation cost refers to the cost of a 65 housing unit facility, per day.

Limited Mental Health (LMH) Assisted Living Facilities

Any facility with three or more mental health residents, licensed by the Agency for Health Care Administration (AHCA), with documentation, placement procedures, and a community living support plan as required for LMH Assisted Living Facilities. Services include personal care and skill training in basis living skills. Stipends are often needed to supplement funding for these facilities.

Unit: Day Rate - Unit Costs: $25

Limited Mental Health (LMH) Assisted Living Facilities - Medical

Any facility with three or more mental health residents, licensed by the Agency for Health Care Administration (AHCA), with documentation, placement procedures, and a community living support plan as required for LMH Assisted Living Facilities. Services include personal care and skill training in basis living skills. This recommended LMH category would also include services for clients who have special medical needs. Stipends are often needed to supplement funding for these facilities.

Unit: Day Rate - Unit Costs: $25

Residential Level 1

These are licensed services that provide structured, live-in, a non-hospital setting with 24-hour supervision daily. There is a nurse on duty in these facilities at all times. For adult mental health, these services include two different kinds of programs, group homes and short-term residential treatment services (SRT). Group homes are for longer-term residents. These facilities offer nursing supervision provided by, at a minimum, licensed practical nurses on a 24 hours a day, 7 days per week basis. Short-term residential treatment (SRT) services provide intensive residential treatment for individuals in need of acute care for an average of 120 days. Medicaid Residential Treatment Centers (MRTC) and Residential Treatment Centers (RTC) are reported under this cost center. On-call medical care must be available. For substance abuse programs, level 1 provides a range of assessment, treatment, rehabilitation, and ancillary services in an intensive therapeutic environment, with an emphasis on treatment, and may include formal school and adult education programs.

Unit: Day Rate - Unit Costs: $241

Residential Level 2

These are licensed, structured rehabilitation-oriented group facilities which have 24-hour, seven days per week, supervision level 2 facilities are for persons who have significant deficits in independent living skills and need extensive support and supervision. For substance abuse, level 2 provides a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation and may include formal school and adult educational programs.

Unit: Day Rate - Unit Costs: $174

Residential Level 3

These are licensed facilities, structured to provide 24 hour, 7 day per week supervised residential alternatives to persons who have developed a moderate functional capacity for independent living. For adults with serious mental illness, this cost center consists of supervised apartments. For substance abuse, level 3 provides a range of assessment, rehabilitation, treatment and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the clients served, the emphasis is on rehabilitation or treatment.

Unit: Day Rate - Unit Costs: $108

Residential Level 4

The facility may have less than 24 hours per day, 7 days per week on-premise supervision. This is the least intensive level of residential care, it is primarily a support service and as such, treatment services are not included in this cost center. For adult mental health, this includes satellite apartments, satellite group homes and therapeutic foster homes. For substance abuse, level 4 provides a range of assessment, rehabilitation, treatment and ancillary services in a transitional living environment with an emphasis on habilitation and rehabilitation. Therapeutic foster homes, and group care with treatment.

Unit: Day Rate - Unit Costs: $34

Permanent Subsidized Housing

Housing that is characterized by a lease agreement between the landlord and tenant, and is designed for persons to be able to live in the housing as long as they choose. This form of housing is subsidized to ensure that the housing is affordable for the tenant (tenant will usually pay no more than 30% of income towards rent). This type of housing does not necessarily include any type of support services.

Unit: Day Rate - Unit Costs: $ 21

REHABILITATION

Supported Employment - Individual

Supported employment service is community-based employment in an integrated work setting, which provides regular contact with non-disabled co-workers or the public. A job coach provides long-term ongoing support for as long as it is needed to enable the person served to maintain employment.

Unit: Hour - Unit Costs: $49

Supported Employment - Group

Supported employment service is community-based employment in an integrated work setting, which provides regular contact with non-disabled co-workers or the public. A job coach provides long-term ongoing support for as long as it is needed to enable group members to maintain employment. This service is designed to facilitate employment on a group-basis, as opposed to individuals.

Unit: Hour - Unit Costs: $49

Sheltered Employment

Sheltered employment service is non-competitive employment within a work-based facility.

Unit: 4 Hour Day - Unit Costs: $74

In-Home and On - Site Services Overlay

Therapeutic services and supports are rendered in non-provider settings such as nursing homes, assisted living facilities (ALFs), residences, school, detention centers, commitment settings, foster homes, and other community settings.

Unit: Hour - Unit Costs: $49

Mental Health Clubhouse Services

Structured, community-based services designed to strengthen and/or regain the client's interpersonal skills, provide psycho-social therapy toward rehabilitation, develop the environmental supports necessary to help the client thrive in the community and meet employment and other life goals and promote recovery from mental illness. Services are typically provided in a community-based program with trained staff and members working as teams to address the client's life goals and to perform the tasks necessary for the operations of the program. The emphasis is on a holistic approach focusing on the client's strengths and abilities while challenging the client to pursue those life goals. This service must be provided by Clubhouse programs that are based upon the International Center for Clubhouse Development (ICCD) International Standards for Clubhouse Programs. ICCD Certification must be obtained within three years of the first billing date.

Unit: Hour - Unit Costs: $20

Behavioral Health Overlay Services

Medicaid funded behavioral health services provided as an overlay to residential group care.

Unit: Day - Unit Costs: $81

Employment Outreach

Employment outreach services are provided through a formal outreach program to both the community and to individuals with specialized mental health related needs. Services include education of the public and risk groups on employment options and programs, identification and linkage with high risk groups, planning and linking with other service providers, and referrals services.

Unit: Hour - Unit Costs: $34

Employment Services

Employment Services assist individuals with mental illness in obtaining and maintaining employment in the community. Individuals may need assistance with job seeking skills such as contacting employers, punctuality, dressing for work, attendance skills, networking, and other job readiness skills. Additional services include: assisting with applications, interview skills, job acceptance, job coaching to learn job skills, and follow-up with the employer and the employee to promote continued job success, as well as assistance with the development of natural supports at the work place in order to encourage self-sufficiency. This is a time-limited service after employment is obtained. This service is geared for individuals who traditionally do not fall into the most severe category but still need assistance in order to be successful.

Unit: Hour - Unit Costs: $49

Drop In / Self Help Centers

These centers are intended to provide a range of opportunities for persons with severe and persistent mental illness to independently develop, operate and participate in social, recreational, and networking activities. These facilities can serve up to 30 clients a day.

Unit: Day Rate - Unit Costs: $296

Appendix I

Service Planning and Evaluation Survey (SPES)

Service Prescription				Optimal Services Across Functioning Levels							Actual Services Across Functioning Levels						Reasons for Discrepancies
		Units	Unit Costs	1	2	3	4	5	6		1	2	3	4	5	6	
	Housing																
26	Supported / Supportive Housing	Hours/ Days		5	15	50	80	50	20		0	5	15	30	30	5	6-2,5 5-2 4-2,3,5 3-2,3,4,5 2-2,3,5,7 1-1
27	LMH Assisted Living Facilities	Day Rate		0	10	80	50	10	0		0	10	80	80	0	0	5-11,13 4-11,13
28	LMH Assisted Living Facilities - Medical	Day Rate		0	5	25	20	5	0		0	5	25	20	5	0	
29	Residential Level 1	Day Rate		15	85	0	0	0	0		0	0	0	0	0	0	2-1 1-1
30	Residential Level 2	Day Rate		0	25	60	0	0	0		0	5	30	0	0	0	3-2,3 2-3,7
31	Residential Level 3	Day Rate		0	0	15	10	0	0		0	0	0	0	0	0	4-1 3-1
32	Residential Level 4	Day Rate		0	0	0	25	10	0		0	0	0	10	5	0	5-2,7 4-2,5,7
33	Permanent Subsidized Housing	Day Rate		0	0	0	0	15	10		0	0	0	25	5	5	6-2 5-2,3 4-11

Reason Codes

If amount received was less than the ideal:	***If amount received was more than the ideal:***
1. Service does not exist 2. Service has insufficient capacity 3. Client was refused for behavioral reasons 4. Inability to pay 5. Accessibility problem 6. Language or cultural problem 7. Client refused service 8. Family/other request 9. Clinician decided service should not be provided 10. Other reason not listed above	11. Service substitute for ideal service 12. Clinician decided service should be provided 13. Client requested service be provided 14. Family requested service be provided 15. Other reason not listed above

Appendix J

Housing Notes

Extent of the problem

Psychiatric disorders account for five of the top ten causes of disability worldwide, according to the World Health Organization (WHO). In fact, five conditions (Unipolar Major Depressive, Alcohol Use, Bipolar Disorder, Schizophrenia, and Obsessive-Compulsive Disorders) account for 11 percent of the total worldwide disease burden. Moreover, the WHO estimates that the total disease burden from these conditions will increase to 15 percent by the year 2020. The WHO cautions that "the United States needs to move ahead aggressively with a promotion and prevention agenda. If it does not do so, the already strained mental health treatment system and other social services will be completely overwhelmed in less than 20 years." The following statistics underscore the severity of the problem:

- During a 1-year period, 22 to 23 percent of the U.S. adult population – or 44 million people – have diagnosable mental disorders. (U.S. Department of Health and Human Services, 1999).
- Only 10 to 30 percent of people in need of mental health services receive appropriate treatment. (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999).
- In 1996, the direct cost of mental health treatment and rehabilitation services in the United States totaled $69 billion. In 1990, indirect costs due to lost productivity were estimated at $78.6 Billion (Rice & Miller, 1996, cited in Mental Health: A Report of the U.S. Surgeon General, U.S. Department of Health and Human Services, 1999).
- In the U.S., 78% of people with major depression do not receive treatment. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

The following estimates related to mental illness take on a particular significance when they are extrapolated using census and demographic profiles for Jacksonville:

Mental Health Fast Facts

1. 2000 census population of Jacksonville was 778,879, a 16% increase over previous census.

Source: US Bureau of the Census 2000

2. 22% of population estimated to have a diagnosable Mental Disorder (MD) in a one year period, which translates to 171,353 for Jacksonville. The most recent statistics for publicly funded mental health services in Jacksonville however, indicate that only 10,298 persons were served. (DCF, District 4 statistics for Jacksonville**)**

3. 5.4% of population estimated to have a Severe Mental Illness (SMI), which translates to 42,059 for Jacksonville.

4. 2.6% of population is estimated to have a Severe and Persistent Mental Illness (SPMI), which translates to 20,250 (State uses 1.5% = 11,683) for Jacksonville.

Source: Healthy People 2010, NIH

5. Studies show that people in lower socioeconomic strata are two to three times more likely to have a mental disorder, and are more likely to have higher levels of psychological stress. Poverty disproportionately affects racial and ethnic minorities. For example, while 8% of the white population is poor, 24% of African American are poor. (Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General)

    a. 11.9% of Duval County's population in 1999 was below the poverty level, and the African American population is 27.8%.

Substance Abuse and Mental Health Fast Facts

1. Adults who used illicit drugs within the past year are more than twice as likely to have SMI.

2. Among persons with SMI, 27.3% used an illicit drug in the past year, while the rate was 12.5 percent among those without SMI.

3. SMI is highly correlated with drug dependence or abuse. Among adults with SMI, 21.3% were dependent on, or abused alcohol or illicit drugs, while the rate among adults without SMI was only 7.9%. Adults with SMI are more likely than those without SMI to be dependent on, or abuse illicit drugs (8.6$ vs. 2.0%) and alcohol (17.0% vs. 6.7%)

Source: National Survey on Drug Use & Health, SAMHSA

Homelessness Statistics

An estimated 842,000 adults and children are homeless in a given week, with that number swelling to as many as 3.5 million over the course of a year. People who are homeless are the poorest of the poor. While almost half (44%) of people who are homeless work at least part-time, their monthly income averages only $367 compared to the median monthly income for U.S. households of $2,840. Those who have disabilities and are unable to work can find it nearly impossible to secure affordable housing in virtually every major housing market in the country.

The majority are unaccompanied adults, but the number of homeless families is growing:

- 66% are single adults, and of these, three-quarters are men
- 11% are parents with children, 84% of whom are single women
- 23% are children under 18 with a parent, 42% of whom are under 5 years of age

Racial and ethnic minorities, particularly African Americans, are overrepresented:

- 41% are non-Hispanic whites (compared to 76% of the general population)
- 40% are African Americans (compared to 11% of the general population)
- 11% are Hispanic (compared to 9% of the general population)
- 8% are Native American (compared to 1% of the general population)

Homelessness continues to be a largely urban phenomenon:

- 71% are in central cities
- 21% are in suburbs
- 9% are in rural areas

People who are homeless frequently report health problems:

- 38% report alcohol use problems
- 26% report other drug use problems
- 39% report some form of mental health problems (20-25% meet criteria for serious mental illness)
- 66% report either substance use and/or mental health problems
- 3% report having HIV/AIDS
- 26% report acute health problems other than HIV/AIDS such as tuberculosis, pneumonia, or sexually transmitted diseases
- 46% report chronic health conditions such as high blood pressure, diabetes, or cancer

People who are homeless also have high rates of other background characteristics:

- 23% are veterans (compared to 13% of the general population)
- 25% were physically or sexually abused as children
- 27% were in foster care or institutions as children
- 21% were homeless as children
- 54% were incarcerated at some point of their lives

Between 2 and 3 million Americans experience homelessness at some point each year. Of these, an estimated 20 to 25 percent have a serious mental illness and up to half of those with a serious mental illness also have an alcohol or drug use problem.

Source: SAMHSA

System analysis

Extrapolating from federal estimates of persons who have diagnosable mental disorders in the general population at any one time, Jacksonville has an estimated 171,353 persons who are in need of treatment. Although the management information data of the current mental health system in Jacksonville is not as comprehensive as it should be, the publicly funded system is currently serving only 10 to 13 thousand people in need on an annual basis. The difference between the estimated need and those currently being served represents the service gap for Jacksonville.

The Adult Mental Health Task Force is conducting a system analysis of the mental health service delivery system in Jacksonville. Part of that analysis consists of identifying the current array of housing services, along with the percentage of clients from varying functioning levels who are using those services. In addition, the Workgroup developed an optimal list of housing services for persons with mental illness, and estimated the percentage of clients who would require each of the services in an optimal system. Factoring in the costs for delivering the actual and optimal services will produce useful planning information in determining how much an optimal system would cost, and how clients will move between services as a function of their illnesses. That analysis is currently underway. A preliminary analysis of the system however indicates that clients are not receiving the amount of housing services they should, due to inability to pay, insufficient capacity of the service, service access problems, or that the service does not exist. Each member of the Housing Workgroup has received a copy of the final Service Planning and Evaluation Survey (SPES) matrix, and the associated Service Descriptions; these data should also be reviewed prior to the SWOT analysis.

- Current Housing Service Array for Jacksonville

  Supported/Supportive Housing
  LMH Assisted Living Facilities
  LMH Assisted Living Facilities - Medical
  Residential Level 1
  Residential Level 2
  Residential Level 3
  Residential Level 4
  Permanent Subsidized Housing

The Blue Ribbon Report on Ending Homelessness in Jacksonville

The Emergency Services and Homeless Coalition (ESHC) has recently completed a comprehensive ten-year plan to address homeless in Jacksonville, known as “Ending Homelessness in Jacksonville: A Blueprint for the Future. At the heart of the plan is the development of new permanent housing units for homeless individuals and families. The cost of homeless to the City of Jacksonville is a staggering $35 million annually, $27 million of which is the result of costs associated directly with emergency shelters, housing, and other services.

Research by the ESHC indicates that of the estimated 2,580 persons who are homeless in Jacksonville on any given day, 50% have recently experienced mental health problems. Persons who are chronically homeless (repeatedly homeless over a period of years), disproportionately impact the cost of homelessness in Jacksonville, are more likely to have serious mental illnesses, often have co-occurring substance abuse problems and/or physical problems.

The Blueprint has a comprehensive strategy to address the problem of homeless in Jacksonville, including strategies that are directed at the long-term or chronic homeless population. The goal is to stabilize the chronically homeless through permanent supportive housing, income sources and employment opportunities. Among specific actions, the plan calls for 145 supportive housing units in two years, and 800 units in five years. The plan has a comprehensive approach to financing the various goals and actions items and has justified the costs against the current and spiraling costs of the traditional crisis approach to dealing with homelessness.

Since homeless persons with accompanying mental illness form a significant portion of the homeless population, it follows that a comprehensive plan to address homelessness, including the chronically homeless, should be supported by the Homeless Workgroup and the Adult Mental Health Task Force. The range of housing and social proposed by the plan should assist persons with mental illness along the entire spectrum of illnesses. Additional work of course will have to be done to align the array of housing services in Jacksonville as delineated by the Housing Workgroup, with the large scale mental health system transformation that will be occurring at the federal and state levels.

The Housing Workgroup has previously been supplied with a table of goals, objectives, actions steps, etc. specifically related to the chronically homeless problem. The Housing Workgroup should review the goals and objectives as preparation for the SWOT.

Appendix K

Housing Workgroup SWOT Analysis

Strengths

1. Good existing models of effective housing programs and options
2. History of effective collaboration among MH Housing Professionals
3. MH Housing Advocates are vocal, knowledgeable, and committed to improving housing options for persons with mental illness
4. Local government structure has potential to respond to housing issues
5. MH choice/recovery movement gaining support among professionals and the public and has the potential to positively impact housing decisions
6. Recent move towards strategic planning, including housing issues
7. City provides bridge-funding for ALF housing options

Weaknesses

1. Local government structure difficult to influence and inclined to business-as-usual thinking
2. Funding Issues
    a. Insufficient funding for necessary housing programs
    b. Constant change in funding support leads to here-to-day, gone-tomorrow programs and services
    c. Programs oriented to funding sources and not customer needs
3. Professional workforce is limited in numbers and quality
4. Restrictive housing regulations tend to limit services to those most in need
5. Stigma and NIMBY limits public support for housing options and funding
6. Current management information system does not provide accurate or comprehensive data, and is not developing to meet future needs, both on the planning level and on the client information sharing level

Opportunities

1. Blueprint to End Homelessness provides excellent information and plan to address spectrum of housing services, including specific goals and objectives needed to address persons with mental illnesses
2. Medicaid reform and managed care changes may provide opportunity to impact emerging housing strategic planning process and goals
3. Monitoring of group living programs contributes to improved case management
4. Area growth can be an opportunity to develop new approaches, pending effective planning
5. Local legislative advocates are supportive and knowledgeable
6. Local advocacy groups are effective and helpful partners

Threats

1. Cutbacks in Medicaid and other funding, insufficient funds to meet demands
2. Lack of affordable housing options
3. Poor dissemination of information regarding mental health issues
4. Lack of consistent, unified political support for mental health and mental health housing issues
5. Stigma associated with mental illness affects support for services, funding, and change
6. No unified local voice for mental health and related housing issues

Appendix L

Service Planning and Evaluation Survey (SPES)

Service Prescription				Optimal Services Across Functioning Levels							Actual Services Across Functioning Levels						Reasons for Discrepancies
		Units	Unit Costs	1	2	3	4	5	6		1	2	3	4	5	6	
	Rehabilitation																
34	Supported Employment - Individual	Hours		0	0	5	20	30	10		0	0	5	10	10	5	6-2,10,4 5-2,10,4 4-2,4
35	Supported Employment - Group	4 hr. Day		0	0	10	5	10	0		0	0	0	3	1	0	5-2,4 4-2,4 3-9,2,8,4
36	Sheltered Employment	4 hr. Day		0	5	20	0	0	0		0	0	1	0	0	0	3-1,4 2-1,4
37	In-home and On-site Services Overlay	Hours		0	40	35	20	0	0		0	20	15	5	0	0	4-2,4 3-2,4 2-2,4
38	Mental Health Clubhouse Services	Hours		0	0	40	50	5	0		0	0	0	0	0	0	5-1,4 4-1,4 3-1,4
39	Behavioral Health Overlay Services	Day		0	60	50	25	0	0		0	30	20	10	0	0	4-2,4,7 3-2,4,7 2-2,4,7,9
40	Employment Outreach	Hours		0	5	5	15	35	25		0	0	1	5	10	5	6-2,5,4 5-2,5,9,4 4-2,5,7,9,4 3-2,5,7,9,3,4 2-2,5,7,9,3,4
41	Employment Services	Hours		0	5	5	15	35	25		0	0	1	5	10	5	6-2,4 5-2,4,8 4-2,4,8,7
42	Drop-in / Self Help Centers	Day		0	0	80	50	30	0		0	0	60	30	20	0	3 through 6 – 5,2

Reason Codes

If amount received was less than the ideal:	***If amount received was more than the ideal:***
1. Service does not exist 2. Service has insufficient capacity 3. Client was refused for behavioral reasons 4. Inability to pay 5. Accessibility problem 6. Language or cultural problem 7. Client refused service 8. Family/other request 9. Clinician decided service should not be provided 10. Other reason not listed above	11. Service substitute for ideal service 12. Clinician decided service should be provided 13. Client requested service be provided 14. Family requested service be provided 15. Other reason not listed above

Appendix M

Rehab Notes

Extent of the problem

Psychiatric disorders account for five of the top ten causes of disability worldwide, according to the World Health Organization (WHO). In fact, five conditions (Unipolar Major Depressive, Alcohol Use, Bipolar Disorder, Schizophrenia, and Obsessive-Compulsive Disorders) account for 11 percent of the total worldwide disease burden. Moreover, the WHO estimates that the total disease burden from these conditions will increase to 15 percent by the year 2020. The WHO cautions that "the United States needs to move ahead aggressively with a promotion and prevention agenda. If it does not do so, the already strained mental health treatment system and other social services will be completely overwhelmed in less than 20 years." The following statistics underscore the severity of the problem:

- During a 1-year period, 22 to 23 percent of the U.S. adult population – or 44 million people – have diagnosable mental disorders. (U.S. Department of Health and Human Services, 1999).
- Only 10 to 30 percent of people in need of mental health services receive appropriate treatment. (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999).
- In 1996, the direct cost of mental health treatment and rehabilitation services in the United States totaled $69 billion. In 1990, indirect costs due to lost productivity were estimated at $78.6 Billion (Rice & Miller, 1996, cited in Mental Health: A Report of the U.S. Surgeon General, U.S. Department of Health and Human Services, 1999).
- In the U.S., 78% of people with major depression do not receive treatment. (The Promotion of Mental Health and The prevention of Mental and Behavioral Disorders: Surely The Time Is Right. Center for Mental Health Services)

The following estimates related to mental illness take on a particular significance when they are extrapolated using census and demographic profiles for Jacksonville:

Mental Health Fast Facts

1. 2000 census population of Jacksonville was 778,879, a 16% increase over previous census.

Source: US Bureau of the Census 2000

2. 22% of population estimated to have a diagnosable Mental Disorder (MD) in a one year period, which translates to 171,353 for Jacksonville. The most recent statistics for publicly funded mental health services in Jacksonville however, indicate that only 10,298 persons were served. (DCF, District 4 statistics for Jacksonville**)**

3. 5.4% of population estimated to have a Severe Mental Illness (SMI), which translates to 42,059 for Jacksonville.

4. 2.6% of population is estimated to have a Severe and Persistent Mental Illness (SPMI), which translates to 20,250 (State uses 1.5% = 11,683) for Jacksonville.

Source: Healthy People 2010, NIH

5. Studies show that people in lower socioeconomic strata are two to three times more likely to have a mental disorder, and are more likely to have higher levels of psychological stress. Poverty disproportionately affects racial and ethnic minorities. For example, while 8% of the white population is poor, 24% of African American are poor. (Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General)

    a. 11.9% of Duval County's population in 1999 was below the poverty level, and the African American population is 27.8%.

6. Adults who used illicit drugs within the past year are more than twice as likely to have SMI.

7. Among persons with SMI, 27.3% used an illicit drug in the past year, while the rate was 12.5 percent among those without SMI.

8. SMI is highly correlated with drug dependence or abuse. Among adults with SMI, 21.3% were dependent on, or abused alcohol or illicit drugs, while the rate among adults without SMI was only 7.9%. Adults with SMI are more likely than those without SMI to be dependent on, or abuse illicit drugs (8.6$ vs. 2.0%) and alcohol (17.0% vs. 6.7%)

Source: National Survey on Drug Use & Health, SAMHSA

Summary of Service System Issues:

The President's New Freedom Report on the nation's mental health system indicates that the current mental health system is fragmented and in disarray. The current system consists of multiple funding source agencies, each with its own set of complex regulations, goals and objectives, and management information systems (Achieving the Promise: Transforming Mental Health Care in America, DHHS, 2003). The complexity and inefficiency of the system contributes to poor services and limits access to mental health services. Services are provided according to program objectives and funding rules, rather than the needs of customers. Moreover, some agencies that are part of this fragmented system are not even directly involved focused on mental health issues, such as Medicaid and Medicare. In fact, the largest Federal program that supports people with mental illness is not even a health service organization – the Social Security Administration, with its SSI and SSDI programs. The fragmentation of the mental health system filters down to virtually all local communities. A recent focus group public opinion analysis of a cross section of Jacksonville's community confirmed that system fragmentation is a major contributing factor to system access and quality of care in Jacksonville.

Recovery and Consumer-driven Issues

As a result of the continuing efforts of Mental Health Consumer Advocacy Groups the mental health system is moving towards developing a mental health system that is driven by the needs of its consumers, and not by the complex web of services and funding sources. Instead of viewing mental illness as a lifelong deterioration, or at best, symptom relief according to a medical model concept, recovery implies restoration of self-esteem and identity, and obtaining a meaningful role in society (Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999). The fragmented mental health system that exists across the county and locally in Jacksonville is service driven and complex; it needs to move towards a Consumer-driven and Recovery-based system that is consistent with the emerging system transformation efforts underway under Federal and State guidance.

Rehab Issues

The following information on Rehab Issues was summarized from Mental Health: A Report of the Surgeon General:

There are a range of multi-component programs called psychosocial rehabilitation services that are distinct from the single component skills training interventions. These psychosocial rehabilitation programs combine pharmacologic treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure activities (WHO, 1997). Randomized clinical trials have shown that psychosocial rehabilitation recipients experience fewer and shorter hospitalizations than comparison groups in traditional outpatient treatment (Dincin & Witheridge, 1982; Bell & Ryan, 1984). In addition, recipients are more likely to be employed (Bond & Dincin, 1986). Cook & Jonikas (1996) review the outcomes of a wide range of psychosocial rehabilitation programs, including Fairweather lodges (Fairweather et al., 1969) and psychosocial clubhouses (Dincin, 1975), some of which were demonstrated as effective 20 and 30 years ago but have not been widely implemented.

It is important to point out that consumers see a **distinction between recovery and psychosocial rehabilitation.** The latter refers to professional mental health services that bring together approaches from the rehabilitation and the mental health fields (Cook et al., 1996). These services combine pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities. Recovery, by contrast, does not refer to any specific services. Rather, according to the writings of pioneering consumer Patricia Deegan, recovery refers to the "lived experience" of gaining a new and valued sense of self and of purpose (Deegan, 1988).

Psychosocial Rehabilitation

The following information on rehabilitation issues was summarized from Mental Health: A Report of the Surgeon General:

Psychosocial skills training strives to teach clients verbal and nonverbal interpersonal skills and competencies to live successfully in community settings. Skills or tasks are divided into small, simple behavioral elements that the client then learns, practices, and puts together. Currently, there is a growing addition of cognitive skill remediation to rehabilitation programs that have focused on social skills training (Bellack et al., 1989; Bellack & Mueser, 1993; Scott & Dixon, 1995a). As one example of the scope of such programs, the program examined by Liberman and co-workers (1998) focused on four skill areas: medication management, symptom management, recreation for leisure, and basic conversation skills. Each area was addressed through concrete topics, with the basic conversation skills module, for example, consisting of active listening skills, initiating conversations, maintaining conversations, terminating conversations, and putting it all together.

The evolution of psychosocial skills training is important yet incomplete. A review in the mid-1990s concluded that its overall impact on social, cognitive, or vocational functioning is modest, and it remains unclear whether these gains are maintained after the training is over and can be used in real-life situations (Scott & Dixon, 1995a). However, a more recent study found greater independent living skills among clients who had received skills training during a 2-year followup of everyday community functioning (Liberman et al., 1998). Several others agree that skills training is effective for specific behavioral outcomes (Marder et al., 1996; Penn & Mueser, 1996). Specific symptom profiles may also influence how effective skills training is for a given person (Kopelowicz et al., 1997). Furthermore, Medalia and coworkers (1998) report recent success adapting cognitive rehabilitation techniques, originally developed for survivors of serious head injuries, for people with schizophrenia, but long-term effects and generalizability have not been determined. This exemplifies both the progress and the need for further refinement of this intervention (Smith et al., 1996b).

In a recent review article, a team of researchers concluded that the most potent rehabilitation programs (1) establish direct, behavioral goals; (2) are oriented to specific effects on related outcomes; (3) focus on long-term interventions; (4) occur within or close to clients' naturally preferred settings; and (5) combine skills training with an array of social and environmental supports. They also note that most programs do not contain all of these elements, but most are much improved over previous eras (Mueser et al., 1997b).

There are a host of multi-component psychosocial rehabilitation services that combine pharmacologic treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure activities (World Health Organization [WHO], 1997). These are discussed in the later section on service delivery.

Vocational Rehabilitation

Vocational rehabilitation emphasizes an array of approaches to maximize functioning and promote recovery, such as employment programs designed to help clients reenter the workforce.

Unemployment is pervasive among people with serious and persistent mental illness. Employment is valued highly by the general public and by people with schizophrenia alike because it generates financial independence, social status, contact with other people, structured time and goals, and opportunities for personal achievement and community contribution (Mowbray et al., 1997). These attributes of employment, combined with the self-esteem and personal purpose that it engenders, make vocational rehabilitation a prominent facet of treatment for serious mental illnesses. Vocational rehabilitation is especially important because early adult onset often disrupts education and employment history.

Controlled studies of vocational rehabilitation interventions have shown mixed results (Lehman, 1995, 1998; Cook & Jonikas, 1996). Although such programs do seem to increase work-related activities while people are engaged in them, the gains do not seem to be translated into more *independent* employment once services cease. This has led to the conclusion that ongoing support is needed for many individuals with schizophrenia who wish to work in competitive employment (Wehman, 1988). Recent controlled studies have shown the effectiveness of this newer type of so-called supported employment models, which emphasize rapid placement in a real job setting and strong support from a job coach to learn, adapt, and maintain the position (Drake et al., 1994, 1996; Bond et al., 1997). These models, which are growing in use, strike a dynamic balance between being supportive yet challenging in order to avoid clients' dependency and maximize their growth (Mowbray et al., 1997).

As vocational rehabilitation has moved away from sheltered workshops and toward supported employment models, the Americans With Disabilities Act of 1990 has helped to open jobs and educate employers about reasonable accommodations for people with psychiatric disabilities (Mechanic, 1998; Scheid, 1998). Additionally, innovations like client-run and client-owned vocational programs and independent businesses have begun to be developed on a larger scale (Rowland et al., 1993; Miller & Miller, 1997). These innovations are part of a larger movement of consumer involvement in the provision of services for people with mental illness.

Employment, Education and Training

People with serious mental illnesses and substance use disorders, including those with histories of homelessness, want and need to work. For many, work helps them recover from their disabilities. Further, income from work may help individuals regain and maintain residential stability.61 Also, adequate standards of living and employment are associated with better clinical outcomes. However, the same factors that place people with serious mental illnesses at increased risk of homelessness are challenges to employment, as well.62 These include symptoms of their illness, lack of housing, stigma and discrimination, and co-occurring substance use disorders. Likewise, people with substance use disorders exhibit problem behaviors that interfere with job success.

Therefore, people who are homeless need more services and support than traditional job training programs offer.

Successful job training programs for people who are homeless include comprehensive assessment, ongoing case management, housing, supportive services, job training and job placement services, and follow-up.63Employment program models that are effective for people with serious mental illnesses, including transitional employment, supported employment, and individual placement and support, must be flexible in how they define success and be prepared to work with individuals who are homeless over the long-term. A “work-first approach,” as opposed to extensive pre-vocational training, can motivate a person who is homeless to address other problems in his or her life. This means that employment programs must strike a balance between requiring complete abstinence or freedom from symptoms and tolerating some substance use-related behaviors or psychiatric symptoms on thejob.64Because mental illness often manifests itself in late adolescence or early adulthood, people’s education and career plans may be interrupted. Individuals re-entering school have similar support needs to people adjusting to a competitive work environment, including a full range of housing, health and mental health, and support services

System analysis

Extrapolating from federal estimates of persons who have diagnosable mental disorders in the general population at any one time, Jacksonville has an estimated 171,353 persons who are in need of treatment. Although the management information data of the current mental health system in Jacksonville is not as comprehensive as it should be, the publicly funded system is currently serving only 10 to 13 thousand people in need on an annual basis. **The difference between the estimated need and those currently being served represents the service gap for Jacksonville.**

The Rehab Workgroup of the Adult Mental Health Task Force is conducting a system analysis of the mental health service delivery system in Jacksonville. Part of that analysis consists of identifying the current array of services, along with the percentage of clients from varying functioning levels who are using those services. In addition, the Workgroup developed an optimal list of mental health services, and estimated the percentage of clients who would require each of the services in an optimal system. Factoring in the costs for delivering the actual and optimal services will produce useful planning information in determining how much an optimal system would cost, and how clients will move between services as a function of their illnesses. That analysis is currently underway. A preliminary analysis of the system however indicates that clients are not receiving the amount of rehabilitation services they should, due to inability to pay, insufficient capacity of the service, service access problems, or that the service does not exist. For example, even though the Clubhouse model is emerging as a significant adjunct to mental health rehabilitation efforts, Jacksonville does not currently have a publicly funded Clubhouse. Each member of the Rehab Workgroup has received a copy of the final Service Planning and Evaluation Survey (SPES) matrix, and the associated Service Descriptions; these data should also be reviewed prior to the SWOT analysis.

- Current Rehab Service Array for Jacksonville

  Supported Employment – Individual
  Supported Employment – Group
  Sheltered Employment
  In-home and On-site Services Overlay
  Mental Health Clubhouse Services
  Behavioral Health Overlay Services
  Employment Outreach
  Employment Services
  Drop-in / Self Help Centers

Data Issues

The collection of data to be used for the Adult Mental Health Strategic Plan was extremely difficult, time consuming, and each data set has at least some caveats.

The first data set collected was the number of persons with mental illness served in the public system in the most recent one year period. The data was obtained from DCF District Four and the number of persons was categorized according to client functioning levels for purposes of the Service Planning and Evaluation Survey (SPES), which is used in conjunction with the Service Descriptions for Jacksonville. The evaluation system produces estimates about the services each functioning group is actually receiving, and those estimates can be compared with an analysis of the services clients should be receiving in an ideal system, along with a comparison of the costs of the current system with the costs projected for an optimal system. The SPES system approach to evaluating mental health systems was introduced at a training workshop conducted by David Hughes of the Evaluation Center, which is affiliated with The Human Services Resource Institute, a SAMHSA funded research and consulting agency. The SPES system has been used in over 20 States and is the recommended method for evaluating mental health systems. The data however was not readily available, and required several meetings with DSF to obtain. In addition, the data had to be converted from GAF scores to SPES Functioning Levels Scores, which in turn required a conversion process. The conversion tables required additional time to obtain and to apply to the data. It is unclear at this time whether the DCF data includes hospital admissions. The SPES system however is a system analysis and looks at services clients are actually receiving and compares that data against an optimal system. The comparison yields useful information regarding the discrepancies between actual services and optimal services. Any missing data with respect to numbers of clients will impact the accuracy of projected costs, as opposed to an understanding of the services clients are actually receiving vs. what they should receive in an optimal system.

Data on costs of the mental health system in Jacksonville was also difficult and time consuming to obtain. In fact, the data on Medicaid costs for Jacksonville is still considered “informal” at this time, and it is unclear whether or not that data includes the cost of hospital admission costs associated with Medicaid reimbursements.

Additional data associated with client satisfaction, outcomes, and other clinical data may be available via the Agency for Health Care Administration (AHCA), and through other State of Florida data sources, but those resources have yet to be tapped. Technical assistance from the State will be required to develop a methodical data collection system that is consistent with long range and ongoing evaluation of the mental health system.

Mental Health and Substance Abuse
Funding Sources and Programs

City of Jacksonville Adult **Mental Health** Funding - FY 04-05

Mental Health Programs	2,415,091
Title I MH Ryan White	258,289
Public Service Grants - MH	209,000
Total MH	**$2,882,380**

City of Jacksonville Adult **Substance Abuse** Funding - FY 04-05

Substance Abuse Programs	3,233,668
Title I SA Ryan White	148,825
Public Service Grants - SA	283,000
Total SA	**$3,665,493**

City of Jacksonville combined MH and SA funding - **$6,547,873**

State of Florida, Department of Children and Families – District 4
Mental Health and Substance Abuse Funding for COJ - FY 04-05

Adult Mental Health Programs	$9,369,458
Adult Substance Abuse Programs	$6,285,845
Total District 4 Funding for COJ	**$15,655,303**

Note: DCF District Four, of which Jacksonville is a part, is the lowest funded district in the State for Adult Mental Health.

Combined City of Jacksonville and DCF District 4 Funding - Mental Health and Substance Abuse

Total COJ MH, SA, and PSG	$6,547,873
Total DCF	$15,655,303
Total MH and SA Funding for COJ	**$22,203,176**

Medicaid Funding for Duval County January 1, 2004 – December 31,

Mental Health	$27,881,204.97
Substance Abuse	$792,355.42
Total MH and SA Medicaid Funding	**$28,673,560.39**

Note: It is unknown at this time if the Mental Health Medicaid billing dollars includes Inpatient services.

Evidence-based programs and System Transformation

The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) is currently in the process of transforming its entire approach to mental health care. One important component of SAMHSA's transformation process is the development and promotion of evidence-based mental health programs for treatment and for prevention. One of the tools SAMHSA uses to promote the use of evidence-based practices is the National Registry of Evidence-based Programs and Practices (NREPP). The NREPP catalogs the most promising evidence-based programs, as well as the latest Model Programs, which are tested programs that include implementation resources and technical assistance. The use of evidence-based and model programs is fundamental to developing approach to promoting mental health, preventing mental illness, and treating mental illnesses. The system transformation is designed to address the special needs of seniors and the homeless, and to include diverse adjunct services such as Faith-based programming.

The following information on system transformation was summarized from SAMHSA website and links:

The mental health system transformation process includes an emerging new set of resources and data systems. An integrated system of National Outcome Measures is under development and will impact the transformation planning process. Therefore, it is essential that the first step in strategic treatment program planning should be obtaining the necessary technical assistance that will ensure that the future prevention programming efforts are integrated with the SAMHSA's emerging data measurement tools and systems. SAMHSA's information system is complex and in a state of transition. It is essential to have close coordination with SAMHSA's new technical assistance services prior to identifying and implementing specific evidence-based or model programs, as well as pursuing grant resources.

Process vs. outcome measures

The development and implementation of a scientifically grounded strategic treatment services plan must begin with an emphasis on process, or system changes that need to be in place before specific programs can be implemented and evaluated. Therefore, the suggested recommendations included below are designed to facilitate the development of a coordinated and strategically sound service delivery system change as a prelude to adopting and tracking evidence-based and model programs. In addition, the actual service providers that implement system improvements will be responsible for developing and tracking outcome measures. Moreover, the acquisition of financial resources through grant acquisitions will have a significant impact on the actual programs implemented and evaluated. The overriding emphasis should be on implementing programs that are consistent with SAMHSA's emerging system transformation platform, and are rooted in evidence-based and model program recommendations.

Adult Mental Health System

The Adult Mental Health Strategic Plan, by definition, focuses on the adult mental and substance abuse system – primarily the mental health system. It is for that reason that the focus of treatment issues presented here is primarily on the adult population.

Appendix N

Rehab Workgroup SWOT Analysis

Strengths

1. MH Rehab Advocates are vocal, knowledgeable, and committed to improving rehab options for persons with mental illness
2. Creative use of scarce resources
3. History of effective collaboration among MH Rehab Professionals
4. Existing Rehab system contains key components
    a. Psychosocial programs
    b. Employment programs
    c. Medication Management programs
5. Mental Health Strategic Planning

Weaknesses

1. Lack of transportation options for Rehab customers
2. Funding Issues
    a. Insufficient funding for rehab programs
    b. Constant change in funding support leads to here-to-day, gone-tomorrow programs and services
    c. Programs oriented to funding sources and not customer needs
    d. Insufficient funding for Medication Management
3. Lack of facility resources
4. Stigma and NIMBY limits support for funding and programs
5. Limited employment options for Rehab customers
6. Lack of major organized political force or voice for consumers

Opportunities

1. Grant funding
2. Mayor's Economic Growth Initiative
3. Area growth and increased number of customers can be an opportunity to develop new approaches, pending effective planning
4. New, non-traditional consortiums have potential to lead to innovative programming

Threats

1. Cutbacks in Medicaid and other funding cutbacks are contributing to insufficient funds to meet current and future demands
2. Lack of sufficient number of high-caliber professionals
3. Rapid economic growth is contributing to disintegration of traditional neighborhood support systems
4. Stigma associated with mental illness affects support for services, funding, and needed system changes
5. Managed Care may cause uncontrolled change, confusion, and limits to services
6. Multiple oversight agencies with unclear monitoring procedures cause disruption to providers

Appendix O

Adult Mental Health Services Questionnaire – Family Member

Please answer the following questions by checking the box or filing in the blanks below.

1. Age of Family Member

☐ 20 - 24 ☐25-29 ☐ 30-34 ☐ 35-39 ☐ 40 - 44 ☐ 45 - 49 ☐50-54

☐ under 55 ☐55-64 ☐ 65-74 ☐ 75-84 ☐ 85 and above

2. Gender of family member: ☐ Female ☐ Male

3. Family member is: ☐ White ☐ Black ☐ Hispanic ☐ American Indian OR Alaskan Native ☐ Asian or Pacific Islander ☐ Multi-Racial ☐Other

4. Zip code __ __ __ __ __

5. What is the family member's major source of transportation?

☐ drive self ☐ public transportation ☐ friend/family ☐ taxi ☐ Other

6. Family member is: ☐ employed full-time ☐ employed part-time ☐ not employed ☐ retired

7. Our main source of information about mental health services in Jacksonville has been from:

☐ Direct experiences ☐ family ☐friends ☐media ☐ mental health or social service agencies ☐ other

8. Where does family member live?

☐ private home ☐ apartment ☐assisted living ☐senior apartment

☐ retirement community ☐ nursing home ☐ other

9. Family member lives with: ☐ spouse ☐ family ☐ friend(s) ☐ alone ☐ other

Please rate your agreement with each of the following categories on the scale from 1-5 with 1 representing "Strongly Disagree" and 5 representing "Strongly Agree."

	Strongly Disagree				**Strongly Agree**
1. My family member's current mental health services needs are being met.	1	2	3	4	5
2. My family member has been able to access all the mental health services that he/she needs.	1	2	3	4	5
3. My family member has not been denied mental health services due to an inability to pay.	1	2	3	4	5
4. All the mental health services have been available to my family member.	1	2	3	4	5
5. My family member has been satisfied with the mental health services received.	1	2	3	4	5
6. All the mental health services available in Jacksonville are needed.	1	2	3	4	5
7. The mental health system in Jacksonville is user- friendly.	1	2	3	4	5
8. We are satisfied with the way mental health services are paid for in Jacksonville.	1	2	3	4	5
9. We think mental health services in Jacksonville are high quality.	1	2	3	4	5
10. Our transportation needs to access mental health services have been met.	1	2	3	4	5
11. Day care needs that help our family access mental health services have been met.	1	2	3	4	5

12. I have been allowed to participate in the mental health treatment plan of my family member.	1	2	3	4	5
13. We understand the mental health treatment options available to us.	1	2	3	4	5
14. The mental health system in Jacksonville needs more money.	1	2	3	4	5
15. There are enough housing options available for mental health clients.	1	2	3	4	5
16. The legal system works well with the mental health system in Jacksonville.	1	2	3	4	5
17. There are adequate mental health services for seniors	1	2	3	4	5
18. The stigma associated with mental illness is a problem.	1	2	3	4	5

Comments/Concerns

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Adult Mental Health Services
Questionnaire - Consumer

Please answer the following questions by checking the box or filing in the blanks below.

1. Age

☐ 20 - 24 ☐25-29 ☐ 30-34 ☐ 35-39 ☐ 40 - 44 ☐ 45 - 49 ☐50-54

☐ under 55 ☐55-64 ☐ 65-74 ☐ 75-84 ☐ 85 and above

2. Gender ☐ Female ☐ Male

3. I am ☐ White ☐ Black ☐ Hispanic ☐ American Indian OR Alaskan Native

☐ Asian or Pacific Islander ☐ Multi-Racial ☐Other

4. Zip code __ __ __ __ __

5. What is your major source of transportation?

☐ drive self ☐ public transportation ☐ friend/family ☐ taxi ☐ Other

6. What is your experience with the mental health system in Jacksonville based upon?

☐ self experiences ☐ family member ☐ friend ☐ other

7. I am ☐ employed full-time ☐ employed part-time ☐ not employed ☐ retired

8. My main source of information about mental health services in Jacksonville has been from:

☐ Direct experiences ☐ family ☐friends ☐media ☐ mental health or social service agencies ☐ other

9. Where do you live?

☐ private home ☐ apartment ☐assisted living ☐senior apartment

☐ retirement community ☐ nursing home ☐ other

10. I live with ☐ spouse ☐ family ☐ friend(s) ☐ alone ☐ other

Please rate your agreement with each of the following categories on the scale from 1-5 with 1 representing “Strongly Disagree” and 5 representing “Strongly Agree.”

	Strongly Disagree				**Strongly Agree**
1. My current mental health services needs are being met.	1	2	3	4	5
2. I have been able to access all the mental health services that I need.	1	2	3	4	5
3. I have not been denied mental health services due to an inability to pay.	1	2	3	4	5
4. All the mental health services I need have been available.	1	2	3	4	5
5. I have been satisfied with the mental health services I have received.	1	2	3	4	5
6. I think that all the mental health services available in Jacksonville are needed.	1	2	3	4	5
7. The mental health system in Jacksonville is user- friendly.	1	2	3	4	5
8. I am satisfied with the way mental health services are paid for in Jacksonville.	1	2	3	4	5
9. I think mental health services in Jacksonville are high quality.	1	2	3	4	5
10. My transportation needs to access mental health services have been met.	1	2	3	4	5
11. My day care needs that allow me to access mental health services have been met.	1	2	3	4	5
12. I have been allowed to participate in my mental health treatment plan.	1	2	3	4	5

13. I understand the mental health treatment options available to me.	1	2	3	4	5
14. I think the mental health system in Jacksonville needs more money.	1	2	3	4	5
15. There are enough housing options available for mental health clients.	1	2	3	4	5
16. The legal system works well with the mental health system in Jacksonville.	1	2	3	4	5
17. There are adequate mental health services for seniors	1	2	3	4	5
18. The stigma associated with mental illness is a problem.	1	2	3	4	5

Comments/Concerns

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Adult Mental Health Services
Questionnaire – Professional/Police/Advocate/Citizen

Please answer the following questions by checking the box or filing in the blanks below.

3. I am a: ☐ Mental Health Professional ☐ Police Officer ☐ Advocate
☐ Concerned Citizen

Please rate your agreement with each of the following categories on the scale from 1-5 with 1 representing "Strongly Disagree" and 5 representing "Strongly Agree."

	Strongly Disagree				**Strongly Agree**
1. Jacksonville's mental health services needs are being met.	1	2	3	4	5
2. Jacksonville residents are able to access all the mental health services they need.	1	2	3	4	5
3. Jacksonville residents are not denied mental health services due to an inability to pay.	1	2	3	4	5
4. A full range of mental health services are available to Jacksonville residents.	1	2	3	4	5
5. Most clients receiving mental health services are satisfied with the services they receive.	1	2	3	4	5
6. All the mental health services available in Jacksonville are needed.	1	2	3	4	5
7. The mental health system in Jacksonville is user- friendly.	1	2	3	4	5
8. Clients are satisfied with the way mental health services are paid for in Jacksonville.	1	2	3	4	5

9. I think mental health services in Jacksonville are high quality.	1	2	3	4	5
10. Transportation needs to access mental health services are being met.	1	2	3	4	5
11. Day care services that allow clients to access mental health services are being met.	1	2	3	4	5
12. Mental Health Clients and their family members are encouraged to participate in treatment plans.	1	2	3	4	5
13. Mental health clients understand the mental health treatment options available to them.	1	2	3	4	5
14. The mental health system in Jacksonville needs more money.	1	2	3	4	5
15. There are enough housing options available for mental health clients.	1	2	3	4	5
16. The legal system works well with the mental health system in Jacksonville.	1	2	3	4	5
17. There are adequate mental health services for seniors	1	2	3	4	5
18. The stigma associated with mental illness is a problem.	1	2	3	4	5

Comments/Concerns

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