Unlocking the Pieces:

Community Mental Health in Northeast Florida

A Report to the People of Northeast Florida

Fall 2014

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Findings

INTRODUCTION

Mental Health, as defined by the Centers for Disease Control (CDC), is a state of well-being in which people realize their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make contributions to their communities. Mental health is essential to people's well-being, healthy family and inter-personal relationships, and the ability to live full and productive lives - it is what allows people to function as good friends and supportive family members, and as productive employees and engaged citizens. In short, mental health is a characteristic that all humans share – and optimizing mental health is what everyone should hope to achieve.

Mental Illnesses are health conditions that impair mental health and are characterized by alterations in thinking, mood, and/or behavior associated with distress and/or impaired functioning. Mental illnesses often result in a diminished capacity for coping with the ordinary demands of life. The severity of mental health issues spans a broad spectrum. Some people experience only temporary symptoms that are not diagnosable mental illnesses, while others have comparatively mild mental disorders that can be easily treated and they go on to lead relatively productive lives. On the other end of the spectrum, severe and persistent mental illnesses can be debilitating and lead to difficult consequences in people's lives.

The CDC estimates that approximately 17 percent of U.S. adults are considered to be in a state of optimal mental health at any given time. Between 20 and 25 percent of all those living in the U.S. (adults and children) lived with a mental illness during the past year, and more than half will at some point in their lives. The majority of people living with a mental illness will go undiagnosed and/or untreated jeopardizing their prospects for long-term recovery and increasing the risk factor for other chronic diseases, including cancer, diabetes, cardiovascular disease, asthma, and stroke.[1] Four of the leading causes of disability worldwide are mental health conditions. For men, these are depression (#1), alcohol use disorders (#2), schizophrenia (#5), and bipolar disorder (#7). These rankings differ slightly for women: depression (#1), schizophrenia (#6), bipolar disorder (#8), and Alzheimer and other dementias (#10).[2] Suicide, the tenth-leading cause of death in the United States and the third-leading cause for those ages 15-24, is nearly always linked to mental disorders.[3] Northeast Florida has higher rates of suicide across all age sectors than the State of Florida. The 2012 rate of suicide among all people in NE Florida was 18.0 per 100,000 vs. 14.2 in the State; among youths ages 10-19, the NE Florida rate was 6.1 compared to 4.9 in the State; and among senior citizens 65 and older, the NE Florida rate was 20.3 vs. 19.6 in Florida.[4]

> "It is important that people understand that mental illness is just that, an illness. People aren't blamed for having breast cancer the way they are blamed for having a mental illness."
> Denise Marzullo, President and CEO of Mental Health America of Northeast Florida.

It was with this backdrop that JCCI undertook this eight-month community Inquiry to examine assumptions about mental health and current mental health systems in Northeast Florida in an effort to find ways to positively impact the quality of life for everyone. Whether it is people who experience mild depression on the one extreme or serious mental illness such as schizophrenia and bipolar disorder on the other, this Inquiry is about improving mental health for all.

This Inquiry process has revealed that in Northeast Florida, mental health is rarely discussed, people with mental illnesses are stigmatized in the community, there is a shortage of mental health professionals, the system of care is fragmented, and the public sector is severely underfunded. All of these factors lead to an undersupply of preventive and rehabilitative services.

Mental illness does not discriminate. People everywhere are vulnerable to mental illnesses. Some have a greater number of risk factors than others, particularly those who experience oppression, trauma and chronic stress resulting from environmental conditions such as poverty and homelessness. There is no question, however, that mental illness touches every facet of society, and its consequences are equally devastating for those at every socio-economic level. It was therefore the intent of this Inquiry to examine mental health across our entire community.

It is impossible to precisely determine the prevalence of mental illness because millions who live with a mental health issue are never diagnosed or treated. National estimates, however, are sobering:[5]

- An estimated one in four adult Americans lives with a mental illness (approximately 61.5 million);
- Four percent of Americans live with a serious mental illness such as schizophrenia, major depression, or bipolar disorder;
- Approximately 46% of youths ages 13-18 either have a mental disorder of some type or have had at some point in their lives; 21% of them have or have had a severe mental illness. For those ages 8-15, approximately 13% have experienced a mental disorder of some type.
- Approximately 60% of adults and almost one-half of youths ages 8-15 with a mental disorder received no mental health services in the previous year.

While one in every four adults is impacted by a mental illness, the World Health Organization concludes that "in spite of this striking figure, concern with and commitment to mental health largely remains a very remote and often obscure component of policy-makers' agendas, which are chiefly dealing with population mortality."

The good news is that most mental illnesses can be managed effectively, particularly with early diagnosis and treatment. Most people who experience mental health problems can recover with proper treatment or are able to manage them effectively. Early intervention is critical.

Myths - Mental illnesses and addictions...

- are not biological conditions and are different than "physical illnesses;"
- are rare;
- cannot be treated effectively.

Facts - Extensive research shows these conditions...

- are biological, impacting both brain and body;
- affect 1/2 of Floridians at some point in life;
- can be effectively treated but not cured.[6]

So, why do so many people who need help fail to seek it? First, many are not even aware they have a mental health issue that requires treatment. The symptoms associated with mental illnesses are not widely understood by average persons. It is recognized, for example, that when someone gets the flu, achiness and fever are likely to occur, and he or she should go see a doctor. But when someone is depressed, the symptoms are not necessarily recognized, and even when they are, the tendency is to think it is only temporary and the problem will get better on its own, or the person is often advised by others to tough it out and cope with it alone.

In addition, the spectrum of degrees of mental illnesses is vast, further complicating an individual's ability to recognize when professional help is needed. Everyone experiences occasional moodiness and temporary depression, but that doesn't mean they necessarily have a diagnosable mental illness. The line of demarcation is often blurry when it comes to knowing when treatment becomes appropriate or necessary.

Another explanation for the vast number of undiagnosed and untreated mental illnesses is the stigma society has attached to mental illness. A veil of silence precludes healthy and open discussion about mental health issues, and when the subject is raised, it is often done in hushed tones, or even in disparaging or derogatory ways. It is not surprising that people living with treatable illnesses are reluctant, if not unwilling, to acknowledge their problems when shame and societal disapproval are frequently the result. Mental illnesses are often made worse and

recovery more difficult due to the effects of social stigma, which can result in discrimination from friends, family, and employers.

The most frequently cited reason for not seeking treatment for mental illness, however, is the cost of care.[7] Mental health services are expensive, and some forms of health insurance are not always accepted by mental health professionals, sometimes leaving individuals seeking treatment to pay for services out-of-pocket. Even a one-time visit to a psychiatrist can be cost-prohibitive.

Health insurance, which has historically covered mental illness in a more limited fashion than physical illness, is a significant issue, but one that is improving. The 2008 Mental Health Parity and Addiction Act was designed to ensure that doctors and insurers treat mental and physical illness on equal footing; and the Affordable Care Act (ACA), which took effect on January 1, 2014, requires that all new individual and small group insurance policies must provide essential health benefits including mental health and substance abuse services. As a result, these benefits will be more generous than they have been in the past, and affordable coverage will be available to more people.

Lessening the positive impact that should come from more people having mental health coverage is the fact that Florida is one of 24 states that has not expanded Medicaid (as of 7/1/14) as part of the Affordable Care Act. As a result, more than one million low-income Floridians who would have been eligible for health insurance will not be covered. As originally enacted, the ACA required states to expand Medicaid eligibility to include more low-income individuals than it previously did, thereby further reducing the number of uninsured. However, a 2012 Supreme Court ruling made it optional for states to expand Medicaid eligibility, and the Florida Legislature voted not to do so.

For those who are willing to seek help, navigating through the complex system can be daunting. Capacity and access issues are commonplace in the mental health sector (public and private), with too few services and mental health professionals available. In addition, state hospitals have systematically reduced the number of psychiatric beds in recent years. Highlighting the capacity problem is the fact that the single largest providers of mental health services in the country are jails and prisons where a disproportionate percentage of incarcerated individuals have a diagnosable mental illness.

The impact of severe mental illness is felt not only by the person with the illness, but by family, friends, and colleagues at work. The stress associated with caring for a person requiring full-time attention can result in mental and physical health crises for the caregivers. The stigma of mental illness is also shared by family members. The ability to maintain full-time employment and healthy relationships can be compromised by the need to provide constant attention to the family member with severe mental illness.

There is wide industry agreement that a holistic approach to health care, where mental health and physical health are integrated, is a worthy goal, but too few family practitioners are equipped to thoroughly address mental illnesses. There are several ways of achieving integration (e.g., embedding a mental health professional within a primary care setting, making primary care available in a mental health facility, etc.). Integration is becoming more widespread but is probably years away from broad application because of challenges associated with funding, insurance reimbursement, and culture change in both the mental and physical health care practices.

Finally, public funding for mental health in this country, and particularly locally, is insufficient to meet the need. Florida ranked 49th of 50 states in per capita state mental health funding in 2012, and Northeast Florida ranked as the second-lowest-funded region in the state.[8] In the three-year period from 2010-2012, Florida cut $20 million in public funding for mental health services.

A recurring theme at nearly every Inquiry meeting was the need for increased education and awareness about mental health throughout the community. Lack of education contributes to the perpetuation of stigma, confusion about how to access the mental health system of care, and failure to recognize steps that can be taken to improve mental health and wellness.

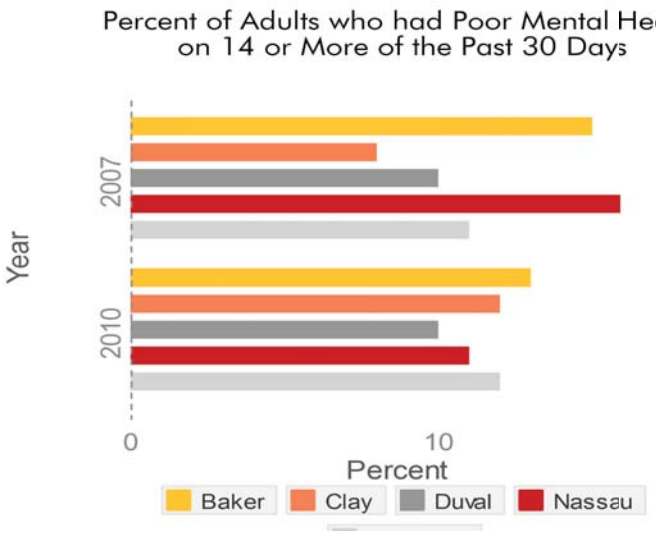
In the pages of this report that follow, these issues will be examined in more detail.

SCOPE OF THE ISSUE

Mental health is an issue important to the overall health and wellness of every individual and the entire community. Similarly, mental illness is an inescapable component of family and community life and deserves the same attention and empathy as physical illnesses in terms of prevention and intervention. Whether an individual has a mental illness or has a friend or family member who does, no one is exempt from the reach of mental illness.

Mental illness is pervasive in Northeast Florida, just as it is throughout the world. It affects people of every age, gender, race, socio-economic standing, and sexual orientation. The National Institute of Mental Health (NIMH) estimates that one in every four adults in the United States (approximately 61.5 million) experiences a diagnosable mental illness in a given year. That means that approximately 268,384 of the 1,073,534 adults in Northeast Florida are living with a mental illness. About 4 percent of adults live with a severe mental illness such as schizophrenia, major depression, bipolar disorder, or other psychotic disorders – or nearly 42,000 in Northeast Florida.[9]

Mental illness can begin early in life, and National Institute of Mental Health estimates that one-half of all chronic mental illness begins by age 14, and 75% by age 24. Furthermore, 21% of youths ages 13-18 (about 22,000 in Northeast Florida) have experienced severe mental illnesses at some point in their lives. For those ages 8-15 (almost 19,000 in Northeast Florida), an estimated 13% have experienced a mental disorder of some type.[10] Nearly half of the 8-15 year-olds received no mental health services in the previous year.[11]



While mental illnesses of all kinds are widespread in the population, it is the four percent or so who suffer from severe mental illnesses who experience the most negative consequences.[12] Individuals with severe mental illnesses die on average 25 years earlier than those who are not mentally ill, and those living with mental illnesses are also four times more likely to die from untreated physical diseases.[13]

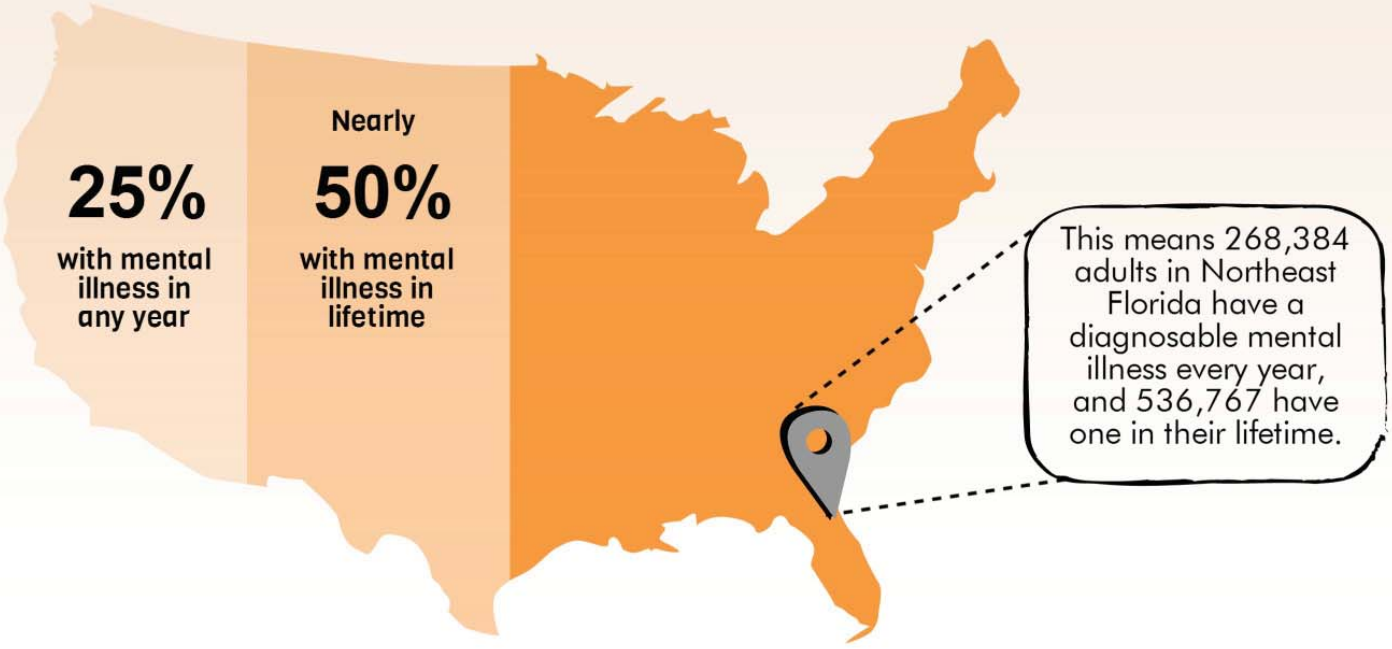
Many people who live with mental illness have multiple diagnoses. Nearly half (45 percent) of those with any mental illness meet criteria for more than one disorder, with severity strongly related to comorbidity (i.e., two or more medical conditions present simultaneously in an individual).[14]

Even though most mental illnesses can be effectively treated, allowing the individual to recover and lead a productive life, an estimated 60 percent of adults and 50 percent of children with mental illnesses are never diagnosed or treated.[15, 16] As will be seen later in this Report, the toll on these individuals and the community as a whole is significant.

Precise data on mental health in Northeast Florida is limited because no epidemiological study on mental health has ever been conducted locally. The prevalence of mental illness in the greater Jacksonville area is extrapolated from national estimates based on studies from other communities and local population data.

While people from every walk of life are vulnerable, some demographic groups have a disproportionate risk of mental illness. The prevalence is higher, for example, among people living in poverty, military veterans, victims of crime, people who are homeless, and persons in non-dominant social groups including women, people of color, and members of the lesbian, gay, bisexual, transgender (LGBT) population. This is due in large part to the chronic stress from trauma, difficult living conditions, and discrimination within society and among service providers.

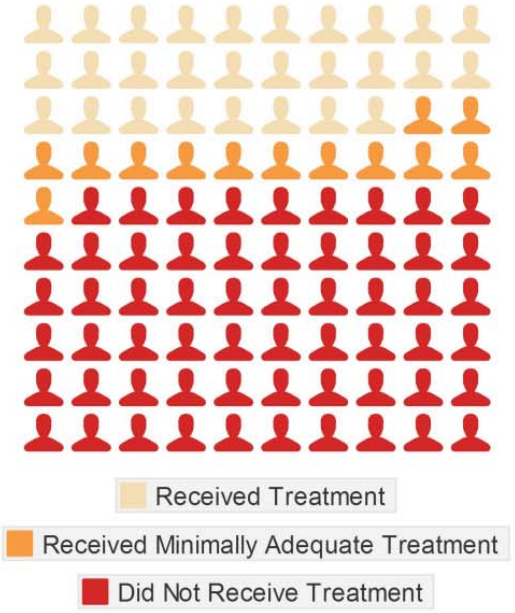
Adults with Mental Illness in the U.S. and Northeast Florida



For those with an illness, 41% are treated.

Of those treated, 33% received only minimally adequate treatment.

This means that 59% do not receive treatment.



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STIGMA - WHY SHAME, PREJUDICE, AND DISCRIMINATION ACCOMPANY MENTAL ILLNESS

One of the most significant factors keeping people with mental illness and their family members from speaking openly about their problem is the fear of being stigmatized because of their mental illness. That fear is well-founded as the stigma of mental illness is both pervasive and firmly entrenched in our society.

An example of how stigma works is evident in everyday language. It is common to call someone "a schizophrenic" or refer to "the mentally ill." For physical illness, things are often handled differently and people usually say that a person has cancer. The person afflicted with cancer remains one of "us" and has an attribute….the "schizophrenic" becomes one of "them" and is the label.[17]

Social stigma refers to the negative label that society places on a person with a discernible mental illness which is considered a sign of weakness, often resulting in prejudice and discrimination. Self-stigma is how the person judges himself and how he perceives the way others treat him because of his disorder.

The stigma of mental illness typically results in a reticence to talk about mental health, both in public and often at home, as well as an unwillingness of many to admit to having a problem that could be effectively treated. People with a mental illness are made to feel weak if they cannot handle the problem on their own, leading to feelings of shame and low self-esteem. They can feel isolated, afraid and rejected by society. Society often accepts broad stereotypes about people with mental illness, labeling them as dangerous or violent. These stereotypes are often reinforced in films, print and social media. People living with mental illness are commonly seen as rebellious, free spirits, or living at the edges of social norms and possessing a perception of the world that is child-like.[18]

These stereotypes sometimes translate into negative assumptions about the best ways to support people living with a mental illness. The result is that persons living with a mental illness, unlike other health conditions, are routinely discriminated against. Employers are less likely to hire them, landlords are less likely to rent to them, and people are more likely to press false charges of violent crimes against them.[19] People living with mental illness are actually more likely to be the victims of abuse or crime than people who are not mentally ill. The Institute of Medicine concluded, "Although studies suggest a link between mental illnesses and violence, the contribution of people with mental illnesses to overall rates of violence is small," and further, "the magnitude of the relationship is greatly exaggerated in the minds of the general population."[20]

To avoid stigmatization, many people keep their illnesses to themselves and go without the treatment they need. Even those who do seek treatment often go to great lengths to hide their illness from family and friends.

> "I frequently field calls from friends or colleagues who ask me to help them access help for a loved one who needs mental health treatment, and almost always before hanging up they ask me to promise to keep the conversation private."
>
> Hugh Greene
> Baptist Health CEO

According to two resource speakers (Dr. Steven Cuffe, a psychiatrist at UF College of Medicine; and Reverend Wayne Lanier of Celebration Church), stigma is one of the most likely reasons that individuals often seek help for mental health issues first from their primary care physician or a resource outside the mental health sector, rather than a mental health professional. The fear of being penalized for having a mental illness – at work, at home, and with friends and acquaintances – is what keeps many from acknowledging their illness.

Mayo Clinic notes that some of the harmful effects of stigma can include:

- Lack of understanding by family, friends, colleagues or others you know
- Discrimination at work or school
- Difficulty finding housing
- Bullying, physical violence or harassment
- Health insurance that doesn't adequately cover your mental illness

Long-term, stigma can lead to poorer treatment outcomes. Self-stigma has also been correlated with less success securing employment since it continues to complicate the lives of those who are stigmatized even after treatment improves their symptoms.[21]

"Once stigmatized, you stay stigmatized. It is very hard to overcome."
Vivian Lanham
Jacksonville mental health advocate who has struggled with mental illness throughout much of her life.

"No one in a family escapes unscathed when mental illness is present. I see a counselor every week for help in dealing with my depression, some of which is a result of stigmatization."
John Boggs
resource speaker and father of a 26-year-old son with paranoid schizophrenia

Because stigma is firmly embedded from an early age, it is difficult to eradicate. People tend to stigmatize regardless of what they actually know about mental illness, and regardless of whether they know someone who has a mental illness. Even some health care professionals and others employed in the mental health system hold strong stigmatizing beliefs about mental illness.

As is the case with many of the impacts of mental illness, stigma is not restricted exclusively to the person with the illness. Stigma by association also impacts family members and caregivers of persons with mental illnesses. Friends, family, and neighbors sometimes place the blame on family members for the mental illness of their relatives. Questions about parenting ability, both internally and from friends and colleagues, are common. Feelings of discrimination and social isolation can result.

RECENT HISTORY OF MENTAL HEALTH SYSTEM IN THE USA

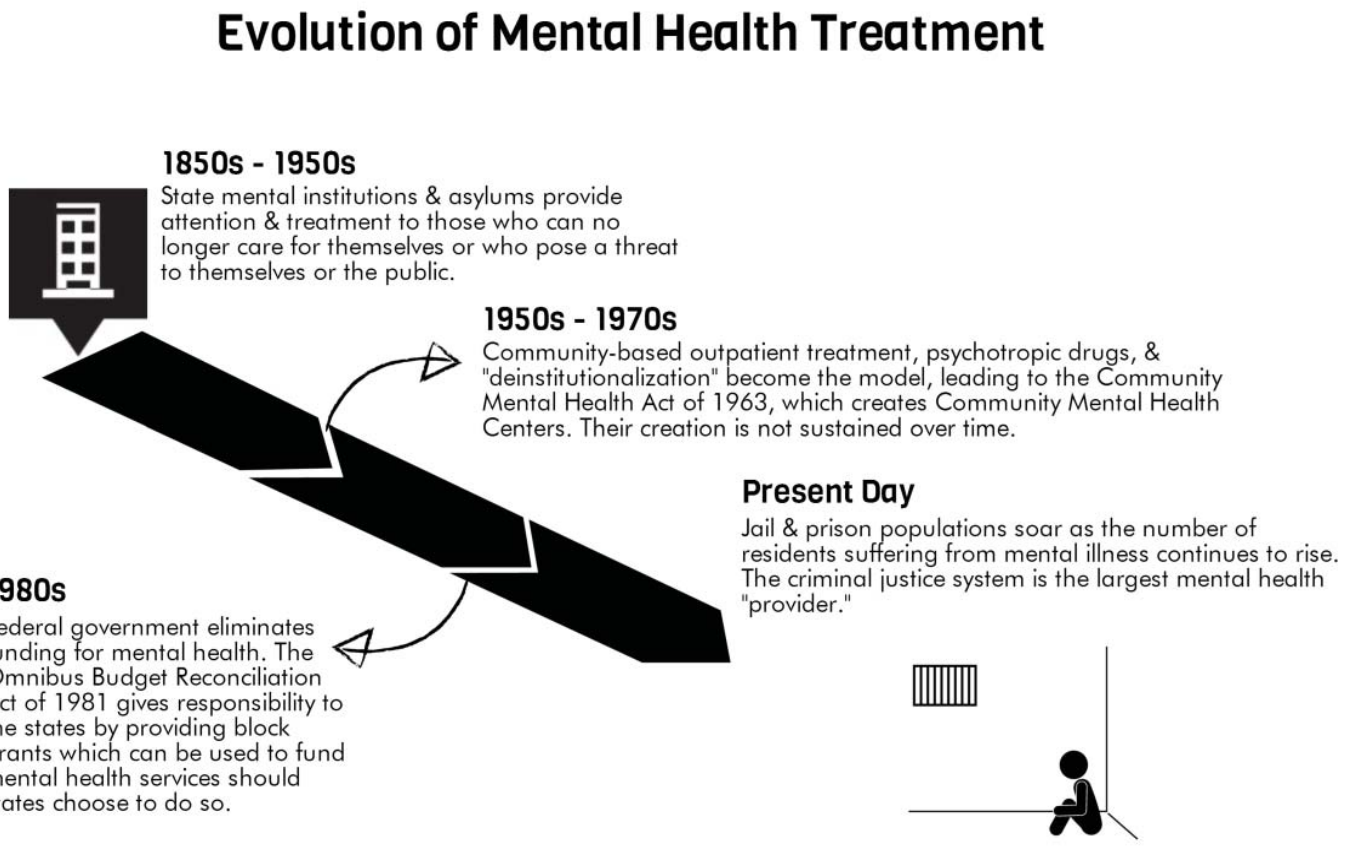
Mental health treatment in the United States has been provided primarily at the community level since a deinstitutionalization movement began in the 1960's. This movement away from institutionalizing people with mental illnesses in state hospitals, psychiatric hospitals, and what once were called insane asylums became the trend following the passage of federal legislation in 1963 (Community Mental Health Act). Institutionalization was supposed to be replaced by a community-based services approach authorizing the development of a series of "Community Mental Health Centers" (CMHCs) across the country. These CMHCs were designed to help previously-institutionalized patients establish new lives in familiar and caring communities and to provide citizens with access to mental health services.

Accordingly, state governments responded by downsizing or eliminating many of the state mental hospitals that for more than a century had been the primary treatment facilities for individuals with severe mental illnesses.

While the community-based concept was well-intentioned and bore significant promise, it didn't meet expectations for a variety of reasons. Only about half of the anticipated 1,500 Community Mental Health Centers were ever constructed, and they were never fully funded.[22] Legislation passed in 1981 (Omnibus Budget Reconciliation Act) effectively eliminated direct federal funding for mental health, replacing it with block grants awarded annually to states by the Substance Abuse and Mental Health Services Administration (SAMHSA). These are noncompetitive grants that provide states with complete mental health spending discretion, and funding decisions are often based

on political expediency. As a result, some CMHCs folded because they (a) were no longer financially sustainable; and (b) were not broadly embraced by citizens reluctant to have people with severe mental illnesses living in their neighborhoods. Other community-based services were not sufficient to meet the need.

A vacuum resulted which still exists today, leaving many people with severe mental illnesses without enough community-based services to meet their needs. Many end up homeless on the streets, or in and out of jails and prisons which are ill equipped to provide the comprehensive mental health services required. Without sufficient support services outside jail, many persons with severe mental illness are recycled back through the system ending up in jail once again. Ironically, this "criminalizing" of mental illness has had the effect of recreating institutionalization, only this time in jails and prisons rather than psychiatric hospitals.



CONSEQUENCES OF MENTAL ILLNESS

Because the severity of mental illnesses varies widely, there are a wide range of potential consequences depending on where one's illness lies on the spectrum. Mental health issues do not necessarily preclude individuals from living fairly normal lives. Millions of people who have relatively minor mental health problems do the things others do on a daily basis: they take their kids to school; perform well at work; share responsibilities around the house; and enjoy a circle of friends. Ignored and left untreated, however, even minor mental illnesses can become chronic and lead to more serious consequences.

For the four percent of Northeast Floridians who suffer from a severe, chronic mental illness, life is usually anything but normal. For these individuals, every day can be fraught with challenges that, over time, may become overwhelming. Many suffering from severe, persistent mental illnesses become caught in a recurring cycle of seemingly hopeless living conditions.

According to the World Health Organization (WHO), "individuals with psychological disorders are at greater risk for decreased quality of life, educational difficulties, lowered productivity, and poverty, social problems, vulnerability to abuse, and additional health problems."

"It is an inescapable fact that people with psychiatric disabilities are systematically and routinely deprived of their rights, and treated as less than full citizens or full human beings," conclude scientist Darby Penney and psychiatrist Dr. Peter Stastny.[23]

The WHO also notes that people with mental disorders are exposed to a wide range of human rights violations. Individuals with severe mental illnesses, mostly those in jails and prisons, are sometimes restrained with metal shackles, confined in caged beds, deprived of clothing, decent bedding, clean water or proper toilet facilities and are subject to abuse and neglect. People with mental illness also face discrimination on a daily basis in the fields of education, employment and housing.[24]

"I went through the revolving door that is the mental health system which often involves homelessness, drug addiction, and jail," explained resource speaker Wes Evans. Evans is doing well after years of dealing with the effects of bipolar disorder, but he has lived the nightmare that is characterized by recurring trips to hospitals, mental health facilities, and jail.

CONSEQUENCES FOR INDIVIDUALS

Early Warning Signs

The personal consequences of mental illness can start with less overt symptoms such as apathy; increased vulnerability to stress; problems with concentration or memory; excessive worries and anxieties; problems with interpersonal relationships; prolonged sadness or irritability; rapid or dramatic shifts in feelings or "mood swings"; social withdrawal; substance abuse; and even suicidal thoughts. For adolescents, signs can include defiance of authority; frequent outbursts of anger; and changes in sleeping and eating habits. Younger children can demonstrate changes in school performance; excessive worry or anxiety; and frequent temper tantrums.

Can Lead to Other Chronic Mental and Physical Disorders

If left untreated, minor mental health issues can lead to more serious mental illnesses such as major depressive disorder. In addition, untreated mental illnesses can contribute to the severity of other chronic diseases, including cancer, heart disease, diabetes, stroke, cardiovascular disease, and hypertension. Severely mentally ill people have a relative risk factor two to five times the rate of the general population for developing one or more of these life-threatening diseases.[25] According to the Robert Wood Johnson Foundation, comorbidity between mental and medical conditions is the rule rather than the exception. In the 2003 National Comorbidity Survey Replication, more than 68 percent of adults with a mental disorder had at least one medical condition, and 29 percent of those with a medical disorder had a comorbid mental health condition.

Substance Abuse

In an attempt to self-medicate or lessen the severity of their symptoms, people living with mental illness are vulnerable to substance abuse (alcohol and/or drugs).

People who experience both substance abuse and a mental illness such as depression, bipolar disorder, or anxiety, have a co-occurring disorder or dual diagnosis and are less likely to follow their treatment plans; adhere to their medication regimens; and more likely to miss appointments. All of which can lead to more psychiatric hospitalizations and other adverse outcomes. The National Alliance on Mental Illness (NAMI) suggests that the

substance abuse problem worsens when a mental health issue goes untreated. And when alcohol or drug abuse increases, mental health problems usually increase too.

It is also noteworthy that 44 percent of the cigarettes smoked in the United States are smoked by people with mental illnesses or substance abuse disorders.[26] Smoking cessation programs in the general population have been highly successful over the past 50 years as smoking rates have plummeted from 42.4 percent of adults in 1965 to 19 percent in 2011.[27] These programs have not been nearly as successful among those with mental illness, and it is estimated that individuals with mental illness smoke at rates approximately twice that of adults living without mental illnesses.[28]

Mental Illness and Children

Coping in school is a common issue for children and adolescents with mental illnesses. According to the U.S Department of Education, more than 50 percent of students with a mental illness drop out of high school. Students with mental illnesses are often the subject of ridicule from classmates and are frequently the victims of bullying. In addition, they can have difficulties starting and maintaining relationships. Involvement in the juvenile justice system is often a consequence, and attempted youth suicide is too frequent. Trauma in childhood resulting from various negative experiences (e.g., sexual abuse, the sudden death of a parent or sibling, etc.) is a frequent cause of mental illness. Mental illness is not restricted, however, to children who are considered at-risk; many children from loving, supportive homes also live with mental illness.

Many of Jacksonville's troubled youth are assessed for mental illness after being arrested. These young boys and girls are screened through the Juvenile Assessment Center where they receive an initial screening utilizing the Positive Achievement Change Tool (PACT) for mental illness and substance abuse. The results of the PACT screening determine whether they need a full mental health assessment. During the 2011-12 school year, 4,201 juvenile arrests were made (476 in school; 3,725 out of school). A total of 3,278 PACT screenings were conducted and 2,140 youths (65%) were directed to have a full assessment.

The Juvenile Assessment Center in Jacksonville has just one assessor. In 2007, there were five assessors. The lone assessor can see only 35 percent of the arrested youth needing a full assessment, so the remaining youth fall through the cracks and may never get the diagnosis and referral needed to address their mental health problems. While a $400,000 three-year reinvestment grant (2014-16) from the Department of Children and Families in Tallahassee will provide the funding for three additional assessors, it is anticipated there still will not be enough assessors to fill the ongoing need.

Research indicates if arrested youths are reached before they appear in court (approximately 21 days), there is a better chance of getting families engaged and connected with services that should lead to more diversion away from the juvenile justice system. Having more assessors will speed the process.

Medication Management

There is no consistent communication system among providers for medication management, which can lead to medication complications. Individuals with severe mental illnesses often see a variety of providers in multiple settings (psychiatrist's office, hospital psychiatric ward, emergency room, jail, etc.). A thorough medication history is necessary, but often difficult to obtain due to multiple providers and/or the individuals' lack of knowledge regarding their medications. The possible interaction effects of psychotropic medications with medications from many chronic medical conditions can have serious consequences for the individual.

In many instances, medications are changed before doctors know what works. This is exacerbated by multiple commitments in different facilities with different psychiatrists who do not have the mechanisms to find out about previously prescribed medications. Medication dosages and different types of medication can take long periods (sometimes several weeks) for an individual to adjust.

"I lived through years of trying to find the right treatment and medication," said resource speaker Wes Evans. "I would start one medication, and then arrive at a different facility only to be placed on another. Before one was allowed to work, I would be prescribed something else."

"The medications are often worse than the illness itself," added resource speaker John Boggs. "One hospital prescribes one thing, a crisis center prescribes another, and the psychiatrist at the local jail something else. No one knows what each other are doing, and the side effects can be horrible."

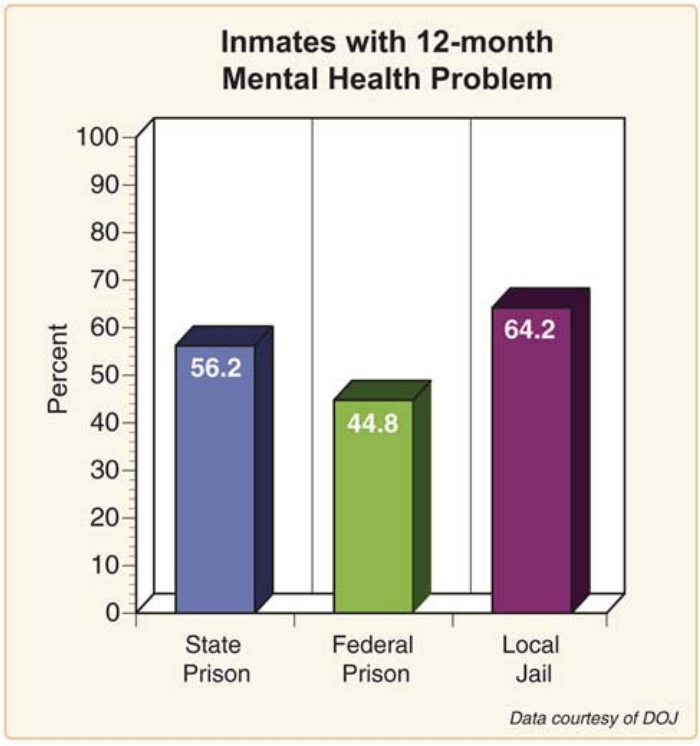
Recent improvements in the communication of medication management among providers give cause for optimism in the years ahead. The development of electronic medical records allows providers to share medication records that were not previously possible.

Even when an effective drug is prescribed, getting the individual to adhere to his medication schedule is another challenge altogether. Transitioning between medications can be costly and can impact the willingness of an individual to be compliant with taking medication. Involuntary Outpatient Treatment is court-ordered treatment for individuals with mental illness who have a history of not following their medication schedules, but it is not used in Duval County.

"Getting my son to take his medications regularly is always an issue because he doesn't believe there is anything wrong with him," explained Boggs.

Incarceration

Many individuals with a severe mental illness who would have been institutionalized in previous decades eventually interact with the criminal justice system, which now serves as the largest provider of mental health services for those with severe and persistent mental illness in most communities across the country, including Jacksonville. The interactions are most frequently non-violent in nature (e.g., trespassing, vagrancy, etc.), but result in repeated arrests and incarcerations for persons unable to receive adequate mental health care in the community.



Deinstitutionalization was supposed to be replaced with a vigorous community-based mental health system. This system was never adequately developed, resulting in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems and leaves enormous gaps in treatment and disparities in access to care.

With mental health providers and services in short supply, the jails and prisons have become the default system for those who have no other options. It is not a role the criminal justice system was ever intended to fill, and it is not equipped to adequately provide mental health services. As a result, the needs of incarcerated persons with mental illness stand in direct contrast to the culture found in jails and prisons.

"A jail is not a therapeutic community," said Jacksonville Sheriff John Rutherford. "It's never going to be, and it can't be. Our priority needs to be diverting people with mental illnesses away from the criminal justice system. That's a challenge because adequate community services have never materialized, and now too many people with severe mental illnesses get their treatment in jail," he added.

As Nicholas Kristof of the New York Times observed in a February 8, 2014 column, "Psychiatric disorders are the only kind of sickness that we as a society regularly respond to not with sympathy but with handcuffs and incarceration."

Data from a 2004 Department of Justice survey of inmates in state and federal correctional facilities indicated that nearly two-thirds (64.2%) of jail inmates satisfied the criteria for a mental health problem (i.e., received a clinical

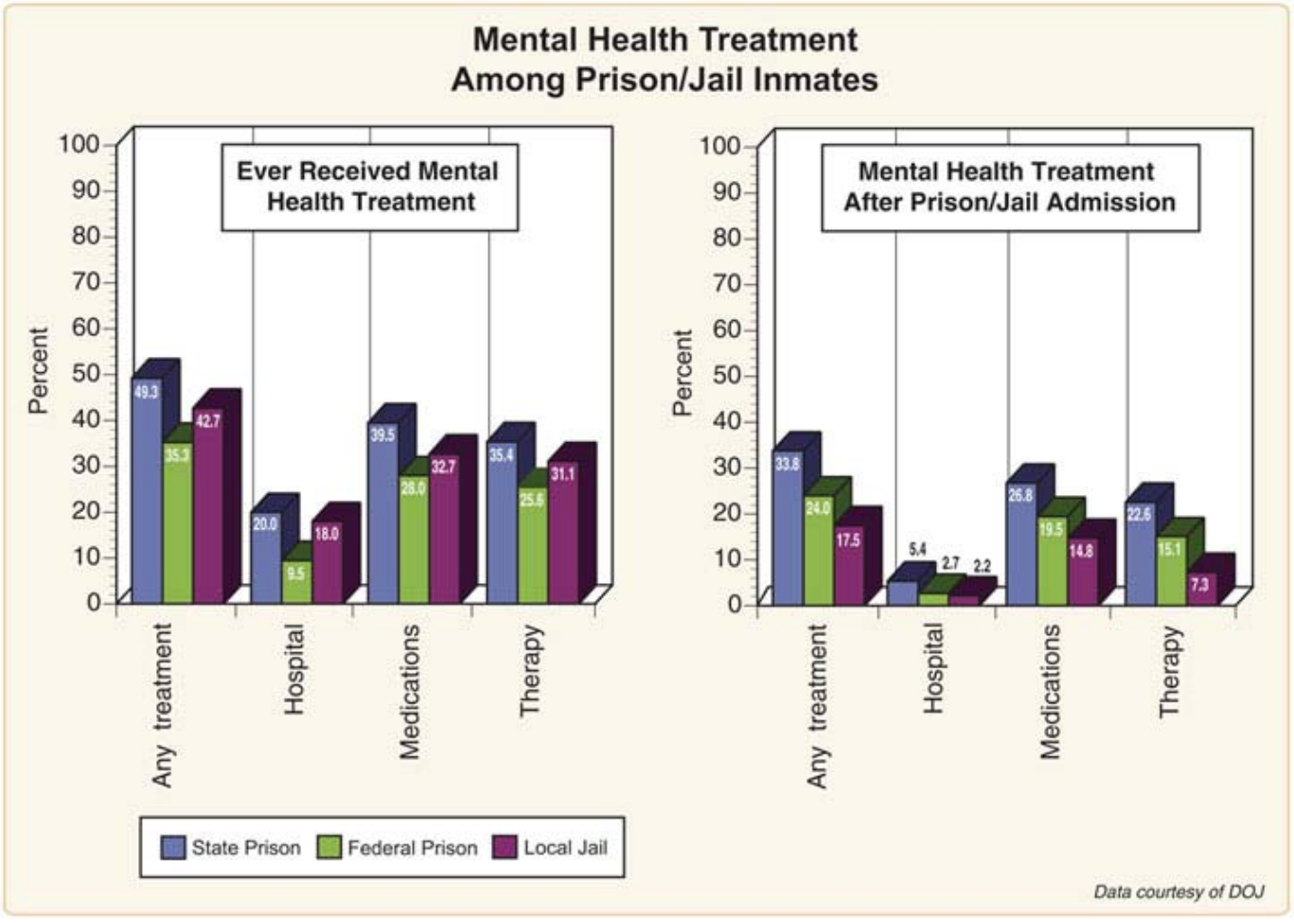
diagnosis or treatment by a mental health professional) currently or in the previous year. In state prisons, the percentage was 56.2, and in federal prisons 44.8.[29]

Florida's sheriffs and police chiefs say that each year 125,000 people needing mental health treatment are arrested and booked into the state's jails.[30] Locally, approximately 10 percent (300) of the 3,000 or so inmates in the Duval County jail on any given day have a severe and persistent mental illness requiring psychiatric attention and/or psychotropic drug treatment, according to Sheriff Rutherford. That figure does not include those inmates with less severe mental illnesses.

Over the last three years, a total of 32,988 calls were made to JSO from persons with mental illnesses or from citizens seeking assistance for a friend or family member in a mental health crisis. These calls involved 21,428 different individuals, demonstrating the large rate of recidivism involving those with mental illnesses. Contact was made on behalf of one individual 83 separate times, and eleven people had 30 or more contacts. About one-third of mental health-related calls were resolved and required no further police follow-up.

The Sheriff noted that in some cases, a referral to a social services agency is made; in others, the person is simply returned to family or friends; and more frequently an officer is able to reduce tension by calming the situation. If police action is required, the majority of individuals are taken to a crisis stabilization unit (mental health receiving facility or medical facility) through use of the Baker Act. In calls specifically related to mental health, only 2.3 percent result in the individual being taken to jail. All JSO officers receive 40 hours of Crisis Intervention Team (CIT) training which instructs them in how to deal with individuals with mental illness and helps change stigmatized attitudes.

Recidivism is largely a result of the fact that people with mental illnesses aren't receiving adequate treatment services from the community outside of jail, so many are cycled back through the criminal justice system. Sheriff Rutherford explained that without adequate support and care, the likelihood of re-arrest upon release from jail is nearly 100 percent. Once released from custody and back on the street, many people with mental illness revert to self-medicating substance abuse, hastening their return to jail.



Prisons and jails are significantly understaffed with psychiatrists and other mental health professionals and are simply unequipped to provide the care required by this unique population. The Duval County jail has one part-time psychiatrist, a psychiatric advanced registered nurse practitioner (ARNP), and five mental health counselors.

The same Department of Justice survey referred to above indicated that fewer than half of inmates with mental health problems have ever received treatment and a third or fewer received mental health treatment after incarceration. Rates differ depending upon the type of correctional facility.

Employment

The biggest challenge according to two resource speakers is getting a job once you have been labeled with a mental health issue, particularly if you have a criminal record associated with it. Some fail to seek treatment for mental illnesses in the first place because of their fear of repercussions from their employers.

For those living with a severe mental illness, the potential risk of job loss is high, often resulting not only in loss of income, but also elimination of health insurance benefits, which results in a reliance on hospital emergency departments for health care. Homelessness and poverty are frequently part of the cycle, making it even more difficult to find self-sustaining employment.

Employers are often unwilling to hire individuals with an arrest record. NAMI reports that persons with severe mental illnesses rarely succeed in obtaining a job despite the fact they want to work. More than 85 percent of individuals with severe mental illnesses are unemployed.[31]

"Employers are afraid you'll wig out on the job, so they are reluctant to consider hiring you," said resource speaker Vivian Lanham.

"Employment is very important to recovery," added Wes Evans. Being labeled as a criminal has a lasting effect and adds to the already significant challenge individuals with mental illnesses face in finding someone who will consider hiring them.

People who are diagnosed with a mental illness and are willing to share this information with a current or prospective employer are offered protection from discrimination under the Americans with Disabilities Act (ADA). Title I of the Act prohibits discrimination in employment and is intended to protect people who are applying for a job, as well as after they are hired. Central to Title I is its requirement that employers provide "reasonable accommodations" in the hiring process and enable employees to perform the essential functions of their job. An employer may not ask a job applicant to take a medical examination before making a job offer, nor make any pre-employment inquiry about a disability or the nature or severity of a disability. While the ADA does provide recourse for those suffering discrimination, the stigma that might result from sharing one's diagnosis, plus the pursuit of a discrimination case, could be costly personally and financially.

Resource speaker Nancy Fudge Sweatland experienced an employment story with a different twist. Her mental illness resulted in numerous stints in psychiatric hospitals and eventually homelessness. While searching for a job, she was approved for Social Security Disability (SSI) coverage, which a counselor advised her to accept. "You're better off living on disability insurance than working, so quit looking for a job," she was told. "Did she really think that was going to help me recover?" Nancy questioned.

Loss of Family, Poverty, and Homelessness

After years of living with mental illness, individuals often lose their support systems due to the stress placed on relatives and friends, cost of care, and uncertain diagnoses. These issues often lead to divorce, losing custody of one's children, poverty, and homelessness.

"After losing my family, I was basically homeless," explained Nancy Fudge Sweatland. "I lived in a halfway house followed by supportive housing which helped me become more stable."

Mental illness and poverty interact in a negative cycle, in which poverty acts as a risk factor for mental illness, and mental illness increases the risk that individuals will drift into or remain in poverty. This negative cycle also may contribute to high rates of homelessness among individuals with mental illness. The Substance Abuse and Mental

Health Services Administration (SAMHSA) estimates that 20 to 25 percent of the U.S. homeless population suffers from severe mental illness, while only four percent of the general U.S. population is severely mentally ill.

The Urban Institute estimates that 31% of homeless adults have a combination of a mental illness and addiction disorder. SAMHSA statistics indicate the following about people who are homeless:

- About 50 percent have co-occurring substance use problems
- Over 60 percent have experienced lifetime mental health problems.[32]

When deinstitutionalization took place in the 1960's and 1970's, there was a commonly-held expectation that affordable, alternative housing would be made available for those who previously would have been permanently committed to psychiatric hospitals. This never occurred, and when coupled with reduced federal support for low-income housing subsidies in the 1980's, the result was a burgeoning homeless population. In Northeast Florida, there were 4,252 homeless persons in 2012, and of those, 2,533 lived in Duval County.[33]

Short-Term and Long-Term Hospitalization

Short-term hospitalizations in psychiatric hospitals, psychiatric units, and Crisis Stabilization Units (CSUs) are one component in the treatment of mental illnesses. The average length of stay of these hospitalizations varies among different facilities, but typically ranges from three to 14 days. These brief hospitalizations usually occur in emergency situations and the primary goal is to help the individuals recover their previous level of functioning by lessening symptoms. Services provided include a comprehensive diagnostic evaluation, initiating or adjusting medications, and developing a plan for follow-up treatment after discharge.

When short-term hospitalization is not effective in lessening the symptoms sufficiently to enable the individuals to return home and live successfully in the community, long-term hospitalization is required. For residents of the greater Jacksonville area, extended inpatient care is provided by Northeast Florida State Hospital (NEFSH) in Macclenny. Although individuals can be admitted to NEFSH on a voluntary basis, most are admitted involuntarily as a result of a judicial commitment process.

The Florida Mental Health Act (Baker Act)

In some situations, individuals may be incapable of making their own decisions regarding hospitalization. Since 1971, Florida has provided for such situations through the Baker Act which allows for the involuntary hospitalization and examination of an individual. It can be initiated by judges, law enforcement officials, physicians, or mental health professionals. In 2012, there were a record 157,352 involuntary exam initiations in the state of Florida. Of those, 49.8% were initiated by law enforcement personnel, 48.1% by mental health professionals, and 2.1% by judges. There were 6,751 involuntary examinations in Duval County alone, up from 4,458 in 1999.

To be admitted to a Baker Act receiving facility, there must be evidence that, due to a mental illness, the individual is a danger to himself/herself or others, or is unable to care for himself or herself. Involuntary examinations may last up to 72 hours (unless extended by the court) and occur in over 100 Florida Department of Children and Families-designated receiving facilities statewide. The primary intent of the Baker Act is to enable families to receive emergency mental health services and provide temporary detentions for people who are impaired because of their mental illness, and who are unable to determine their needs for treatment.[34]

Very few of those brought to a Receiving Facility under the Baker Act ever go before a judge for a commitment ruling because they consent to voluntary treatment shortly after arriving at the receiving facility. If they do not convert to voluntary status but still require inpatient treatment after 72 hours has elapsed, then a petition must be filed with the court in order to continue involuntary inpatient treatment in the Baker Act receiving facility. For those individuals who do not stabilize while in the receiving facility, and therefore require long-term hospitalization, the receiving facility must file a petition with the court to commit the individual to the state hospital. It can sometimes take several weeks for the judicial process to be completed. The court's ruling options include: (a) discharge back into the community; (b) involuntary inpatient treatment in the state psychiatric hospital; or (c) involuntary outpatient commitment, which is hardly ever used in Duval County.

Since the Baker Act involves involuntary institutionalization, it can be a source of controversy. People are sometimes hospitalized who should not be, presumably in the interest of protecting public safety. In some cases, family members of hospitalized individuals complain they were not notified of their relative's hospitalization. However, due to confidentiality laws, psychiatric hospitals and CSUs cannot inform family members of an adult's hospitalization unless the patient signs a release of information allowing this communication.

The Baker Act can also be misused by individuals desperate to get their basic needs met. For example, a homeless individual may tell a police officer that he or she is going to commit suicide in order to be taken to a receiving facility where a bed and hot meals will be provided.

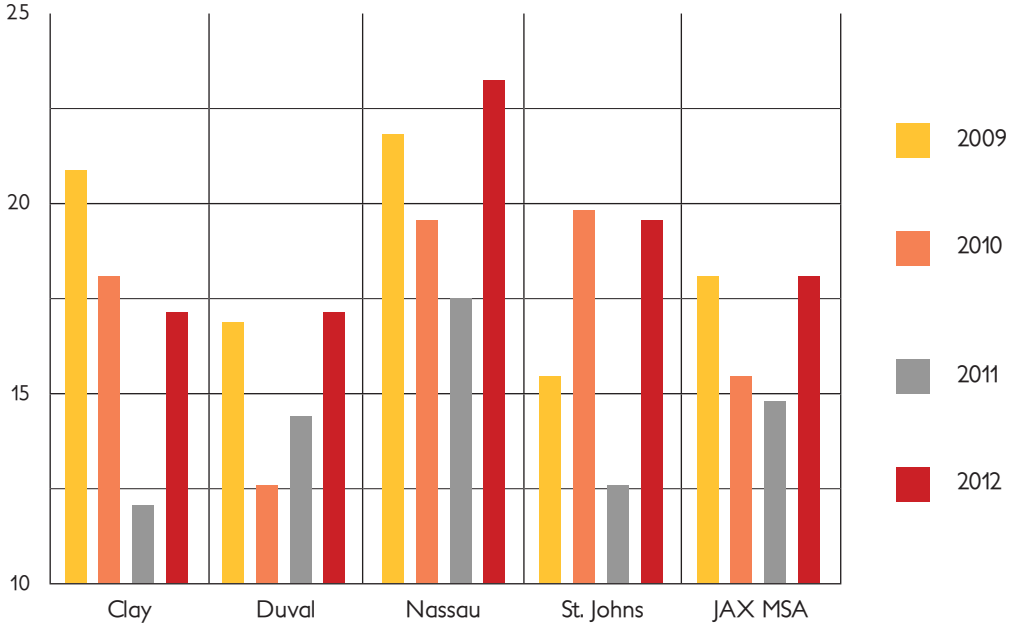
Suicide

For some individuals who live with the burden of severe mental illness, suicide is the final outcome. It is the tenth-leading cause of death in the US and the third-leading cause for ages 15-24; suicide is almost always the result of untreated or under-treated mental illnesses. In Duval County, the suicide rate in 2012 was 17.1 per 100,000 population, the highest since 1991, and the Northeast Florida region experienced a 13.2 percent increase over the five-year period 2008-12 (approximately 15.9 in 2008; 18.0 in 2012). According to Duval County's Youth Risk Behavior Survey 2013, 21.5 percent of middle school students have "thought seriously of killing themselves".

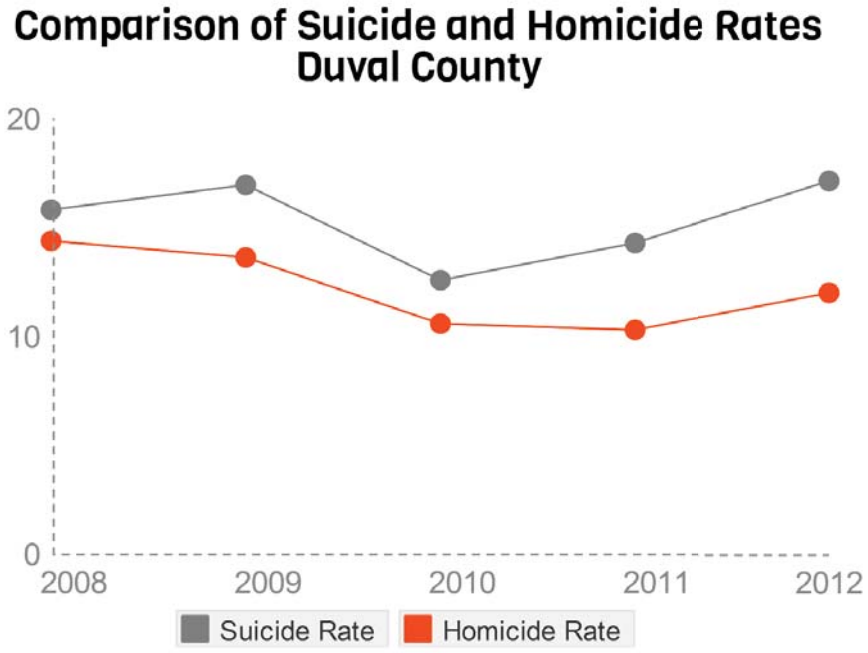
Suicide rates among the elderly are higher than all population groups in Northeast Florida. Over the same five-year period the suicide rate for people age 65 and above increased approximately 33.6 percent from 15.2 per 100,000 in 2008 to 20.3 in 2012. The percentage increase was even higher among youths ages 10-19 where the rate for the region rose by about 126 percent during the same time period (2.7 in 2008; 6.1 in 2012).

Emphasizing the severity of the local suicide problem, more people in Duval County die by suicide than by homicide. There were 94 murders in Northeast Florida in 2012 and 151 suicides.

Suicide Rates (per 100,000 people)



Source: Florida Charts



More people in Duval County die by suicide than homicide.

Note: Rates are age-adjusted per 100,000 population.

Source: Florida Charts, Florida Death Rate Query System; www.floridacharts.com

CONSEQUENCES OF MENTAL ILLNESS FOR FAMILIES

The consequences of mental illness are not confined to the person living with the illness. Family members and caregivers are impacted as well. For those families who have experienced living with and caring for a person with a severe mental illness, words like indescribable, bizarre, agonizing and heartbreaking are very familiar.

The stress associated with caring for a person with mental illness is constant and has a cumulative effect on family members, often impacting their own physical, emotional, and financial health. The demands of providing care make it difficult, if not impossible, to hold down a full-time job, which can lead to reduced income and increased risk of poverty. Divorces are common, and money management is almost always an issue since health insurance is rarely enough to cover the high costs of care. Siblings can experience their own mental health issues because they feel neglected or obligated to help care for a brother or sister. Caregivers also frequently experience social isolation from friends because of their family member's mental illness.

"The worse my son's illness became, the harder it was to know what to do," said John Boggs. "Life in our home became one of walking on eggshells. I've had to deal with my own depression because of the experiences I've had with my son."

For Wes Evans, his personal recollections are that his parents were loving and well-meaning, but they simply did not know what to do. "They weren't ready to receive me when I would be released from the hospital or jail," he said. "They didn't know how to deal with it, or what questions to ask."

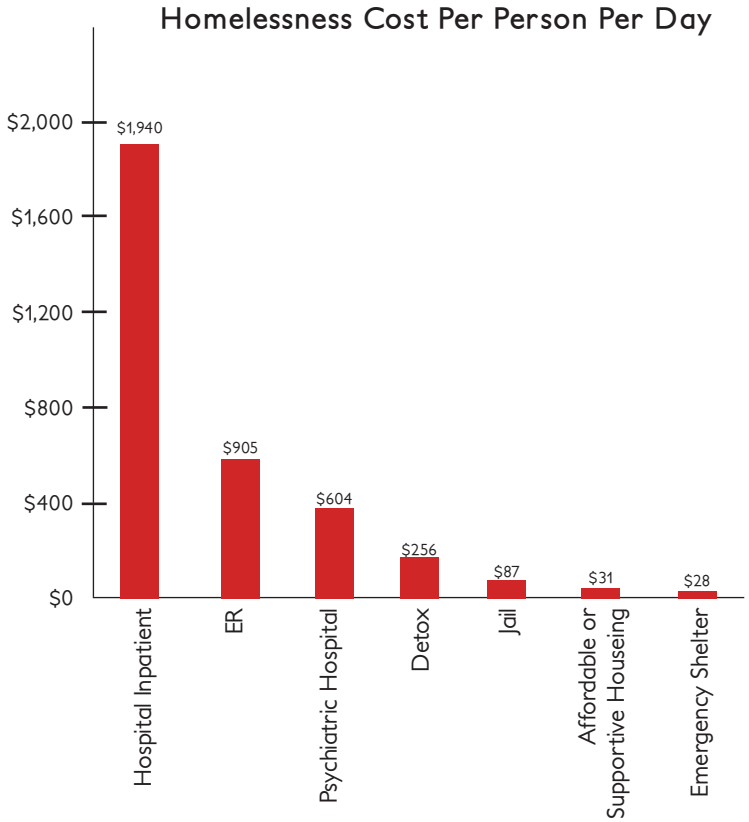
CONSEQUENCES OF MENTAL ILLNESS FOR COMMUNITIES

Direct costs associated with the treatment of mental illnesses include medication, clinic visits, and hospitalization, but these costs are only a small portion of the economic burden these illnesses place on an entire community.

Indirect Costs: Some of the indirect costs include lost earning potential, costs associated with treating coexisting medical conditions, homelessness, and incarceration. These costs account for enormous expenses, but they are very difficult to quantify.

Housing instability involving persons with chronic mental illnesses is expensive to society because of the recurring cycle of emergency medical care, hospitalizations, and incarcerations. Permanent supportive housing is the linkage of affordable housing with individualized, voluntary support services (e.g., medical, food, clothing, etc.). This is an evidence-based practice that seeks to help people live more stable, productive lives. Permanent supportive housing is also highly cost-effective for persons requiring supports to obtain and maintain their housing; it is documented to provide significant cost savings to publicly-funded systems of care.

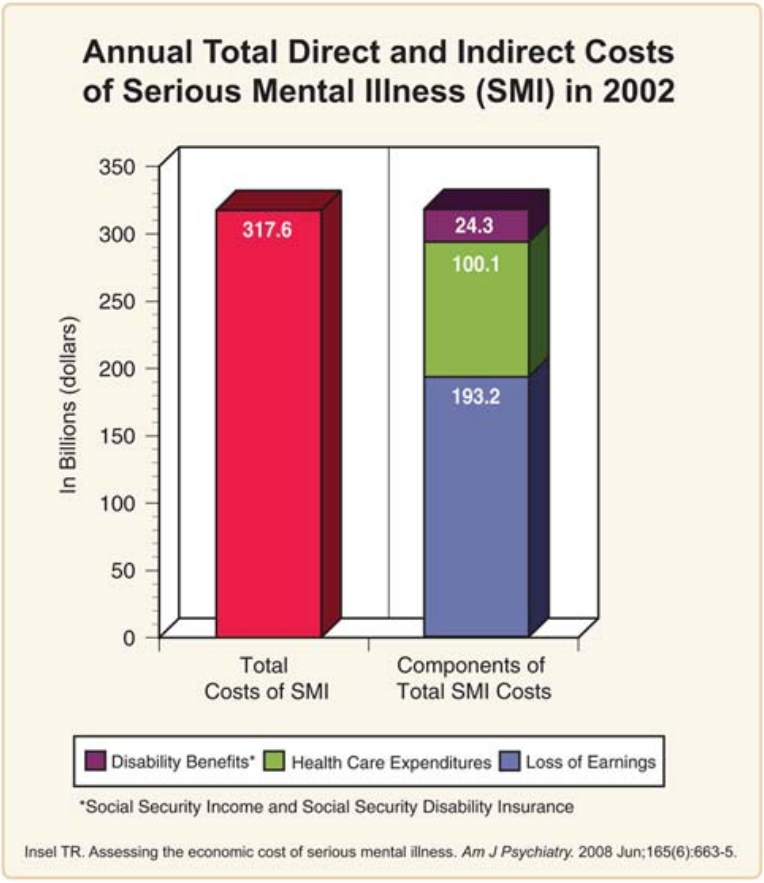
The cost to society of repeated incarceration – common among individuals with severe mental illness - is also high. Every booking into Duval County Jail costs $764, and the daily cost of incarceration for those without mental illnesses is $60 per inmate. Jacksonville Sheriff's Office is also responsible for the cost of medications for its inmates. Since inmates with mental illnesses require not only mental health services, but also increased medical services and more intensive supervision, the cost per day to incarcerate these individuals is higher than the average.



Source: U.S. Interagency Council on Homelessness

Source: "The Cost of Not Caring: Nowhere to Go." USA Today. May 12, 2014.

Forensic commitments represent another aspect of the mental health landscape that result in a disproportionately high cost to society. These are commitments in forensic treatment facilities (there are five in Florida), resulting from defendants adjudicated to be incompetent to stand trial. Because of their mental illness, these defendants have been judged to be a danger to themselves or others, and they are involuntarily committed to highly secure but expensive forensic facilities. A 2010 report by the Florida Senate noted that the state spends more than $210 million annually - one third of all adult mental health dollars and two thirds of all state mental health hospital dollars –on 1,700 beds, serving roughly 3,000 individuals under forensic commitment.[35] Most of these individuals are receiving services for the purpose of restoring their competency to stand trial on criminal charges.



Serious mental illnesses (SMIs), which afflict about 4 percent of American adults, cost the U.S. a total of $317.6 billion in 2002, including $193.2 billion in lost earnings, according to a 2008 study authored by Ronald Kessler, a Harvard professor of health care policy. That amount doesn't account for other associated costs, like the cost of incarcerations. People suffering from a SMI earned at least 40 percent less than people in good mental health. "The results of this study confirm the belief that mental disorders contribute to enormous losses of human productivity," writes Kessler.

MAINTAINING MENTAL HEALTH AND TREATING MENTAL ILLNESS

The picture of when and how to address a mental health issue is not as clear as with other health problems. When someone breaks an arm or suffers from asthma, it is easy to see how the person's body is affected. There is little debate about the diagnosis or treatment. The individual with a mental health issue may understand the feeling of being mildly depressed, but the challenges of everyday life often produce those effects. It does not always mean the person has a diagnosable mental illness. So, it is often difficult for people to recognize the symptoms of mental illnesses. Even when people recognize that something is wrong, society expects them to "buck up" or "be tough" and handle the problem on their own. When individuals admit they need help dealing with a problem, it can be interpreted by that person and others as a character flaw or weakness. As a result, millions of people with mental health issues never seek a diagnosis, which can lead to chronic and sometimes severe consequences as documented in the previous section. For those who do seek help, the first step is obtaining a diagnosis from a medical professional.

Getting a Diagnosis

Diagnosing mental illness is more difficult than diagnosing other medical disorders because there are no definitive laboratory tests, scans, or biopsies for mental illness. Although recent technological advances involving brain imaging show promise, mental health professionals have to rely on the medical history and the symptoms exhibited by an individual. This can be particularly challenging when the individual exhibits the symptoms of more than one mental illness. In some cases, the symptoms of a mental illness can be misread or incompletely revealed, leading to an improper diagnosis and/or course of treatment.

While there are many entry points to the mental health care system, getting professional treatment often begins with a visit to a primary health care provider. As part of their overall focus on health and wellness, primary care physicians play an important role in identifying the signs of mental health issues in their patients. Primary care providers typically have a very cursory background and training in mental health, however, so their ability to effectively diagnose and treat mental illnesses is limited.

St. Vincent's Medical Center offers a local example of an attempt to bridge this gap. The hospital's residency program for family physicians incorporates training in psychiatry, including diagnosing and treating mild to moderate emotional illnesses. The residents also learn to diagnose more serious mental illnesses.

Referral to the appropriate mental health professional, usually a psychiatrist, psychologist, or psychiatric Advanced Registered Nurse Practitioner (ARNP) provides the patient with the next step along the path to identifying and treating his/her condition.

Other important mental health professionals who can treat mental illnesses include licensed mental health counselors (LMHC), licensed clinical social workers (LCSW), and licensed marriage and family therapists (LMFT). These professionals work in community mental health agencies, in private practice, as well as Baker Act receiving facilities. While they do not prescribe medication, they conduct group therapy, individual psychotherapy, and are trained in mental health emergency care.

Treating the Illness

Once diagnosed, there are many places to obtain treatment, and there are also many different types of treatment. Because the options are so numerous, they can be confusing and not generally understood by a person new to the system. Treating a mental illness involves more than taking a pill every morning and going about one's day. Treatment may include support groups, weekly outpatient therapy, and/or regular visits to a psychiatrist.

Keeping appointments can be a challenge because of the frequency required. Taking time off from work every week for personal appointments can threaten job security, and most mental health professionals, like other medical offices, maintain regular office hours – 9 am to 5 pm Monday through Friday.

Mental illnesses are of different types and degrees of severity. Some of the major types are depression, anxiety, schizophrenia, bipolar mood disorder, personality disorders, post traumatic stress disorder, and eating disorders. The most common mental illnesses are anxiety and depressive disorders. While everyone experiences strong feelings of tension, anxiety, or sadness at times, a mental illness is present when these feelings become so disturbing and overwhelming that people have difficulty coping with normal day-to-day activities.

A sampling of the different levels of treatment options available include:

- HOSPITALIZATION – Hospitalization is designed for the most severe cases requiring intensive 24/7 mental health treatment including observation, diagnosis, individual and group psychotherapy and medication management. Because inpatient care interrupts daily life and is expensive, most hospital stays are only long enough to resolve the most urgent issues, from a few days to a few weeks.
- PARTIAL HOSPITALIZATION – Partial hospitalization is intended to avert or reduce in-patient hospitalization and can be provided in either a hospital or a community mental health center. Typically, an individual lives at home and commutes to a treatment center several times a week.
- RESIDENTIAL TREATMENT – Residential treatment is appropriate for an individual whose mental illness is severe enough to warrant 24-hour monitoring and supervision but not in a hospital setting where the length of stay is usually too brief for a patient to develop the necessary skills and habits to function well. Residential facilities help residents establish normal, stabilizing routines.
- OUTPATIENT- These are services provided without being admitted to a hospital, and include evaluation, medication, group therapy, and individual counseling.
- INTENSIVE OUTPATIENT TREATMENT (IOP) - IOP is more intensive than traditional outpatient and is designed to achieve short-term stabilization and resolution of immediate problem areas. The person lives at home but receives services from a team of professionals typically 3-4 hours per day up to five days a week (minimum of nine hours per week).
- CASE MANAGEMENT- A person is assisted with finding a job, a place to live, and staying compliant with his or her treatment plan.

Because every individual's case is unique, personalized plans often involving combinations of treatment options are usually suggested by qualified mental health professionals. The best course of treatment is often a combination of psychotherapy and medication, according to local resource speakers. Self care should include getting enough sleep, regular exercise, and a healthy diet.

In addition to the traditional forms of treating mental illnesses (e.g., psychotherapy, drug therapy, behavioral therapy, electroconvulsive therapy, support groups, etc.), several other innovative methods were presented during the Inquiry process. These include:

- ASSERTIVE COMMUNITY TREATMENT (ACT) – Uses a multi-disciplinary approach to provide intensive services for those with severe and persistent mental illnesses where and when they need them – in their homes, at work, and in other community settings – 24 hours a day, seven days a week. ACT programs can be operated on a state, county, or local level by mental health centers, private non-profit or for-profit organizations, outpatient units of hospitals, managed care companies, and other providers.[36] In Florida, ACT programs are called FACT (Florida Assertive Community Treatment) and are primarily funded by Department of Children and Families (DCF). Sometimes referred to as the "hospital without walls," FACT is geared toward adults who have not been successfully treated in other outpatient programs and include persons who skip doctor appointments, are not compliant with their medication plans, or have repeated hospitalizations and/or arrests. Mental Health Resource Center operates two FACT teams in Jacksonville, each one comprised of 12 staff including a psychiatrist, three nurses, a licensed mental health professional, a substance abuse specialist, and a peer specialist. Each team serves 100 adults at any given time, and as discharges occur, new individuals are admitted.
- WRAPAROUND SERVICES - Individualized community-based services that focus on the strengths and needs of individuals with mental illness and their families. Wraparound is an intensive, holistic method of engaging with individuals with complex needs (typically children, youth, and their families) so they can live in their homes and communities and realize their hopes and dreams. Although Wraparound has been defined in different ways, it has primarily been described as an intensive,

individualized care planning and management process. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based (e.g., youth, families, therapists, clergy, etc) planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members.

- SELF-DIRECTED CARE - An increasingly popular alternative for people with mental illnesses is Self-Directed Care (SDC). The Florida SDC concept, started in Nassau County in 1998, is built on choice and self-determination. SDC allows individuals to take personal control of their recovery by giving them authority over life planning and associated personal budgets that are normally directly contracted to a public community mental health provider. Northeast Florida is one of only two areas in Florida that offer Self-Directed Care, and even here, there is only enough public funding to serve 200 individuals.
- ALTERNATIVE TREATMENT PRACTICES – While little evidence-based research has been done about the specific benefits of alternative health care practices experienced by those with mental illnesses, there is growing interest within the field. Some of the options for Alternative Treatment Practices include: religious/spiritual activities; meditation; massage; exercise; yoga; guided imagery; acupuncture; chiropractic; herbs; and nutritional supplements.
- ASSISTED OUTPATIENT TREATMENT (AOT) - Also called "outpatient commitment" and "involuntary outpatient treatment," AOT is court-ordered treatment (including medication) for individuals with severe mental illnesses who have a history of medication noncompliance, as a condition of their remaining in the community. Studies and data from states using AOT prove that it is effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance, while reducing caregiver stress. Florida is one of 45 states where state law permits AOT, but other than Seminole County, where it has had considerable success, most counties in the state (including Duval) do not use it.[37]
- MENTAL HEALTH COURT – In Jacksonville, an adult offender with a misdemeanor or specified non-violent felony who has a diagnosis of mental illness (e.g., bipolar disorder, schizophrenia, anxiety, etc.) is eligible for treatment services. Each eligible offender is assigned to a Peer Specialist and a Case Manager. The goals of Mental Health Court are to ensure the offenders' compliance with their treatment plans, and to effectively treat such individuals without labeling them with a criminal record.

Integration of Primary and Mental Health Care

A growing treatment strategy that much of the health care community agrees would improve both physical and mental health outcomes is the integration of primary care and mental health care, which the Substance Abuse and Mental Services Administration (SAMHSA) defines as the systematic coordination of general and behavioral healthcare.

The health care system has historically treated mental and physical health separately. This fragmentation is often costly, frustrating, and has not led to the best outcomes. This is changing, however, as the healthcare delivery system evolves in response to the Affordable Care Act. Resource speaker Chuck Ingoglia, Senior Vice President of the National Council for Behavioral Health, said the tipping point has now been reached and mental health is no longer viewed separately by many health care professionals. A healthy person is one with a healthy body and a healthy mind, and the integration concept recognizes that the two are inextricably linked.

Primary care physicians are not fully trained to diagnose or treat mental health problems, yet people with mental illnesses typically are seen in the primary care setting more frequently than any other. Mental health training for primary care physicians tends to be superficial, so they are often unprepared to deal with anything but the most basic mental health problems. According to resource speaker Dr. Elise Fallucco, a psychiatrist at Nemours Children's Clinic, pediatricians in Jacksonville average only about 2 ½ weeks of mental health training, including time spent during their three-year residency program. Connecting the primary care physician with a mental health professional is designed to overcome this.

Integration can be accomplished in different ways, including coordination between specialty behavioral health organizations and general medical providers; co-locating primary care practices within mental health practices (or vice versa); or capacity-building of primary care practices to include mental health units (or vice versa). The goals of integration are to reduce the fragmentation of health care; make more efficient use of the limited supply of mental health professionals; and improve health outcomes.

Co-locating a mental health professional within a primary care practice (i.e., embedding) is one approach to integration. Integration can serve to reduce stress on primary care providers, offers the patient more points of service, reduces patient wait times, and may lead to improved continued treatment.

Integrated health care is a central feature of many of the federal government's delivery system experiments being operated by the Center for Medicare and Medicaid Innovation. Additionally, many technological solutions are being implemented to support integrated care delivery from electronic health records, health information exchanges, and remote monitoring technologies.

Mr. Ingoglia provided an example of how modern technology is poised to play a significant role in supporting the integration of mental and physical health. A device called Health Buddy is being used in New Hampshire to help manage the care of a select group of patients who have been diagnosed with diabetes and schizophrenia. The device prompts patients to answer a series of questions throughout the day regarding their health, medications, and well-being. A nurse care manager monitors the inputs to determine whether some form of intervention is necessary, perhaps a phone call or a home visit.

It has been estimated that effective integration could save $26-$48 billion annually in the United States in general health costs.[38] Currently, integration is not a widespread reality, and although it appears inevitable, it will probably be years before the concept is broadly applied. Barriers that must be addressed include: problems with reimbursement of mental health services in the primary care setting; coordination and sharing of electronic medical records; limitations of HIPAA laws; scheduling of appointments; and lack of training of primary care physicians and psychiatrists in working as a primary care team.[39]

The Jacksonville System of Care Initiative (JSOCI), in collaboration with Nemours Children's Clinic, has introduced a promising Collaborative Care model emphasizing mental health training for primary care physicians. This program provides primary care doctors with specialized training in adolescent depression and suicide risk assessment. Doctors are trained to identify signs of depression and suicide risk, determine appropriate treatment, and know when and where to refer.

To date, 36 primary care physicians have received the training, and each one sees over 300 teens annually. Results show this training improves pediatrician confidence in screening for and diagnosing depression, discussing suicidal thoughts with patients, and treating depression with medication. The program is also designed to develop a network linking primary care physicians with psychiatrists, therapists, and other referral resources in the community.

In addition, Nemours and JSOCI have introduced a pilot Collaborative Care Consultation Clinic in which primary care physicians and psychiatrists form a partnership. Primary care providers can refer patients to a psychiatrist for a priority consultation, after which the patient returns to the primary care provider for treatment. The psychiatry consultation feature has improved access to a psychiatrist. Wait time has decreased from the typical two to four-plus months to two to four weeks. To expand the program from a pilot to a community-wide initiative, the project's lead, Dr. Elise Fallucco, said additional buy-in from primary care providers and psychiatrists will be necessary.

Baptist Health System has also identified four of their primary care offices in which psychologists or psychiatrists will be integrated to improve coordination of care between medical and mental health services. The impact is expected to benefit providers of care and consumers since it will make access to both primary medical and mental health services easier.

Baptist's Agewell Center currently uses an integrated model for senior citizens. An in-depth assessment is conducted over two visits considering all of the factors that can affect their health and wellness, including mental health. At the initial assessment, senior citizens and their families meet with a Geriatrician, along with other team members. They may include a clinical physical/occupational therapist, pharmacist, dietician, clinical nurse specialist, and care coordinator. There is a psychiatrist on site for "curbside consultations" with the team or referral for a comprehensive evaluation and treatment if indicated. Over the next week, the Geriatrician collaborates with the team and the senior citizen's primary care doctor to develop a personalized care plan. At a follow-up visit, the senior citizen receives a Health Passport that he or she takes to all subsequent medical appointments to help ensure that all health professionals refer to the same patient information, no matter where the patient is being cared for and treated.

Continuum of Mental Healt

Causes of mental illness range from environmental factors such as job loss or divorce to biological factor mental illness. Causes are provided as examples. In general, individuals will react to causes differently. D

Well | Emotional Problems or Concerns

Examples: *Mild distress • Occasional stress Generally happy* | *Loneliness • Mild depression Abandonment • Grief*

Prevention

WHAT
- healthy diet
- regular exercise
- relaxation
- rest
- social network
- education

WHO
- family physician/ pediatrician
- clergy
- coaches

WHERE
- gym
- home
- outdoors

Early Intervention

WHAT
- psychotherapy
- wellness check with primary care
- behavioral therapy
- crisis counseling
- case management
- support groups
- employee assistance program

WHO
- licensed therapist or social worker
- counselors
- family physician
- psychologist
- clergy
- family services agency
- school guidance counselor
- hotlines, such as 2-1-1
- case manager
- peer specialist

WHERE
- faith institution
- medical or therapist office
- workplace
- school
- community based organization

Health insurance may also be a pathway for treatment as insurance carriers may be able to direct you to a preferred provider.

h & Pathways to Well-being

s like genetics or brain chemistry. Psychological factors such as abuse and neglect also contribute to epending on the issue, there are various ways to get help and connect to treatment.

Mental Illness — Severe & Persistent Mental Illness

Mood disorder ♦ PTSD
Eating disorder

Bipolar disorder ♦ Dementia
Schizophrenia

Treatment

WHAT

- cognitive therapy
- crisis stabilization
- life skills training
- psychotherapy
- medication (drug therapy)
- evidence-based treatment
- residential treatment
- electroconvulsive therapy (ECT)
- assertive community treatment (ACT)
- assisted outpatient treatment (AOT)
- self-directed care (SDC)
- partial hospitalization

WHO

- psychiatrist
- psychologist
- licensed therapist or social worker
- psychiatric nurse
- primary care physician/ psychiatric consult

WHERE

- hospital, in-patient or out-patient
- rehabilitation & treatment facilities
- medical or therapist office
- community based organization

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

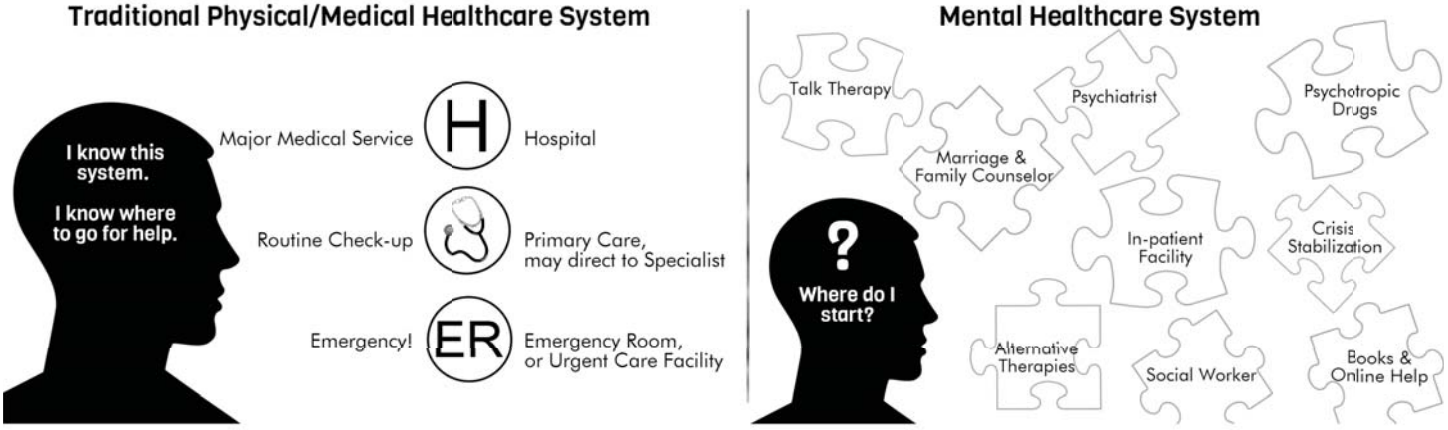
There is little question that access to mental health care in this country has historically been - and remains - very challenging. That is true for people at every socio-economic level, not just the economically disadvantaged or those without health insurance.

Complex System

The complexity of the mental health system is a significant impediment to accessing care. The system is multi-faceted, fragmented and generally not familiar to most people. Because there are multiple approaches and disciplines, people seeking care often do not know where to go. "There is an art to navigating the system, and unless you are familiar with it, it can be very daunting," said Jacksonville psychologist Dr. Whitney George. "People in crisis do not have time to wade through the system and need to know where to turn for services."

Because there are a wide variety of approaches to care, there is sometimes disagreement on which is the most effective and/or efficient. Due to shortages of mental health hospital facilities and psychiatrists, a significant responsibility for mental health care is shouldered by the social services sector and the primary care system.

There is also a general lack of understanding about the services that licensed mental health professionals provide and where to find them. Many people are not aware of the types of services available and which professionals provide what. Notably, there is no one place to access information about services. It is challenging for someone who is not a mental health insider to know whether he or she needs a psychiatrist, clinical psychologist, licensed clinical social worker, licensed mental health counselor, certified addictions professional, psychiatric nurse practitioner, marriage and family therapist, or pastoral counselor. Each of these providers plays a role in the mental health arena, but the differences in the services they provide are not commonly understood.



Too Few Mental Health Professionals

Access to mental health care is hindered by a shortage in the number of mental health professionals (psychiatrists, psychologists, mental health counselors, etc.), particularly for the poor living in rural areas.

The Federal government designates "Mental Health Professional Shortage Areas" (MHPSAs) where there is only one psychiatrist for every 30,000 people or more. In 2010, 89.3 million Americans lived in MHPSAs, eighty-five percent of whom resided in rural areas. By comparison, 55.3 million Americans lived in "Primary Care Shortage Areas." In Northeast Florida, three counties have designated MHPSAs (Baker, Duval, and St. Johns). While precise statistics are not available, it is estimated that Florida has about 2,100 psychiatrists to serve a population of 19.3 million, or

approximately one for every 9,200 residents.[40] For children and adolescents under the age of 18, the situation is even worse: there are only seven child psychiatrists in the State of Florida for every 100,000 kids, according to Dr. Elise Fallucco. As a result, many child psychiatrists are not accepting any new patients, and long waiting lists of up to eight months are common.

With too few psychiatrists already an issue nationwide, the long-term trend is not encouraging. The American Psychiatric Association (APA) reports that over half of the psychiatrists in the United States are over the age of 55 and nearing retirement. Psychiatrists are also among the lowest paid of all physician groups. Limited pay in comparison to other doctors, plus debt burden incurred during medical school, results in too few medical students gravitating toward psychiatry.

Since there is a shortage of available mental health providers, waiting lists for services in Northeast Florida can often range from one to several months. Highlighting the shortage of mental health professionals is the fact that 2014 is the first year Jacksonville has ever had a psychiatric residency program (UF Health Jacksonville). Since doctors often settle in the places where they completed their residencies, Jacksonville has not previously been top-of-mind for psychiatrists. Even nationally, the number of psychiatric residency slots has remained flat over the last 20 years or so, while the demand for services has grown significantly.

To help address issues resulting from the shortage of psychiatrists, several options were brought to the attention of the Inquiry Committee, including: expansion of the collaborative care model; greater use of psychiatric advanced registered nurse practitioners; and wider use of telepsychiatry, in which mental health professionals treat patients via a secure video link without being in the same location.

Not Enough Psychiatric Hospital Beds

Access to mental health services is also impacted by a shortage of long-term state inpatient psychiatric hospital beds, which have been systematically reduced in number in recent years as a result of the deinstitutionalization movement. A 2005 report by the Treatment Advocacy Center noted that 95% of the psychiatric beds available in 1955 (before deinstitutionalization) were no longer available in 2005. In 1955, there were 340 public psychiatric beds available per 100,000 population; in 2005, there were 17. The same report characterized Florida's psychiatric bed shortage as "severe" since there were only 12.1 beds per 100,000 population in 2005. While the national trend of reducing psychiatric beds continues, some recent progress has been realized in Northeast Florida, but it has been confined to for-profit facilities. During the past year, at least four such facilities have added beds to their inpatient programs (i.e., Memorial Hospital – 40 beds added; Wekiva Springs – 40 beds; Orange Park Medical Center – 26; and Riverpoint Behavioral Health– 26).

An example of underfunded mental health facilities is UF Health Jacksonville, our city's safety-net hospital serving the indigent population. The facility has received $23.8 million in annual funding for all services from the City of Jacksonville every year since 2002, but since the City's payment has been fixed, the hospital has not been able to keep pace with rising costs of medical care over that period. The hospital's psychiatric department is responsible for providing no-cost mental health services to the 10,000 or so annually who arrive at UF Health with no health insurance or ability to pay for services. The department receives a total of $60,000 per year of the $23.8 million, or $6 per patient per year. As a result, only those patients with the most severe mental illnesses receive any treatment, and there is a waiting list of at least three months for those requiring non-urgent care.

Transportation

Transportation plays a vital role in enabling access to health care. Yet for many people, it is a major barrier adversely impacting their ability to receive the health care they need. The best mental health services cannot be effective if people are not able to get to them.

For people living in rural areas that have the largest shortages of mental health professionals, merely finding a psychiatrist within a reasonable distance is often a challenge, even if they have a car. In addition, public transportation is usually scarce in such areas, making it difficult to travel more than a short distance to access care. In fact, Nassau County has no public transportation system at all.

For people of low socioeconomic standing, spending money on transportation to access mental health services is often cost-prohibitive. Instead of trips to healthcare facilities, they spend their limited funds on housing, food and other essential bills. Missed or delayed appointments with mental health professionals can be the result. However, Medicaid will provide transportation to medical appointments for its beneficiaries.

For a growing number of senior citizens who have reached the stage in their lives when they require more health services, viable transportation options are not always available, particularly if they have a mental or physical disability.

Communications

The Health Insurance Portability and Accountability Act (HIPAA) was passed by the U.S. Congress in 1996. HIPAA's privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. As was noted repeatedly during the Inquiry, HIPAA and other laws designed to assist people living with mental illness, by ensuring the confidentiality of health information related to their illness, can become an impediment to effective communication between mental health professionals and family members.

In complying with HIPAA, doctors typically cannot talk to family members unless the patient gives permission, making it difficult for family to understand what is happening and how to provide assistance. This dilemma is particularly noteworthy for families of children who are 18 and may still be in high school and dependent on their parents. Unless the young person gives permission, the parents have no legal right to find out what is happening with their child's health care. Families can overcome this by a power of attorney or appointing a health care surrogate, but hiring an attorney to handle these procedures is not always an option for families with limited income.

Another communications issue involves the civil rights of individuals with mental illness who, by statute, can refuse the treatment they may desperately need. Unless patients are obviously an imminent threat to themselves or others, mental health professionals are not permitted to force treatment without consent, even if individuals are in no condition to understand the implications of their decisions, and even if their doctors know it is critical.

Cost of Services

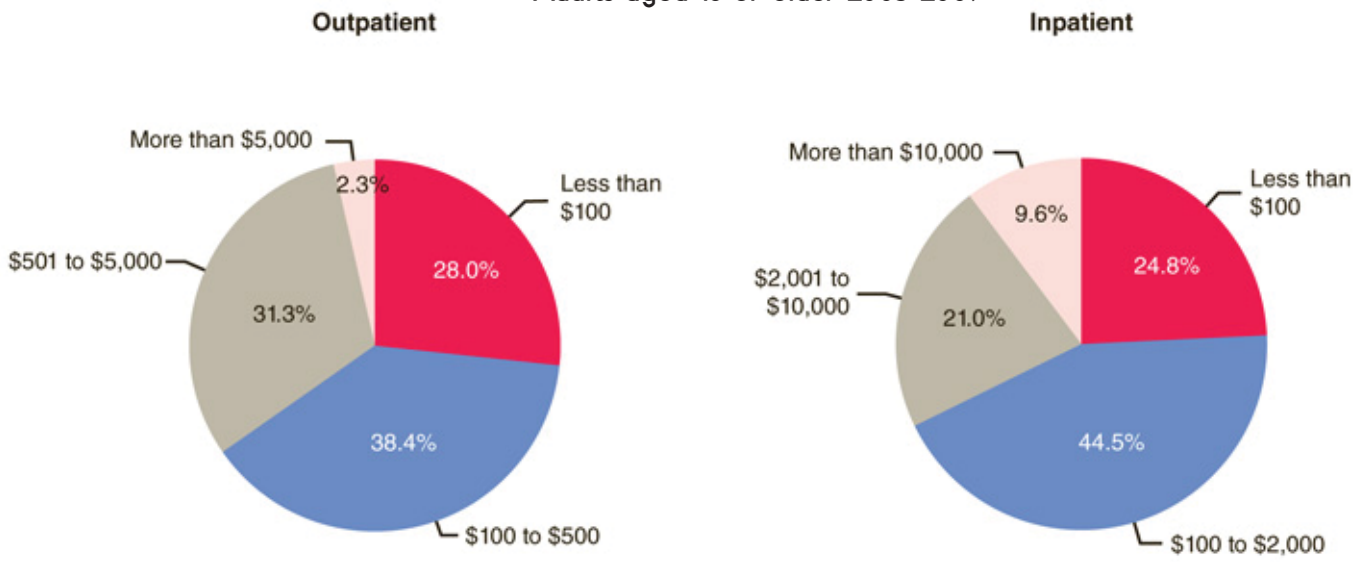
Affordability of mental health services is also a major issue impacting access. Surveys conducted by SAMHSA from 2005 through 2009 found that over 45 percent of those needing mental health services who went untreated cited cost as a barrier. For the 15.7 million Americans who received treatment, one-fourth listed themselves as the primary payer for the services. This is due, in part, to the fact that some forms of health insurance (notably Medicaid and Medicare) are not universally accepted by many psychiatrists, often forcing patients to pay for services out-of-pocket.[41] Locally, there are 135 psychiatrists located within a 25 mile radius of Jacksonville – 134 (99%) accept some form of insurance (primarily Aetna, Blue Cross, Cigna, and Humana); but only forty-four of the psychiatrists listed accept Medicaid (33%); and 73 accept Medicare (54%).[42]

Because most treatment for mental illness extends over a lengthy period of time, costs accumulate quickly. Denise Marzullo (MHA of Northeast Florida) said that the cost of short-term residential care is out of reach for most families, and outpatient therapy can also be a costly form of treatment because of its recurring nature, usually requiring one visit a week.

As the SAMHSA chart below indicates, nearly 70 percent of individuals receiving outpatient mental health services paid between $100 and $5,000 in out-of-pocket expenses. For those receiving inpatient services, 65.5 percent had out-of-pocket expenses of $100 or more, and 21 percent of them paid between $2,000 and $10,000. For those in need of recurring mental health services which are normally required, these costs can be prohibitive.

Out-of-Pocket Costs for Medical Health Services

Adults aged 18 or older 2005-2009



Note: Percentages do not add to 100 percent due to rounding.

* Outpatient mental health services is defined as having received outpatient care for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Estimates were based only on responses to items in the Adult Mental Health Service Utilization module.

** Inpatient mental health services is defined as having received inpatient care for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Estimates were based only on responses to items in the Adult Mental Health Service Utilization module.

Source: 2005 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

Health Insurance

Health Insurance in this country has historically covered mental health in a more limited fashion than primary health care. With recent federal legislation, the picture is finally improving. New rules recently applied to the 2008 Mental Health Parity and Addiction Act are designed to ensure that doctors and insurers treat mental and physical illness on equal footing in the future. While the 2008 legislation was ground-breaking in some ways, its impact was limited because the Act did not require employers to offer mental health or substance abuse disorder benefits, only that if they are offered they must be offered on par with medical/surgical benefits.

The Affordable Care Act, which took effect January 1, 2014, requires that all new individual and small group insurance policies must provide a number of essential health benefits including mental health and substance abuse services such as individual counseling, psychotherapy, and mental health screenings. As a result, mental health and substance abuse benefits will be more generous than they have been in the past, and affordable coverage will be available to more people. People with pre-existing mental conditions will no longer be denied coverage, and a mental illness diagnosis will no longer trigger a potential loss of coverage.

"The inclusion of mental health in the Affordable Care Act (ACA) is a huge win," said Inquiry resource speaker Jason Altmire, Senior Vice President, Public Policy and Community Engagement for Florida Blue. "Millions of people who were previously uninsured will now get health coverage, and it will include mental health benefits."

"The ACA did an excellent job of addressing coverage, but it could have done better at addressing costs and quality," he added.

Three gaps in the ACA in regard to mental health coverage include:

a. The Act only applies to individual and small group insurance plans. It does not include large group plans which cover millions of people across the country.

b. It does not account for the acute shortage of mental health professionals and providers, already a significant

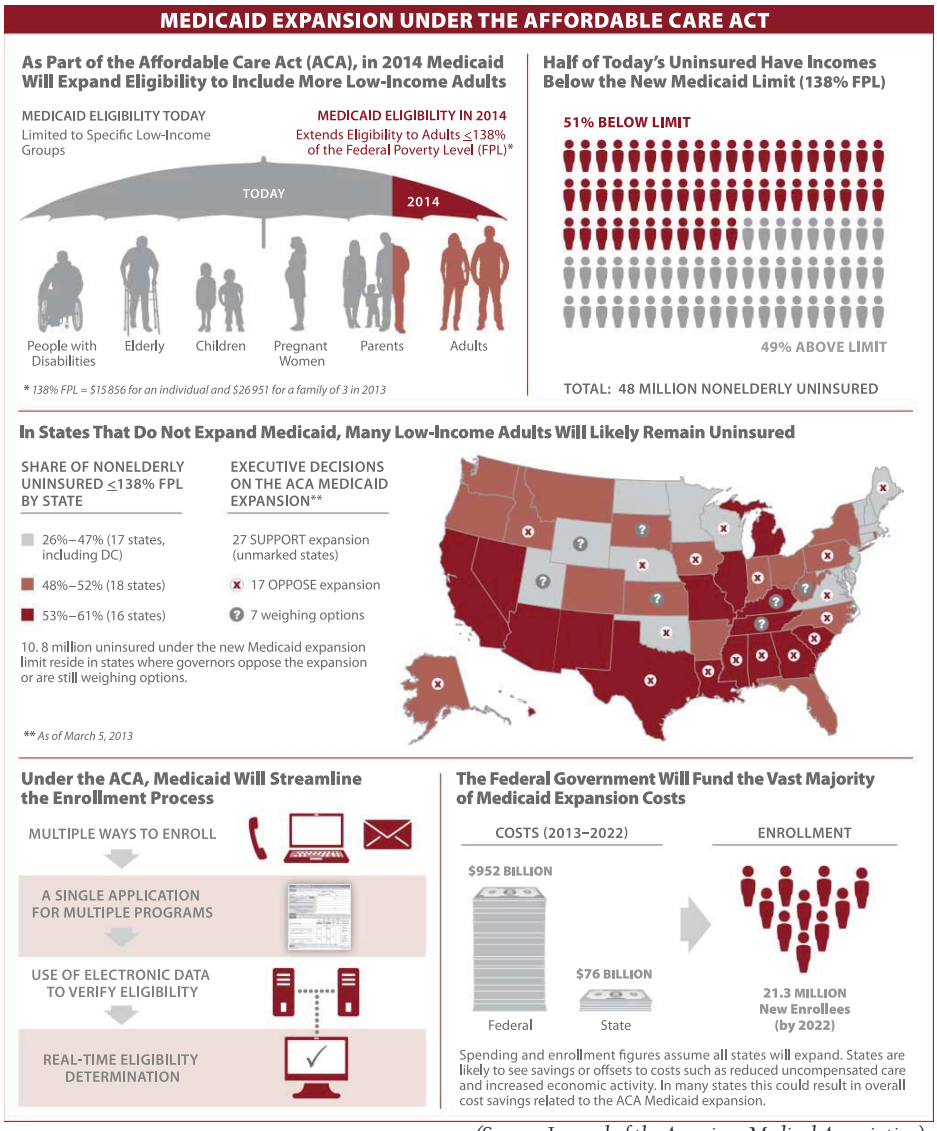
issue as described above. So, while millions of people are newly-covered by health plans with mental health provisions, without increased capacity, they will likely contribute to the strain caused by the shortage of providers. Lengthy waiting lists to see a psychiatrist or other provider will inevitably get longer.

c. As noted above, about half of Northeast Florida's psychiatrists accept Medicare and only one-third recognize Medicaid as forms of payment for services. The primary form of health insurance for low-income people, Medicaid does not adequately reimburse providers for mental health services, so most psychiatrists are reluctant to accept it.

In the State of Florida, one of 24 states that, as of June 2014, have opted not to expand Medicaid as part of the Affordable Care Act, the positive impact of the Act is lessened. Medicaid eligibility in Florida varies by family size and other conditions, but it has typically been limited to those with gross incomes considerably below the federal poverty level ($31,721 for a family of four in 2014). In states that do not expand Medicaid, uninsured adults fall into a coverage gap because their incomes are too high for Medicaid eligibility and not high enough to make them eligible for federal health care subsidies.

Under the terms of the ACA, incomes between 133 percent and 400 percent of the federal poverty level are eligible for Premium Tax Credits, which subsidize the purchase of health insurance through the ACA's Health Insurance Marketplace. As originally passed by Congress, the ACA also expanded Medicaid eligibility to cover everyone up to 133 percent of the poverty level. However, a 2012 Supreme Court decision issued after the ACA became law made it optional for states to expand Medicaid.

As a result, in states declining to expand Medicaid (like Florida), people with incomes above the Medicaid eligibility limit but below 133% of the poverty line have neither Medicaid nor subsidized exchange coverage and will likely remain uninsured.[43] More than one million Floridians fall into this category.



(Source: Journal of the American Medical Association)

When people do not have health insurance and they earn low wages, the only alternatives for accessing mental health care are hospital emergency departments and publicly-funded community mental health agencies, which are typically overburdened, often resulting in long waits for service.

"It is truly unfortunate that we will continue to have a group of our poorest citizens going without health care," Altmire said. "People in low socio-economic demographics are often forced to make poor decisions because of the environmental conditions in which they live, and mental health is a key part of that. We should not be satisfied until everyone in our community is covered by health insurance."

"It is important that we all understand the implications of leaving more than one million people in Florida without health coverage." he said. "The simple truth is that health insurance rates will go up dramatically if we do not expand Medicaid because there will be a hidden tax for providing care to the uninsured. Someone will pay for costs incurred, and it will be all of us. Hopefully we can find a way to provide coverage to the one million being excluded," he said. "It may or may not be through Medicaid."

We Care, a local non-profit organization, serves those who do not have health insurance and whose household incomes fall below 200 percent of the federal poverty level. The Indigent Care Committee of the Duval County Medical Society (DCMS) founded We Care Jacksonville in 1993 as a volunteer coalition of healthcare professionals, clerical personnel, and local church groups to provide donated primary and specialty care to the uninsured, the homeless, and the medically underserved people of Jacksonville. The We Care mission is to build a community-wide network of care for those uninsured by providing free health care services to the eligible population. Physicians, nurses, and other licensed health professionals participate in We Care voluntarily. Among the resources We Care provides are five volunteer psychiatrists, two volunteer licensed counselors, and one social services case manager. We Care partners with 11 volunteer-led free clinics to provide mental health services, and also with Baptist Health for inpatient and outpatient services.

Mr. Altmire emphasized that the most cost-effective development in the health insurance industry is the growing long-term trend toward preventive care. Empowering people by providing them increased access to information and free preventive services will serve to lower health care costs for everyone. In addition, the industry is rapidly moving away from the traditional fee-for-service system that has been in place for generations. In its place, insurers are creating partnerships with providers to reward quality of service rendered rather than quantity. It is hoped this will lower costs and benefit those requiring treatment for mental illness, in particular, because their care is frequently long-term in nature.

Frequently, major health insurance carriers contract with other companies to manage their mental health benefits packages and customers. The claimed advantage is that managed care plans are better able to coordinate the customers' care, so they receive better health care at an efficient price. New Directions Behavioral Health, a national company covering 7.5 million people across the country, is one example of a managed care company that handles mental health care for a large insurance company. In 2013, New Directions began managing all mental health benefits for Florida Blue. New Directions is responsible for determining what services will be covered and at what subsidy level, as well as whether or not a Florida Blue member will be approved for a treatment service recommended by a mental health professional.

New Directions is also the entity charged with managing the behavioral health customer services provided under Florida Blue's insurance plans. Resource speaker Patrick Kimball, a Vice President of New Directions, said they offer a 24/7 customer service access line to field a full range of questions from members, as well as a clinician trained to talk to people in crisis, guiding them to emergency care or a psychiatrist if needed. The range of services in the New Directions network includes: acute care services, partial psychiatric, intensive outpatient services, and outpatient services.

As is customary in the health insurance industry, members must meet their policy's annual deductible before insurance kicks in, and they are also responsible for the applicable co-pay for each service delivered. Since mental health treatment is usually provided on a recurring schedule over an extended period of time, these costs compound quickly and can become unmanageable for many families.

It should be noted that since companies like New Directions are under contract with the insurance carrier, one of their top priorities is to manage services in a manner that maximizes profit for the carrier. As is the case throughout the insurance industry, an inevitable tension results between doing what is best for the member vs. what is most profitable. In some cases, a managed care plan may have an incentive to deny care in order to cut expenses and increase profit.

Florida's Medicaid program is in the process of switching from the traditional fee-for-service system to managed care. The Managed Medical Assistance (MMA) program is being rolled out in different stages throughout the state. Circuits 3, 4, and 5, which include all counties in Northeast Florida, were among the first with a May 1, 2014 implementation date. The four plans chosen for Area 4 by Florida Agency for Healthcare Administration (AHCA)

are First Coast Advantage, Sunshine, United, and Staywell. There are also two specialty plans (Sunshine Child Welfare Plan and Magellan) for people with severe mental illness.

The transition period will inevitably pose some challenges as individuals begin seeking services from their new providers for medical, behavioral, and transportation services, among others. Since Baker, Clay, Duval, and Nassau Counties were part of a pilot program for managed Medicaid that began in 2006, the switch to managed care will effectively extend statewide the Medicaid systems that have been in place in this region since then. As a result, transition issues such as enrollment procedures, availability of services, and quality assurance may be more frequent and more challenging in other parts of the state.

Access for Senior Citizens

Medicare, the federally-funded health insurance program provided to citizens 65 and older (and for some younger who are permanently disabled), has historically been less generous for mental health services than other medical services. Until this year, it provided a smaller share of the expenses for treatment by mental health professionals (50 percent until 2013; 65 percent in 2013) than it did for medical services (80 percent). In addition, Medicare imposes a lifetime limit of 190 days for covering costs associated with inpatient stays in psychiatric facilities, though no such limit exists for other illnesses requiring hospitalization.[44]

Additionally, Medicare does not cover a broad range of community-based services, unlike most Medicaid programs. Medicare pays for outpatient office visits with a limited range of professionals, such as psychiatrists, psychologists, and advanced registered nurse practitioners (ARNPs). Medicare also pays for prescription drugs under the Part D program.

Effective January 1, 2014, federal legislation has increased the Medicare share of mental health costs to 80 percent, in parity with what it pays for other medical services. While this represents good news for senior citizens, the 190-day lifetime limit on hospital stays remains, so those with severe and persistent mental illnesses that require extended hospitalization are left to pay for their own care once they have reached the limit.

Just as those with Medicaid, Medicare patients struggle to find mental health professionals who will accept them. When there are not enough psychiatrists to meet the demand, and when many do not accept Medicare, there are limited options for obtaining affordable mental health care.

Access for Military Veterans

An increasingly important aspect of mental health care in this country is finding ways to deal effectively with large numbers of military veterans, particularly those returning from more than a decade of uninterrupted war in Iraq and Afghanistan. Of the 2.4 million veterans who served in these two wars, nearly 30 percent (730,000) have a mental health condition requiring treatment. An estimated 18.5 percent suffer from Post-Traumatic Stress Disorder (PTSD) or major depression, and 11.6 percent have disorders other than PTSD and major depression.[45] In Florida, veterans and active military account for one in every four suicides. As a result, there is a growing need for mental health professionals specifically trained to treat PTSD and Traumatic Brain Injury.

The Veterans Administration (VA) offers a variety of mental health services for veterans and their families, including: inpatient care at VA Medical Centers, intensive outpatient care, outpatient care in a psychosocial rehabilitation and recovery center (PRRC) for veterans with severe mental illnesses, regular outpatient care in a VA clinic, and supported work settings to help veterans re-enter the civilian work force. To address the shortage of mental health professionals trained to treat PTSD and Traumatic Brain Injury, VA offers treatment through telemedicine.

According to a 2012 report from the VA's Office of the Inspector General, however, a little more than half of the new patients seeking mental health treatment at the VA waited an average of 50 days for a full mental health evaluation. After that initial evaluation, some veterans waited months to be seen by a mental health specialist.[46] To help address these issues, the VA announced plans to hire an additional 1,900 mental health professionals later in 2012.

In Northeast Florida, the VA has three Outpatient Clinics (Duval, St. Johns, and Clay Counties), and the nearest VA Medical Centers are located in Gainesville and Lake City. A recent investigation by the Inspector General's Office has uncovered an apparent secret waiting list of over 200 patients at the Malcolm Randall VA Medical Center in Gainesville, part of a growing crisis involving other VA hospitals across the country. VA hospitals have been pressured in recent years to reduce waiting times for services to a maximum of 14 days, so it appears that some facilities may have tried to comply by disguising the real length of their waiting lists.

The national VA investigation, which forced the resignation of Secretary of Veterans Affairs Eric Shinseki in May 2014, continued to unfold as this Inquiry concluded. It is unclear whether an eventual outcome will include more mental health services for military personnel, both active and retired.

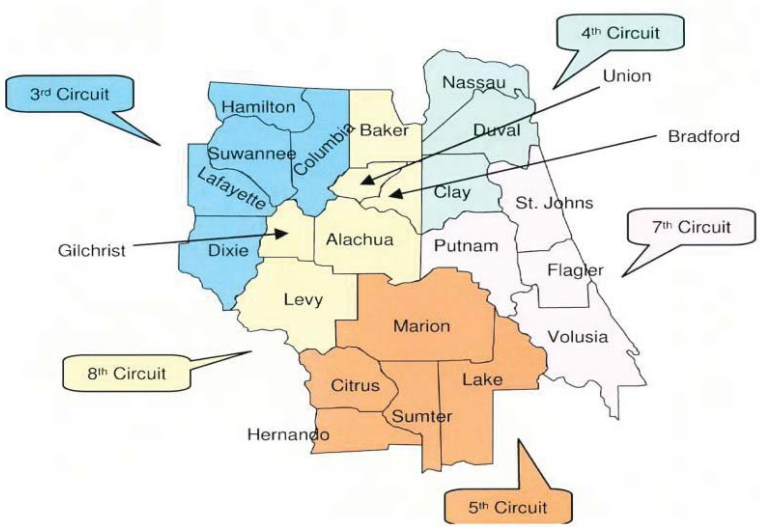
THE MENTAL HEALTH SYSTEM IN NE FLORIDA/FUNDING ISSUES

How the Publicly-Funded Network of Service Providers Works

Lutheran Services Florida (LSF), also known as LSF Health Systems, is one of seven managing entities (ME) in the State of Florida. LSF serves as the ME for Northeast and North Central Florida and is responsible for coordinating the publicly-funded mental health system of care. Contracting with the Department of Children and Families (DCF), LSF is responsible for oversight and management of the publicly-funded substance abuse and mental health system of care for a 23-county area, which includes the five counties in Northeast Florida (Baker, Clay, Duval, Nassau, and St. Johns).

LSF began its work as the ME for Northeast and North Central Florida in July 2012, assuming the Department of Children and Families (DCF) role of contracting with community mental health providers. According to Inquiry resource speaker Tina St. Clair, Executive Director of LSF Health Systems, their service area includes a population of 3.5 million, 31 percent of whom live in Circuit 4 (Duval, Nassau, and Clay Counties). LSF Health Systems, in fiscal year 2013-14, received approximately $92.7 million in funds. Federal block grants make up about one-third of the total funds received by LSF, and funding appropriated by the State Legislature provides the rest. LSF manages the distribution of those funds to a network of service providers with which they contract. The funds are specified for either substance abuse or mental health and cannot be commingled. These dollars are also appropriated for specific use by either children or adults.

LSF Health Systems
Map of Coverage Area



State Hospital

Since 1959, this region has been served by the Northeast Florida State Hospital (NEFSH) in Macclenny (Baker County), which provides long-term inpatient services to people with severe mental illnesses whose needs cannot be met in community-based programs; or whose assessed needs require extended inpatient care. NEFSH, one of seven state mental health treatment facilities, operates 633 beds and serves residents from 30 of the 67 counties in Florida. It is the largest state-owned provider of psychiatric care and treatment in Florida. While a state mental institution such as NEFSH is designed as a treatment center of last resort, accessing it

is difficult even for those persons for whom it is intended, due to the insufficient number of beds and the legal requirements that must be met to commit an individual.

Network Service Providers

Mental Health Resource Center
Cathedral Foundation/Urban Jax (Aging True)
NACDAC
Quality Life Center
daniel Memorial
River Region Human Services
Clay Behavioral Health Center
St. Augustine Youth Services
Clay County School Board (SEDnet)
St. Johns County Sheriff's Office
Gateway Community Services
EPIC Community Services
Flagler Hospital
CCA (Community Coalition Alliance)
Starting Point
Northwest Behavioral Services
Child Guidance Center
Community Rehabilitation Center
Volunteers of America

Crisis Stabilization Units

Individuals experiencing emergency mental health conditions often require inpatient treatment to stabilize their symptoms. The Florida Agency for Healthcare Administration (AHCA) licenses Crisis Stabilization Units (CSUs) that provide short-term inpatient psychiatric treatment for individuals who are in crisis. The purpose of a CSU is to stabilize the individuals and then direct them to the most appropriate and least restrictive community-based services, consistent with their individual needs. Inpatient stays generally range from 3 to 14 days (average is 4.5), ending with a return to the individual's residence or, if necessary, placement in a long-term mental health facility.[47]

CSUs and most psychiatric hospitals and hospital-based inpatient psychiatric units are designated by the Department of Children and Families (DCF) as Baker Act Receiving Facilities, which means they are required to accept individuals who have been "Baker Acted" regardless of the individual's ability to pay for services, and regardless of the availability of beds. Within 72 hours of arrival, the facility must discharge the individual or file a petition for involuntary placement unless the individual consents to voluntary treatment. If an individual is ordered to involuntary inpatient placement (IIP), he or she will likely be transferred to Northeast Florida State Hospital in Macclenny where the average length of stay is 1.7 years.[48]

There are currently nine Baker Act Receiving Facilities in Northeast Florida. Those designated with a (*) are publicly-funded receiving facilities. Requirements of public and private receiving facilities, however, are basically the same.

1. Baptist Medical Center (Jacksonville)
2. Flagler Hospital (St. Augustine)
3. Memorial Hospital (Jacksonville)
4. Mental Health Center of Jacksonville (MHCJ)*
5. Mental Health Resource Center (MHRC)* (Jacksonville)
6. River Point Behavioral Health (Jacksonville)
7. UF Health Jacksonville
8. Wekiva Springs Center (Jacksonville)
9. Orange Park Medical Center (Orange Park)

Individuals who are "Baker Acted" or who present themselves voluntarily to a Baker Act Receiving Facility are generally assessed on a first-come, first-served basis. To qualify for hospitalization, individuals must be a danger to themselves or others, or be unable to care for themselves, due to a mental illness. After assessment, those individuals who do not require hospitalization are typically referred to outpatient clinics in the community, according to Dr.

Robert Sommers, President and CEO of Renaissance Behavioral Health Systems, Inc, which operates MHCJ and MHRC.

The same is generally true at private treatment centers such as Wekiva Springs Center (68-bed inpatient facility), whose parent company also operates River Point Behavioral Health (93 beds). Sheila Carr, Chief Operating Officer at Wekiva Springs, told the Inquiry Committee that both facilities are currently operating at full capacity. As Baker Act receiving facilities, they must accept patients who are brought to them under the Baker Act, but when no beds are available, they are sometimes only able to provide temporary stabilization before referring them to other treatment centers (e.g., Baptist Health, Memorial Hospital).

Baker Act Receiving Facilities are required to accept "Baker Acted" persons whether or not they have health insurance (Emergency Medical Treatment & Labor Act - EMTALA legislation – see Appendix 1). However, that does not mean their services are free. At the publicly-funded facilities, a financial assessment is conducted and a sliding fee scale is applied in order to determine what the individual can afford to pay. The private facilities try to ensure payment for services during the admissions interview, but patients who cannot pay upon leaving the facility are billed. Cases in which patients fail to pay can eventually be turned over to a collection agency.

Community-based Mental Health Centers

Florida's community mental health system is comprised mostly of private organizations, some for-profit and some not-for-profit. People who need services access these providers by contacting them directly.

Local organizations and facilities of this type include (but are not limited to): Mental Health Center of Jacksonville, Mental Health Resource Center, daniel, Inc., Gateway Community Services, River Region Human Services, Wekiva Springs Center, River Point Behavioral Health, Northwest Behavioral Services, Child Guidance Center, Youth Crisis Center, Children's Home Society, Women's Center of Jacksonville, and Sulzbacher Center. These providers offer a wide range of services, with some specializing in specific services (e.g., inpatient services) and some specializing in specific populations (e.g., children).

Individuals are often referred to these community-based providers by psychiatrists and other mental health professionals, physicians, hospitals, insurance companies, Jacksonville Sheriff's Office, schools, family members and friends, and employers.

Following discharge from inpatient treatment, it is important that individuals be able to access quality outpatient programs in the community to continue their treatment. Some centers such as Wekiva Springs have the resources to provide extensive support after inpatient care is completed. Wekiva Springs COO Sheila Carr explained that long-term recovery is enhanced when patients "step down" from inpatient care to partial hospitalization or intensive outpatient treatment. However, the capacity of community-based services is often insufficient to meet the demand. The number of such services has decreased over the years due to funding cuts. Dr. Robert Sommers explained that other significant gaps in the system include a shortage in housing options and a lack of vocational rehabilitation programs. Another issue is that some individuals decline to participate in follow-up care even when it is offered.

New Directions executive Patrick Kimball offered that individuals often discontinue mental health services whether they utilize private insurance or community-based mental health services. Data collected by New Directions shows that only 37 percent of people leaving inpatient treatment go on to outpatient care. These data also indicate that their members entering treatment through involuntary commitment are most likely to continue care.

Assisted Living Facilities (ALFs)

Assisted Living Facilities are licensed facilities that provide full-time living arrangements, including housing, meals, personal care services, and supportive services to adults who are unable to live independently. Standard License ALFs provide direct physical assistance with or the supervision of the activities of daily living, the self-administration of medication and other similar services.[49] ALFs are regulated in a manner so as to encourage dignity, individuality, and choice for residents, while providing reasonable assurance for their safety and welfare.[50]

ALFs are often the destination for persons with mental illness who have been discharged from hospitals or released from jail. In addition to the Standard License, ALFs that serve three or more mental health residents must have a Limited Mental Health License (LMH). Services must be provided for the special needs of these residents, along with the basic services of an assisted living facility. Facilities with this license are required to consult with the resident and the resident's mental health case manager to develop and carry out a community living support plan.[51] ALF quality varies, however, and in some cases, the needs of residents with mental illness may not be given the priority attention necessary. There are 54 LMH ALFs in Northeast Florida with a total of 1,146 beds. Duval County has 37 of the facilities and 680 beds.[52]

For-profit facilities comprise 95% of the 3,024 ALFs in Florida. Some may not have the same mission-driven orientation toward community wellbeing as non-profit facilities. Jacksonville Sheriff John Rutherford told the Inquiry Committee that he has observed issues with for-profit ALFs that may have been avoided if they were managed by the local or state government, or by a non-profit agency. He said that because of a representative payee system for reimbursing ALFs, checks arrive every month to pay rent whether or not a client is on the premises. In some cases, a person living with severe and persistent mental illness is arrested after living for months on the street while an ALF has been taking their rent checks.

Public Funding

In 2012, Florida ranked 49th of 50 states in public funding for mental health, spending just $37.28 per person annually, less than one-third the USA average ($124.99). Only Idaho funded at a lower level than Florida.[53] By comparison, Maine, Alaska and Washington DC, where mental health funding exceeds $300 per person, are at the top of the ladder nationally. A broader continuum of care with more service variation is provided in those locations, including funding for prevention and early intervention services.

According to AHCA, its mental health expenditures were 2.6% of the total Medicaid expenditures for Florida in 2012, about one-half the national average (4.9%) reported by state mental health agencies (SMHA). By comparison, SMHAs reported Medicaid expenditures in Maine (17.0 percent), Arizona (15.6 percent), and Alaska (13.7 percent) that were first through third respectively among the 50 states. If AHCA were able to increase the percentage of its mental health-related Medicaid expenditures to the national average, it could have nearly doubled the amount that went to mental health and substance abuse (approximately $250 million vs. $131 million).

In addressing the Inquiry Committee, Karen Koch, Vice President of the Florida Council for Community Mental Health (FCCMH) in Tallahassee, explained that Northeast Florida has historically been under-funded relative to other portions of the state, and it has actually lost ground since 2001. She said that those regions with the strongest voices in the State Legislature have been the ones receiving the highest allocation of public funds, with the Florida Panhandle traditionally getting the largest share of mental health funding. For new state funds that may be approved in the years ahead, a 2013 Florida Statute (394.908) provides for a revised allocation method that is designed to provide funding equity throughout the state. No new general revenue funding has been allocated since the statute was enacted, so a more equitable allocation of funds has not yet been achieved.[54]

Florida has experienced a budget surplus for two straight years, yet as the 2014-15 budget was being finalized, there was little optimism that mental health would receive much of a boost. "It's time to put pressure on those running for public office," Ms. Koch said. "It is our responsibility to educate them so that mental health receives the attention it deserves."

How Public Funds are Utilized in NE Florida Across the Continuum of Care

In 2012, LSF received $92.7 million to provide mental health and substance abuse services to a geographic area with over 3.5 million people in Northeast and North Central Florida. Of that, nearly $32 million was spent in Duval, Clay and Nassau Counties (Circuit 4). Statewide, the level of funding for mental health was reduced by $20 million over the three-year period 2010-12, and on a per capita basis, funding for mental health in Florida (adjusted for inflation) is less than it was in the 1950's.[55]

LSF District 4 (Duval, Clay, Nassau Counties) commits $27.80 per person annually ($16.42 for mental health and $11.38 for substance abuse), second-highest district in the Northeast Region but nearly one-third less than the Florida average. Northeast Florida is the second-lowest funded Region in the state.

State Mental Health Spending, Per Person 2012

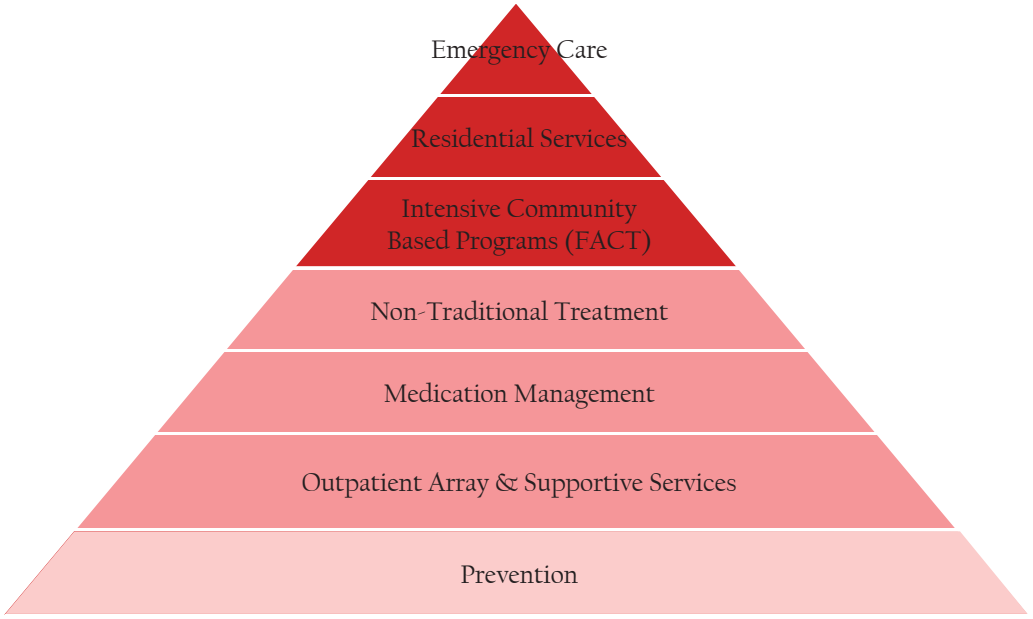
State Mental Health Agency Data Search. NRI. www.nri-incdata.org

The funds allocated to LSF for management and oversight are intended for use by uninsured, low-income residents of Florida. The majority of funds received by LSF are for the treatment of adults. Since most low-income and uninsured children qualify for Medicaid, LSF utilizes their children's mental health and substance abuse dollars to cover treatment, services or community-based interventions not reimbursed by Medicaid. The LSF-directed system of funding mental health care applies primarily to a subset of individuals in the community. Specifically, it serves adults and children who (a) are indigent and have no form of insurance coverage (employer-provided coverage, disability insurance, Medicare, Medicaid, etc.); and (b) meet the priority population of individuals - as defined by DCF - in need of mental health treatment.

Due to the limited public funding available, LSF must prioritize the mental health services that can be offered. Therefore, a significant portion of these funds must be used to provide emergency and crisis stabilization services to individuals who require immediate care. Public funding is esitmated to be meeting only 34% of adult mental health needs and 27% of children's mental health needs.

The ideal continuum of care for public mental health services can be viewed as a pyramid, with the most pressing needs (emergency and crisis stabilization services) at the top of the ladder and preventive services comprising the largest part of the pyramid. In an ideally organized system, the largest number of services would be provided in preventive care, which is the service with the lowest cost, and the smaller number of services would be provided in emergency care, which is the most expensive type of care.

Continuum of Care



Source: Lutheran Services Florida

Jacksonville System of Care Initiative (JSOCI)

In 2010, Jacksonville received a $9 million grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to facilitate the transformation of Northeast Florida's mental health services for youth with serious emotional disturbances into a system of care that integrates home and community-based services and supports. By using existing agencies and joint ventures with other community stakeholders and initiatives, the System of Care Initiative focuses on improving access and assuring that services to all at-risk children and youth, specifically those in the child welfare, juvenile justice, subsidized child care, and homeless systems are family-driven, youth-guided, and culturally responsive.

Children and youth who have been identified as at-risk by the child welfare or juvenile justice system are frequently marginalized within their schools and from mainstream institutions that shepherd youth into adulthood. Children and youth who are homeless are often marginalized as well. Frequently, marginalized youth develop a social identity in relation to their life condition: they think of themselves as less than in relation to other youth. JSOCI is building a system of care that takes into consideration the inequities and oppression thousands of Jacksonville children and youth face.

While JSOCI focuses on at-risk youth, its system of care principles can be applied across all populations. As such, the purpose of JSOCI is to serve as a template for building a system of care for all persons seeking mental health care.

Notable accomplishments of JSOCI to date include:

- **YouthMOVE** - Youth M.O.V.E. (Motivating Others through Voices of Experience) Jacksonville, is a youth organization dedicated to improving the services and systems that serve young people by uniting the voices of youth who have experience within the mental health, foster care, juvenile justice, substance abuse and homeless systems. The youth use their familiarity with these systems as they build their voices. YouthMOVE engages youth in oral history projects and other forms of collecting life stories.
- **Jacksonville Youth Council** - The Jacksonville Youth Council is comprised of 25-30 young leaders within the community that come together and work collectively to find solutions to the issues that impact them through the advancement of the rights of children and youth.
- **Federation of Families of Northeast Florida** – A family support organization that focuses on education, support and advocacy for families with children living with emotional challenges.

- **Screening Process for Social and Emotional Challenges** - A screening process was developed and implemented for children in subsidized childcare in October 2013. Year to date, 590 children were screened in 30 subsidized childcare centers. 137 children were referred for needing additional services based on their screening scores.

- **Implementation of Medical Home** - The purpose of the Medical Home concept is to ensure that all children, especially children in the targeted populations (foster care, homeless) have their medical, dental and behavioral health needs identified and addressed through a coordinated system of care. Since 2012 more than 1,200 children and youth in foster care and 400 children and youth in the homeless system have been connected with a medical home and provided nurse care coordination for their medical, dental and behavioral health needs.

- **Implementation of the Collaborative Care Model** - Since 2013, more than 11,000 adolescents were screened by their pediatrician for suicide and depression. (NOTE: Discussed in more detail under Integration of Primary and Mental Health Care)

- **Implementation of High Fidelity Wraparound Care Coordination** – JSOCI contracts with Jewish Family and Community Services, daniel, Mental Health Resource Center, Children's Home Society, and Child Guidance Center to provide high fidelity wraparound. In Duval County, there are currently five trained wraparound coordinators providing services to 50 youth at any given time who are living with mental health challenges. (NOTE: Wraparound services are discussed in more detail under the section on Treatment Options)

Philanthropic Support of Mental Health

With public funding for mental health in such short supply, the philanthropic community has been forced to play an increasingly large role in supplementing federal and state funds. For example, a $10 million endowment from J. Wayne and Delores Barr Weaver enabled Baptist Health to expand its mental health services for children and adolescents at a time when many other hospitals across the country are eliminating psychiatric services.

Another committed philanthropic supporter of increased attention to mental health is the Women's Giving Alliance (WGA). WGA, whose philanthropic mission is to use research and grants to better the lives of women and girls in Northeast Florida, recognized in 2012 that mental health plays a key role in issues facing women and girls. Beginning in that year, WGA focused its two-year grants on mental health. To date, WGA has awarded seven grants for a total of $658,656, and will announce additional grants in October 2014. This year's grants will continue the focus on mental health with proposals submitted in the areas of Strategic and Systemic Reform, Education and Awareness, as well as Service Delivery.

In 2013, United Way of Northeast Florida convened a committee of community leaders and stakeholders in health to recommend strategies for United Way to improve health in the community, and mental health was a primary focus of their research and discussions. In early 2014, the committee's recommendations, which included working with partners to increase access to mental health services and reduce the stigma associated with mental illness, were approved by United Way's Trustees and Board of Directors. United Way's current funds to increase access totals more than $2 million for mental health services, including outpatient therapy, suicide intervention (through calls to 2-1-1), programs providing supported housing and employment for individuals with mental illness, and Full Service Schools.

Other local philanthropic organizations are also funding mental health programs and services, including Community Foundation for Northeast Florida, Jessie Ball duPont fund, and Arthur Vining Davis Foundation.

COMMUNITY ROLE IN MENTAL HEALTH

Public School System

Because children spend a significant percentage of their daily lives at school and community mental health services are in such short supply, schools have been thrust into a position of addressing mental health needs. The reality, however, is that a number of issues preclude them from making the most effective contributions. Funding issues are certainly real, but beyond that, public schools were never designed for the purpose of providing mental health services. It is not their primary role.

Many mental health issues contribute to everyday classroom problems such as discipline and safety. A recent survey of Duval County Public Schools (DCPS) administrators, principals and teachers revealed that students are dealing with a host of problems, including testing stress, depression, substance abuse, homelessness, interpersonal relationships, neglect, abuse, and even thoughts of suicide. Mental health issues also negatively impact a child's ability to function in an academic setting and to learn.

DCPS Superintendent Dr. Nikolai Vitti envisions a three-tiered approach to mental health in schools. He believes there are presently pockets of excellence in Tiers 1 and 2, but little is done at the Tier 3 level:

1. Every school will have a behavior support plan where positive behavior is encouraged and rewarded.
2. Students with recognized behavioral issues will be connected with additional supports through guidance counselors.
3. Students with severe behavioral challenges will be provided with one-to-one supports, whether or not they have an Individual Education Plan (IEP).

DCPS budgets $35-40 million per year for mental health services, primarily for psychologists and social workers, special needs students, and programs such as Full Service Schools. DCPS has also benefited from several community partnerships that play a role, as well as collaborative grants with service providers in which DCPS is the lead agency.

> "We need to give serious consideration to creating a Children's Trust to support mental health like Miami and other communities have done. They have their own taxing authority which gives them a dedicated revenue stream, allowing them to plan their futures and have greater control over their own destiny. With that kind of structure, we could do some of the things we cannot now."
>
> Dr. Nikolai Vitti, Superintendent
> Duval County Public Schools

Ideally, Dr. Vitti said, each school should have one school nurse and one psychologist. Instead, DCPS has only one nurse for every 6-8 schools, and a total of 52 staff psychologists, or about one for every four schools.

Florida state law requires public schools to provide Individual Education Plans (IEPs) for students who are not responding to a standard learning environment academically or behaviorally. Such students participate in a comprehensive evaluation to help them reach their potential. IEPs lead to additional federal funding, providing more options for positive program development. Some parents and physicians, however, are reluctant to recommend an IEP because of the fear of having their child stigmatized.

Full Service Schools (FSS) is a collaboration coordinated by United Way of Northeast Florida with several primary partners: DCPS, the Jacksonville Children's Commission, Florida Department of Health-Duval, St. Vincent's Mobile Ministry, and several community-based mental health services providers (Big Brothers Big Sisters of Northeast Florida, Child Guidance Center, Children's Home Society, daniel, Family Foundations, Gateway Community Services, Lutheran

Social Services of Northeast Florida, Mental Health Resource Center, Northwest Behavioral Health Services, and Youth Crisis Center).

FSS assists children whose grades are dropping, families in crisis, and students who are having trouble controlling their emotions. The program serves to bolster the mental health team in Jacksonville's public school system by providing behavioral help for students, individual and family counseling, mentoring, case management, and medical/health services. There are 8 FSS sites providing referrals through 87 schools whose attendance is approximately 57,000 students. The FSS network includes 37 full-time therapists who conduct thorough assessments to identify problems. The size of the waiting list for FSS counseling services varies, but through March of the 2013-14 school year, it ranged from a low of 32 students to a high of 193. Recently, a $172,000 gift from Baptist Health contributed to reduction of the waiting lists.

Full Service Schools has demonstrated success in effecting positive outcomes. In 2012-13, 95% of parents/caregivers and non-parent referral sources indicated they saw an improvement in their child's behavior upon completion of treatment; 96% of students completing treatment demonstrated a measurable increase in overall functioning; and 92% of students were promoted to the next grade level.[56]

Homeless Facilities

Emergency Services and Homeless Coalition of Northeast Florida (ESHC) coordinates efforts to prevent and end homelessness within the greater Jacksonville community. ESHC works with over 50 member organizations to provide solutions for homelessness in the region by shaping the direction of services and policy.

Jacksonville's most prominent facility providing services to the hundreds of people who are homeless is Sulzbacher Center. It incorporates two federally qualified Behavioral Health Clinics that provide multiple services including assessments, psychiatric counseling, individualized treatment plans, medication management, and substance abuse. The staff includes a licensed psychiatrist, along with psychiatric nurse practitioners, and licensed mental health counselors.

In addition, Sulzbacher operates a street outreach program (HOPE Teams) that involves medical teams reaching out, meeting homeless people, and building relationships throughout the community. Dr. Richard Christensen, Director of Behavioral Services at Sulzbacher, told the Inquiry Committee that three HOPE Teams engage persons who appear to be homeless, make a quick assessment of what services they may need, and then help direct them to the appropriate place. Sometimes that may be to a community mental health facility, and other times it may involve temporary residency at Sulzbacher Center itself. In 2013, HOPE Teams made 500 patient contacts per month.

Dr. Christensen emphasized that recovery from mental illness means locating the "non-illness self" (e.g., finding care that promotes respect and dignity). Crisis Stabilization Units, jails, and emergency hospitalizations are designed to stabilize a person but they do not identify the "non-illness self." As a result, people living with mental illnesses are looking for care in all the wrong places, according to Dr. Christensen. The system that exists is designed to temporarily stabilize them, but it does little to move people out of homelessness and mental illness.

The Workplace as a Component of the Mental Health System

Stress is considered by employers and employees alike as the most common workplace issue in America, according to resource speaker Angela Lee, a workplace wellness expert. The culture in a company plays a prominent role in the mental health of its employees, she told the Inquiry Committee. A negative culture can contribute to emotional disorders, while a positive, supportive culture contributes to mental well-being.

In recent years, corporate America has therefore increasingly focused on strategies to promote mental health and wellness, recognizing that by improving the personal well-being of employees, health care costs can be lowered and worker productivity improved. There are two ways that employers are promoting health through the workplace: 1) Employee Assistance Programs (EAPs); and 2) wellness programs. Only about one-third of workers in the US have access to an EAP, but an estimated 97% of companies with 5,000 or more employees offer one. EAPs are

designed to alleviate workplace issues due to mental health, substance abuse, and personal problems. They can cover everything from a mental health examination to assistance with aging parents. Despite the growing availability of EAPs, only 3-6% of the employees who have access to one actually utilize it, in part because of the fear of being stigmatized by coworkers or their own self-stigma.

> "Employers who are doing it right are seeing positive results. They are impacting the company's bottom line, but more importantly, they are enhancing the personal well-being of their employees."
> Angela Lee
> workplace wellness expert

Wellness programs, on the other hand, have a universal scope and touch all employees. Wellness programs emphasize education and awareness among all, and do not rely on an employee identifying himself or herself as "in need." Employee wellness is monitored through health assessments, which include questions about social and emotional health. Based on the assessments, employees are determined to fall into high, moderate, and low risk groups. Universal wellness programming is built around the outcomes of these periodic assessments. Worksite wellness programs have resulted in savings for many companies. Over 50 studies reveal that worksite wellness programs have contributed to a 27 percent decrease in absenteeism, 26 percent reduction in health care costs, and 32 percent decrease in workers compensation and disability claims.

The First Coast Workplace Wellness Council is a non-profit organization assisting local companies interested in installing a workplace wellness program of their own. While no specific data have been compiled, Ms. Lee says that more than 100 companies in the region have wellness programs, and more are adopting one every year.

Local companies awarded top platinum level status for their wellness programs in 2013 by the First Coast Workplace Wellness Council included CSX, Florida Blue, Baptist Health, St. Vincent's Health Care, JEA, UNF, and the St. Johns County School District. CSX, for example, maintains 36 Health and Wellness Centers throughout its network to help employees take active responsibility for their health. The centers include licensed dietitians, health fitness specialists, wellness coaches, certified diabetic educators, registered nurses, and ergonomists.

Faith-Based Community's Role

For millions, a holistic approach to achieving a healthy lifestyle includes a spiritual component. Accordingly, the religious community plays an important role on the front line of the mental health arena, and for many, it represents the entry point for accessing the mental health system of care.

"A pastor represents a safe place with privacy for people seeking assistance," said resource speaker Reverend Wayne Lanier of Celebration Church in Jacksonville. "For many of our congregants, we are the first ones they turn to if they need help with emotional issues. Our ability to provide necessary support is dependent on our success in developing relationships in the community," he explained.

Celebration Church says it emphasizes building partnerships with service providers throughout the community in order to develop a network of mental health providers to whom they can refer individuals in need. While the Church's care ministries team does not include mental health professionals, they are exposed to various training vehicles designed to help them recognize the signs of mental illness in their consultations with people seeking their help. It should be noted that Celebration Church has more than 12,000 members, and as a large religious institution, it has the resources to offer services that smaller congregations and faith communities cannot.

According to Mental Health Ministries, effective partnerships with community provider groups can serve a variety of needs, including peer counseling, programs for addiction and other medical issues, transitional housing, employment referrals, family advocacy, training in daily living skills, and help with legal issues.[57]

The Pew Research Landscape survey found that nearly eight in ten African Americans (79%) say religion is very important in their lives, compared with 56% among all adults in the United States.[58] A 2010 Gallup Poll also found that persons who identify as Black (55%) and Black Hispanics (52%) are more frequent church goers than their White (41%) and White Hispanic (46%) counterparts.[59] The strong connection to faith among people of African

descent presents an opportunity for housing mental health education and outreach efforts within places of worship that serve African American/Black communities.

Noted during one Inquiry meeting was the significant educational role the religious community could potentially play in helping reduce the stigma attached to mental illness. Bringing stigma to the attention of their congregations could help elevate awareness about the harm it causes.

PREVENTION & EARLY INTERVENTION

Some mental illnesses seem to run in families, suggesting that there may be a genetic predisposition to developing these illnesses.[60] However, research during the past decade has shown that certain mental illnesses can be prevented.

Because so many mental illnesses begin in childhood, it is critical that preventive measures be taken by prospective parents during and even prior to pregnancy. In a 2014 report on mental illness, the University of Washington School of Social Work concluded that "damage from exposure to alcohol, illegal drugs and tobacco, low birth weight, brain injury or oxygen deprivation, infection, poor nutrition, or exposure to toxins in the environment may negatively affect the development of the fetus and newborn contributing to the onset of mental disorders." In addition, babies with parents who have mental illnesses are five times more likely to develop mental health issues of their own.

These facts clearly indicate that parents who take care of their own health, including getting proper treatment for any mental health problems they may have, are helping prevent mental illness in their children. Proper nutrition, regular exercise, avoiding substance abuse, and attention to health care are effective ways for parents to give their kids the best chance at avoiding mental health issues.

Once the baby is born, strong parent/child relationships in the earliest stages of life are critical in preventing mental illness, and it is important to emphasize bonding with both parents, not just the mother. A consistently loving and nurturing environment with plentiful stimulation is important for the baby's brain development.

For babies with at-risk mothers, intervention early in infancy can be effective, particularly evidence-based maternal, infant and early childhood home visitation programs. These programs offer voluntary home visits to eligible families who receive education and support to strengthen their relationship with their infants and young children. Home visit interventions during pregnancy and early infancy have demonstrated improvement in the mental health of mothers, newborns and infants. Mothers typically receive information on issues such as maternal smoking, poor social support, parental skills, and early child–parent interactions.[61]

The chronic stress that results from living in poverty or suffering abuse and neglect makes children more vulnerable to depression and anxiety. Trauma early in life (e.g., death of a parent or divorce) can trigger major depression that will last a lifetime.

The Delores Barr Weaver Policy Center in Jacksonville provides prevention and intervention services for at-risk girls and women. Executive Director Lawanda Ravoira told the Inquiry Committee their experience shows that gender-specific prevention is more effective than gender-neutral. The Weaver Policy Center takes a holistic approach to working with girls, addressing the whole girl within the social context of her life. The first critical step is to establish a safe environment, both physically and emotionally.

The Center's Girl Matters program focuses on preventing school dropouts. The girls involved have experienced horrible traumatic experiences in their lives (sexual abuse, seeing their parents shot, etc.), and they bring their problems to school, which are played out in the form of discipline or safety violations. The response of the local public school system has been to suspend or expel them from school. Girl Matters is attempting to shift the school culture towards understanding the needs of girls rather than punishing them.

Resource speaker Dr. Richmond Wynn, Assistant Professor of Clinical Mental Health Counseling at UNF, addressed oppression and observed that it is linked to mental health outcomes. For example, a dominant racial group has shaped Northeast Florida for decades and the fact that there are fewer female elected officials, suggests there is a dominant sex. At the same time, individuals live within dominant and non-dominant groups. Age (whether young or old), family income, sex, race, religion, sexual identity and gender expression, and physical ability have all been recognized as markers of discrimination in the U.S., and efforts to combat potential discrimination and oppression are written into many communities' laws.

Research has shown that members of stigmatized identity groups experience chronic stress from constantly trying to meet normative expectations, not being valued, and frequent denial of access. Marginalized individuals are always 'trying to fit in.' Chronic stress of trying to fit in can lead to anxiety, substance abuse, depression and suicide. This is especially true for marginalized youth, many of whom come from neighborhoods and families where chronic stress defines too many lives.

Resource speaker Dr. Richard Christensen observed that homeless individuals are marginalized and stigmatized as well. Belonging to multiple stigmatized groups (marked by income, race, age, whether or not they are homeless) can be especially challenging, diminishing personal resiliency through poor self-concept, inadequate coping skills and compromised health. Individuals living with marginalized social identities often make poor decisions and lack agency, the ability to act on one's own behalf.

A 2004 World Health Organization report lists a series of macro-strategies for reducing the risk of mental illness[62]:

- Improving Nutrition
- Improving Housing
- Improving Access to Education
- Reducing Economic Insecurity
- Strengthening Community Networks
- Reducing Use and Abuse of Addictive Substances
- Reducing Child Abuse and Neglect

EXAMPLES OF BEST AND PROMISING PRACTICES

Wraparound Milwaukee

Wraparound Milwaukee is a unique type of managed care program operated by the Milwaukee County Behavioral Health Division designed to provide comprehensive, individualized and cost effective care to children with complex mental health needs. The program serves families who have a child with serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System, and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital. A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the State Division of Health Care Financing, who operates Medicaid, provide funding for the system. Wraparound Milwaukee contracts with eight community agencies for the over 100 care coordinators who facilitate the delivery of services and other supports to families using a strength-based, highly-individualized Wraparound approach.

Mental Health Facilitator Training

The National Board for Certified Counselors (NBCC - a credentialing organization for more than 53,000 mental health counselors around the world) developed an effective, evidence-based Mental Health Facilitator Program nine years ago that is now used in 37 countries. Developed at the request of the World Health Organization, the MHF program is a grassroots, community-based training that draws on competencies from psychiatry, social work, sociology, and mental health counseling. MHFs are able to return to their communities to provide identification of those in distress, assessment of need and referral, as needed, to appropriate professional resources, in addition to a listening ear. NBCC has trained 20 Master Trainers in the Northeast Florida area and will begin implementing the training in schools and faith-based communities in the fall of 2014.

Mental Health First Aid

An evidence-based program under the direction of the National Council for Behavioral Health, Mental Health First Aid is an in-person training that teaches people how to help individuals who may be developing a mental illness or who experience a mental health crisis. It instructs people on: identifying the signs of addictions and mental illnesses, understanding the impact of mental illness and substance use disorders, a five-step action plan to assess a situation and help, and understanding the network of local resources and where to turn for help. Eight-hour instructor training courses are held regularly in various locations across the country. The following organizations offer Mental Health First Aid in Northeast Florida: Nassau Alcohol Crime and Drug Abatement Coalition (NACDAC), Starting Point Behavioral Health Care, Jacksonville System of Care Initiative, Federation of Families Northeast Florida, and Mental Health America of Northeast Florida.

Changing Minds Campaign

On May 1, 2014, the NBC network affiliate in Washington, DC, (NBC4 Washington) launched a year-long multi-platform campaign focused on mental health. Under the banner Changing Minds, the campaign will consist of compelling elements including news stories, public service announcements, town hall meetings, specials and partnerships. "By shining a light on a topic that unfortunately carries stigmas and does not get all the attention it deserves, we hope to make a difference and save lives," said Mike Goldrick, Vice President of News for NBC4.

Oral History

Oral History is a concept of educating people about mental health using audio recordings of interviews of individuals living and dealing with mental illness. A website called "Inside Stories" was maintained from 2006 to 2013, providing a resource for writers, film makers, researchers, policy makers and family members of individuals with mental illnesses. That website has since been discontinued, but a group called Oral History Matters offers services and expertise around oral history projects and other forms of collecting life stories.

"Hot Spotting" and The Camden Coalition of Healthcare Providers

Begun in 2002, the Camden Coalition of Healthcare Providers is an independent non-profit organization incorporated in the State of New Jersey with a mission to improve the quality, capacity, and accessibility of the healthcare system for vulnerable populations in the City of Camden. The Coalition has popularized the concept of "hot spotting" which uses data to identify small groups of people who account for the most healthcare dollars. It is estimated that five percent of the nation's sickest citizens account for more than half of healthcare costs. According to National Council for Behavioral Health, Camden Coalition used hospital data to map "hot spots" of healthcare high-utilizers. These individuals repeatedly used the emergency room for care, at great cost to the healthcare system. Through hot spotting, healthcare providers send a team, a nurse, or care manager to a person's home to assess why a person uses healthcare resources the way they do, and how their health can be improved — and ER use diverted — through other settings and models.[63]

The Saint Louis Mental Health Board (STLMHB)

The Saint Louis Mental Health Board (STLMHB) is a special tax district in the City of St. Louis approved by voter referendum in 1992. STLMHB is the Substance Abuse/Mental Health and Children's Services authority for the City of St. Louis. As such, STLMHB administers public funds for behavioral health and children's services for the benefit of city residents. It administers these funds by investing in community programs, projects, partnerships and initiatives that are focused on supporting city residents to achieve positive results and/or experience favorable impacts. It has been employing a strategic approach to making funding decisions that has resulted in improved conditions for the people served, as well as cost-effectiveness.[64]

Housing First

Housing First is a national evidence-based best practice that looks at housing as a tool, rather than a reward, for recovery. It is an approach to ending homelessness that centers on providing permanent, supportive housing first, and then providing services as needed and as requested.[65] Florida-specific data concerning the cost effectiveness of Housing First does not exist. To address this, Ability Housing of Northeast Florida, in collaboration with area non-profits and governmental entities, has introduced a Housing First pilot program called "The Solution that Saves." This pilot is designed to produce a Florida-specific cost-benefit analysis of the Housing First model. Shannon Nazworth, Executive Director at Ability Housing of Northeast Florida, told the Inquiry Committee that the Housing First approach has been shown in other communities to produce the best outcomes for homeless people with mental illnesses. She emphasized that Northeast Florida is in the infancy stage with respect to Housing First, and that the community could benefit by becoming proactive in applying it broadly across the region.

Bring Change 2 Mind

A national anti-stigma campaign founded by film actress Glenn Close, the idea was born out of a partnership between Ms. Close and Fountain House, where she volunteered to learn more about mental illness. Both her sister and nephew live with mental illness. Bring Change 2 Mind has produced a comprehensive website that includes facts, stories, and videos, as well as a call to action. Ms. Close has appeared in several of the public service announcements that have been used in various communities across the country.

Community Book Read: Crazy

The Gainesville, FL chapter of NAMI recently initiated a series of community meetings to discuss the implications of the book "Crazy: A Father's Search through America's Mental Health Madness" by Pete Earley, the best-selling author of Hot House. The meetings were designed to create a sustainable conversation about mental health, not just a one-off event, with the ultimate goal of reducing stigma associated with mental illness. NAMI began by inviting stakeholders to attend the meetings, recognizing they were individuals who could keep the discussion going.

ok2Talk Community Conversations

A series of four community conversation meetings initiated by Mental Health America of Palm Beach County, FL were held in the first quarter of 2014, attracting over 400 people who, it turned out, were very eager to tell their stories related to mental health and to engage with other affected individuals. The conversations raised the awareness level of mental health throughout the community and led to the development of a series of recommendations that are being advanced to legislators, local government officials, and other stakeholders for action. The work of MHA of Palm Beach County has been recognized nationally by Creating Community Solutions.

Appendix 1

RESOURCE SPEAKERS

Jason Altmire, Senior Vice President, Public Policy & Community Engagement, Florida Blue
John Boggs, Family Advocate
Sheila Carr, COO, Wekiva Springs Center
Dr. Richard Christensen, Community Psychiatry, UF College of Medicine
Mike Clark, Editorial Page Editor, Florida Times-Union
Sandy Cook, Community Trustee, Women's Giving Alliance
Dr. Steven Cuffe, Psychiatrist, UF College of Medicine
Dr. Michael De La Hunt, Pediatric Psychiatrist, Baptist Health
Wes Evans, Consumer Advocate
Dr. Elise Fallucco, Psychiatrist, Nemours Children's Clinic
Dr. Whitney George, Psychologist, Private Practice and Adjunct Professor, University of North Florida
Pam Gionfriddo, CEO, Mental Health America of Palm Beach
Dr. Jeff Goldhagen, Principal Investigator, Jacksonville System of Care Initiative
A. Hugh Greene, President and CEO, Baptist Health
Dr. Candace Hodgkins, CEO, Gateway Community Services
Robert Hutchinson, NAMI Gainesville
Chuck Ingoglia, Senior Vice President, Public Policy and Practice Improvement, National Council for Behavioral Health
Patrick Kimball, Vice President, New Directions Behavioral Health
Karen Koch, Vice President, Florida Council for Community Mental Health
Vivian Lanham, Consumer Advocate
Reverend Wayne Lanier, Pastor and Director of Life Development, Celebration Church
Angela Lee, Project Manager/Lead Health Educator, Health Designs, Inc.
Denise Marzullo, President and CEO, Mental Health America of Northeast Florida
Terrie Mullin, President, NAMI Gainesville
Shannon Nazworth, Executive Director, Ability Housing of Northeast Florida
Dr. Sue Nussbaum, Former Executive Director, We Care Jacksonville
Joan Pfau, NAMI Gainesville
Lawanda Ravoira, Director, Delores Barr Weaver Policy Center
Sheriff John Rutherford, Jacksonville Sheriff's Office
Sheriff David Shoar, St. John's County Sheriff's Office
Dr. Michael Solloway, Medical Director, Baptist Behavioral Health and Baptist AgeWell Institute
Dr. Robert Sommers, President and CEO, Renaissance Behavioral Health Systems, Inc.
Dr. Jennifer Spaulding-Givens, Assistant Professor and Program Director, Bachelors of Social Work, UNF
Tina St. Clair, Executive Director, LSF Health Systems
Nancy Fudge Sweatland, Consumer Advocate
Dr. Nikolai Vitti, Superintendent, Duval County Public Schools
Dr. Richmond Wynn, Assistant Professor, Brooks College of Health, UNF

Appendix 2

DEFINITIONS

Americans with Disabilities Act (ADA) – The Americans with Disabilities Act (ADA), adopted in 1990, gives civil rights protections to individuals with disabilities (including mental illnesses) that are like those provided to individuals on the basis of race, sex, national origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, State and local government services, and telecommunications. (Source: US Dept. of Justice)

Baker Act - Florida Mental Health Act of 1971 (commonly known as the "Baker Act"; Florida Statute 394.451-394.47891), allows the involuntary institutionalization and examination of an individual (what some call emergency or involuntary commitment). It can be initiated by judges, law enforcement officials, physicians, or mental health professionals. There must be evidence that the person possibly has a mental illness (as defined in the Baker Act); and is a harm to self, harm to others, or self neglectful (as defined in the Baker Act). Examinations may last up to 72 hours after a person is deemed medically stable. (Source: Florida Department of Children and Families)

Crisis Stabilization Units (CSUs) – Crisis Stabilization Units (CSUs) are public receiving facilities receiving state funding designed to examine, stabilize, and redirect individuals with severe mental illnesses to the most appropriate and least restrictive treatment settings consistent with their mental health needs. CSUs screen, assess, and admit for short-term services persons brought to the unit under the Baker Act, as well as those who present themselves for services. CSUs provide services 24 hours a day, 7 days a week through a team of mental health professionals. (Source: The Florida Senate – September 2011)

Deinstitutionalization – The process of transferring individuals with mental illnesses from long-term institutions, which isolate the patient, to more integrated community-based mental health services. A significant deinstitutionalization movement began in the United States in the 1960's. (Source: PsychCentral)

Electroconvulsive Therapy (ECT) – ECT is a procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. It often works when other treatments are unsuccessful. (Source: Mayo Clinic)

Emergency Medical Treatment and Labor Act (EMTALA) - Federal legislation passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) that requires hospitals to provide emergency health care treatment to anyone needing it, regardless of ability to pay. Participating hospitals may not transfer or discharge patients needing emergency treatment except with the informed consent or stabilization of the patient or when their condition renders transfer to a hospital better equipped to administer the treatment.
(Source: www.cms.gov)

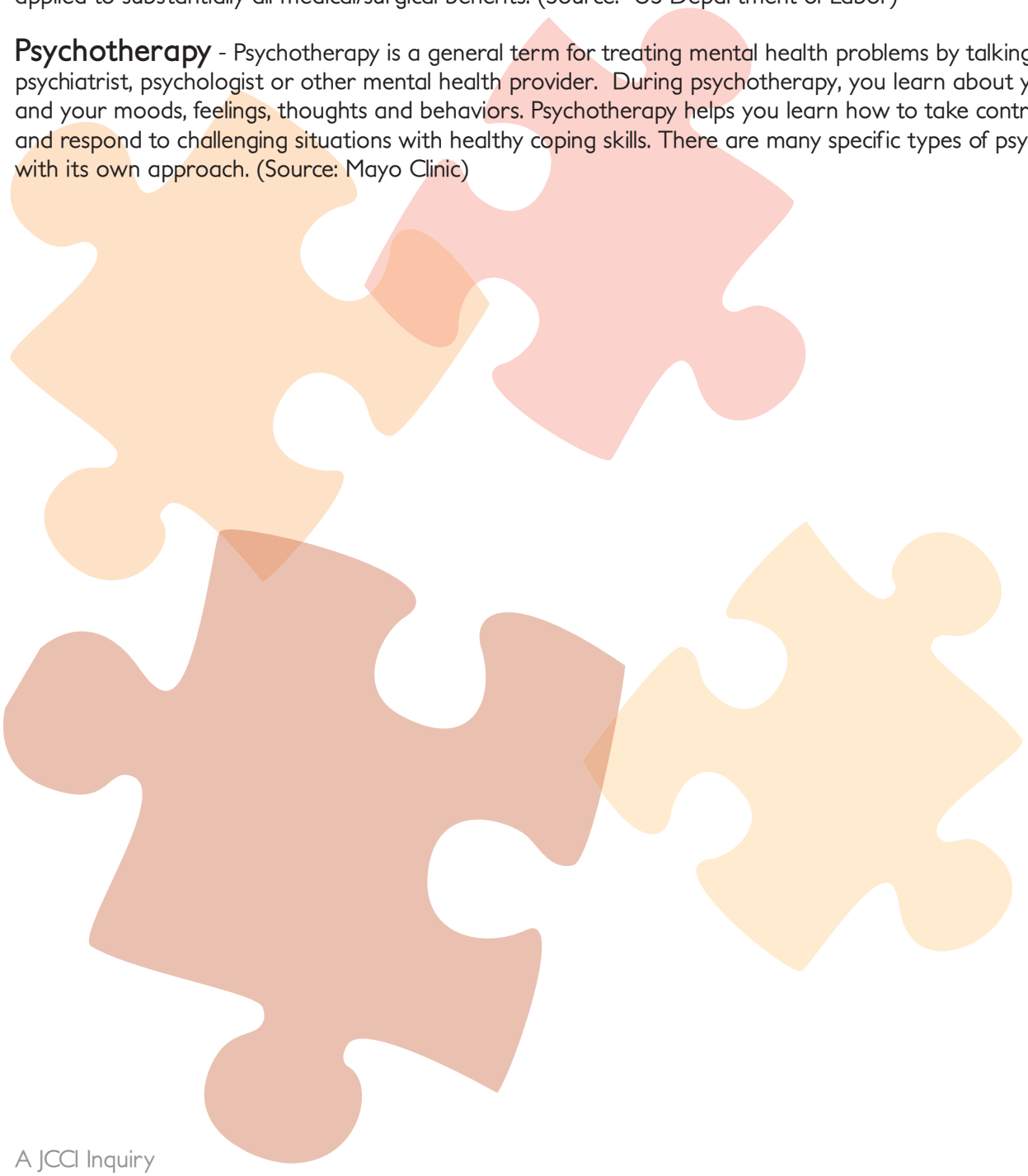
HIPAA – An acronym that stands for the Health Insurance Portability and Accountability Act, HIPAA is a federal law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. HIPAA took effect on April 14, 2003. (Source: MedicineNet.com 2014)

Holistic Approach to Health Care – Holistic health care is an integrated approach to health care that treats the whole person, not simply symptoms and disease. Mind and body are integrated and inseparable. Holistic health is not only concerned with the absence of disease, but with a positive state of being. (Source: New York College of Health Professions – 2014)

Mental Health Parity Act (MHPA) of 1996 - This landmark law addresses the long-held practice of providing less insurance coverage for mental illnesses, or brain disorders, than is provided for equally serious physical disorders. The Act requires parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The MHPA does not require health plans to include mental health benefits in their benefits package. (Source: US Department of Labor)

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 – Designed to strengthen the MHPA of 1996, this law requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. (Source: US Department of Labor)

Psychotherapy - Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health provider. During psychotherapy, you learn about your condition and your moods, feelings, thoughts and behaviors. Psychotherapy helps you learn how to take control of your life and respond to challenging situations with healthy coping skills. There are many specific types of psychotherapy, each with its own approach. (Source: Mayo Clinic)



Appendix 3

MENTAL HEALTH INQUIRY ISSUE STATEMENT

Issue Statement

How can Northeast Florida examine current cultural assumptions about mental health to positively impact quality of life for all?

A JCCI inquiry will:

- Examine the prevalence of mental, emotional, and behavioral disorders in Northeast Florida;
- Understand the consequences and costs of untreated mental and emotional disorders on the quality of life in Northeast Florida, including challenges for parenting and children's educational attainment; impacts on businesses and schools; and the burden on the criminal justice system;
- Examine any stigma attached to seeking mental health treatment and look at ways to de-stigmatize mental health care in Northeast Florida;
- Explore federal, state, and local policies, laws and public funding streams shaping the current services for prevention, diagnosis and treatment of the most prevalent disorders and illnesses;
- Create a profile of the current system of mental health care in Northeast Florida, including existing community mental health programs and services in schools, local military bases, the jail, and other large institutions in which residents are working and learning;
- Review cutting-edge research on community mental health planning; and
- Develop community-wide recommendations for systems change in mental health care to improve access and services in Northeast Florida.

Conclusions

LOOKING AT THE WHOLE PERSON IS KEY

1. Every person has a place on the mental health continuum from wellness to severe and persistent mental illness. Societal beliefs and stereotypes often serve to marginalize those individuals and families seeking to manage the symptoms and behaviors that can cause significant emotional distress. The failure to recognize that positive mental health is a shared community issue creates further obstacles for those who need care and treatment. This can diminish their capacity to be fully productive members of the community.

2. Scientific and experiential evidence show that the brain and body are connected, as are their disorders. Despite such evidence, there is insufficient integration of mental and physical health care in Northeast Florida, resulting in missed opportunities to diagnose and appropriately treat the person's whole health. The consequences to the individuals living with mental illness, their families, and the community can be enormous and in many cases avoidable.

LACK OF PREVENTION AND EFFECTIVE TREATMENT IS COSTLY

3. Residents of Northeast Florida have significant access to physical health providers, yet the current delivery system for mental health services is fragmented and badly broken. This results in limited access to services, disrupted referral systems, lack of coordination among providers, and significant negative financial impact to individuals and the community.

4. In maintaining good mental health, early identification and intervention are critical, and Northeast Florida can improve in both areas. We know that evidence-based practices work, yet our mental health system is often too slow to adopt these proven practices.

5. Community-based treatment is the most cost-efficient treatment option for most mental illnesses. The absence of adequate services for individuals in need leads to an increased risk for: disruption of families; substance abuse; involvement with the criminal justice system; low productivity; loss of employment; poverty; homelessness; and exacerbation of coexisting physical disorders. These consequences lead to a diminished quality of life not only for the individuals living with the illness and their families, but the entire community. Enormous costs to society could be avoided if enough adequately funded community-based services were in place to address mental health issues.

6. In Northeast Florida, children are at unacceptably high risk for mental health issues due to a myriad of factors beyond their control: the absence far too often of a safe and nurturing home environment; an insufficient number of early interventions and developmental screenings; a public school system that is forced to deal with children's mental health needs and crises at the expense of its primary responsibility for academic achievement; and a local juvenile justice system that frequently favors incarcerating children rather than remediation.

MORE UNDERSTANDING AND AWARENESS ARE CRITICAL

7. There is a lack of awareness and understanding about mental health issues across our community that leads to polarization, stigmatization, and a lack of personal and collective ownership.

8. The stigma associated with mental illness can lead to shame, prejudice, and discrimination which prevent individuals living with mental illness from reaching their full potential. Stigmatization can be imposed both from the outside community (social stigma) and by individuals with mental illness themselves (self-stigma). Both forms can be equally damaging and long-lasting.

9. Stigma is rooted in fear, ignorance, and lack of empathy. Education and increased awareness about the challenges individuals face while living with mental illness and the impact on their families and society are crucial. Mental illness is no different from physical illness in this regard, and it is illogical for society to discriminate against one while sympathizing with the other. Educating the general public about the harmful effects of stigma will lead to a healthier, more empathetic, more productive, and better-informed community.

ROAD BLOCKS TO OVERCOME

10. Northeast Florida's publicly-funded mental health system is severely and chronically underfunded compared to the rest of the state and nation. Florida ranks 49th of the 50 states in public funding for mental health and Northeast Florida is the second-lowest funded region within the state. This inadequate funding results in more costly forms of care in jails and prisons, public schools, emergency rooms, and crisis stabilization units. The consequences of this (e.g., increases in crime, incarceration, child abuse, domestic violence, homelessness, etc.) diminish our community's ability to flourish. If more public funding were available and invested wisely, we could replace the significant costs of incarcerating individuals with mental illness and focus instead on housing, treatment, and employment.

11. The ongoing indifference to mental health by the Florida state government is detrimental to the health and well-being of all residents (e.g., refusal to expand Medicaid; consistently low state funding for mental health). This indifference is exacerbated by the fact that other communities in Florida receive disproportionately larger amounts of the limited available funding.

12. Insurance reimbursement rates do not cover the full costs of providing mental health care. Because of this, many mental health professionals do not accept various forms of health insurance, particularly Medicaid and Medicare. The result is unaffordable out-of-pocket expenses for Northeast Florida residents, many of whom do not seek diagnosis and treatment because they cannot afford the care.

13. Northeast Florida has a shortage of mental health professionals, leading to unnecessarily long waiting lists for services and an increased number of mental health crises. Although effective preventions and treatments exist for mental illnesses, it is difficult to access care in a timely manner because of this shortage. Serious but avoidable consequences can result when individuals with mental illness are forced to wait weeks or months for appointments to receive care.

14. Florida's Baker Act, which allows for involuntary hospitalization of some individuals with serious mental illness, is narrowly defined in practice to include only those individuals deemed "imminently dangerous to themselves or others." This makes it difficult to attend to those who may have obvious mental illnesses and require treatment but do not meet this definition. This often results in missed opportunities to prevent serious outcomes such as suicide.

15. In Northeast Florida, there is insufficient collaboration throughout the mental health delivery system. This impedes our ability to maximize the mental health of the community and is a major barrier to an efficient and effective system of mental health care. Collaboration across many sectors- not just the health care sector - is critical to improving our broken system of care; these include but are not limited to public and private schools, religious institutions, law enforcement, businesses, insurers, and the philanthropic sector.

16. Northeast Florida residents are becoming increasingly frustrated by the negative outcomes of the current mental health system and their inability to enact change. Community mental health is not treated as a priority public health issue that requires an infrastructure change that includes long-term planning, implementation and oversight. In addition, the delivery system is too often governed by state and federal policies and laws that limit local impact. This further alienates residents who do not have a voice in shaping Northeast Florida's mental health system.

Recommendations

ADVOCACY AND COMMUNITY ENGAGEMENT

1. Mental Health America of Northeast Florida (MHA), Lutheran Services Florida (LSF), and Behavioral Health Network of Northeast Florida should convene a coalition of mental health stakeholders to serve as an advocacy channel for the advancement of mental health policy in the region. The coalition should include people living with mental illness and their family members, business leaders, mental health agencies, providers of primary care and behavioral care services, representatives of the criminal justice system (Jacksonville Sheriff's Office, judicial), Department of Children and Families, Jacksonville System of Care Initiative, the faith-based community, and other interested stakeholders.

The Coalition should establish and implement a regional strategic plan for mental health that includes, but is not limited to, the following:

- Establish advocacy priorities at the local, state, and federal levels for mental health.
- Develop a strategy to secure funding from multiple sources (local, state, federal) for mental health prevention, diagnosis, and treatment for people of all ages.
- Advocate for expansion of Medicaid in the State of Florida.
- Advocate (with support from the Florida Council of Community Mental Health and Northeast Florida Nursing Association) for passage of pending legislation increasing the scope of practices of Advanced Registered Nurse Practitioners (ARNP) by the Florida Legislature, allowing for writing prescriptions for controlled substances and signing certificates of involuntary examinations under the Baker Act.
- Advocate for an increase in the number of mental health professionals who accept one or more forms of health insurance, including Medicaid and Medicare, to make health care more affordable and increase patient access to treatment.
- Work with the Florida Council of Community Mental Health, local criminal justice entities, NAMI, and persons living with mental illness to review involuntary commitment laws in other states and develop an advocacy plan to modify the Baker Act to include a broader range of criteria for compulsory psychiatric treatment.
- Work with professional associations to close loopholes in the Mental Health Parity Act, which are currently used by insurers to bypass the intent of the law.
- Continue to evaluate evidence-based practices and expand their use in Northeast Florida.

COORDINATION OF CARE

2. Lutheran Services Florida and We Care should convene a broad coalition of providers that serve individuals living with chronic mental illness, including the criminal justice system, to develop a mechanism for coordinating care, medication management, and wrap around services. The goals should be to ensure follow-up care, reduce homelessness, and lessen the frequency of emergency issues for those who are living with severe and persistent mental illness.

3. Renaissance Behavioral Health and River Region Human Services should lead a group of stakeholders (including community mental health centers, law enforcement, the State Attorney, Public Defender, and the local judicial system) to:

- Evaluate Assisted Outpatient Treatment for its applicability to Northeast Florida. If deemed germane to Northeast Florida, this stakeholder group should advocate for the judicial system and law enforcement to utilize Assisted Outpatient Treatment in Northeast Florida as has been done successfully in Seminole County, Florida;
- Strengthen and expand the Mental Health Court to reduce the criminalization of mental illness in Northeast Florida.

4. The Clinton Health Matters Initiative in Northeast Florida should convene a group of stakeholders to investigate, develop and implement a community-wide coordinated system of intake, referrals, and case management that incorporates mental health treatment.

5. The City of Jacksonville, Jacksonville Sheriff's Office, and community mental health providers should work with Ability Housing of Northeast Florida to implement a pilot to demonstrate the efficacy of providing permanent supportive housing for high utilizers of crisis services. The data derived from this pilot should be used by stakeholders to develop sustainable systems to enable chronically homeless individuals with mental illness to stop cycling through costly systems of care. This will reduce the community's costs of incarceration and medical care while improving the quality of life for homeless individuals living with mental illness.

6. Baptist Health and We Care should convene other area hospitals and psychiatric inpatient providers to identify persons who are frequent users of mental health services in order to evaluate the current cost of treatment, and examine alternative treatment plans and protocols that could reduce repeated hospitalizations and improve patient outcomes.

BUILDING CAPACITY

7. In order to improve diagnosis and treatment for mental illness, more access should be created to mental health professionals who are well-trained, reimbursed fairly, able to work collaboratively, and are technologically savvy. Specific actions include:

- UF Health Jacksonville should expand the number of psychiatric residency slots it offers.
- The coalition referred to in Recommendation 1 should meet with mental health professional associations to identify a strategy for increasing licensing reciprocity for physicians and other mental health providers to make it easier to practice in Florida.
- The Florida Chapter of the National Association of Social Workers should identify funding streams for loan forgiveness and scholarships for education and training of mental health providers who will commit to working in the local region.

8. The Clinton Health Matters Initiative in Northeast Florida should convene local hospitals, the Jacksonville System of Care Initiative (JSOCI), Nemours Children's Clinic, and other health care stakeholders for the purpose of forming a coalition that expands existing programs to better integrate mental and primary health care across all age groups in the community. In order to accomplish these goals, the following solutions should be deployed.

- The local residency programs in primary care and psychiatry should establish a working relationship to cross-train their residents to have a stronger foundation in mental health diagnosis and treatment.
- The pilot Collaborative Care Consultation Clinic (a partnership between Nemours and JSOCI) should be expanded to a community-wide initiative to more thoroughly train primary care physicians to identify mental health issues in children, adults, and senior citizens with consideration given to cultural competency.
- The coalition should discuss, identify, and encourage the implementation of integration techniques utilizing new technology, including expanded use of telemedicine, to encourage consultation between primary care physicians and psychiatrists.

9. In order to promote wellness and assess, identify, and treat early signs of mental illness in children, the Full Service Schools collaboration (led by United Way of Northeast Florida, Duval County Public Schools, Jacksonville Children's Commission, Duval County Health Department, and others) should work to increase private and public funding for early intervention, treatment, and case management services to ensure that all children in Duval County have access to needed health services. This will require additional nurses, school psychologists, and other mental health professionals working in schools (i.e., Florida Certified School Social Workers and Licensed Clinical Social Workers) in sufficient quantity to meet or exceed national best practice staffing ratios.

10. Mental Health America of Northeast Florida, River Region Human Services, daniel Inc., and others should convene a task force to coordinate training efforts for licensed and non-licensed mental health professionals. The trainings should be scheduled regularly, presented in multiple platforms for maximum access (i.e., web-based, in person, by phone, and an annual conference of providers), and be based on evidence-based practices.

PUBLIC AWARENESS AND EDUCATION

11. United Way of Northeast Florida should convene community members and decision makers (MHA of Northeast Florida, JSOCI, National Alliance On Mental Illness, health systems, community-based providers, National Board for Certified Counselors Foundation, etc.) to implement research-supported strategies to decrease stigma related to mental illness and change the conversation about mental health. Strategies should include:

- Identifying community influencers to serve as champions and speak out publicly against prejudice and discrimination of persons with mental illness;
- Framing public messaging and information to cultivate a community-wide sense of responsibility and commitment to a healthier region and recognition that every person falls somewhere on the continuum of mental health; and
- Collaborating with The Florida Times-Union and other area media sources to produce a specific community education campaign regarding mental health issues that includes a website, print, digital and broadcast stories of mental health.

12. Mental Health America of Northeast Florida, United Way 2-1-1, and the Non-Profit Center of Northeast Florida should work together to develop a web-based data system for individual organizations/agencies to post primary services, events, group self-help programs, calendars of events, and training opportunities. This consumer- and provider-friendly data system should be accessible by internet, telephone, face-to-face contact with agency staff, and other technologies.

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Year	Inquiry Title	Inquiry Chair
1977	Local Government Finance	Robert Davis
1977	Housing	Thomas Carpenter
1977	Public Education (K-12)	Robert W. Schellenberg
1978	Public Authorities	Howard Greenstein
1978	Strengthening the Family	Jacquelyn Bates
1979	Citizen Participation in the Schools	Susan Black
1979	Youth Unemployment	Roy G. Green
1979	Theatre Jacksonville	Richard Bizot
1979	Civil Service	Max K. Morris
1979	Planning in Local Government	I.M. Sulzbacher
1980	Capital Improvements for Recreation	Ted Pappas
1980	But Not in My Neighborhood	Pamela Y. Paul
1980	The Energy Efficient City	Roderick M. Nicol
1981	Coordinating Human Services	Pat Hannan
1981	Higher Education	R.P.T. Young
1982	Disaster Preparedness	Walter Williams, Jr.
1982	Teenage Pregnancy	Mari Tebrueggen
1982	Downtown Derelicts	Earle Traynham
1983	Mass Transit	David Hastings
1983	Indigent Health Care	Linda McClintock
1984	Jacksonville's Jail	Eleanor Gay
1984	Growth Management	Curtis L. McCray
1985	Visual Pollution	Doug Milne
1985	Minority Business	Jack Gaillard
1986	Private Devliery of Public Services	George Fisher
1986	Mental Health and Drug Abuse Services for Children and Youth	Flo Nell Ozell
1987	Child Day-Care Services	George W. Corrick
1987	Infrastructure	Joan Carver
1988	Local Election Process	Jim Rinaman
1988	School Dropout Prevention	Gene Parks
1989	Reducing the Garbage Burden	Jack F. Milne & James L. White III
1989	Independent Living for the Elderly	Roseanne Hartwell
1990	Future Workforce Needs	Yank D. Coble, Jr.
1990	Philanthropy in Jacksonville	Juliette Mason
1991	Adequate Water Supply	Russell B. Newton, Jr.
1991	Positive Development of Jacksonville's Children	Henry H. "Tip" Graham
1992	Long-Term Financial Health of the City of Jacksonville	Mary Alice Phelan
1992	Young Black Males	Chester A. Aikens & William Scheu
1993	Planning for Northeast Florida's Uncertain Military Future	David L. Williams
1993	Public Education: The Cost of Quality	Royce Lyles
1994	Reducing Violence in Jacksonville Schools	Dale Clifford
1994	Jacksonville Public Services: Meeting Neighborhood Needs	Michael Korn
1995	Teenage Single Parents and their Families	Afesa Adams
1995	JAXPORT: Improvement and Expansion	Jim Ade
1996	Creating a Community Agenda: Indicators for Health & Human Services	Bruce Demps
1996	Leadership Meeting Community Needs	Bill Brinton
1997	Improving Public Dialogue	Jim Crooks
1997	Transportation for the Disadvantaged	Cathy Winterfield
1997	Children with Special Needs	Virginia Borrok
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1998	Incentives for Economic Development	Henry Thomas
1999	Improving Adult Literacy	Edythe Abdullah
1999	Arts, Recreation and Culture in Jacksonville	Ed Hearle
2000	Affordable Housing	Bill Bishop
2000	Improving Regional Cooperation	Jim Rinaman
2001	Services for Ex-Offenders	Dana Ferrell Birchfield
2001	Growth Management Revisited	Allan T. Geiger
2002	Making Jacksonville a Clean City	Brenna Durden
2002	Beyond the Talk: Improving Race Relations	Bruce Barcelo & Brian Davis
2003	Neighborhoods at the Tipping Point	Randy Evans
2003	Public Education Reform: Assessing Progress	J.F. Bryan, IV
2004	Town & Gown: Building Successful University-Community Collaborations	Audrey Moran
2004	Public Education Reform: Eliminating the Achievement Gap	Bill Mason
2005	River Dance: Putting the River in River City	Ted Pappas
2006	Attracting and Retaining Talent: People and Jobs for the 21st Century	Adrienne Conrad
2007	Air Quality	A. Quinton White, Jr.
2008	Infant Mortality	Howard Korman
2009	Our Money, Our City: Financing Jacksonville's Future	J.F. Bryan, IV
2011	Recession Recovery...and Beyond	Elaine Brown
2012	Children: 1-2-3 Creating Early Learning Success	Jill Langford Dame

About JCCI

We bring people together to **learn** about our community, **engage** in problem solving, and **act** to make positive change.

JCCI is headquartered in Northeast Florida, and works in the local area and beyond; from Walla Walla, Washington to Londrina, Brazil, our efforts in community engagement span six continents. Across the world, we understand that tracking only GDP as the measurement of success for nations misses the human side of progress. Quality of life has become the new standard benchmark for success, and we're proud at JCCI to be recognized internationally for being the first organization to track community quality of life progress with an annual report card spanning 30 years.

We bring people together to act on these indicators, and have created lasting community change through our inquiries and subsequent implementations. We have seen and documented real improvement in the quality of life in dozens of communities. At JCCI, we do the work that we do because we believe in community – and we believe in the power that the people who live in those communities have to shape their future.

Are you involved with JCCI yet? From Forward, our action program for new leaders, to JAX2025 and building a better future, there are always opportunities to get engaged. We are a volunteer-based organization and continually strive to involve you – the caring citizen, the community hero, the devoted doer – in our work in celebrating our community and making it the place we all know it can be.

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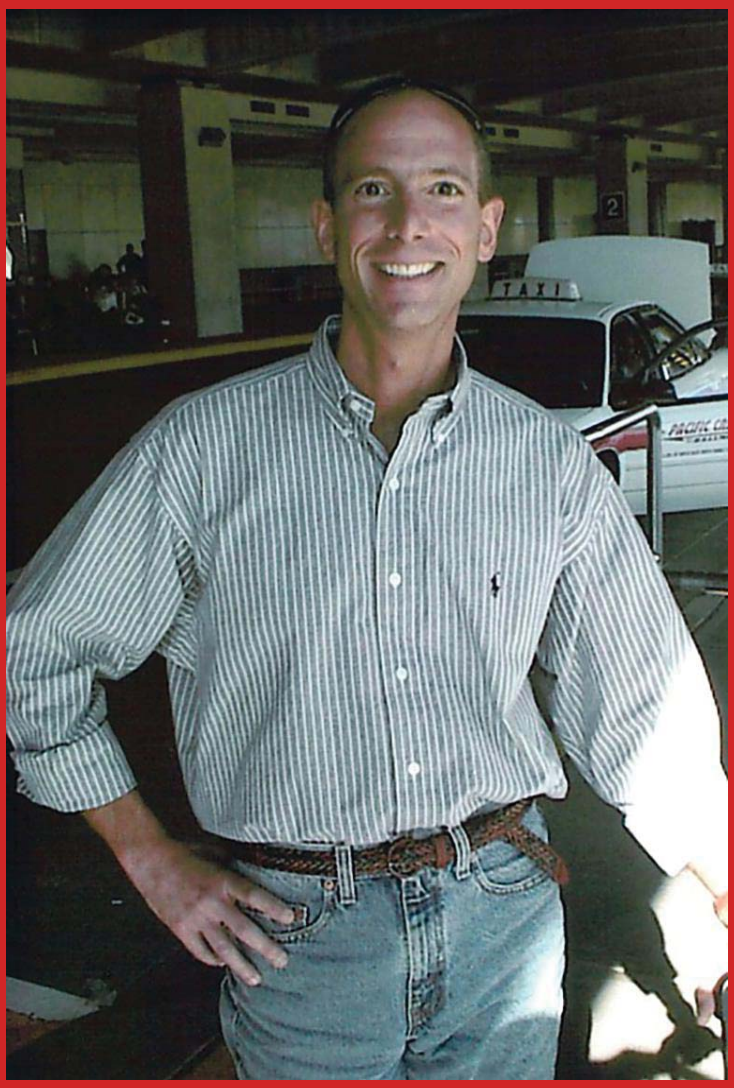

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Every day, JCCI is driven by the bold idea that together as a community we can build a better future.

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