Commission on Mental Health and Substance Use Disorder
Third Interim Legislative Report

1. **Subcommittee Name: Access to Care**

2. **Background Information:** As directed by the Legislature, this Subcommittee will identify barriers in the delivery of services and assess the adequacy of the current infrastructure of the 988 Florida Suicide & Crisis Lifeline system. Additionally, this Subcommittee will consider ways in which the current delivery of behavioral health care might be enhanced by addressing any barriers to service utilization and access. This Subcommittee will examine solutions to those obstacles, such as public information and marketing campaigns to promote available behavioral health resources and reduce stigma, and other options besides law enforcement transport for clients moved under the Baker and Marchman Acts.

   The Subcommittee established three workgroups to study three separate aspects of Access to Care:

   - **Barriers to Care**
   - Marketing Solutions to Barriers
   - Acute Care Transportation Options

   The Barriers to Care Workgroup was directed to gather data concerning any barriers to service utilization and access created by stigma or public fear of seeking behavioral health services that may be used by the Subcommittee to inform recommendations to address public confusion on available service choices.

   To help identify the types of barriers to care that Florida residents experience, the Barriers to Access to Care workgroup conducted a statewide survey between March 25 and April 19, 2024, targeting three groups of Florida residents: individuals living with behavioral health conditions ("peers"), family members of those individuals, and providers of behavioral health services.

   The survey was disseminated through contact lists of individuals and organizations active in the Florida Mental Health Advocacy Coalition and other behavioral health organizations. A total of 472 individuals responded to the survey questions. One set of questions focused on a predefined list of 25 barriers created by the workgroup, while respondents were also asked to make open-ended comments on their experiences. The survey results were shared with all other work groups.

   It should be noted that the peers and family members responding to the survey were already connected to a support group of some type, whether it be a local NAMI or Mental Health America affiliate, peer recovery organization, or other advocacy group; thus, it was unlikely that homeless individuals were represented in these groups. The behavioral health providers'

responses related to experiences with clients of all types in the general population, including homeless individuals.

The workgroup reviewed and analyzed the survey results, which revealed many types of barriers to access and utilization. The top barriers, listed in order by the number of respondents identifying this as a major barrier, are as follows:

The family/individual didn't know where to go for help	**189**
The individual was unable to recognize their illness	**178**
The individual had no health insurance	**171**
The individual had a fear of being labeled mentally ill or addicted	**145**
The individual had a bad experience with a behavioral health service provider	**124**
The individual had a fear of the effects of medication	**122**
The individual or family did not understand what was happening to the person	**117**
The individual had no transportation	**112**
The individual/family couldn't find a behavioral health provider within their insurance plan	**110**
The individual had health insurance but the co-pay was too expensive	**103**
The individual was homeless	**101**

The survey summary of results and top barriers identified by each of the respondent groups is included in Appendix A.

3. Recommendations from Barriers to Care (Workgroup #1):

RECOMMENDATION #1: Increase Funding to Expand Capacity of the 988 Suicide & Crisis Lifeline System

- **To ensure a 90% answer rate, secure recurring funding for Florida's 988 Lifeline Centers.** As of May 2024, Florida's average answer rate was at 78% (See Appendix B for the 988 Lifeline Data Chart for May 2024). According to the Department of Children & Families (DCF), the call volume for Florida's 988 Lifeline Centers is expected to steadily increase due to several factors: increased public awareness of 988, implementation of geo-routing (as of July 2024, calls are still routed by area code) to cell phone towers over the next two years, and increased national, state, and local advertising. The future of Florida's 988 Lifeline Centers will include operating the text and chat lines currently managed at the national level; this will result in an increase of about 5,000 contacts per month and will require additional staff, as well as additional training.

- Lifeline centers would use funding to hire additional staff and enhance operational and administrative infrastructures. As of May 2024 when Florida's average answer rate was 78%, an estimated additional 164 crisis counselors would have been needed to achieve a

90% answer rate (See Appendix B for the 988 Lifeline Data Chart for May 2024). Recurring funding could be achieved through a combination of fund sources.

- **Enhance/strengthen 988 Suicide & Crisis Lifelines as a component of Florida's behavioral health crisis system of care.** To ensure that 988 Lifelines provide a smooth and seamless entry into the crisis system and pathway to care and treatment, 988 Lifelines statewide should be directly linked to their community behavioral health providers. 988 Lifelines and community behavioral health providers should have established processes for transitioning clients in crisis to mobile response teams or central receiving facilities, when necessary, as well as providing warm hand-offs to behavioral health providers to link to follow-up care. Some areas of the state have highly effective processes and practices in place that could be replicated and applied across the state.

  It is important to be forward looking and recognize the potential of a 988 Lifeline system that is systematically linked to behavioral health providers, able to show available beds in real time, and schedule outpatient appointments 24/7, so that callers have their next appointments before hanging up the phone. The Department of Children and Families is developing a public facing Florida 988 Data Dashboard that will identify trends, show outcomes, and identify gaps in services. The accessibility of outcome data provided by the dashboard, along with the continued development of partnerships with community providers and stakeholders, will help build a more complete continuum of care.

Partners: DCF, 13 988 Suicide & Crisis Lifeline centers; Managing Entities; counties and municipalities, and community behavioral health providers

Prospective Positive Impact

- The suicide lifeline supports and strengthens the ability of Florida's system of care to help individuals and families manage a behavioral health crisis, utilizing the appropriate level of care and services, avoiding unnecessary inpatient hospitalizations and Baker Acts, reducing cost and resources tied to law enforcement involvement, and decreasing the likelihood of additional trauma as a result. The Florida 988 System can also provide important data to inform the behavioral health system of care.

- Ultimately, and most importantly, expanding the capacity of Florida's 988 Lifelines will save more lives. From October 2022 to May 2024, 2,064 calls to Florida's 988 Lifelines included a suicide attempt in progress. None resulted in suicide while in contact with 988 (See Appendix B for the 988 Lifeline Data Chart), meaning that for over 2,000 instances an individual reached out to 988 for an intervention during a suicide attempt in progress, and in every instance that individual reached the next phase of care alive.

- Increasing capacity of the free, 24/7 resource ensures Floridians get help when they need it, linking them to warm hand-offs and referrals, Mobile Response Teams, centralized receiving facilities and other crisis walk-in services, detox facilities, and other

treatment providers. Most crises can be de-escalated on the phone, with about 95% of calls being resolved by 988 crisis counselors.

- 988 provides an anonymous option, and calls are confidential. In addition, 988 offers help in Spanish (and software to translate into 249 other languages) and a Veterans Crisis Line.

- 988 Lifelines will connect young people experiencing first episodes to vital Early Treatment Programs for evidence-based treatment, avoiding additional disability from delayed treatment.

- By providing early intervention, education and access to services, the 988 Lifeline System will decrease the need for acute care, and Baker Acts and hospital emergency room admissions will decrease.

- Local 911 systems will be relieved of behavioral health calls, avoiding unnecessary law enforcement involvement. This also reduces further trauma for individuals and families during mental health and substance use crises and allows local law enforcement to focus on other community needs and priorities.

RECOMMENDATION #2: Increase Awareness and Knowledge of Local Behavioral Health Systems

- **Develop information to educate communities about their local behavioral health system of care.** Provide guidance and funding to Managing Entities to provide directly and/or contract with local organizations, such as NAMI, Mental Health America affiliates, Recovery Community Organizations, or United Way, to provide easy-to-access regional information to the public on its local behavioral health safety-net and free resources.

  Information could include regional maps of local resources with contact information, hours of operation, services, populations served, and payment types accepted. QR codes linked to maps could be disseminated on printed materials and websites.

  The map would include, but not be limited to, the following information:

  - Behavioral health providers that offer safety-net and free services
  - Resources for children and adults with autism and related disorders, e.g., Centers for Autism and Related Disorders
  - Resources on treatment centers that support co-occurring disorders as well as FARR-certified sober living and sober living/supported living for adults with primary substance use disorder diagnoses
  - Affordable and supportive housing options for adults with serious mental illness

- **Disseminate the system of care map and the QR code to the general public, including stakeholders and agencies that interact with the behavioral health care system:**

  - Law enforcement and first responders
  - K-12 public and private schools, colleges, universities, technical and vocational schools, PTAs
  - Public libraries, hospitals, community centers, food banks, and homeless shelters
  - Clergy
  - Agencies on Aging, including those in CRAFT (Community Reinforcement and Family Training) that help support family members who have a loved one with substance use disorder

- **Create and implement public awareness campaigns to educate individuals and families on recognizing and responding to mental health and substance use needs.**

  - Provide guidance and funding to the Managing Entities and local partner organizations to increase public awareness via free webinars, social media posts, PSAs, and other means of communications on communities' behavioral health

services, with the goal of targeting broad populations in local communities, including in underserved areas.

- Coordinate with the Agency for Persons with Disabilities to advertise Centers for Autism and Related Disorders (CARD) and other resources in settings such as preschools, pediatrician offices, and public and private schools. Advertising should include information on testing young children for developmental disabilities. Parents can call the CARD center closest to them for information (See Appendix C for information and CARD locations).
- Address the "I didn't know what was happening" factor. Disseminate information on behavioral health issues at the state and local level to help people and families seek help when they know something is wrong but do not know what to do.
    - Ensure 988s and 211s are aware of Early Treatment Programs, evidence-based treatment for first-episode psychosis. Notify high school Parent/Teacher associations and high school and college counselors of Early Treatment Programs in the state.
    - Advertise Mental Health America (MHA) screening: https://screening.mhanational.org/screening-tools/

      Notify Parent/Teacher associations to alert parents, teachers, school counselors, and administrators of screening.
    - Include questions from MHA screening as part of radio PSAs (Spanish and English stations) and social media. Include information on support, education, and advocacy organizations such as NAMIs, MHAs, and RCOs.

Partners: DCF, Managing Entities (including their housing specialists), NAMI Florida, NAMI affiliate organizations, Mental Health America, Recovery Community Organizations, Peer Organizations, United Way, Jewish Family Services, Catholic Services and other faith organizations, Centers for Autism and Related Disorders, Agency for Persons with Disabilities, CIT and Mental Health First Aid Training Organizations, local law enforcement and sheriff's organizations, high schools and colleges, 988 and 211 call centers, county governments, providers of early treatment programs

Prospective Positive Impact

- Improved knowledge of the local behavioral health system would result in more quickly linking individuals to early intervention and treatment and fewer acute crisis episodes, e.g., Baker Acts and emergency room/hospital admissions. This recommendation would also enhance understanding of mental illness and substance use disorders, including that some individuals require ongoing, lifelong treatment. In addition, this recommendation could:

- Improve prognosis of individuals with behavioral health conditions, including avoidance of homelessness, incarceration, and use of crisis services
- Decrease trauma for individuals and families experiencing behavioral health crises
- Decrease stigma of mental health and substance use conditions via better knowledge of local behavioral health resources and connection to local support groups
- Better inform first responders and other ancillary social services regarding behavioral health resources
- Better inform and support individual, client, family, community partners and other support persons

RECOMMENDATION #3: Share Best Practices on the use of de-stigmatizing person-first language and trauma-responsive care to improve patient experience and engagement in treatment

- Provide guidance to Managing Entities, via their Recovery-Oriented System of Care (ROSC) committees, to have providers share best practices for using person-first language and other de-stigmatizing behaviors to engage and retain patients for improved outcomes. (See information in Appendix D on person-first language.)

- Include peers and family members to collaborate with providers on the use of de-stigmatizing language and behaviors. Involve local peer specialist organizations, RCOs, NAMI, and MHA. Trainings can include evidence-based curricula established by local peer organizations and/or personal stories from peers.

- Behavioral Health Teaching Hospitals and academic behavioral health programs can teach and support the need for behavioral health staff to use de-stigmatizing language and behaviors and better understand symptoms and behaviors of patients. Engage the Managing Entities in this effort. (See Appendix D for training resources and programs that include CommonGround Software, Health Providers Train the Trainer Program, and Cognitive Behavioral Therapy for psychosis.)

- Adopt a trauma-responsive framework to improve client care, increase engagement, and reduce staff turnover. By aligning providers' policies, procedures, and physical spaces to reflect best practices in trauma-informed care—institutionalizing destigmatization in accessing behavioral health services throughout the entire system of care. Broward County's Trauma Responsive Learning Initiative, involving over 1000 staff from 73 providers, serves as a model. (See Appendix D for resources and contact information for the Trauma Responsive Learning Initiative.)

- Use hospital bridge peer specialists to support and de-stigmatize substance use. DCF and AHCA could encourage hospitals to actively use hospital bridge peers as part of their social work case management programming to link with ongoing treatment services including MAT programming, emergency detox situations, and other appropriate services for patients identified as having a substance use disorder.

Partners: DCF, AHCA, Managing Entities, peer specialist organizations, United Way, behavioral health teaching hospitals and other hospitals that provide behavioral health and emergency care, university behavioral health programs, behavioral health provider organizations

Prospective Positive Impact

- Providers and patients experience improved and more trusting relationships.
- Patients remain engaged in treatment plans; fewer “drop-outs.”
- Staff are more supported.
- Patients see improved outcomes; more lasting recovery
- Providers can model appropriate use of language for patient’s family members and other support persons.
- Patients experience less treatment-related trauma.