oppaga
OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

February 2006 **Report No. 06-12**

Centralizing DCF Substance Abuse and Mental Health Programs Produced Benefits

at a glance

The department has restructured the substance abuse and mental health programs to support the centralized organizational structure required by law. The centralized structure created some challenges but has produced several benefits, including improved system outcomes, better service coordination, more streamlined functions, greater use of evidenced-based practice, and enhanced data collection and analysis. Therefore, the current structure and placement of the substance abuse and mental health programs should be continued beyond the October 2006 sunset date.

Some additional changes could further streamline functions and improve system outcomes:

- **consolidating the programs' budget unit and the program functions of supported employment and supported housing, and**
- **designating an entity to convene regular meetings of state agencies involved in the mental health system.**

Scope

As directed by Ch. 2003-279, *Laws of Florida,* OPPAGA and the Auditor General examined the state's substance abuse and mental health systems and management. This report assesses the impact of organizational changes within the Department of Children and Families (DCF) on the substance abuse and mental health programs. [1, 2] This report addresses four questions.

1. What changes have occurred in the programs' organizational structure as a result of the 2003 law changes?
2. What challenges have arisen with the revised organizational structure?
3. What benefits of the centralized structure have been realized?
4. Should the current structure and placement of the substance abuse and mental health programs be continued?

Background

The Department of Children and Families is responsible for planning, evaluating, and implementing comprehensive statewide programs for mental health and substance abuse. The department's mental health programs are intended to reduce the occurrence and disabling effects of mental health problems. These programs include adult community mental health, children's mental health, and

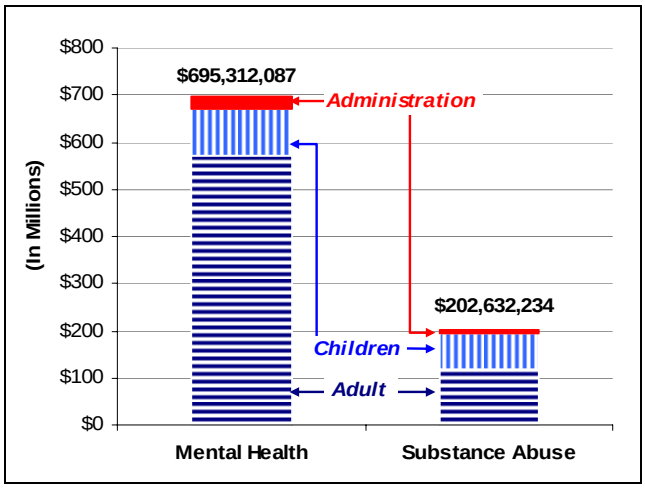
[1] OPPAGA issued a preliminary report on these changes in February 2005, *Centralizing DCF Substance Abuse and Mental Health Programs Provides Benefits But Also Challenges,* OPPAGA Report No. 05-07.

[2] A future report will evaluate the Substance Abuse and Mental Health Corporation. We issued a preliminary report on the corporation in March 2005, *The Substance Abuse and Mental Health Corporation Has Not Addressed Its Responsibilities Fully,* OPPAGA Report No. 05-17.

receiving and treatment facilities.[3] The department's substance abuse programs are intended to lessen the detrimental effect of use and abuse of legal and illegal substances. These programs include prevention, intervention, and treatment services for adults and children.[4] The substance abuse program also licenses not-for-profit and for-profit treatment providers.

For Fiscal Year 2005-06, the Legislature appropriated nearly $900 million to the Department of Children and Families for mental health and substance abuse services, with most of these funds (nearly $700 million) appropriated to mental health programs (see Exhibit 1). The Legislature appropriated 112 full-time equivalent positions (FTEs) to administer community-based mental health programs, 4,283.5 FTEs to mental health treatment facilities for services, and 59 FTEs to administer substance abuse programs. Administration for both programs totaled $32 million.

Exhibit 1
Mental Health Services Receive the Bulk of Program Funding



Source: Fiscal Year 2005-06 General Appropriations Act, Ch. 2005-70, *Laws of Florida.*

Role of other state agencies in the state's system for substance abuse and mental health services. Several other state agencies are involved in the state's system for providing and/or funding substance abuse and mental health services. These agencies include the Departments of Education, Corrections, Juvenile Justice, and Law Enforcement, and the Agency for Health Care Administration. Appendix A shows the funding these agencies receive for various substance abuse and mental health services, while Appendix B shows funding transfers between the agencies and the portion of funds that are used for in-house and contracted services.

- The Florida Department of Education provides federal funds to school districts for substance abuse prevention education and coordinated community services for students who are severely emotionally disturbed.
- The Department of Corrections operates substance abuse and mental health programs in the state prisons and relies on community substance abuse and mental health providers for services to offenders on probation or community control.
- The Department of Juvenile Justice operates substance abuse and mental health programs in its residential detention and commitment facilities and relies on community substance abuse and mental health providers for juveniles in community programs or on probation.
- The Florida Department of Law Enforcement provides grant funding to local criminal justice agencies for substance abuse enforcement, prevention and education, and treatment activities.
- The Agency for Health Care Administration operates the state's Medicaid program, which provides health coverage for selected categories of persons with low incomes, such as children, the elderly, and the disabled.

[3] Services include emergency stabilization, case management, outpatient services, assertive community treatment teams, juvenile competency restoration, community support services, residential care, forensic treatment, and civil treatment.

[4] Services include prevention, detoxification, residential treatment and aftercare, and outpatient treatment and aftercare.

Questions and Answers —

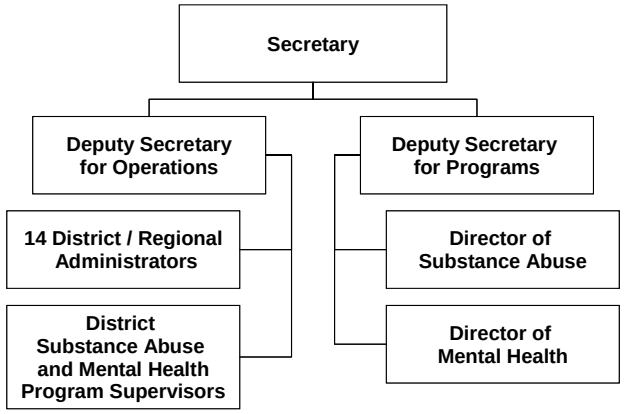
Question 1: What changes have occurred in the programs' organizational structure as a result of the 2003 law changes?

With Ch. 2003-279, *Laws of Florida,* the Legislature reorganized the department's substance abuse and mental health programs into a centralized structure. The department reorganized the programs' central and district offices to support the reorganization and is in the planning stages for some other organizational changes. Stakeholders identified some additional changes that could further streamline functions and encourage the sharing of best practices.

The Legislature reorganized the substance abuse and mental health programs into a centralized organizational structure. Before 2003, the Department of Children and Families' substance abuse and mental health programs operated within the department's decentralized district structure. Under this structure, the department operated through a central office and 13 districts and one region. Local substance abuse and mental health programs operated under the supervision of their respective district offices and received administrative support services from these offices.

As shown in Exhibit 2, a major characteristic of the prior structure was that the programs' central office and district staff had separate chains of command. Local program supervisors who oversaw substance abuse and mental health programs reported to their district administrator, who reported directly to the department's deputy secretary for operations. At the central office, the substance abuse and mental health programs each had a separate director who answered to the deputy secretary for programs.

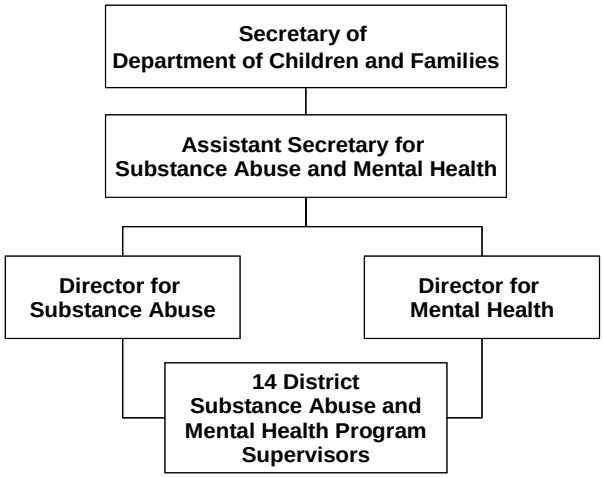
Exhibit 2
Previously, Programs and Operations Had Separate Chains of Command



Source: Department of Children and Families.

With Ch. 2003-279, *Laws of Florida,* the Legislature reorganized the substance abuse and mental health programs into a centralized structure. This structure will expire on October 1, 2006, unless reenacted by the Legislature before that date. The law established the position of deputy secretary for substance abuse and mental health, who answers to the Secretary of the department. This position was re-titled as an assistant secretary when the department established a deputy secretary position over administration and all programs. The assistant secretary oversees a program director for substance abuse and a program director for mental health. Each program director has line authority over district substance abuse and mental health program supervisors and direct control over the program's budget and contracting functions (see Exhibit 3). In addition, supervision of the mental health treatment facilities was transferred from district administrators to the director for mental health.

Exhibit 3
New Organizational Structure Provides Direct Central Office Oversight of District Staff



Source: Department of Children and Families.

In addition to reorganizing the substance abuse and mental health programs, the department has reorganized its administrative functions by consolidating its districts and programs into six large zones.[5] However, the substance abuse and mental health district offices were not consolidated into zones and are the only programs remaining at the district level. Functions of the substance abuse and mental health programs at the district level are contract management, budget, policy implementation, and working with providers and other agencies. The programs rely on the zones for most of their administrative support.

The department reorganized the substance abuse and mental health programs to support the reorganization. To support the centralized structure, the department made organizational changes in contracting, budget, mental health treatment facilities, clinical consultation, and district operations (see Exhibit 4). These changes streamlined functions, enhanced accountability, and made better use of limited staffing.

[5] Administrative functions consolidated at the zone level include program offices, human resources, financial management, information technology, general services, purchasing, and contract administration.

Exhibit 4
The Department Made Several Changes in the Organizational Structure of the Substance Abuse and Mental Health Programs

Area of Change	Description of Changes
Contracting	Initially established separate contract units for substance abuse and mental health, but subsequently consolidated them into a single unit supervised by the mental health program director. The consolidated unit Includes central office contract managers.
Budgeting	Established a separate budget unit each for substance abuse and mental health. Moved the mental health budget unit from the chief of operations to the mental health program director. The substance abuse budget unit reports to the substance abuse program director.
Treatment Facilities	Moved the supervision of mental health treatment facilities from district administrators to the mental health director. Also transferred the sexually violent predator program to the mental health treatment facilities unit.
Clinical Consultation	Initially created a clinical unit in the mental health program, but subsequently eliminated this unit and dispersed staff to other units.
District Operations	Moved direct supervision from district administrators to the central office. Also began sharing functional responsibilities between small and large districts.

Source: OPPAGA analysis.

The department initially created separate contract units for the substance abuse and mental health programs that were charged with developing model service contracts and guidelines for districts. The department subsequently combined these units under the supervision of the director for mental health with indirect supervision by the director for substance abuse. The merged unit is now responsible for contract development, contracting guidelines, and specialized contract training geared to the needs of individual districts. In addition, the department moved substance abuse and mental health program staff who manage contracts in the central office to the consolidated contract unit. These changes have standardized contract procurement, development, and management between the substance abuse and mental health programs and strengthened accountability by placing contract responsibility directly with the director of mental health.

The department also created budget units in each program to oversee the central office and district substance abuse and mental health budgets. Two operations managers, one for each program, were added to the central office to assist with supervising district program supervisors.

As part of centralizing the organizational structure, the department also transferred supervision of civil mental health treatment facilities from the district administrators to the director of mental health. [6] This transfer was intended to standardize practices and enhance accountability in the areas of budgets, personnel, and utilization of facility beds. To further enhance accountability and uniformity of practice, the mental health program office moved the sexually violent predator program under the mental health treatment facilities unit. [7] This organizational change is designed to address concerns about the sexually violent predator program in the areas of clinical practice, program management, contract management, and quality assurance.

To support the new organizational structure in the area of clinical consultation, the mental health program office initially created a clinical unit to consult on treatment practices with central office and district staff, as well as to provide clinical quality assurance for mental health treatment facilities. However, after testing this model of clinical consultation, program managers decided that eliminating this unit and dispersing its staff to other mental health program units would be a better method of ensuring that clinical best practices were in place.

To address staffing reductions, the department informally aligned smaller districts with larger districts to share functional responsibilities in areas where these reductions affected district personnel's ability to provide sufficient support. These areas include licensing, data support, and budget. [8]

The department is planning additional organizational changes to the substance abuse and mental health programs. The department is planning two additional organizational changes. First, the department plans to combine the functions of operations and community programs in mental health to address communication problems. Program managers told us that creating a chief of operations, to whom district supervisors reported as a part of the centralized structure, resulted in too much separation between the program administrators who established program policies and district operational supervisors who are responsible for carrying out those policies. The managers indicated that program supervisor meetings and other communications tend to focus on operational rather than programmatic issues. These managers also expressed concern that their previous frequent contact with program supervisors became infrequent under the centralized structure.

To address these concerns, the mental health program's central office is combining the functions of its operations and community programs. A new community unit will supervise district operations as well as adult community mental health and children's mental health units. The renewed emphasis on programmatic issues should improve communication between district program supervisors and central office program managers.

Second, the department is planning to begin using managing entities to administer substance abuse and mental health services. A managing entity is an organization that administers mental health and substance abuse services through a network of service providers. This organization can be a for-profit, not-for-profit, or public entity.

[6] Forensic mental health treatment facilities were already supervised by the director of mental health.

[7] The sexually violent predator program is a civil commitment program to provide residential treatment to sexual predators committed to the program by the courts.

[8] The mental health and substance abuse programs have also experienced several management changes, including a new assistant secretary, new directors of the mental health and substance abuse programs, a new head of operations for mental health, and the creation of a deputy director position for mental health.

This change would introduce managed care into state-funded mental health and substance abuse services for clients who are not Medicaid-eligible. The managing entities would perform some administrative functions currently performed by department staff, such as negotiating contracts with local providers, managing these contracts, and paying providers for services. This could enable department staff to concentrate their efforts on statewide planning for substance abuse and mental health services as well as working with other state agencies to better coordinate and integrate mental health and substance abuse services. In addition, the managing entities would perform important administrative functions not currently performed by the department, such as creating provider networks, conducting quality assurance reviews of providers, and credentialing of providers.

The move to managing entities is in the early planning stages. The department has created three teams composed of providers, district and central office staff, and advocates to develop options and recommendations in the areas of the role and responsibilities of the department and managing entities, contracting and financing, and the data system needed to support managing entities. The anticipated implementation date for managing entities is 2008.

Additional organizational changes could further streamline functions and enhance the sharing of best practices. Two additional organizational changes may further improve support and program functions. First, program staff recommended combining the substance abuse and mental health budget units, as the two programs currently share planning, data support, and contracting. Second, staff recommended consolidating functions such as supported housing and supported employment (the two programs currently share the Temporary Assistance to Needy Families (TANF) diversion program). These changes would better integrate the substance abuse and mental health programs, enhance the sharing of best practices between the programs, and reduce the number of central office staff with whom district staff must work.

Question 2: What challenges have arisen with the revised organizational structure?

The new centralized organizational structure for the substance abuse and mental health programs has created challenges due to using temporary employees to carry out program functions, difficulties in working within the department's zone structure, and delays caused by reorganizing the contract monitoring function. However, the reorganization has not hindered the program's ability to work with other stakeholders, which was a concern at the time of our prior report.

Limited program staffing has resulted in using temporary employees to perform critical program functions. In our February 2005 report, we noted that staffing reductions in the substance abuse and mental health programs in Fiscal Year 2004-05 over-extended staff resources, especially in the districts. The department made organizational changes to address this issue, including sharing district resources.

However, due to the reduction in permanent positions, the department is using temporary employees in Other Personnel Services (OPS) positions to perform critical program functions including contract management, budget support, and substance abuse provider licensing. Program managers report that a large percentage of staff are in OPS positions. [9] These positions tend to have high staff turnover, which has contributed to inconsistent application of policies and procedures. [10]

The department's administrative zone structure continues to present challenges to the programs. As noted in our previous report, district program staff continue to report that they experience delays in receiving administrative support from the zones in

[9] Five of 14 program supervisors could readily report this information. The average percentage of OPS employees reported by these supervisors was 64%, with a range of 50% to 72%.

[10] For example, program managers noted that district licensure staff were not consistently applying the correct licensure fees to providers.

purchasing equipment, having provider contracts reviewed, hiring staff, and network support for information systems. District and central office program staff attribute these delays to having a different organizational structure and priorities than the zones.

Transferring contract monitoring caused delays and communication barriers. In recent years, the department has reorganized its contract monitoring function, moving these staff first from the districts to the zones, then transferring these staff to its inspector general's office and finally moving this function to a new performance management unit in the central office. These reorganizations led to delays in district staff receiving monitoring reports on substance abuse and mental health providers. Program supervisors also asserted that moving the function away from districts reduced their ability to meet regularly with contract monitoring staff to exchange information.

Program supervisors also continue to be concerned about the qualifications and background of department contract monitors and whether they can adequately monitor substance abuse and mental health providers. Contract monitors tend to be generalists who do not have a background in substance abuse or mental health and lack the clinical and program expertise to review critical programmatic aspects of provider performance. Program supervisors instead rely on their contract managers, who have clinical and programmatic experience, to monitor the quality of provider services and rely on the contract monitors for the technical aspects of contract compliance.

Reorganization did not affect interorganizational working relationships. At the time of our prior report, district staff were concerned that the new centralized organizational structure could hinder their ability to maintain relationships with other department programs and external agencies. However, this potential problem has not materialized. District staff report that they have maintained strong working relationships with department programs and external agencies. Central office staff report that the centralized structure has instead strengthened their working relationship with other department programs, especially child welfare as well as other state agencies, especially the Departments of Juvenile Justice and Corrections.

Question 3: What benefits of the centralized structure have been realized?

The centralized structure has produced numerous benefits, such as faster decision making, increased standardization of practices, and greater use of performance data in decision making. The reorganization also has led to some improved system outcomes, such as better coordination of services among agencies. Stakeholders recommended an additional change that could enhance system outcomes.

Centralizing the substance abuse and mental health programs produced several benefits

Despite creating some challenges, centralizing the organizational structure of the substance abuse and mental health programs led to more streamlined functions and improved accountability. Benefits noted by stakeholders include faster decision making; greater visibility for the substance abuse and mental health programs; more cohesion between the substance abuse and mental health programs; stronger working relationships between the districts and the central office; increased standardization of policies and practices; improved accountability for treatment facilities, contracting, and personnel; a stronger professional cadre of contract staff; fewer budget reversions; and increased use of performance data in decision making.

Faster decision making. The centralized structure allows for more immediate decision making and problem solving. For example, when a district had a problem with a child welfare lead agency being able to access therapeutic foster care services, it raised the issue directly to the appropriate staff at central office, who immediately provided the district with a decision. District program supervisors stated that decisions are being made quickly and that they have direct access to those making the

decisions. Also, under the current structure, central office staff with expertise in substance abuse and mental health programs can provide decisions to district supervisors without first going through the deputy secretary of programs, the deputy secretary for operations, district administrators, and district program managers.

Greater visibility for the substance abuse and mental health programs. As intended, the new structure appears to have elevated the visibility and support of the programs. District and central office substance abuse and mental health staff noted that the new structure improved relationships between the substance abuse and mental health programs and stakeholders. District and central office staff both indicated that the ability to work directly with substance abuse and mental health providers, advocates, and other stakeholders, rather than channeling communication through the former district structure, has improved communication with these key groups.

More cohesion between the substance abuse and mental health programs. The new organizational structure enhances intra-departmental coordination by creating more cohesion between the two programs and among the central office and districts. The creation of the assistant secretary position has improved coordination between the substance abuse and mental health programs rather than leaving them to operate in separate program silos.

Stronger working relationships between the districts and the central office. The centralized structure provides district staff with a sense of identification with a statewide program. Program supervisors noted that they are more responsive to the central office than under the previous district structure. They also observed that because of the shift in responsibility from districts to the central office, the central office now has ownership of what happens in local communities, which helps it ensure that functions are completed.

Increased standardization of policies and practices. Under the current structure, the central program office is standardizing policies and practice through more frequent contact with program supervisors and regional meetings. These meetings create a forum for program managers to see statewide trends and share expertise, resulting in greater use of best practices. From the perspectives of both district program supervisors and central office staff, the new structure provides more uniformity in the programs and sharing of best practices has been enhanced through more frequent contact with central office staff and other program supervisors.

Improved accountability for treatment facilities, personnel, and community programs. A key benefit of the centralized reporting structuring is that it has provided a more systematic approach to oversight and accountability, especially in the areas of supervision of facilities, personnel management, and contracting.

District and central office staff asserted that the central supervision of the state's civil mental health facilities has produced several advantages, including better incorporation of the facilities into the mental health system of care, a better view of system assets and client need, and more accountability for facility administrators. For example, central office staff are better able to track facility admissions and discharges and to change catchment areas as needed. The central office now receives census counts directly from the facilities. The central office also stated that direct supervision of the facilities is improving the transition of residents to community-based services. Furthermore, there is now more scrutiny of facility budgets and personnel actions. Treatment facilities are now required to follow common procedures. This is reinforced by monthly visits and annual quality assurance reviews by central office staff, which did not occur under the previous decentralized structure.

Personnel management also has improved. The central office, rather than the district administrator, now has hiring and firing authority for program supervisors. With this new authority has come the ability to clarify performance expectations for district staff, implement more stringent performance expectations for supervisors, and add quality measures in performance evaluations. District performance is enhanced through direct access

to experts in clinical best practices in the central office and the improved training and technical assistance now provided by the substance abuse and mental health programs in the central office.

The central office now has the lead for developing substance abuse and mental health contracts, rather than serving in a consulting capacity to the department's contract office. The central office substance abuse and mental health contracting unit develops model service contracts and guidelines for districts' use. This has reduced variability in contracts across the state through the ability to ensure that contract content and performance measures are not changed at the district level.

A stronger professional cadre of contracting staff. Program staff report that consolidating contract units, transferring central office contract managers into this unit, and providing training to central office and district staff to standardize contract practices has produced improvements in procurement and contracting practices. Program managers report that these improvements created a stronger professional cadre of contracting staff in the districts and central office than existed before the reorganization.

Fewer budget reversions. In the mental health program, budget employees were moved from supervision by the chief of operations to direct supervision by the director, giving him greater control over the mental health budget. The budget unit for the substance abuse program is under the supervision of the substance abuse director. Program managers report that the centralized budget units have enabled the central office budget staff to work more closely with district budget staff, which has led to fewer fund reversions in the past year.

Increased use of performance data in decision making. The substance abuse and mental health programs actively participate in the department's new performance management system. This system involves districts, the region, zones, the central office, and providers. The system has several components, including strategic and business planning, performance review and improvement, and resource management. Program managers report that the performance management system has resulted in providers focusing more on data integrity and performance results and district and central office managers using data for decision making.

The centralized organizational structure has lead to several anticipated system outcomes being achieved

The 2003 law that directed the department to centralize the substance abuse and mental health programs' organizational structure established several goals for this initiative. While the reorganization has not attained all of these outcomes yet, several improved outcomes appear to be associated with the new organizational structure. Stakeholders noted improved service coordination, greater use of evidence-based practices, and improved data collection and analysis of information among the benefits for the reorganization. [11]

Improved service coordination. The centralized structure appears to have improved coordination of services between the Department of Children and Families and other agencies by giving the central office staff the authority to commit staff and resources to important projects. For example, the department and the Agency for Health Care Administration are working closely on the planned shift to behavioral health services managed by Medicaid Health Maintenance Organizations (HMOs) and pre-paid behavioral health plans and establishing protocols for data sharing necessary to serve Medicaid recipients through different funding streams. The Departments of Children and Families and Juvenile Justice also are working on developing suicide prevention strategies for juvenile justice residential facilities.

Increased service delivery efficiency. Stakeholders report that the centralized structure has improved the delivery of aftercare services to former Department of Corrections inmates who need community mental health services upon release from prison. Program

[11] These stakeholders include department staff, advocates, trade associations, and other state agencies.

managers credit the centralized structure with providing the authority to establish direction for the districts and ensure such direction is followed. As a result, the Departments of Children and Families and Corrections have updated policies and procedures and developed an interagency agreement to ensure that former inmates are linked to mental health services in the community. DCF staff now participate with Department of Corrections staff in planning aftercare services for inmates. The mental health director told district staff and providers that former inmates are priority clients for services. The department also makes available a list of district forensic coordinators on its intranet site for corrections staff to use.

Greater use of evidence-based practices. The centralized program structure appears to have increased use of evidence-based practices in mental health and substance abuse services. Department staff reported that the centralized structure provided stronger mechanisms to ensure that provider agencies and mental health treatment facilities use these practices. The centralized contracting and supervision of providers and mental health treatment facilities has facilitated dissemination of information about these evidence-based practices. For example, the Departments of Children and Families and Juvenile Justice are now working together to ensure that mental health and substance abuse evidenced-based practices are in use in juvenile justice residential facilities.

Enhanced data collection and analysis. Program managers note that the centralized structure has given them a greater ability to make data sharing with the Agency for Health Care Administration a priority and commit resources to this initiative. For example, stakeholders reported that the Department of Children and Families and the Agency for Health Care Administration are working together to develop common data sets, share data on mutual clients, and develop common client outcomes.

Quality of and satisfaction with services not affected. Although improving service quality and client satisfaction was a goal of the reorganization, stakeholders we interviewed were not able to identify examples by which the new centralized structure had produced these outcomes. These stakeholders noted that the reorganization did not directly affect the allocation of resources within the programs or the other state agencies and private providers that deliver most program services. Also, the stakeholders noted that determining community satisfaction is difficult since state agencies do not systematically measure this aspect of the programs.

An additional change could enhance system outcomes. Stakeholders noted that the state lacks a forum for agencies that fund or provide mental health services to discuss and resolve service coordination and integration issues. Such a forum exists for substance abuse prevention and treatment services through the Governor's Office of Drug Control. Several stakeholders suggested that a mechanism be created for convening regular meetings of all state agencies that purchase, provide, or fund mental health services to discuss and overcome barriers to collaboration. This would help eliminate barriers to the effective integration of mental health services across agencies. The Behavioral Health Services Integration Workgroup, which was established by the 2001 Legislature but is no longer active, could serve to coordinate these meetings.

Question 4: Should the current structure and placement of the substance abuse and mental health programs be continued?

Due to the benefits that have been gained through the centralization of the substantive abuse and mental health programs, we determined that the program's current organizational structure should be retained. The organizational assignment of the programs in the Department of Children and Families remains the most appropriate placement.

The centralized organizational structure should be continued

The consolidated administrative structure of the substance abuse and mental health programs has been beneficial to both programs by enhancing their visibility and accountability, streamlining functions, better standardizing policies and practices, and improving some system outcomes. Stakeholders we contacted supported this centralized structure. These stakeholders noted that the two programs share a high percentage of clients and providers. In addition, the programs share many functions, such as planning, data, contracting, and the TANF diversion program.

We found no consensus on the option of fully merging the substance abuse program with the mental health program. These programs now share an administrative structure, but they remain separate programs under the assistant secretary for substance abuse and mental health. The programs each have a director in the department's central office with line authority over district program supervisors and direct control over the program's budget and contracting functions. Stakeholders supporting the continuation of separate programs note that despite the large number of clients with both mental health and substance abuse problems, the programs have distinct client groups with specialty providers and advocacy groups. In addition, the separate program structure mirrors the federal structure, with separate mental health and substance abuse programs and separate funding streams. [12] In contrast, stakeholders supporting merging the two programs noted their similarities, the need to better share best practices, the need to improve service delivery to clients with co-occurring disorders, and aligning the central office with the district structure. [13]

The programs should remain within the Department of Children and Families

The program's current placement in the Department of Children and Families is appropriate and should be continued. [14] We considered other organizational placements, including transferring the programs to the Department of Health, the Agency for Health Care Administration, and creating a separate agency for these programs. However, benefits of continuing the current structure include

- the mission, core functions, and organizational structure of other state agencies do not lend themselves to managing substance abuse and mental health community services and institutions;
- management of the programs by DCF does not hinder collaborative efforts with other state agencies involved with substance abuse and mental health services, and facilitates collaboration with other department programs, such as child welfare;
- creating a separate agency would require additional resources to support the agency's infrastructure; and
- many other states have substance abuse and mental health services in their human services agency. [15]

Recommendations

To further support the centralized organizational structure of the substance abuse and mental health programs, we recommend that the department

- consolidate the substance abuse and mental health programs' budget functions; this change would further streamline the organizational structure and align this support function with the others that are consolidated, such as planning, contracting, and data systems; and

[12] In 26 states, substance abuse and mental health services are provided by different divisions or agencies.

[13] In 23 states, the same office is responsible for both substance abuse and mental health services.

[14] *State Mental Health Agency Organization and Structure: 2004,* No. 05-2, National Association of State Mental Health Program Directors Research Institute, Inc., August 24, 2005.

[15] In 24 states, substance abuse and mental health services are in their human service agency.

- consolidate program functions such as supported living and supported employment, to enhance the integration and coordination of the substance abuse and mental health programs.

Regarding the structure and placement of the substance abuse and mental health programs, we recommend that the Legislature

- continue the centralized organizational structure of the programs, which has produced enhanced accountability, increased efficiencies, better standardized policies and procedures, and improved system outcomes;
- continue the substance abuse and mental health programs under the same administrative structure, which produces benefits due to the high percentage of clients with co-occurring disorders, similar clinical issues, and a shared provider network; and
- continue the placement of the substance abuse and mental health programs within the Department of Children and Families, which as the state's human service agency is the most appropriate placement for these programs.

To enhance the achievement of improved system outcomes in the substance abuse and mental health systems, the Legislature should consider revising s. 394.9083*, Florida Statutes,* to create the Behavioral Health Services Integration Workgroup as an ongoing workgroup. The Department of Children and Families could be given the authority to convene regular meetings of those state agencies involved in mental health services to assess barriers to the effective and efficient integration of mental health services across agencies, and propose solutions to these barriers.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes,* a draft of our report was submitted to the Secretary of the Department of Children and Families for review and response.

The Secretary's written response to this report has been reproduced in its entirety in Appendix C, page 15.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

Florida Monitor: www.oppaga.state.fl.us

Project supervised by Nancy Dufoe (850/487-9242)
Project conducted by Drucilla Carpenter (850/487-9277) and Deanna Hamilton
Becky Vickers, Staff Director for Health and Human Services (850/487-1316)
Gary R. VanLandingham, OPPAGA Director

Appendix A

Substance Abuse and Mental Health Funding by Service Type for Fiscal Year 2004-05

The table below shows funding by type of service for those state agencies that provide or fund substance abuse and mental health services. Funding is based upon appropriations for Fiscal Year 2004-05.

	AHCA	DCFS	DJJ	FDLE	DCOR	DOE[2]	Total	State	Federal
Mental Health									
Emergency Stabilization		$105,028,474			$ 3,335,569		$108,364,043	$ 97,754,039	$ 10,610,004
Residential Care		81,663,946	$12,152,864				93,816,810	86,821,106	6,995,704
Case Management		25,768,146	2,035,713				27,803,859	18,724,065	9,079,794
Outpatient Services		58,918,368			36,378,155		95,296,523	84,049,008	11,247,515
Community Support Services		42,025,090					42,025,090	30,527,502	11,497,588
Assertive Community Treatment Teams		37,305,985					37,305,985	26,292,529	11,013,456
Juvenile Restoration Support		6,062,772					6,062,772	6,062,772	---
Forensic Treatment		106,234,156					106,234,156	102,032,559	4,201,597
Civil Treatment		185,642,636					185,642,636	90,003,645	95,638,991
Other [1]	$1,049,009,240	52,756,919			189,485		1,101,955,644	435,747,431	666,208,213
Total	$1,049,009,240	$701,406,492	$14,188,577		$39,903,209		$1,804,507,518	$978,014,656	$826,492,862
Substance Abuse									
Prevention/ Education		34,114,967	1,104,490	4,055,430		316,000	39,590,887	9,345,583	30,245,304
Treatment		131,727,202	1,874,319	2,678,193	34,804,370		171,084,084	88,183,260	82,900,824
Enforcement		27,265,921	552,245	3,833,923			31,652,089	10,826,419	20,825,670
Other [1]	899,869	6,538,209		302,144	877,866		8,618,088	3,976,665	4,641,423
Total	$ 899,869	$ 199,646,299	$ 3,531,054	$ 10,869,690	$ 35,682,236	$ 316,000	$ 250,945,148	$ 112,331,927	$138,613,221
Total Mental Health and Substance Abuse	$1,049,909,109	$ 901,052,791	$17,719,631	$ 10,869,690	$ 75,585,445	$ 316,000	$2,055,452,666	$1,090,346,583	$965,106,083
State	$ 403,483,336	$ 602,566,042	$12,997,217		$ 70,983,988	$ 316,000	$1,090,346,583		
Federal	$ 646,425,773	$ 298,486,749	$ 4,722,414	$ 10,869,690	$ 4,601,457	---	$ 965,106,083		

[1] Includes administrative costs and amounts that agencies were not able to identify by type of service. AHCA's amount represents payments to medical providers.

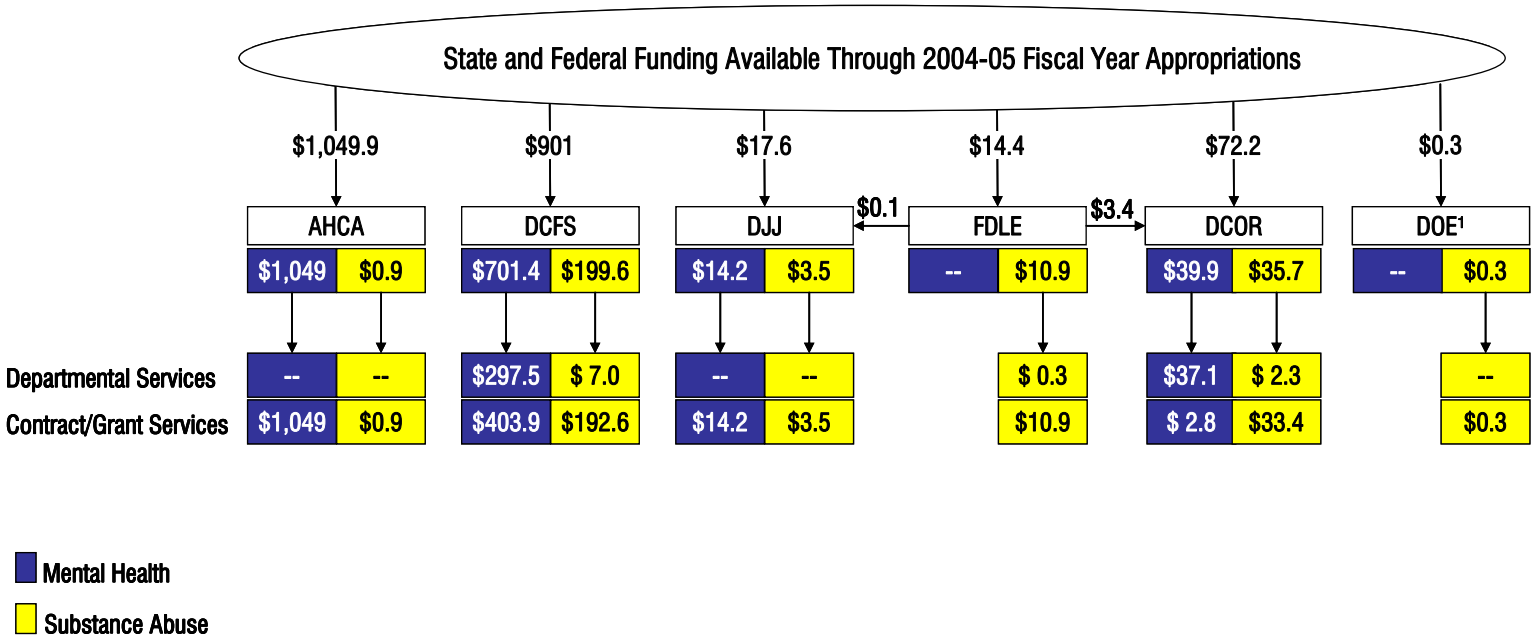
[2] DOE identified additional appropriations provided directly to district school boards for various programs that were broadly related to substance abuse and/or mental health (e.g., Safe Schools and Exceptional Students Education). However, these funds could not readily be categorized into specific substance abuse and mental health services.

Source: Compiled from agency-provided information by the Office of the Auditor General.

Appendix B

Allocation of Substance Abuse and Mental Health Funding for Fiscal Year 2004-05

The diagram below shows funding by department or contracted services, as well as funding transfers between agencies, for those state agencies that provide or fund substance abuse and mental health services. Funding is based upon appropriations for Fiscal Year 2004-05.



[1] DOE identified additional appropriations provided directly to district school boards for various programs that were broadly related to substance abuse and/or mental health (e.g., Safe Schools and Exceptional Students Education). However, these funds could not readily be categorized into specific substance abuse and mental health services.

Source: Compiled from agency-provided information by the Office of the Auditor General.

Appendix C

State of Florida
Department of Children and Families

Jeb Bush
Governor

Lucy D. Hadi
Secretary

February 3, 2006

Mr. Gary R. VanLandingham, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Tallahassee, Florida 32399-1475

Dear Mr. VanLandingham:

Thank you for your January 23, 2006 letter accompanying the preliminary findings and conclusions of your report titled "Centralizing DCF Substance Abuse and Mental Health Programs Produced Benefits."

We found the report to be a concise and clear follow-up to the February 2005 report. We are pleased that your recommendations include continuation of the organizational structure required under Chapter 2003-279, Laws of Florida. Enclosed is the department's response to the specific recommendations you provided.

We appreciate the dedicated work of your staff and look forward to our continued analysis and review of these programs that provide services to some of Florida's most vulnerable citizens. If you or your staff have additional questions, please feel free to call Susan Dickerson, Senior Management Analyst, at (850) 921-8596.

Sincerely,

/s/
Lucy D. Hadi
Secretary

Enclosure

Department of Children and Families
Response to Office of Program Policy Analysis and Government Accountability
"Centralizing DCF Substance Abuse and Mental Health Programs Produced Benefits"

Recommendation

We recommend that the department consolidate the substance abuse and mental health programs' budget functions; this change would further streamline the organizational structure and align this support function with the others that are consolidated, such as planning, contracting, and data systems; and consolidate program functions such as supported living and supported employment, to enhance the integration and coordination of the substance abuse and mental health programs.

Response

Since each of the program directors now has responsibility for the statewide operation and management of their program area, consolidation of budget functions would not be suitable. The department's new performance process includes Performance and Resource Management Teams (PaRTs) that address both programmatic performance and budget issues. The Substance Abuse and Mental Health programs have a combined PaRTs that meets monthly and addresses budget issues for both programs.

The program functions for supported employment and supported housing are two important program areas that promote individual recovery, which if combined might lead to confusion and fragmentation in the array of recovery-based services.

Below are comments about various issues presented in the report

The report mentions the reliance on temporary OPS employees to conduct critical functions, due to the reduction in permanent positions. The reliance on OPS personnel in performing mission critical functions throughout the department is a concern. I have tasked Greg Keller, Assistant Secretary of Operations to assess the reliance on OPS personnel and recommend alternatives to addressing these critical staffing needs.

The report states that the department could be given the authority to convene regular meetings of the state agencies providing substance abuse and mental health services. We believe the Substance Abuse and Mental Health Corporation accomplishes this through regular meetings to address the broad spectrum of needs and service delivery. Both the Agency for Health Care Administration and the Department of Children and Families serve as ex officio members of the Substance Abuse and Mental Health Corporation. Consideration should be given to including the Department of Juvenile Justice and the Department of Corrections as ex officio members. Additionally, through the TWG (Mental Health Transformation Working Group) appointed by Governor Bush, we are looking at system integration and removal of barriers to effective treatment and services. The TWG is composed of representative group of state agencies that address the needs of individuals with mental illnesses and substance use issues.

The TWG held its first statewide meeting in October 2005 and will reconvene in March 2006 to continue to address system changes and the implementation of a recovery-oriented system of services and supports.