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Office of
Program Policy Analysis
And Government Accountability

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Review of the Efficacy of Community-Based Services to Severely and Persistently Mentally Ill Persons

Abstract

- **The Adult Mental Health Program historically has not had an effective performance accountability system to assess the effectiveness and efficiency of community-based mental health services; however, the Department of Children and Families is currently establishing better accountability mechanisms for the program.**
- **Available data on program outcomes are limited but suggest that adults with mental illness are generally satisfied with the services they receive and that community-based mental health services are effective in keeping adults in the community. In addition, some service districts appear to experience better outcomes than others given efforts to improve employment, transportation, and housing services for clients.**

Purpose

The Joint Legislative Auditing Committee directed our office to review the efficacy of community-based services for adults with serious and persistent mental illnesses and these clients' satisfaction with the services they receive.

To assess program efficacy, we analyzed data being collected by the Department of Children and Families (DCF) on client outcomes. We also reviewed the program's performance-based program budgeting measures and analyzed data collected by the department on these measures.

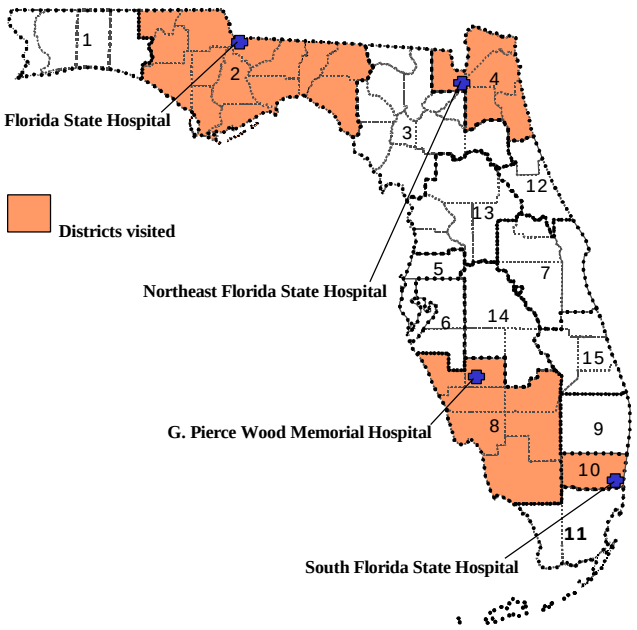
We conducted site visits to 4 of the department's 15 service districts to observe 16 mental health facilities and interview almost 70 program and mental health provider staff. During these visits, we conducted 18 discussion groups with 189 clients regarding their satisfaction with services. Service districts visited included Districts 2, 4, 8, and 10 as shown in Exhibit 1.

Background

The Department of Children and Families administers the state's Alcohol, Drug Abuse and Mental Health Services programs. These programs provide services to individuals with mental illness to stabilize their conditions and enable them to function in the community. One of the client groups served is adults with severe and persistent mental illness. These clients include adults who are disabled due to mental illnesses such as manic depression, phobic disorders, or schizophrenia and who are at risk of institutionalization, incarceration, or homelessness.

In Fiscal Year 1996-97, the Mental Health Program was allocated $185 million to serve approximately 133,000 mentally-ill adults who have either severe and persistent mental illness, forensic involvement, or who experience a mental illness crisis. The department cannot readily identify the number of adults with severe and persistent mental illness it serves, but estimates this number to be approximately 63,800. The department's 15 service districts contract with community-based mental health agencies to provide mental health services for adults living in the community. See Exhibit 1 for a map of the department's services districts.

Exhibit 1
Map of the Department's 15 Districts and 4 State Hospitals



Source: Compiled by OPPAGA based upon information supplied by Department of Children and Families Services

Findings

Historically, the department's mental health programs have not had effective performance accountability systems to assess the efficiency and effectiveness of community-based mental health services.

Concerns about the efficacy of Florida's adult community mental health services are not new. Since the program's establishment in the 1960s, questions have been raised regarding the program, its cost-effectiveness, and its accountability for program results. Four factors have historically limited the program's ability to establish mechanisms to hold community mental health service providers accountable for program performance.

First, the program was initially established as a grant-in-aid mechanism with very limited state oversight. The state gave local mental health providers money to cover their costs, but these providers were not required to report information on the number of clients they served, the services provided to individual clients, the cost of these services, or how these services benefited clients. As a result, providers operated independently and some have been reluctant to give up this independence.

Second, the state did not establish any eligibility criteria regarding the clients that mental health centers were to serve. In practice, community providers tended to serve citizens who were experiencing mild mental disturbances. Individuals with severe and persistent mental illnesses generally received services from state mental health institutions rather than the community centers.

Third, historically, confidentiality requirements were interpreted to forbid mental health providers from disclosing information about individuals with mental illnesses without the clients' informed consent. Consequently, little statewide data was available on the individuals served by providers, the services received, and outcomes of these services. Further, the department has been unable to determine the actual number of persons being served in different client groups–those with severe and persistent mental illnesses, those in crisis, and forensic clients—because the department lacks the information it needs from local mental health service providers. Although the confidentiality restriction has been lifted, a substantial number of providers still do not submit this information to the state.

Finally, the community mental health service delivery system has been highly decentralized. Although the program's central office promulgates rules governing the system and has general oversight over program activities, it does not have direct control over mental health providers. Instead, these providers operate under contracts established by the department's 15 service districts, which report directly to the department's secretary. Consequently, the central program office cannot direct the districts or mental health service providers to provide the required accountability data without strong support from the secretary. Past secretaries have placed priority on directing limited resources toward service provision and have not placed priority on establishing the data collection and analysis system needed to judge program performance.

As a result of these factors, community mental health centers operated relatively autonomously. The state had little authority to determine what services the centers provided, the unit costs of these services, or what clients were served. This limited the state's ability to hold centers accountable for the outcomes they produce for citizens or the cost effectiveness of their services.

The Department of Children and Families is establishing better accountability mechanisms for the adult community mental health program. However, weaknesses in performance measures and ongoing data problems limit the effectiveness of these efforts.

The department has taken steps to improve accountability for the adult community mental health system. While these steps have been only partly implemented to date, they have the potential to improve system operation and results. The department's accountability initiatives include:

- developing a performance-based measurement system;
- tying payment to services and outcomes; and
- certifying state-funded clients and setting service priorities.

In December 1996, the Florida Senate also published a report outlining recommendations to the department for improving the accountability and implementation of its performance contracting system.[1]

The department is beginning to develop a performance-based measurement system. As part of the state's performance-based program budgeting initiative, the Legislature has established five performance measures for the program. The department began requiring providers to collect and report data on these five measures in Fiscal Year 1996-97. The measures are:

1. the average number of days per month that clients spend in the community rather than in mental health institutions, crisis stabilization units or other treatment facilities, in jail, or homeless;
2. the average number of days that clients work for pay each month;
3. the average monthly income of clients;
4. clients' average mental functioning level as measured by Global Assessment of Functioning scores; and
5. client satisfaction with services they receive, based on average scores clients give on the Behavioral Healthcare Rating Scale.

To improve accountability for community-based mental health services, the department started in 1996 to include performance standards, units of service, and performance reports as part of its contracting process. Establishing performance measures and standards should improve accountability of the system and enable the department to assess the performance of mental health service providers.

However, the usefulness of this reported information is limited because many providers are not reporting performance data. Although providers are required to submit data on all their clients, the department has not received usable information on all its estimated 63,800 clients. In Fiscal Year 1996-97, providers reported information for only about 25% of the clients served. Because the department does not know how providers selected these clients, it may not be able to use the data to make generalizations about the entire mental health population. As a result, the Legislature cannot use this data with any degree of reliability or confidence.

In addition, since 1994, the department has required providers to submit information on the number of clients they serve, the services provided, and the cost of these services. These data are intended to identify the unit costs of state-funded mental health services. However, the usefulness of this information has been limited because centers report data on all clients they serve, including those funded by private funds and third-party sources, rather than just state-funded clients. This occurs because the statutes define mental health clients to include all persons who receive center services rather than just state-funded clients. As a result, the department has been unable to identify unit costs for state funded clients.

The department intends to tie payment to services and outcomes. Starting in Fiscal Year 1998-99, the department intends to change its provider contracts and pay only for those services that are provided to the state's funded clients. The department also plans to use performance data in its decisions to renew or terminate provider contracts and in negotiating the rates it pays for mental health services.

Currently, the department is withholding payment from providers failing to submit required performance information, but current law may limit the department's ability to withhold payments beyond the end of the fiscal year. Current law provides a funding system based on a formula that does not consider performance. Specifically, the law provides for state reimbursement of providers' service costs minus revenues from private pay clients and third-party sources such as insurance companies, Medicaid, and local matching funds. This

[1] Florida Senate, "Service Contracting in the Department of Health and Rehabilitative Services," December 1996.

requirement may limit the department's ability to make performance-based funding decisions or use efficiency measures to determine the rates it will pay for services. If successfully challenged by providers, the department would be required to eventually pay providers at the end of the fiscal year to fulfill its statutory obligations.

The department is certifying clients to prioritize services. The department is currently certifying clients to ensure that individuals with the most severe mental illness receive resources. In effect, certification will enable the department to shift resources away from clients with relatively mild mental illness toward clients with long-term involvement in the mental health system and with multiple problems and needs. In addition, beginning in 1998-99, the department intends to change its contracts with mental health providers and pay only for those services they provide to the certified clients.

However, state funding is not limited to serving priority clients. Although the department is certifying clients, there is some debate as to whether current law allows the department to develop client eligibility criteria unless resources are inadequate to meet demand. While the department believes existing law gives it authority to pay only for services to certified clients, some providers are likely to challenge this position.

There are other opportunities to improve performance. The department could also examine its system of contracting services to community-based mental health providers. In its December 1996 report, Florida Senate staff recommended that the department:

- adjust the contracting period;
- assess the adequacy of performance contracting standards;
- centralize contracting functions in the service districts and report to the Legislature effectiveness of centralization; and
- determine consequences for failure by contract service providers and agency staff for not meeting performance expectations.

Taken together, these recommendations afford the department greater opportunities to streamline contracting functions while providing greater accountability for service delivery outcomes.

Available data on program outcomes, while limited, suggest that the mental health program is effective in keeping adults in the community and that clients are reasonably satisfied with the services they receive. However, data problems limit the conclusions that can be made about program outcomes.

Due to poor data reporting by many providers, only limited conclusions can be made about program efficacy. Overall, the available data suggest that the program may be reasonably effective in keeping clients in the community and satisfying clients' expectations. Only tentative conclusions can be made about client work, income (or more appropriately, support), and functioning levels.

Days in the Community. Available data indicates that the program is relatively effective at keeping persons with severe and persistent mental illness in the community. Fiscal Year 1996-97 statewide data indicated that clients were in the community an average of 27 days per month. (See Exhibit 2.) *Days in the Community* represents the number of days that program clients spend in community settings and not in jails, detention facilities, crisis stabilization units, residential treatment facilities, inpatient psychiatric units, or homeless. The Legislature adopted a standard for this measure of 300 days per year, or 25 days per month in the community. The department appears to be meeting its performance standard.

Exhibit 2
Clients Were In the Community An Average of 27 Days Per Month

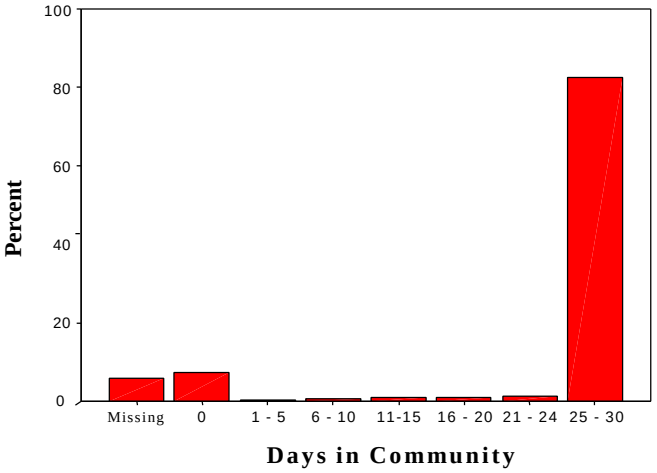
Performance Measure and Standard	Standard	Fiscal Year 1996-97 Performance	Number of Clients
Number of Days in the Community (Monthly)	25	27	17,151

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

However, weaknesses with these data limit the Legislature's ability to assess the program's effectiveness in keeping clients in the community. Although average days spend in the community is a reasonable measure of performance, it provides little information about how performance varies among clients. It is also useful to know what proportion of clients are meeting or exceeding the performance standard. Exhibit 3 shows that the distribution of days clients spend in the community is highly skewed, with most clients (88%) spending 25 or more days in the community. Adding a measure describing this performance variability would better enable the

Legislature to judge the program's success in maintaining clients in community settings.

Exhibit 3
The Majority (86%) of the Clients Met or Exceeded the Days in the Community Standard



Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

Also, providers reported little data on this measure. Data were available for 17,151 of the program's estimated 63,800 clients, or about 26% of the clients served. Since the department does not know how providers selected the clients for which they reported performance data, it does not know whether the data are representative.

Days Worked for Pay. Available data suggest that mental health clients, on average, increased the number of days worked per month from fiscal years 1995-96 to 1996-97. Although the days worked for pay in fiscal year 1995-96 was based on a very small sample, the average number of day`s clients worked for pay increased from 1.4 days to 2.0 days per month. The Legislature's adopted standard for this measure is 1.8 days per month (see Exhibit 4).

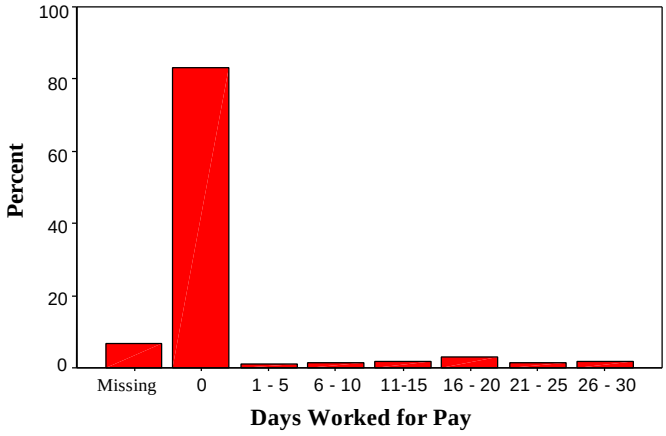
Exhibit 4
Clients Worked An Average of Two Days Per Month

Performance Measure and Standard	Standard	Fiscal Year 1996-97 Performance	Number of Clients
Number of Days Worked for Pay (Monthly)	1.8	2.0	17,037

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

However, there are weaknesses with this measure and the way it is reported. Like *Days in the Community*, average days worked for pay provides little information about how performance varies among clients. The distribution of days clients worked for pay is also highly skewed, but in the opposite direction from the days in the community. While the average number of *days clients worked* for pay exceeds the performance standard (2.0 days versus 1.8 days), this average describes only a small part of the population. The majority of clients, 89%, did not work at all (see Exhibit 5). Only about 11% of the clients worked 1 or more days per month. Adding a measure describing performance variability (such as the percentage of mental health clients who are working) would improve the Legislature's ability to assess program effectiveness.

Exhibit 5
Only 11% of Clients Worked One or More Days Per Month



Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

Further, like the *Days in the Community* measure, providers reported useful data for only about 17,037 clients, or about 26% of the estimated clients statewide. Since the department does not know how providers selected the clients for which they reported performance data, it does not know whether the data are representative.

Average Monthly Income. Reported data indicate that clients received an average of $506 per month in Fiscal Year 1996-97. This is below the $550 standard established in the General Appropriations Act (see Exhibit 6). This measure reports the average income received by program clients each month and is intended to induce mental health provider staff to help their clients obtain financial support.

Exhibit 6
Clients' Average Monthly Income
Was 8% Less Than the Standard

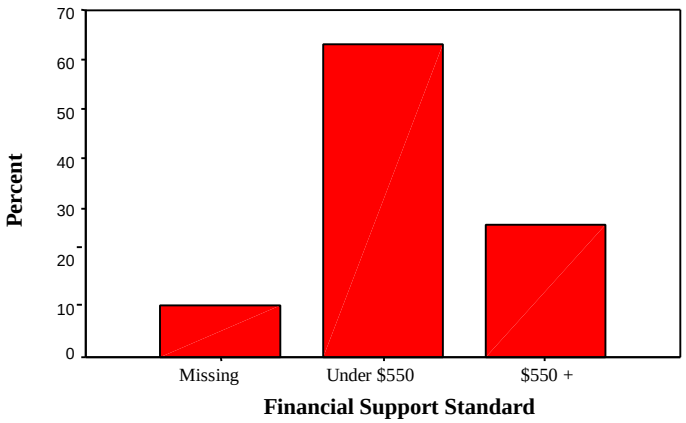
Performance Measure and Standard	Standard	Fiscal Year 1996-97 Performance	Number of Clients
Average Monthly Income	$550	$506	16,362

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

However, there are weaknesses with this performance measure. First, although the measure is labeled *Average Monthly Income*, the term "income" could be interpreted as "earned income" and thus be misleading. What the department is actually measuring is the level of financial support clients receive each month from all sources including their families or government programs such as Supplemental Security Income and Optional State Supplementation. When *Average Monthly Income* is viewed in tandem with the performance measure *Number of Days Worked For Pay* it becomes apparent that most mental health clients do not receive much of their financial support from employment. A better term might be *Average Monthly Support* or other more suitable terminology.

Second, as is the case with other performance measures, the use of averages is not fully informative in describing the program's performance. Although the average client received about $506 in financial support, only about 34% of all clients had financial support of $506 or more per month. Only about 29% of the clients met or exceeded the Legislature's $550 per month standard. One percent of the clients had support of $1,600 or more per month, which raised the average of the entire group. (See Exhibit 7.)

Exhibit 7
Only 29% of Clients Met or
Exceeded Financial Support Standard



Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

Finally, providers again reported data on only about 25% of the state's estimated 63,800 clients, or about 16,362 clients. Since the department does not know how providers selected the clients for which they reported performance data, it does not know whether the data are representative.

Client Functioning. Reported data indicated that in Fiscal Year 1996-97, clients attained an average Global Assessment of Functioning Scale (GAF) score of 50.2, which is below the program's performance standard of 52.9 on a 100-point scale (see Exhibit 8). The GAF is intended to measure a client's overall mental health status by conducting periodic evaluations of clients. The department's five-year goal is to increase the average functional level of clients statewide to 55.

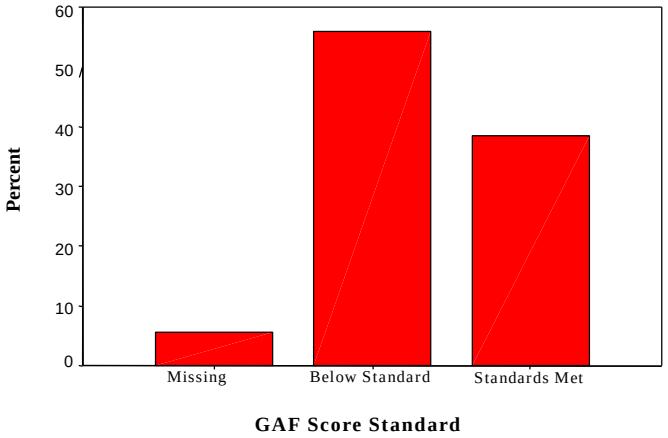
Exhibit 8
Client Functioning Scores
Were 5% Below the Program Standard

Performance Measure and Standard	Standard	Fiscal Year 1996-97 Performance	Number of Clients
Client Functioning Score as measured by the Global Assessment Functional Scale	52.9	50.2	17,248

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

However, there are two problems in using GAF scores to measure program performance. First, the reported GAF score measures client functionality at only a single point in time. While this gives an overall indication of how well the program's population is doing, it does not reflect changes in the functionality of individual clients over time. Adding a measure describing performance variability (the proportion of clients whose functionality is improving, getting worse, or staying about the same) would enhance the Legislature's ability to assess the program's outcomes.

Exhibit 9
Less Than 40% of Clients Meet the Global Assessment Functional Score Standard



Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

Second, providers reported the number of clients evaluated using GAF was only 17,248 or about 27% of the state's estimated 63,800 clients. Since the department does not know how providers selected the clients for which they reported performance data, it does not know whether the data are representative.

In addition, the department indicates that it may recommend that the Legislature discontinue using the GAF score because it can be difficult to interpret and may not provide conclusive information on the stability of the adult mental health population. Department staff suggest higher GAF scores may be an indication that some clients should not continue to be served in the program. The department could choose to use the GAF score measure internally to assess an individual client's progress in mental health treatment.

Client Satisfaction. Reported data indicates clients are relatively satisfied with services received from community mental health providers as reported through the Behavioral Healthcare Rating Scale (BHRS). The BHRS was designed by the Florida Mental Health Institute to obtain client satisfaction data from the mental health population. The BHRS contains 26 statements clients are asked to respond to using a six-point range of answers from "Disagree Strongly" to "Agree Strongly." Statements address quality of services provided, care facility environments, and whether services have helped clients deal with their problems. These 26 items are scored and the composite result is what the department considers client satisfaction. Using this method, clients scored an average of 129.5 out of a possible 156 on the BHRS in Fiscal Year 1996-97, which is below the performance standard of 140 for this measure (see Exhibit 10).

Exhibit 10
Client Satisfaction Scores
Were 7.5% Below the Program Standard

Performance Measure and Standard	Standard	Fiscal Year 1996-97 Performance	Number of Clients
Client Satisfaction Score as measure by the Behavioral Healthcare Rating Scale	140	129.5	9,007*

* Behavioral Healthcare Rating Scale data for this client group is for the six-month period ending December 31, 1996.

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

However, meaningful use of this measure is problematic for several reasons. First, while scores were reported for 9,007 (14%) of the state's estimated 63,800 clients, the number of forms turned in by some community mental health providers was too small to generalize to those providers. Thus, the department cannot yet use this measure to compare providers' performance in client satisfaction.

Second, some providers told us that they did not have access to BHRS results after returning forms to the Florida Mental Health Institute. Consequently, the providers could not use results to adjust services problems identified by the survey.

Third, provider staff and clients reported the BHRS survey is lengthy (26 questions) and may be difficult for some clients to complete. In addition, these items cover a range of subjects, many of which are not related to mental health services, such as whether the building and facilities are clean and comfortable, and whether the program is too controlling. Limiting the kinds of questions to those more specifically related to the quality of service delivery could be more helpful than the current questionnaire.

Finally, the survey was not properly administered in some areas because provider staff reportedly completed the surveys rather than clients. At other providers, clients were properly given the survey but returned incomplete forms. Consequently, the reported data may not reflect actual client satisfaction levels.

The department is developing a new client satisfaction survey designed to determine if program services are meeting clients' needs. The survey is shorter than the BHRS (14 versus 26 questions), but asks similar

questions. The survey was administered to a statewide sample of 960 mental health clients in May and June, 1997. The survey had a 70% response rate and was primarily completed by mental health clients. The department reported responses in January 1998 and found that clients were generally satisfied with the timeliness and quality of services answering most survey questions with either an "agree" or "strongly agree" response. [2] Overall, as improvements are made with the new client satisfaction survey, it could replace the BHRS as the department's mechanism to obtain client satisfaction data.

In developing its new satisfaction survey, the department should also develop information about clients who drop out of the program. Since this is a voluntary program, measuring the dropout rate could be a very useful proxy for gauging client dissatisfaction.

OPPAGA Assessment of Client Satisfaction. We independently assessed client satisfaction and found that clients were generally satisfied with the services they received but had some reservations about the effectiveness of some services. To independently assess client satisfaction, we conducted 18 discussion groups with 189 clients in four of the department's fifteen service districts (Districts 2, 4, 8, and 10). The clients were 18 years of age and older, mostly female, and volunteered to participate in the focus groups. We did not randomly select participants because the department did not have a complete list of clients from which to independently select participants and due to time limitations in completing our fieldwork. We relied upon providers to ask clients if they would participate in focus groups so our focus groups may not be representative of all program clients.

Clients in our focus groups were generally satisfied with services they received from mental health providers and indicated that these services helped them function more independently. Clients reported that the services they received typically include case management, outpatient treatment, supported job placement, and housing assistance. Clients also reported receiving individual and group therapy, day treatment, emergency consultation and basic living training on subjects such as budget management and cooking.

However, some clients told us that some of the services they receive are too limited to be effective. Clients complained about frequent turnover of case managers, the lack of affordable housing and transportation, and limited access to ancillary medical services. Clients noted recent service cutbacks in individual counseling and day treatment services. In some districts, clients also complained that there were few job or vocational opportunities.

Preliminary data from four districts suggests that those providing more employment, transportation and housing services could have better client outcomes.

According to available information, some districts may be experiencing better mental health outcomes than others (see Exhibit 11). There are several possible explanations for the differences in outcomes. For example, some districts may have collected performance data on clients with less severe and persistent mental illnesses than other districts. However, available data suggest that clients have better outcomes for employment, financial support levels, and functional levels in those districts (8 and 10) we visited where providers offer more housing, transportation and employment services than in districts (2 and 4) where providers offer fewer of these services. These services can help improve client outcomes by making clients' lives as normal as possible and better integrating clients with their communities.

Exhibit 11
Preliminary Data Suggest That Some Districts We Visited May Have Better Outcomes Than Others We Visited

Performance Measures (Standard)	Districts That Do Not Supplement Mental Health		Districts That Do Supplement Mental Health Services	
	District 2	District 4	District 8	District 10
Days in the community (25 days or more)	27.40	27.00	27.40	26.40
Days Employed (1.8 days or more)	1.60	1.60	2.10	2.67
Support ($550 per month)	$466	$489	$553	$512
Functional level (52.9 GAF)	47.90	47.20	54.00	52.60

Source: Office of Program Policy Analysis and Government Accountability based on Department of Children and Families performance data for Fiscal Year 1996-97

Providers that offer more employment services may have better outcomes. Districts 8 and 10 provide a

[2] District 10 also holds discussion groups with clients to determine their opinion on mental health services throughout the district. Clients comment on mental health service issues, policy areas affecting them, barriers to effective service delivery, and services area needing improvement. Survey responses are analyzed and results are forwarded to mental health providers.

wide range of employment services. For example, one provider in District 8 developed a job skills and placement program where clients worked for private businesses in the area. In District 10, providers employ clients for assembling electronic devices and food service work at provider sites. Higher-functioning clients in Districts 8 and 10 also clean buildings and do public works projects through supervised work crews.

In contrast, in Districts 2 and 4, which provide fewer employment services and rely more on the Department of Labor's vocational rehabilitation program, have lower employment outcomes for their clients (see Exhibit 11). For example, District 4 provider staff and clients told us that their efforts to prepare clients for gainful employment had been frustrated by reductions in vocational rehabilitation services. The employment outcome for these districts is lower than for district 8 and 10.

Providers that offer more transportation services may have better outcomes. Districts 8 and 10 also provided more transportation services to their clients. For example, District 10 provides clients with bus passes through an arrangement with the district program office. Some providers in District 10 also transport residential and other clients to day treatment programs using program vans.

Transportation appears to be more limited in Districts 2 and 4. Clients in these districts told us that they had difficulty making transportation co-payments and said transportation service was poor. Some clients received rides from provider staff in rural areas, but complained of difficulties in accessing medical and mental health services because transportation was not available.

Finally, providers that offer more housing services may have better outcomes. Districts 8 and 10 provide a variety of housing arrangements for their clients, including satellite apartments, supervised apartments, group homes, residential treatment facilities, and (in District 8) therapeutic foster homes. Providers in these districts have obtained U.S. Department of Housing and Urban Development grants to set up residences for mental health clients.

In contrast, Districts 2 and 4 approached housing services differently than Districts 8 and 10. District 4 primarily uses assisted living facilities while District 2 had few assisted living facilities. These group facilities may not encourage independent living as do the housing arrangements offered in Districts 8 and 10.

Conclusions and Recommendations

Historically, the adult mental health program has not had an effective performance accountability system to assess the effectiveness and efficiency of community-based mental health services. However, the Department of Children and Families is establishing better accountability mechanisms for the program. Available data on program outcomes are limited but suggest that adults with mental illness are generally satisfied with the services they receive and that community-based mental health services are effective in keeping adults in the community. In addition, some service districts appear to experience better outcomes than others because they provide more employment, transportation, and housing services for clients.

To improve community-based mental health services for severe and persistent mentally ill, we recommend that the Legislature:

- Enact statutory language to clarify the department's authority to establish eligibility criteria for the clients it contracts for with mental health providers and to enable it to competitively bid for services for these clients. Enacting the statutes would clarify the Legislature’s public policy interest in establishing performance contracting as a means of improving program accountability;

- Modify Section 394.76, F.S., to provide a different method of funding community-based mental health services. Currently, Florida law provides grants to mental health providers equal to the excess of costs over available financial support from local funding and Medicaid reimbursements. Changing the way mental health services are funded should enable the department to make the current system more accountable. Strengthening the department's authority to insert performance measures into its contracts with providers should enable the department to determine what services mental health centers provide, the unit costs of these services, and what clients will be served. Only by changing the funding mechanism will the Legislature enable the department to hold providers more accountable for the services the state buys and the outcomes of those services; and

- Modify some of the existing performance measures for community-based mental health services. The Legislature should change the name of the measure

entitled *Average Monthly Income* to something more appropriate such as *Average Monthly Support*. Also, in addition to using averages to report performance, the Legislature should require the department to add measures describing performance variability.

To improve program accountability, we recommend that the department:

- Consider implementing recommendations made by Senate staff on performance contracting as summarized in the December, 1996 study "Service Contracting in the Department of Health and Rehabilitative Services." This might include centralizing contract functions in service districts, adjusting contracting periods, assessing the adequacy of performance standards in contracts and the impact of performance contracting on service delivery outcomes, and providing for consequences for providers and agency staff when performance standards are not met.

- Continue to collect information about community-based mental health services provided in different districts. If districts could use existing resources to provide employment, transportation and housing services for their clients, they may be able to improve client outcomes.

We also recommend that the department examine the use of the Behavioral Healthcare Rating Scale (BHRS) to determine whether it should be modified or replaced as a method of measuring client satisfaction. The department could:

- Modify BHRS by reducing the number of questions and insuring that clients understand the remaining questions. Provider staff could then administer the survey properly by allowing clients to fill out the instrument themselves. Alternatively, the department could discontinue using the BHRS and further develop its statewide survey of adult mental health clients. Currently, the department has analyzed data for 960 surveyed mental health clients as part of its ADM client satisfaction survey. The department can continue to strengthen this survey and enlarge its sample size to better generalize results to Florida's mental health population. This would provide the state with valid information on client satisfaction while reducing the costs associated with administering the BHRS at every provider in the state; or

- Develop another method to measure client satisfaction. Because the community mental health program is voluntary, a better indication of client satisfaction may involve determining the number of clients that leave the program or refuse services. The department could then record the number of clients who are dissatisfied with the program and leave prior to the end of their treatment. This would give the department a proxy of client dissatisfaction with services.

Agency Response

March 5, 1998

John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
Post Office Box 1735
Tallahassee, Florida 32399-1300

Dear Mr. Turcotte:

I am responding to your February 20 letter regarding the preliminary findings of your review of the "Efficacy of Community-Based Services to Severely and Persistently Mentally Ill Persons."

The department generally supports the findings in the report and is willing to study or implement the recommendations. Our comments to the findings are attached.

Thank you for the opportunity to comment on this report. If I may be of further assistance, please let me know.

Sincerely,

/s/Edward A. Feaver
Secretary

Attachment

DEPARTMENT OF CHILDREN AND FAMILIES

RESPONSE TO PRELIMINARY FINDINGS OF THE OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY'S REVIEW OF THE EFFICACY OF COMMUNITY-BASED SERVICES TO SEVERELY AND PERSISTENTLY MENTALLY ILL PERSONS

1. **Historically, the department's mental health programs have not had effective performance accountability systems to assess the efficiency and effectiveness of community-based mental health services.**

The department concurs. For at least the last five years, the department has been aware of this issue and has been working to increase accountability with providers as well as districts. This began by requiring service units and budget specifications. Current initiatives include client enrollment (certification) and outcome reporting via contracts. It should be noted, however, that, while the department has been requiring these additional efforts, compliance has been voluntary by the providers. A statutory change would have to be made in order to actually enforce these requirements.

The Alcohol, Drug Abuse and Mental Health contract has served as a vehicle to specify with providers who will be served, and the type and amount of services to be provided. Service event data has been submitted by providers for several years and compliance is high on the submission of that data.

Based on an independent study of the Alcohol, Drug Abuse and Mental Health system by the legislature in 1990-91, the department has submitted to the legislature, for the last five years, statutory revisions which would have given it the authority to insure the level of accountability that this study is recommending. Sponsors of the department's bill include Senator Bankhead and Representative Brennan. While these statutory revisions have not been passed in prior sessions, we continue to pursue these necessary changes this upcoming session.

2. **The Department of Children and Families is establishing better accountability mechanisms for the adult community mental health program. However, weaknesses in performance measures and ongoing data problems limit the effectiveness of these efforts.**

The department concurs. The department annually reviews the performance measures and is currently in the process of a major reengineering of the data system.

3. **Available data on program outcomes, while limited, suggest that the mental health program is effective in keeping adults in the community and that clients are reasonably satisfied with the services they receive. However, there are not sufficient data to reliably assess other program outcomes.**

The department concurs. Implementation is continuing with increased report rates during the present year.

4. **Preliminary data from four districts suggests that supplementing community-based mental health services with employment, transportation and housing services could lead to better client outcomes.**

The department concurs. Districts and providers are currently reviewing their services in order to better pursue these outcomes. The department is in support of the governor's recommendation for Assertive Community Treatment (ACT) funds. Clearly, additional community-based resources will help us achieve this outcome.

Recommendations to the Legislature

The department generally supports the recommendations. The proportion of clients meeting a certain standard will be studied and can be reported in future years.

Recommendations to the Department

The department generally supports the recommendations.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

ANNOUNCEMENT

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