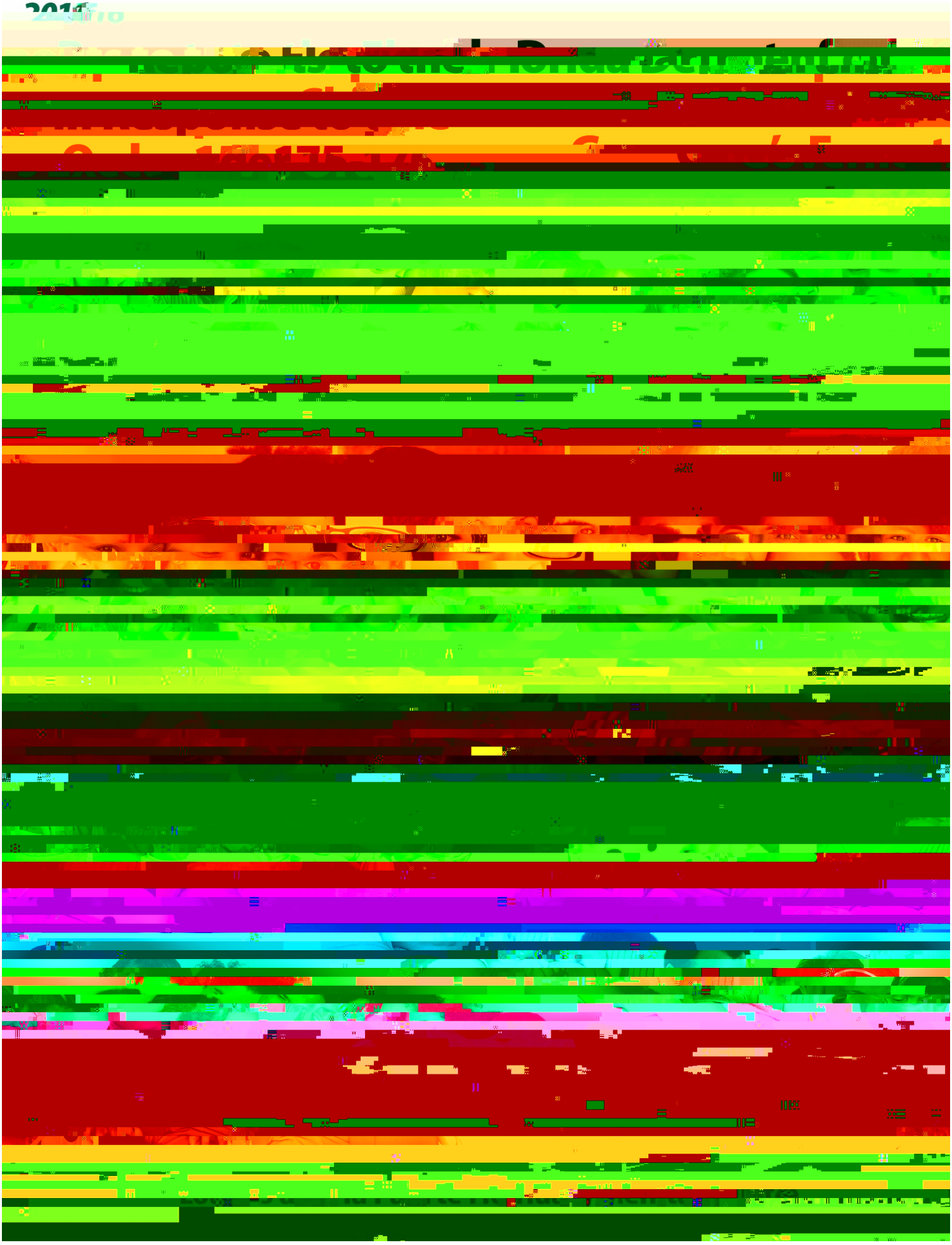

## Alachua County

The case file review team was asked by the local Alachua County Executive Order Steering Committee to review one youth case file. The file indicated that the youth had prior involvement with the child welfare system, ongoing involvement with juvenile justice system, and behavioral issues within the school. The parent in this particular case was actively engaged in services and was the impetus for the child receiving services through the agency. The agency documented effective coordination and communication between the active service providers. As reported during the supervisor interview, important decisions about services for consumers are made in conjunction with the consumer and parent/guardian. The agency seeks input from the child welfare case managers and juvenile justice probation officers in decision making. However, the supervisor also indicated that coordination of services and communication across agencies is not always optimal and is an area across all providers within the county that is in need of improvement.

The file reviewed indicated that the youth received a number of services through the provider agency and there was indication that the youth's needs were being met. Across the system, however, the supervisor indicated that a barrier to service coordination is not having an appropriate program available to accept a child at all times. Transportation and housing are ongoing issues, presenting challenges to clients receiving an array of services.

While there was only one case review, the review is consistent with a number of findings from the administrative data analysis. Of the 97 youth in Alachua County that received RTC/TGH services, only 7 were not also in the inpatient, justice or child welfare categories; 26 youth were in all four categories. Most youth in the child welfare system (954 of 1,193) were in only the child welfare category and did not have RTC/TGH services, inpatient services, or justice involvement. The majority of youth that had RTC/TGH or inpatient services were diagnosed with an episodic mood disorder. The most common diagnosis among youth in the justice system was hyperkinetic syndrome of childhood (i.e., ADHD), while adjustment reaction was the most common primary diagnoses among youth in the child welfare system.

Total Medicaid behavioral health spending in Alachua County was $33.3 million, and total SAMH behavioral health spending was $5.5 million. Combined Medicaid and SAMH services totaled over $12 million f

We also examined behavioral health service use in the 6 months before and after RTC/TGH services. Outpatient, assessment, targeted case management, and treatment planning services were common in the 6 months prior to entry and the 6 months after RTC/TGH services. Fourteen percent of RTC/TGH admissions took place within 6 months of a prior RTC/TGH episode. Examination of behavioral health service use in the 6 months prior to an incarceration found the most prevalent services were outpatient, assessment, and treatment p (ti)-10.2 (e)5.5 (n2 (or)cf0.2 (e)5.5c)6.3 ( o)11 s.58 Td ( )Tj

- Create program slots for high need clients by establishing mechanisms to provide housing and less intensive supports for current FACT clients who no longer require intensive services but are maintained in the program primarily for housing.

- Develop specialized Forensic Assertive Community Treatment Teams or Forensic Intensive Case Management Teams in the community.

- Expand the role of drop-in centers in providing support with community integration for high risk clients.

- Have system of care partners and community partners work together to develop and present cross system training opportunities to help facilitate collaboration across the system of care. Cross training should include information about roles and responsibilities at the clinician, case manager, supervisor levels.

- Develop a locus of accountability at the community level for crossover youth to ensure coordination of the child and family plan of care within and across participating systems, manage and provide intensive care coordination, including linkages to peer supports and community resources. Identify, develop and utilize quality management tools to measure and report outcomes at the youth and family level.

# Final Case File Report

Contract # LH245

Amendment #0002

Revised

July 15, 2016

Mary I. Armstrong
Lisa Coy
Norin Dollard
Mark Engelhardt
Holly Hills
Monica Landers
Cassandra Thomas
Jim Winarski

Louis de la Parte Florida Mental Health Institute
College of Behavioral & Community Sciences
University of South Florida

Table 1

Case Record Reviews by County

| County | Child & youth | Adult | Total |
|---|---|---|---|
| Alachua | 1 | 8 | 9 |
| Broward | 12 | 14 | 26 |
| Pinellas | | | |

also includes whether services that were provided were appropriate in terms of their scope,

Table 5

Fidelity to Identified Youth Strengths

their families, even though those strengths were noted in the record. Not surprisingly, the youth in our sample have suffered a great deal of trauma, as the files indicated histories of child abuse, multiple placements and significant loss. However, it was not clear from the file reviews if these traumatic events had been adequately addressed at any time in these children's lives. There was a lack of documentation in the files we reviewed to indicate if the trauma had been addressed either from the current or a prior provider.

Treatment planning that is comprehensive and adequately meets the needs of the child and family was indicated in about one half of the cases. The majority of the cases indicated that there was a history of or current substance use by either the child's family or the child. However, unless the child was specifically receiving substance abuse services, there was a lack of indication that substance use and abuse prevention was addressed with the youth. Typically, the strengths of the services the children were receiving were based on the type of services or programs they were involved in. If they were involved in case management, then generally

There were two case files reviewed that documented interagency coordination with the schools and with child welfare. In one of the cases there was evidence of the therapist meeting with school officials and the caregiver in response to the child having behavior and academic problems at the school. In the same case, there was evidence of frequent contact with the child welfare case manager to discuss the stability of the child's living arrangement. In another case the case manager for the child documented contact with Medicaid and dental providers to assist the child with ongoing issues. There was also ongoing contact with the child's caregiver and the child welfare case manager and biological family to help coordinate the needs of the child. However, this particular case also highlighted the lack of communication and coordination throughout the system of care when the therapist documented traveling to the child's group home only to find that the child had move

producing a score between '0' and a maximum of '12'. Within each domain, these items were summed to obtain an overall domain score. This total was divided by the number of endorsed items within each domain to obtain an average score. The average score was categorized as 0-2 being implemented with high fidelity to identify needs and strengths, 3-4 being rated as moderate fidelity, 5-7 being rated as partial, 8-9 being implemented with low fidelity and scores of 10-12 rated as no fidelity.

For the state overall (see Table 11) needs identified in Life Domain Functioning, e.g., self-care, legal needs, and job performance, were addressed in the assessment, the service plan, and in other areas of the chart with moderate or high fidelity, 46.5% of the time. This score also includes an assessment of whether services that were provided were appropriate in terms of their scope, frequency, and intensity with which they were provided.

Table 11

Fidelity to Needs and Strengths Life Domain

| | | | | |
|---|---|---|---|---|
| No fidelity | 7.2% | 14.3% | 0% | 12.5% |
| Low fidelity | 17.8% | 28.6% | 0% | 37.5% |
| Partial fidelity | 28.6% | 14.3% | 38.5% | 25% |
| Moderate fidelity | 14.3% | 14.3% | 23.1% | |

obesity, and sleep problems, disorders often associated with behavioral health problems. However, there was no evidence of how these issues were being addressed or of coordination with primary health care providers.

Although each of the individuals identified for review has a history of involvement with the criminal justice system, the case record provided little evidence regarding the individual's experience at the critical junctures of entry into the system for court ordered residential trf6.m11.5 (ll)-4.3 (ee)11.5 (p pr)4.4 (d [(hea)1

on linkage to primary care providers because of its vital importance on whole-

treatment plans could be identified, the page associated with the client's goals for treatment were typically blank, except for their signature at the bottom of the page. No note was typically included to indicate whether the consumer was unable or refused to respond; in one instance, a clinician had noted that the individual was too incapacitated to respond. Associated treatment plans could not be identified for all stays; in at least one instance this might be attributable to the brevity of the contact. In all other instances, with some treatment episodes lasting several weeks, treatment plans could be found but included little personalized information. The majority of the focus was on medication

histories, verifying intake diagnoses, or outlining consumer strengths and challenges (on intellectual or personologic dimensions) were not found in the records reviewed.

In the acute care setting, progress notes described a focus on improving coping and medication compliance. Typically, there was some comment related to the ongoing nature of their psychotic symptom experience, whether the consumer had episodes of agitation, and what action had been taken. Most of the focus was on revision of medication and related symptom reduction over the course of their stay. It was unclear from the record 1) whether individual or group therapy was occurring, focused on content unrelated to medication issues, 2) whether licensed clinicians (other than nurses) were involved, and 3) what the length, intensity or focus of these contacts might have been. In the residential setting, progress notes reported that the consumers were working on 'identified goals,' but insufficient detail was included to determine what the focus of these ongoing goals were and whether incremental gains had been achieved prior to their discharge / elopement.

All of the individuals in the sample reviewed presented with forms of chronic mental illnesses that would require collaboration and coordination across providers for the long term treatment of their disorders. In each case, upon release, a referral to external providers was indicated in the individual's record. There was no evidence in the medical chart that the agency to which they had been referred had requested their records or been in contact with their previous care provider. Typically it would be noted, upon subsequent admission to the CSU that the individual had missed their appointment. In some cases it was noted that they had missed the last 9-14 referral snehatpici5 (s)1 ( w)7.1 (at

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that the forensic team was following up through visitations, but there was very little continuity of care information.

Given the high service needs of all eight cases reviewed, the provider was able to provide appropriate and timely assessments for their behavioral health needs through the CSU and detoxification. It should be noted that six of the eight individuals had no health insurance, so access to ongoing outpatient and case management upon discharge from the CSU is dependent upon either whatever publicly funded resources are available or dedicated funding through a forensic team. One person had Medicaid, and one had Medicare, and services for these individuals were accessible.

The provider in Alachua County has offered forensic services for the past seven years through Florida's Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant funded by the Department of Children and Families SAMH Program office. Despite this dedicated fund source, and as indicated in the cas ofit ther wavs demanaoramndihe eiovis decn.( C)-4.4 (pi)-4up5 (on d)1 (t)6.3 (m)4.52 (v)12.3

# Final Administrative Data Analysis Report

Contract # LH245

Amendment #0002

Revised: July 12, 2016

Timothy L. Boaz

John Robst

Annette Christy

Gregory B. Teague

Louis de la Parte Florida Mental Health Institute

College of Behavioral & Community Sciences

University of South Florida

# Introduction

In September 2015, the Governor of Florida issued Executive Order 15-175 directing the Department of Children and Families (DCF) to conduct a comprehensive review of local, state, and federally funded behavioral health services and to analyze how those services are delivered and how well they are integrated with other similar and/or interdependent services within a community. The goal of the review is the development of a statewide model for a coordinated system of behavioral health care services and a streamlined budgeting process that integrates and tracks behavioral health care spending across multiple funding streams. The overall review was designed to draw on information from two principal sources: 1) data on local, state, and federally funded behavioral health services used by a) adults with serious mental health problems and b) children and youth with serious emotional disturbances in Alachua, Pinellas, and Broward counties; and 2) case file reviews analyzing how the target populations in those counties move through the local systems of care.

Separate sections of this report address the corresponding population and method groups. Section II provides a detailed breakdown of population subgroups' characteristics and service use and costs during calendar years 2010 – 2014 for adults with serious mental illnesses (SMI) in the three selected counties. Section III provides corresponding breakdown for children and youth with serious emotional disturbances.

A preliminary report for this project was submitted in February, 2016. The focus of the preliminary report was on the overall sample of persons who received any public sector behavioral health services during 2010 – 2014 while residing in the three identified counties (Alachua, Broward, and Pinellas) compared to similarly defined persons residing in the remaining counties of the state. Data were provided on demographics, diagnosis, service utilization and costs. The results presented in the preliminary report indicate that the characteristics of the samples of persons receiving any public sector behavioral health services and the pattern of services received within Alachua, Broward and Pinellas counties are rather similar to those for similarly defined persons in the remainder of the state with a few exceptions. The sample in Alachua County had a lower percentage of persons of Hispanic background; the sample in Broward County had a higher percentage of persons who were Black; and the sample in Pinellas County had a higher percentage of persons who were White compared to the sample from the remaining counties in the state. In terms of service utilization, Pinellas County had a higher percentage of persons who received services in the SAMH (DCF) system and who had had a Baker Act initiated compared to the remaining counties in the state; whereas Alachua and Broward counties both had somewhat higher average costs per person for Medicaid services than the remaining counties in the state. For the persons who had received any public sector behavioral health services who also were on Medicaid, physical health costs were four times higher than

persons in the initial overall sample. Felony and misdemeanor arrests were included in the data.

- Florida Department of Corrections (FDOC) data: A copy of FDOC data are maintained in the PSRDC. Admission and release data for all Florida prisons and inmate demographic data were used.
- County Jail data: Data on bookings and incarcerations in county jail for the three counties in this study were obtained. These data included the dates of incarceration, the nature of the charges for incarceration (felony vs. misdemeanor), and demographic data. However, the data from the Broward County Jail did not include SSNs, so we were not able to accurately link these data to our other databases, and they are omitted from this report. Further, since jail data came from only two counties, unlike the other statewide datasets, the jail figures underestimate somewhat the actual jail involvement by the individuals included in this report, even for residents of Alachua and Pinellas counties; some number of unreported jail events and days may have occurred outside their counties of residence.
- Mental Health Court data: Alachua and Broward Counties operate mental health courts. However, these counties would not release SSNs with the mental health court data so we could not accurately link the data to the other databases. Thus, these data are not included in the analysis.

## Initial Overall Sample: Adults and Children/Youth

The initial overall sample included all persons who received any public sector behavioral health services within Alachua, Broward and Pinellas Counties between January 1, 2010 and December 31, 2014. This was established by identifying all individuals who had any events within the SAMHIS, State Hospital, or Baker Act data between January 1, 2010 and December 31, 2014 (inclusive) on which the service recipient's county of residence was identified as Alachua, Broward, or Pinellas counties. In addition, all persons residing in Alachua, Broward or Pinellasr(t)17.6 (9u85b.3 (i)- ( )-11 fe:)-5.1 4.5 .8 (e

Table 2c: Pinellas County - State and Community Behavioral Health Hospital Utilization, Arrests and Incarcerations for Persons Who Had Any Contact with Each High Intensity Service Setting

| | Group | | | | | |
|---|---|---|---|---|---|---|
| | Any State Hospital | | Any Community Hospital Behavioral Health Inpatient | | Any Felony Arrest or Any Incarceration | |
| Total Number/% in Group | 895 | 1.7% | 16,224 | 31.6% | 16,398 | 31.9% |
| State Hospital | N | % | N | % | N | % |

Table 4: Group Distribution by County

| Group | County | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Alachua | | Broward | | Pinellas | | | |
| | N | % | N | % | N | % | N | % |
| Any Forensic State Hospital | 503 | 4.5% | 1,029 | 1.8% | 540 | 1.1% | 2,072 | 1.7% |
| Any State Hospital, but no Forensic | 163 | 1.5% | 718 | 1.2% | 355 | 0.7% | 1,236 | 1.0% |
| Community Behavioral Health Inpatient, but no State Hospital | 3,701 | 33.2% | 24,082 | 41.8% | 15,685 | 30.5% | 43,468 | 36.2% |
| Any Felony Arrest or Incarceration, but no BH Hospitalization | 1,962 | 17.6% | 5,160 | 9.0% | 10,469 | 20.4% | 17,591 | 14.6% |
| None of the Above | 4,833 | 43.3% | 26,613 | 46.2% | 24,321 | 47.3% | 55,767 | 46.4% |
| Total | 11,162 | 100% | 57,602 | 100% | 51,370 | 100% | 120,134 | 100% |

| Alachua County | Group | | | | | OVERALL |
|---|---|---|---|---|---|---|
| | FOR_SMH | CIV_SMH | CM_BH_INPT | CRIM_JUST | NONE | |
| Race | | | | | | |

Table 5a2: Alachua

Table 5b1. Broward County - Demographics, for each group and overall

| Broward County | Group | | | | | | | | | | OVERALL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | |
| N (%) | 1,029 | 1.8% | 718 | 1.3% | 24,082 | 41.8% | 5,160 | 9.0% | 26,613 | 46.2% | 57,602 |

| Broward County | Group | | | OVERALL |
|---|---|---|---|---|
| | FOR_SMH | CIV_SMH | CM_BH_INPT | |

| Pinellas County | Group | | | | | | | | | | OVERALL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | | |
| Multiracial | 9 | 1.7% | 8 | 2.2% | 196 | 1.2% | 205 | 2.0% | 346 | 1.4% | 764 | 1.5% |
| Missing | 0 | 0.0% | 0 | 0.0% | 103 | 0.7% | 7 | 0.1% | 329 | 1.4% | 439 | 0.8% |
| Ethnicity | | | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Hispanic | 40 | 7.4% | 25 | 7.0% | 1,017 | 6.5% | 648 | 6.2% | 1,901 | 7.8% | 3,631 | 7.1% |
| Not Hispanic | | | | | | | | | | | | |

Table 5c2: Pinellas County - Diagnosis and Medicaid Status for Each Group and Overall

| Pinellas County | Group | |
|---|---|---|

Tw8.84 149.08 489.6re f 220.12 4.12 4562.16 0.4 Tm [(36428.9.04.12 4562.16 739.2.e f 20.12 456.84 149.08 0.48 re64 Tm .84 1411.1 ( )]8 .48 re 64 Tm 8 43811.1 ( )

| | Group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | | |
| Multiracial | 48 | 2.3% | 19 | 1.5% | 1,123 | 2.6% | 498 | 2.8% | 1,946 | 3.5% | 3,634 | 3.0% |
| Missing | 0 | 0.0% | 0 | 0.0% | 490 | 1.1% | 37 | 0.2% | 1,950 | 3.5% | 2,477 | 2.1% |
| Ethnicity | | | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Hispanic | 241 | 11.6% | 208 | 16.8% | 5,092 | 11.7% | 1,415 | 8.0% | 8,128 | 14.6% | | |

Figure 7:  Percent with Any SSI

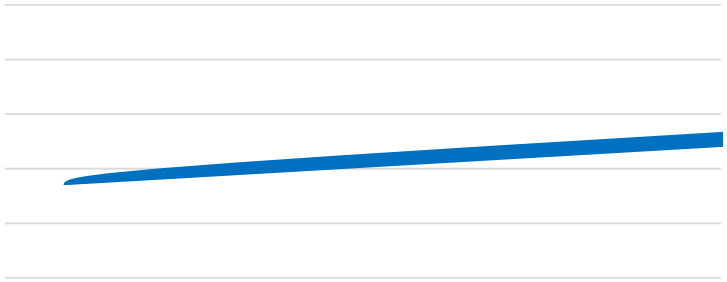


Figure 8:  Percent with Substance Abuse

| Alachua County | Group | | | | | | | | | | OVERALL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | |
| Total #/% in Group | 503 | 4.5% | 163 | 1.5% | 3,701 | 33.2% | 1,962 | 17.6% | 4,833 | 43.3% | 11,162 % |
| Nursing Home | | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | | | |

Table 6b1: Broward County - Service Utilization/Adverse Events and Costs by Group and Overall

| Broward County | Group | | | | | | | | | | OVERALL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | |
| Total #/% in Group | 1,029 | 1.8% | 718 | 1.3% | 24,082 | 41.8% | 5,160 | 9.0% | 26,613 | 46.2% | 57,602 |

Table 6c1: Pinellas County - Service Utilization/Adverse Events and Costs by Group and Overall

Table 6c2: Pinellas County -

Table 6d1: Three Counties Combined - Service Utilization/Adverse Events & Costs by Group & Overall

| Three Counties | Group | | | | | | | | | | OVERALL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FOR_SMH | | CIV_SMH | | CM_BH_INPT | | CRIM_JUST | | NONE | | | |
| Total Number in Group | 2,072 | 1.7% | 1,236 | 1.0% | 43,468 | 36.2% | 17,591 | 14.6% | 55,767 | 46.4% | 120,134 | |
| State Hospital | | | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Number of Adults | 2,072 | 100% | 1,236 | 100% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 3,308 | 2.8% |
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| Admissions | 1.4 | 0.8 | 1.3 | 0.6 | *** | *** | *** | *** | *** | *** | 1.4 | 0.7 |

average data how that group differed from the group that received no behavioral health outpatient service in terms of the receipt of other types of service or the occurrence of other events (i.e., arrests, Baker Acts, inpatient stays, etc.). A third challenge is that one cannot identify the relative timing of occurrence of these events which may be a very important factor. For example, one cannot tell from these data the timing of when outpatient behavioral health services are received after discharge from a high intensity setting – do they occur promptly after discharge or do they tend to occur near or after the occurrence of adverse events such as Baker Acts or re-hospitalization? Analyses such as these would be very important in order to gain a fuller understanding of the issues regarding these transition periods; however, these analyses would be very complex and beyond the scope of what could be done in the very short time period available for conducting the current study.

The next set of Tables (7a1 through 7d2) report on service utilization/adverse events during the six months before admission to state hospital, prison, or County Jail.

Table 7a1: Alachua County - Service Utilization/Adverse Events during Six Months Prior to Admission to State Hospital, Prison, or County Jail – Behavioral Health Settings

| Alachua County | Admission Site | |
|---|---|---|

| Alachua County | Admission Site | | | | | | | | Overall | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Forensic State Hospital | | Civil State Hospital | | Prison | | County Jail | | | |
| Days | 109.4 | 51.0 | 64.1 | 63.3 | 104.2 | 54.4 | 51.2 | 44.3 | 80.3 | 56.5 |
| Prison | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % |
| Number of Adults | 4 | 2.3% | 1 | 0.9% | 19 | 3.2% | 50 | 5.9% | 74 | 4.3% |
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |

| Pinellas County | Admission Site | | | | | | | | Overall | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Forensic State Hospital | | Civil State Hospital | | Prison | | County Jail | | | |
| Days | 1.7 | 1.1 | 2.2 | 1.3 | 1.3 | 0.8 | 1.7 | 1.4 | 1.7 | 1.3 |

Table 7c2: Pinellas County - Service Utilization/Adverse Events during Six Months Prior to Admission to

| Three counties | Admission Site | | | | | | | | Overall | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Forensic State Hospital | | Civil State Hospital | | Prison | | County Jail | | | |
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| Days | 1.7 | 1.2 | 2.1 | 1.6 | 1.5 | 1.1 | 1.7 | 1.3 | 1.7 | 1.4 |
| Community Behavioral Health Outpatient | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % |
| Number of Adults | 520 | 40.5% | 473 | 75.2% | 1,078 | 23.5% | 1,403 | | | |

Table 7d2: Three Counties Combined - Service Utilization/Adverse Events during Six Months Prior to Admission to State Hospital, Prison, or County Jail – Arrests & Incarcerations

| Three counties | Admission Site | | | | | | | | Overall | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Forensic State Hospital | | Civil State Hospital | | Prison | | County Jail | | | |
| Total Number/% in Group | 1,284 | | 629 | | 4,585 | | 4,399 | | 10,897 | |
| Arrests | | | | | | | | | | |
| | N | % | N | % | N | % | N | % | N | % |
| Number of Adults | 673 | 52.4% | 83 | | | | | | | |

BH outpatient services during the preadmission period (on average about 20 days of service each). A much smaller percentage received more intense community BH services (i.e., inpatient, ER, and CSU/SRT, etc.).

Civil State Mental Institutions. For admission to civil state mental institutions, 13.0% of the cases were people who were previously discharged from a state mental institution within the preceding six month period which is very similar to the finding for admissions to the forensic institutions. Not surprisingly, a large percentage (77.9%) of persons admitted to the civil institutions received inpatient behavioral health hospital treatment in the community during the preadmission period (average LOS = 77.8 days). Over 20% were t3 (t)6.3 (26.3 (ed t)6.3 ((n t)6.3 (f)

Table 8a2: Alachua County - Service Utilization/Adverse Events during Six Months after Discharge from State Hospital, Prison, or County Jail – Arrests & Incarcerations

| Alachua County | Discharge Site | | | | Overall |
|---|---|---|---|---|---|
| | Forensic State Hospital | Civil State Hospital | Prison | County Jail | |
| Total Number/% in Group | 156 | 40 | 579 | 802 | 1,577 |
| Arrests | | | | | |
| | N | % | N | % | N |

Table 8b1: Broward County - Service Utilization/Adverse Events during Six Months after Discharge from State Hospital, Prison, or County Jail – Behavioral Health Setting

| Broward County | Discharge Site | | | | Overall |
|---|---|---|---|---|---|
| | Forensic State Hospital | Civil State Hospital | Prison | County Jail | |
| Total Number/% in Group | 788 | 277 | 1,788 | Not Available | 2,853 |
| State Hospital | | | | | |

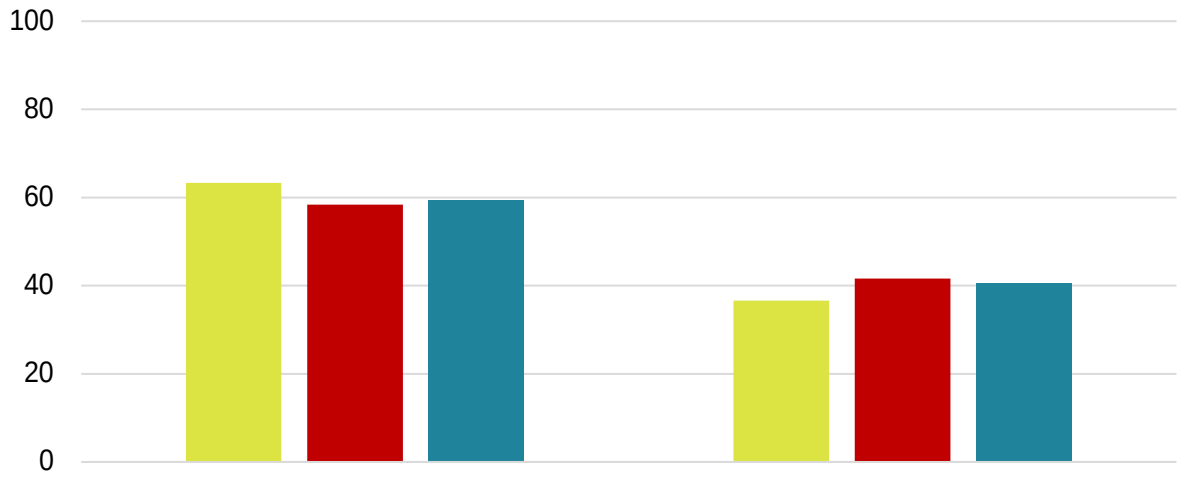
Table 8b2: Broward County - Service Utilization/Adverse Events during Six Months after Discharge from

Table 8c2:  Pinellas County -  Service Utilization/Adverse Events during

Table 8d1: Three Counties Combined - .001 Tc -0.-

Table 8d2: Three Counties Combined - Service Utilization/Adverse Events during Six Months after Discharge

Figure 13: Rebooking vs. No Rebooking in  County Jail [36]




Overall, the rate of reincarceration to county jails was much higher than the rates of readmission to prisons or state hospitals.  In this sample, nearly half (45.6%) were reincarcerated within one year of release from jail. Alachua County had a higher rate of early reincarceration (37.3% within six months) than did Pinellas County (29.0%).

## Characteristics Associated with Readmission

To examine factors associated with risk for readmission, we used all the episodes for which the length of stay was at least 90 days.  Risk for readmission was analyzed separately by type of facility.  In order to maintain power in the analysis, we analyzed the data for all 3 counties combined in each analysis with 'county' entered as a factor.  Cox proportional hazards regression was used for this analysis.  This method has the advantage that both the likelihood of occurrence of the readmission and the time to the readmission are factored into the risk estimate.  Also, risk is estimated for each variable after all the other variables are taken into account which reduces the problem of confounding.  The relative readmission risk associated with each predictor variable is reflected in the hazard ratios (HRs).  If the HR is greater than 1 then risk for readmission increases with an increase in the value of the variable.  For grouping variables, the HR reflects the difference in risk for the identified group compared with those not in the identified group (i.e., the reference group).  For example, the HR associated with the variable 'Male' reflects the difference in risk for Males compared to those who are not Males (i.e., Females).  Proportional hazards regression also allows one to include all discharge episodes regardless of

[36] Two counties combined are shown, rather than three counties combined, because Broward County jail data could not be used for these analyses.

the length of follow-up period available.  Episodes where only a short follow-up period is available are simply

occuring substance use disorder were at 28% increased risk. Being enrolled in Medicaid was associated with a 12% decreased risk of readmission to county jail. Finally, being older was associated with a decreased risk of reincarceration (about 0.5% less risk per year of age).

## Conclusions Regarding Adults with SMI

Overall, the adult administrative data analysis revealed fairly consistent results across the three counties with a few exceptions. First, Alachua County had a substantial higher rate of state hospital utilization than the other counties, mostly due to having more forensic utilization. Second, Broward County had a substantially higher rate of community behavioral health inpatient utilization than the other two counties, and Broward County had a somewhat lower rate of legal involvement ieerle e
c4.3 (a had uut)6.3 (id r)4.5 ((r)4.5 (os)M-)7.1 (on r)alc(i)-4h4.3 (a)11.6her (a)11.6h3 ( )11.7 (m24.3 (.)6.3 ( F3-1.6 (i)-4.2

reported with a cost center of inpatient). We also used Hospital Discharge data to identify individuals with inpatient stays with a primary behavioral health diagnosis.

Juvenile Justice (JJ) – JJ involvement was measured using several data sources. First, we used all records in Florida DJJ encounter data and placement data. Arrests or offenses from encounter data and placements in CY 2010-2014 were defined as JJ involvement. DJJ data has a high rate of missing identifying information. Thus, it was important to augment DJJ data with additional data sources. Second, we used Florida Department of Law Enforcement data on arrests. Third, we used SAMHIS Events data where the service setting was a jail or juvenile detention facility to identify additional individuals. Third, we used SAMHIS Mental Health Outcome files

Table 12a: Descriptive Statistics - Alachua

| | RTC/TGH | Inpatient |
|---|---|---|

Table 12c: Descriptive Statistics - Pinellas

| | RTC/TGH | Inpatient | Justice | Child Welfare | BH services only |
|---|---|---|---|---|---|
| Pinellas (n) | 483 | 1,435 | | | |

## Treatment and Criminal Justice Events

For each of the groups, we next examined the:

- number of RTC/TGH episodes and number of RTC and TGH days
- number of community hospital mental health episodes and days
- number of incarceration/juvenile detention and days
- number of arrests (felony and misdemeanor)
- number of Baker Act events
- types and amount of community based mental health and substance abuse treatment

The following tables provide data for each of the above bullet points using data for the years 2010-2014. First, we report the number of youth that recei ( t)6.3 (he nu)11.6 (m)-6.i(h of)-5.1 ( t)6.31t.1 (or)9j6 Tw -4484.3 ( Tw -.4 (s)]TJ)4

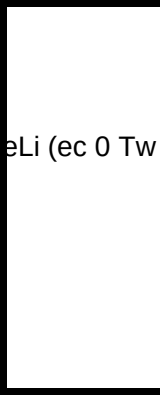
Table 15: Incarcerated Episodes and Total Days by Group 15 re 6 W8n5 re f 292.8 616.2 0.481 0.4.52 601.2 62.4 15

| | Group | | |
|---|---|---|---|
| | RTC/TGH | Inpatient | Justice |
| Alachua County (n) | 97 | 452 | 429 |
| Youth with incarcerations | 36 | 48 | 197 |
| Episodes | 151 | 184 | 724 |
| Total days | 7,150 | 9,731 | 37,185 |
| Broward County (n) | 388 | | |

Table 16: Number of Arrests by Group

| | Group | | |
|---|---|---|---|
| | RTC/TGH | Inpatient | Justice |
| Alachua County (n) | 97 | 452 | 429 |
| Youth with arrests | 54 | 98 | 410 |
| [redacted] | | | |
| Number of misdemeanor arrests | 158 | 229 | 935 |

935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The following tables examine behavioral health service use in each county. We included behavioral health services reported in Medicaid data (fee-for service, PMHP, and MMA), and SAMHIS service event data where the services were provided in CY 2010-2014. We looked at total service use over the five year period; thus for youth in the RTC/TGH group, the services represent those received over the entire five years, not just while they were in RTC/TGH treatment. Once again, we attempted to remove duplicate services. In SAMHIS data, we removed events where Medicaid was listed as the funding source. For the Hospital discharge data, we only included records where there was not a corresponding Medicaid or SAMHIS record for the same service day. There is one table for each group in each county. Given the large number of potential results to discuss, we focused on the overall findings. User counts that were less than 10 have been changed to '<10'.

In Alachua County (see Table 18a), $7.5 million of the $11.9 million in Medicaid services for RTC/TGH youth were for SIPP services. The largest service category (in terms of expenditures) for SAMH services was outpatient. Combined Medicaid and SAMH services totaled over $12 million for the 97 youth (the total number of youth receiving RTC/TGH services, see Table13) in the RTC/TGH group (which is $113,091 per youth). For

Table 18a:  Behavioral Health Service Expenditure in Alachua

| Alachua, Justice | | | | |
|---|---|---|---|---|
| | Medicaid | | SAMHIS | |
| | Users (n) | Total Paid | Users (n) | Total Paid |
| Assessment | 246 | $83,096.99 | 179 | $60,868.97 |
| Clubhouse | | | <10 | $2,868.42 |
| Crisis Care | 24 | $6,905.31 | 48 | $3,628.72 |

| Alachua, BH users only | | |
|---|---|---|
| | Medicaid | SAMHIS |

| Broward, BH users only |
| --- |

Table 18c: Behavioral Health Service Expenditure in Pinellas

| Pinellas, RTC/TGH | | | | |
|---|---|---|---|---|
| | Medicaid | | SAMHIS | |
| | Users (n) | Total Paid | Users (n) | Total Paid |
| Assessment | 396 | $342,639.28 | 367 | $121,756.55 |
| Crisis Care | 189 | $78,305.03 | 43 | $5,967.62 |
| Developmental Disability | 43 | $6,576.49 | | |
| Incidental Expenses | | | 21 | $6,876.00 |
| Inpatient | 239 | $4,685,820.05 | <10 | $3,732.09 |
| Outpatient | 401 | $2,303,138.98 | 379 | $1,160,740.43 |
| Rehabilitation | <10 | $2,234.00 | <10 | $636.19 |
| RTC | | | 132 | $1,434,414.32 |
| SIPP | 241 | $21,928,397.61 | 38 | $82,405.39 |
| STFC | 104 | $3,474,132.31 | 10 | $88,746.95 |
| Targeted Case Management | 337 | $1,559,100.75 | 286 | $797,269.31 |
| TGH | 198 | $8,994,944.18 | 24 | $270,157.35 |

the prior 6 months. Given that the sample is limited to the first RTC/TGH episode, there was no prior RTC/TGH service use during the sample time frame. Most youth received outpatient (68 youth), assessment (38), and/or targeted case management (50 youth) services in the 6 months prior to entry. Among SAMH

Table 19: Behavioral Health Service Expenditures, Baker Ac t Exam Initiations and Arrest in 6 Months Before and After RTC/TGH Services

| Alachua, RTC/TGH | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Medicaid | | SAMHIS | | Medicaid | | SAMHIS |
| | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) |

| Broward, RTC/TGH | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 6 months before RTC/TGH N=321) | | | | 6 months after RTC/TGH (n=257) | | | |
| | Medicaid | | SAMHIS | | Medicaid | | SAMHIS | |
| | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid |
| Behavioral Health Expenditures | | | | | | | | |

[redacted]

[redacted]

Pinellas, RTC/TGH

Table 20 looks at the demographic characteristics of youth that were readmitted to RTC/TGH treatment within 6 months of the end of the previous RTC/TGH treatment. The youth did not have to re-enter the same type of facility to be considered a re-admission. Thus, a youth discharged from SIPP services and then admitted to a TGH three months later would be considered a re-admission. Of the 196 RTC/TGH episodes in Alachua County, 28 (14.2%) were re-admissions. A slightly higher proportion of re-admits in Alachua County were female, and a slight majority were White. Ninety-three percent had a classification of SED, and 94.3% had a primary diagnosis of episodic mood disorders (ICD-9 296). Of the 654 RTC/TGH episodes in Broward County, 105 (16.1%) were re-admissions. A slightly higher proportion of re-admits were male in Broward County. The proportion was similar for Blacks and Whites with each group comprising 46-47% of re-admits. Over 90% had an SED classification and had an episodic mood disorder. In Pinellas County, 147 of 1,058 (13.9%) RTC/TGH episodes were re-admissions. The majority of re-admits in Pinellas County were male, White, were classified as SED, and also had an episodic mood disorder. Overall, the proportion of RTC/TGH episodes that were re-admissions varied between 13.9% and 16.1% across the three counties.

Table 20: Youth Readmitted to RTC/TGH within 6 Months

| | Alachua | |
|---|---|---|

## Service Utilization and Adverse Events Prior to and Post Incarceration

For those children and youth who had episodes of incarceration, we summarized the service event and adverse event history over the 6 months preceding admission, and the 6 months following discharge. For this analysis we limited the sample to youth that were admitted after July 1, 2010 in order to have six months of data preceding the admission. Similarly, youth had to be discharged before July 1, 2014 in order to have 6 months of follow-up data. In addition, when summarizing behavioral health service use we limited the sample to the first incarceration episode for the youth. The limitation to the first incarceration episode for each youth avoided double counting services for re-admissions.

Table 21 contains for each county the summary of service use and adverse events in the 6 months before and after incarceration. There was behavioral health service use reported for 144 of the 281 youth with incarcerations in Alachua County in the 6 months prior to entry, and 148 youth in the 6 months after discharge from RTC/TGH. First, we looked at Medicaid-funded services. Twenty of the 144 youth had psychiatric inpatient stays in the prior 6 months. Most youth received outpatient (97 youth), assessment (61), and/or targeted case management (50 youth) services in the 6 months prior to entry. Expenditures for out-of-home (OOH) mental health treatment (SIPP, STFC, or TGH) were $291,652. Among SAMH services, the most common services were outpatient (61 youth), assessment (30 youth), crisis care (30 youth), or targeted case management (29 youth). Fifty-one youth had a Baker Act in the 6 months prior to incarceration.

In the 6 months after incarceration, a majority of youth received Medicaid funded assessment (60 youth), outpatient (92 youth), targeted case management (30 youth), and/or treatment planning (49 youth) services. Eleven youth subsequent SIPP services. Expenditures for Medicaid-funded OOH mental health treatment increased to $553,224. Among SAMH funded services, the most common were outpatient (62 youth), assessment (32 youth), and targeted case management (30 youth).

For youth in Broward County, there was behavioral health service use for 258 of the 470 youth in the 6 months prior to incarceration, and 257 youth in the 6 months after discharge. First, we looked at Medicaid-funded services. Thirty-one of the youth had psychiatric inpatient stays in the prior 6 months. Most youth received outpatient (197 youth), assessment (153 youth), and/or targeted case management (100 youth) services. Thirteen youth received STFC services and 12 youth TGH services. Expenditures for Medicaid-funded OOH mental health treatment were $580,375. Among SAMH services, the most common services were outpatient (76 youth), assessment (32 youth) and targeted case management (24 youth) in the six months prior to incarceration. Fifty-two youth had a Baker Act in the 6 months prior to incarceration.

In the 6 months after incarceration, the most common Medicaid funded services included assessment (174 youth), outpatient 228 youth), targeted case management (77 youth), and treatment planning (114 youth) services. Thirty-two youth had subsequent admissions to SIPP services, 12 had subsequent STFC services and 23 received TGH services. Medicaid expenditures for OOH mental health treatment increased to $669,144. Among SAMH funded services, the most common were outpatient (100 youth), assessment (35

youth), and targeted case management (26 youth) services. Forty-one youth had subsequent Baker Act examinations.

For youth in Pinellas County, 483 of the 842 youth with incarcerations had behavioral health service use in the 6 months prior to incarceration, and 536 youth in the 6 months after discharge. First, we looked at Medicaid-funded services. Forty-seven youth had psychiatric inpatient stays in the prior 6 months, while 16 youth received STFC services. Most youth received outpatient (311 youth), assessment (212 youth), and/or targeted case management (169 youth) services. Total Medicaid expenditures for OOH mental health services were $633,265. Among SAMH services, the most common services were outpatient (177 youth), assessment (145 youth), or targeted case management (136 youth). There were 155 youth that had a Baker Act in the 6 months prior to incarceration.

In the 6 months after discharge, the most common Medicaid funded services included assessment (237 youth), outpatient (313 youth), and targeted case management (188 youth) services. Thirty-nine youth had subsequent SIPP admissions, 17 had TGH admissions, and 15 subsequent STFC services. Total Medicaid expenditures for OOH services increased to $2,029,909. Among SAMH funded services, the most common were outpatient (249 youth), assessment (175 youth), and targeted case management (212 youth) services. There were 112 youth with Baker Act examinations.

| Broward County | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 6 months before incarceration (n=258) | | | | 6 months after incarceration (n=299) | | | |
| | Medicaid | | SAMHIS | | Medicaid | | SAMHIS | |
| | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid |
| Behavioral Health Expenditures | | | | | | | | |

| Pinellas County | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 6 months before incarceration (n=483) | | | | 6 months after incarceration (n=536) | | | |
| | Medicaid | | SAMHIS | | Medicaid | | SAMHIS | |
| | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid | Users (n) | Total Paid |
| Behavioral Health Expenditures | | | | | | | | |
| Assessment | 212 | $39,540.65 | 145 | $23,015.87 | 237 | $58,939.03 | 175 | $27,500.17 |
| Crisis Care | 36 | $8,404.33 | <10 | $936.75 | 34 | $11,550.89 | 12 | $1,035.77 |
| Developmental Disability | <10 | $212.91 | | | <10 | $522.86 | | |
| Incidental Expenses | | | <10 | $1,550.00 | | | | |

## Conclusion and Recommendations

This report examined youth in three counties in Florida (Alachua, Broward, and Pinellas), and reported on their behavioral health service use over a five year period. Youth can have complex behavioral health needs and home environments and as a result, some youth come into contact with several state systems including the behavioral health system, the justice system, and the child welfare system. The combined public sector costs are substantial for youth with complex behavioral health needs, and efforts are necessary to ensure that these youth receive the most appropriate treatment. This report provides detailed information on the demographic characteristics of these youth and types and amounts of behavioral health services received over the five-year period.

## Reference

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