October 18, 2022  
9:00 a.m. to 1:00 p.m.

**Commission on Mental Health and Substance Abuse Members**

Sheriff William Prummell

Chair

Ann Berner

Speaker of the House Appointee

Representative Christine Hunschofsky, Co-Chair

Speaker of the House Appointee

Clara Reynolds

Governor Appointee

Senator Darryl Rouson

President of the Senate Appointee

Doug Leonardo

President of the Senate

Jay Reeve, PhD

Governor Appointee

Dr. Kathleen Moore

President of the Senate Appointee

Dr. Kelly Gray-Eurom

Governor Appointee

Larry Rein

Governor Appointee

Chief Judge Mark Mahon

Governor Appointee

Melissa Larkin-Skinner

Speaker of the House Appointee

Ray Gadd

President of the Senate Appointee

Shawn Salamida

Speaker of the House Appointee

Secretary Shevaun Harris

Florida Department of Children and Families

Secretary Simone Marstiller

Florida Agency for Health Care Administration

Dr. Uma Suryadevara

Speaker of the House Appointee

Judge Ronald Ficarrotta

Governor Appointee

Wes Evans

President of the Senate

Appointee

**Call to Order and Welcome**   
Co-Chair Hunschofsky called the Commission on Mental Health and Substance Abuse meeting to order at 9:00 a.m.

**Roll Call**

The roll was called by Aaron Platt and a quorum was confirmed

**Attendance Summary**

**Members in Attendance**

Commissioner Wes Evans Commissioner Simone Marstiller

Commissioner Darryl Rouson Commissioner Ann Berner

Commissioner Christine Hunschofsky Commissioner Shevaun Harris

Commissioner Ray Gadd Commissioner Clara Reynolds

Commissioner Doug Leonardo Commissioner Jay Reeve

Commissioner Kathleen Moore Commissioner Kelly Gray-Eurom

Commissioner Larry Rein Commissioner Shawn Salamida

Commissioner Melissa Larkin-Skinner Commissioner Uma Suryadevara

Commissioner Ronald Ficarrotta Commissioner Mark Mahon

**Approval of Minutes**

August 24-25 meeting minutes are incomplete and will be submitted for approval at the next commission meeting.

**Interim Draft Report Submission Timeline**

Co-Chair Hunschofsky – Reviewed timeline for submission

**Criminal Justice Subcommittee Interim Draft Report Review and Discussion**

Judge Leifman – In today's world the criminal justice system is the de facto mental health system in America. People with mental illnesses or 10 times more likely to find a bed in the criminal justice system than at any mental health facility and they are 19 times more likely to find a bed in jail that in any state hospital. In the United States, and that's pretty consistent with Florida's data. The key is making sure that we help people get access to treatment. Mental illness in and of itself is not a risk factor to commit a crime. There are other factors that are contributing to individuals and being up in the criminal justice system. The same factors that other people without mental illnesses end up in the criminal justice system. In Florida, the fastest growing population in our prison by prisons, by far our people with mental illnesses. Most of these individuals that are ending up in prison in Florida with serious mental illnesses are not committing a serious or heinous offenses. The average stay for someone in Florida's prison with a serious mental illness is only 2 1/2 to four years. There are several recommendations that we believe will improve our public safety, will spend tax dollars more effectively and will allow people with these illnesses to get access to care. Looked at his Florida's competency restoration system. This is an area that is systematically broken. And it's not just Florida, this is a national crisis.

It is recommended that we limit competency restorations and keep it for cases where people really are looking at longer term prison sentence sentences that really need to have competency restored, we should be doing what we basically do in Miami, divert people into treatment and then the court monitors them for a significant period of time. We use the treatment system more for stabilization than for competency restoration. We have a program for people that are incompetent to stand trials on nonviolent felonies that cannot be restored in the community. And what we do is we direct them it to this program. It's at a lock facility at Jackson Memorial Hospital. It cost about 1/3 less than what the state currently pays. And instead of just focusing on restoration, we actually focus on community reintegration.

We also strongly recommend that we modernize the Baker Marchman Act. Those laws were written about 50 years ago, and again, this is not just a Florida problem, it's a national problem.

There is a bill by Representative Manny who's a former judge.   
We also recommend that there is an establishment of pre and post arrest diversion systems.

You know, mind where they screen the 9/11 calls and the ones that do not need law enforcement responses. They do a warm hand off to their 988 system and they have a non-law enforcement response in about 80 percent, 90% of their calls and their outcomes have just been tremendous. So we recommend that we do pre and post arrest. The other thing on the post arrest side, we are recommending using validated screening tools that all the jails can use to do a better job identifying people when they do come into jail and that if they have been charged with low level offenses or nonviolent offenses.

If you gave me $2 billion in added to the existing system, nothing would change. This really requires a structural change, we need real structural change.

Commissioner Mahon – Thanks judge Leifman. He is recognized as the expert for this type of information. There are states that are ahead of the state of Florida in these types of things and particularly as it impacts on the state system, this is competency restoration, which is a huge waste of money to try to restore competency only to send people back out in the community without any follow up. It is mismanagement of financial resources on the local level, the jail population, which is typically misdemeanors. The Baker Act and competency restoration are just begging for some type of repair. I hope this Commission report is looked at in the future and pointed to as a blueprint for things that we can do better.

Commissioner Reynolds - The key elements of the proposed plan, including the limited use of competency restoration, modernizing the Baker Marchman Act and establishing pre and post arrest diversion programs. Those are the three main recommendations. Is that correct?

Co-Chair Hunschofsky - I also heard that there may be a need to have validated screening tools for all the jails, so that might be an additional legislative proposal.

Commissioner Marstiller - I commend all of you for putting together a very comprehensive report. I think we should make clear in the introduction to this report somewhere what you said, which is that mental illness is not a cause of criminal activity, it is very often co-occurring, but there are other criminogenic factors that lead to criminal activity. I think it's important that we say that expressly so that the public doesn't come away and the legislature doesn't come away with the perception that mental health is causing criminal activity. Also, I would like to make it a clear that those diversion programs, while we would be recommending mental health treatment, that those diversion programs are all-encompassing. It's mental health plus the criminogenic factors, all of those things go into rehabilitating individuals.

Commissioner Berner - Question for Judge Leifman. What are your thoughts on a statutory change that would allow jails to provide involuntary psychotropic medication to inmates?

Judge Leifman – It sounds great but its complicated on two levels. One, is the person still has to meet criteria, there still has to be some legal procedure to do that and the jail is not set up to start the process or file the petition. Second, there are legal strategy implications, you have someone charged with a heinous offense and their lawyers may want to rush to get them stabilized because they may be working on a defense of not guilty by reason of insanity and if you rush, you may remove a defense strategy.

Commissioner Ficarrotta – Hillsborough is trying to catch up to Miami Dade. The recommendations make fiscal sense, and they are the right thing to do. These are solid recommendations. We should not loose sight of the juveniles.

Commissioner Salamida – Where does assisted outpatient fit in the recommendations?

Judge Leifman - Florida has an assisted outpatient treatment law. It's rarely used. I'm only aware of two or three counties that actually use it consistently. Right now, in order to qualify for assisted outpatient treatment, a separate petition under the law has to be followed and it creates a separate track in the probate court system. We are recommending these laws be put together so that you can have one process and based on what criteria the person is meeting at the time of the hearing, whether it's a civil commitment or if it's outpatient commitment. The judge would have the discretion to be able to order that. Instead of having two separate processes which are very complicated, we would have one process and based upon what the person's needs were at the time they were in front of the court, the court could order it and what it means is the person would not be committed to a state hospital, but they would be committed to treatment out in the community.

Commissioner Hunschofsky – Add the recommendation regarding validated screening tools at all the jails (if it is a recommendation). Also, all commission members should make sure you review the backup documentation that accompanies the reports

**Data Subcommittee Interim Draft Report Review and Discussion**

Commissioner Reeve – The data subcommittee has come up with a framework for how we can have clear, validated data related to the behavioral health system in Florida. Commissioner Moore and Dr. Flynn are content experts and will present the report.

Commissioner Moore – We have developed three aims to help guide the report based upon literature review. Aim one, formulize a stakeholder coalition to determine optimal sources, uses and outcomes of data. We reviewed a roadmap created by the Actionable Intelligence for Social Policy housed with the University of Pennsylvania. Helps state and local government collaborate to create a strong legal framework for data integration. In order for policymakers and practitioners to be able to understand the complex needs of both individuals and families, allocate resources, measure impact on both policy and programs be able to engage in shared decision making and then also institutionalized compliance. We also dived in and looked at what examples are there across the US in terms of data collaboratives at both the county and the state level. We were able to find 5 county and seven state examples that have created different types of data collaboratives. It is recommended that we implement a pilot to start small and collect data that might already be aggregated and merged between ACHA and DCF or possibly other relevant data sets to create a road map for an analytic plan before expanding to statewide.

Aim two is to create a statewide behavioral health data repository or comparable system that includes data sources for analysis. The statewide data collaborative, then a behavioral health repository, can be formed to include various data from organizations like DCF, AHCA, DJJ, DOE, HUD, Department of Housing, and Urban Development, FDLE, with the overall goal to provide information on access prevalence, quality, cost and, outcomes of the behavioral health system in Florida. Cost analysis is being performed because of the up-keep that will be required. Also want to implement innovative technology in order to address privacy concerns and incorporate technological and data science innovations in order to improve data collection, cleaning, uploading and allow for all types of data analysis. We need to ensure appropriate initial funding for this initiative, including a fiscal analysis of what this would cost as well as establishing and maintaining the repository.

Heather Flynn – Aim 3 focuses on the analysis and utilization of the data. The goal of AIM 3 is really to begin to use the data to provide the information that we're all looking for on the availability and adequacy and getting towards outcomes of the behavioral health data sources in Florida for the individual served through Medicaid or DCF and then ideally over time, bringing in other populations and to evaluate those key questions related to cost, access, quality of services, which links to outcomes. We are looking at creating a catalog of mental health and behavioral health resources. What are the demographic and diagnostic characteristics of people being served, the prevalence of specific psychiatric and medical diagnosis served within the system, the array and timing of specific services, including provider service type location.

Commissioner Berner – MOU between AHCA and DCF has been executed and includes the data format. In regard to the implementation of the pilot, my managing entity is actually implemented and completed our pilot and we're in the process of rolling it out to two other managing entities. We have literally merged the encounter data and pharmaceutical data. We have both institutional and individual provider data.

Commissioner Reeve - Is the Medicaid data that you guys are pulling in, is that across the board for all enrolled members or just those who cross over between Medicaid and the managing entity?

Commissioner Berner – Just the crossover.

Will send the DCF, AHCA mou to include in data interim draft report.

*Break*

**Business Operations Subcommittee Interim Draft Report Review and Discussion**

Co-chair Hunschofsky – Business Operations subcommittee is next. Commissioner Berner will present.

Commissioner Berner – Identify other publicly funded behavioral health services and have a way to communicate across those funding sources. This will promote care coordination. Recommendation number 1 is a master client index. We have had discussion about overlapping services. For example, someone with substance exposure, we can see funding coming from Department of Health for their program, a specialized program we can see funding coming from healthy start and then also managing entity. The idea is to have a repository of individuals receiving services. Longer-term expectations are to have a way to measure quality of behavioral health services.

Commissioner Reynolds – Second recommendation is titled Closing the Coverage Gap in Florida and the recommendation is to create a pilot that would adjust the income eligibility criteria for Medicaid for young adults aged 18 to 26, whose parents are not insured, to improve access to care for behavioral health and for primary and preventative care that would promote better long term physical outcomes. If you adjust the income eligibility criteria for Medicaid for young adults in the coverage gap whose parents are not insured, this would improve access to care for behavioral health and primary preventive healthcare that would promote better long term physical health outcomes. And this approach levels the playing field and reduces disparities in care for young adults whose families are not able to afford health insurance and for youth pursuing technical education without access to college health clinics and those who are living independently.

Recommendation three is to pilot a single behavioral health entity in a county for 3 years. one managing entity as defined in statute manages all public behavioral health funding in a single channel county, minimally including DCF safety, NET funding, DCF, child welfare prevention, funds related to substance abuse, and mental health, criminal justice funding, both Department of Corrections and Juvenile Justice Medicaid Managed Care funding Medicaid fee for service funding, local funding and Department of Education and local school boards, mental health funding. This is to ensure that community has access to timely quality and comprehensive services. It's recommended that the pilot implement the certified community Mental Health Clinic model. This is a model that nonprofit organizations are using that must provide a minimum of nine types of services directly or through contracts with partner organizations, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with community partners and integration with physical health care. There are concerns and challenges with this model, stakeholder engagement, as well as aligning initiatives will be imperative for the model to be successful.

Commissioner Berner – Recommendation four is to establish a standardized substance abuse and mental health quality of care metrics and that the proposed methodology would be to establish a Commission that would develop core metrics to be used by all organizations statewide to provide substance abuse and mental health related care and services. Metrics would address safety, effectiveness, patient centered timeliness, efficiency and… establishing a standard data dictionary that is uniform.

Recommendation five is to create a coordinated community behavioral health approach for our public schools. The system of care for children's mental health, and so one of the things that we identified was an opportunity to align the statutes where the mental health responsibilities of the school did not necessarily align with the with the expectations that were set out for. In this recommendation we actually went to the Florida statutes. We identified where in the school  
Chapters that we could identify and provide some alignment taking from the chapter on mental health (Chapter 394) and incorporating some of the general performance outcomes into the school system.

Commissioner Reeve – There is a lot of overlap with the Data subcommittee and places where we could support each other. Comment regarding age cap measures.

Commissioner Gadd - Schools should be held accountable just like anybody else but not for expertise they don't have, because the idea was that we have these deep end kids out there that we need a more intense level of services than schools can provide. Therefore we get them into that network of community care. So is that the direction of the recommendation?

Commissioner Berner – Yes, that is the intent, identifying the highest need of those children in direct support of the school system, so that there is an efficient handoff and that doesn't just rest with the school.

**Interim Report Open Discussion**

Co-chair Hunschofsky – Encourages everyone to read all the reports and backup materials.

Commissioner Salamida – Will it be one comprehensive report.

Chair Prummell – Yes, DCF will take all these draft reports and put them together into one comprehensive report. Will probably pull a meeting together around the end of November to to review final report.

Commissioner Berner – Will there be opportunities for two subcommittees to meet (Data and Business Operations) to work out issues that may cross committees.

Commissioner Reeve – Will be out-of-pocket, maybe DCF can handle the some of the overlap between committees and incorporation integrations and smoothing out when creating the final version.

Commissioner Salamida - It's not just the business operations and data committees where there's overlap. The Finance Committee report has some of the things were outlining in the Business Operations report.

Commissioner Marstiller – Is this the end of our work or is there more to be done? It is okay at this point to have overlaps because we will have time to continue collaborating and iron out overlaps. Suggest we look at the next phase of the Commissions work to synthesize overlaps.

Chair Prummell – Agree but want to make sure we do not have contradicting recommendations.

**Public Comments**

Jack Wood - This has been the most refreshing experience I've had with my child's mental illness in the possibilities of the future. You all should be incredibly proud of the work you're doing in the collaboration and the challenges on every step of this thing along the way. Just want to say thank you to all of you and I will do anything in my power to advance this cause.

**Closing Remarks by** Co-Chair Hunschofsky.

Meeting adjourned around Noon

**Day 2**

**October 19, 2022**

**9:00a.m. to 11:00 a.m.**

**Call to Order**

Co-chair Hunschofsky called the Commission on Mental Health and Substance Abuse, day two meeting to order at 9:00 a.m.

**Roll Call**

The roll was called by Aaron Platt, quorum confirmed.

**Attendance Summary**

**Members in Attendance**

Chair, Sheriff Robert Prummell Commissioner Wes Evans

Commissioner Darryl Rouson Commissioner Ann Berner

Commissioner Christine Hunschofsky Commissioner Simone Marstiller

Commissioner Ray Gadd Commissioner Clara Reynolds

Commissioner Ronald Ficarrotta Commissioner Jay Reeve

Commissioner Kelly Gray-Eurom Commissioner Uma Suryadevara

Commissioner Shawn Salamida Commissioner Melissa Larkin-Skinner

Maggie Cveticanin for Commissioner Harris

**Finance Subcommittee Interim Draft Report Review and Discussion**

Commissioner Salamida – Added verbiage that ties the recommendations from the Data Subcommittee report to the finance report. Also included one paragraph referencing the pilot for one county that is included in the Business Operations report.

Natalie Kelly – Fragmentation is a huge area of concern. Reviewed the behavioral health funding from several agencies. A few years ago, Governor Rick Scott, asked 3 counties Alachua, Broward and Pinellas to look at the different funding streams of behavioral health. They saw they had a lot of funding for mental health and substance abuse programs but, they did not have integration, there was duplicative funding. Chair Prummell sent a letter to different state departments asking about behavioral health funding. We saw there are only two departments that have outcomes, DCF and AHCA. We need to ask more questions and be methodical in order to really look at all the funding streams. Linda McKinnon took all the responses and combined them onto a matrix.

Linda McKinnon - I followed what we had done with the initiative by Governor Scott and essentially but paired it down because we were looking at a lot more, but essentially tried to look at where is the funding for each department, the number of people being served and what are the outcomes. What we found is that we really do not have complete information at this time. Counties may have five different funders for the same services with very different contract requirements. Makes it administratively burdensome at the service level and, makes it very difficult to look at a person across the system of care and their needs and what services might be available. We want to look at what we are funding and see where there’s duplications or where we can work more collaboratively. That is where we are in the process.

Commissioner Salamida – Our scope of work includes a lot of the information we received from Chair Prummell data request. Primarily we are recommending additional analysis in the form a second data request to the state agencies. Our responses were excellent, especially from DCF and AHCA. This next information request that we're recommending would ask each agency about needs assessment. How does the agency assess needs and gaps and behavioral health services for populations and communities served, how is adequacy of available resources, including funding levels and workforce determined? Will ask agencies about outcomes and accountability.

Natalie Kelly – The first recommendation is dealing with the opioid settlement funds. What is the accountability process, what's the oversight process of the settlement funding, what's the data where are we going to get this data to see that this is working? Secondly, who is going to be compiling the data? The third and fourth are very similar and it's really based off the first look at that matrix.

Commissioner Rouson – Importance of Opioid settlement dollars, fundings streams. Overall, there is more work the needs to be continued from the Finance subcommittee. Letters will go out to the Departments for additional information.

Commissioner Evans – What do you feel the recommendations might address? Often times dollars are reverted. Do you feel that what you've kind of developed here or what you're thinking about doing would address the barriers that you've identified? And are you thinking about an allocation methodology?

Commissioner Rouson – We will be looking at both those things.

Linda McKinnon - We talked about that briefly also I think that you are totally right. We need to look at equity of funding across the state. I think that we are still operating on a system that's 30 years old where we have a lot of opportunity to make where possible that funding much more flexible that it could be used.

Commissioner Reeve – I agree. It’s really the way DCF funding has been handled but, I think there are certainly models nationally that we use to funding methodology make more sense with less administrative burden.

Commissioner Marstiller – Medicaid is not a funding stream, it is a health care program that AHCA is responsible for administering. Starting in 2014, the Legislature made the decision to move Medicaid from a fee for service model to a managed care model, that significantly affects how rate setting is done. I can bring some team members to do a full presentation for the Commission about Medicaid, how it is funded, structured, who we serve and how rates are set.

Commissioner Suryadevara – In reviewing the Matrix, some funding sources had outcomes and outcomes listed, and some others did not have the outcomes listed. Is there a possibility to make recommendations to the funding sources that these are the outcomes that you could be looking at?

Co-chair Hunschofsky – I think so, your direction is correct.

Commissioner Leonardo - Echo the secretary's comments regarding the need to really look at the complexities of the Medicaid funding and would like to see maybe our finance subcommittee, maybe even go a little further and do some sort of a feasibility study in terms of how that would actually work.

Commissioner Larkin-Skinner – Should we include the original source of the dollars and any parameters around spending of those dollars?

Commissioner Salamida – If the Chair is receptive to it, I can come up with some language.

**Final Review and Open Discussion**

Co-Chair Hunschofsky - The Data subcommittee, Business Operations subcommittee and Finance subcommittee. Some of those recommendations have overlap, and we wanted to talk about putting together some wording at the beginning or somewhere in the report to acknowledge that.

Jay Reeve – Suggest developing a data repository. Also, the certified community behavioral health centers, the pilot for the single payer got me so excited and interested and you know sort of moving away from my initial profound skepticism about that pilot was the idea that the managing entity in that pilot area would contract with a certified community behavioral Health Center, because the natural flow there is that whole concept is set up for prospective payment system. And if the plumbing is all flowing through single entity, that makes sense that they would be contracting with that entity, not that the managing entity would become that entity. That's where the ambiguity is that I found in the report.

Commissioner Reynolds – No, that was not the intent that the managing entity would become the CBHC.

*Continued discussion regarding the pilot*

*Edits incorporated directly into the Finance subcommittee report.*

Commissioner Evans – Please add language to say the behavioral health system would be designated as the entity responsible for the implementation of recovery-oriented system of care among various systems for addressing behavioral health treatment and recovery.

Co-chair Hunschofsky – Please read all the subcommittee reports very thoroughly and come with notes ready.

*Further discussion continued*

*Co-chair Hunschofsky*

and local and the politics involved.

**Criminal Justice Subcommittee Report Update and Workshop**

Judge Leifman – The updated data from DCF does not change any of the subcommittee recommendations. These issues are not unique to Florida. The structure is substantially part of the problem. Jails and prisons have become the de-fact-to mental health and substance abuse system in America. The justice system was never intended to serve as the safety net for the public mental health system and is ill-equipped to do so.

Presented data on mental health and substance abuse prevalence rates and discussed the impact on jails and prisons.

Competency, we still utilize the same system today that we used 50 years ago. We must develop a better system of care in the community so that we can reduce the number of people coming into our system and use competency restoration for what it was designed for.

The Criminal Justice subcommittee recommends we limit the use of competency restoration to cases that are inappropriate for dismissal or diversion, competency restoration should be limited to people that need to go to long term prison or worse. Second, the baker and marchman acts need to be modernized. Every community needs to establish a pre and post arrest diversion system for individual with serious mental illness. Additional details and recommendations are in the draft criminal justice subcommittee report.

With regards to the baker act, we should be considering other models besides having law enforcement initiate (the Houston model, the Denver model). We are over reliant on law enforcement. We are approaching mental illness as a crime instead of an illness.

The criminal justice subcommittee supports Representative Maney’s proposed bill.

We collect good data on baker act but not on Marchman. FMHI can collect the data and identify high utilizers. Peers are huge and inexpensive.

*Lengthy discussion regarding competency restoration, Baker and Marchman Act.*

**Finance Subcommittee Report Update and Workshop**

Commissioner Rouson – Draft report is incomplete but there is a framework for developing. Letter from Chair Prummell to agencies was instrumental in developing framework. In reviewing an analysis of funding streams, we developed a matrix. Linda McKinnon will discuss.

Linda McKinnon – Developed a matrix that showed funding form all the different funding streams for all the major agencies. Not everybody answered everything. Only a few agencies report on outcomes (two agencies, DCF and AHCA). Method of payment was missing from several agencies. We are asking for clarification. Will make recommendations for standardizing how agencies report outcomes on the way the dollars are expended, and the number of people served.

Commissioner Salamida – DCF was detailed by providing by service type, age group, population served etc. In our follow-up, we will try to determine if this is adequate funding, where the gaps are, how to determine if this is effective. Continuing to work on the format of our report, suggest some follow-up questions around the aforementioned areas.

Commissioner Hunschofsky – We keep running into a few blocks in terms of behavioral health. The data is one, lack of data sharing and, funding a program or service but not the person. What would the best funding practice look like to make sure the care is patient focused and not service focused?

Linda McKinnon – Ultimately, we want to be able to match the dollar to the person and not the person to the dollar.

*Further discussion surrounding financing of the behavioral health system.*

**Public Comment**

No public Comment

**Closing Remarks by** Co-chair Hunschofsky

Meeting adjourned around 11:00am